BAAT Guidelines on Art Therapy for People with a Psychosis-Related Diagnosis

The British Association of Art Therapists
(BAAT)

In association with

Salomons Institute for Applied Psychology
Canterbury Christ Church University
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the british association of art therapists

Canterbury Christ Church University

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Cover artwork by Nat Burgess. Refuse to Sink. Lino print on paper. "Sometimes we can all feel like this little boat battling a big storm, but like this boat we must also refuse to sink."

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Service user ratings (where applicable): *** Essential; ** Quite important; * A bit important; ° Not important; xx Don't do.
Position of artworks and service user statements do not signify agreement with specific nearby practice statements.

EXECUTIVE SUMMARY

This document is in three parts. Part 1 presents the guidelines on key art therapy practices for people with a psychosis-related diagnosis. There are 10 broad areas of practice, summarised very briefly on the next page. Art therapists' core practice is adapting to individuals in context, within these broad principles.

In Part 1 we illustrate these principles with examples. Comments from service user consultation are included.

Part 2 explains how we developed these guidelines

Part 3 describes how we understand psychosis.

Both Parts 2 and 3 make reference to the research evidence and theory upon which these guidelines are based. The reference list is attached to Part 3.

John Williams. Untitled. Chalk pastel and charcoal on paper. "It's an oak tree I pass very day. It made me stop and stare rather than rushing off everywhere. It sounds daft but I call him Mr. Oak Tree! Nature is probably one of the best healers."

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10 BROAD PRINCIPLES OF ART THERAPY PRACTICE FOR PEOPLE WITH A PSYCHOSIS-RELATED DIAGNOSIS

Working together in organisations

- Working with professionals and experts by experience
- Supporting service users to speak through art

A

Working with friends and family

- Welcoming family and friends
- Supporting relationships through art

C

Collaborating with service users

- Inviting service users into art therapy
- Supporting culturally specific art
- Enjoying art
- Creating a shared formulation

B

Group art therapy

- Groups for different needs
- Facilitating creativity
- Connecting through artwork and discussion

D

Working with real-world contexts

- Trauma-informed art therapy
- Working with mental health stigma
- Working with poverty & disadvantage
- Working with mental health systems

E

Service user ratings (where applicable): *** Essential; ** Quite important; * A bit important; ° Not important; ×× Don't do.
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Adapting and attuning art therapy

- Adapting to changing needs
- Holding boundaries but not rigidly
- Relief through art
- 'Concrete' art and craft
- Going deeper when it's time

F

Ending art therapy

- Facilitating expression about ending
- Enabling evaluation
- Supporting bigger goals

H

Supporting recovery through art therapy

- Enabling expression in art and words
- Making sense of psychosis
- Supporting personal agency
- Supporting everyday coping

G

Art therapists' reflection & wellbeing

- Using supervision
- Reflective art-making
- Maintaining self-awareness
- The art therapist's self-care

I

Continuing professional development

- Seeking further skills and knowledge
- Learning new art-making techniques
- Keeping up to date

J

Service user ratings (where applicable): *** Essential; ** Quite important; * A bit important; ° Not important; xx Don't do.
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PART 1:
THE GUIDELINES

IMPORTANT NOTES:

a. This guide is evidence-based (Part 2, How we developed these guidelines) and intended to support qualified and trainee art therapists and to inform other professionals, lay people, and researchers.

b. **The guide should direct researchers'** specifications of art therapy for people with a psychosis-related diagnosis when planning trials.

c. We use the term 'psychosis' for experiences that can attract diagnoses such as 'schizophrenia' and 'schizo-affective disorder', but not to imply a diseases with predictable course and outcome (Part 3, Understanding Psychosis).

d. Art therapists work in a range of settings, including early intervention for psychosis (EIP), acute inpatient, community mental health teams (CMHTs), forensic and rehabilitation, and in different geographical locations. Art therapists will need to tailor their practice to individual service users within their local service-related, societal and cultural contexts.

e. The practice examples illustrate how practices can be adapted to some specific contexts and specific needs of service users. Whilst we cannot represent all contexts in detail, we have noted some adaptations for working with people who are experiencing severe psychotic states versus others.

f. Service user quotations are from consultations on practice statements during the preparation of these guidelines. Statements representative of each practice area were presented and rated, and service users also suggested their own statements. Where practice statements have been rated by service users we have indicated the rating: Essential; Quite important; A bit important; Not important; Don't do. Service users designated/suggested very few practices as "Not important" or "Don't do". Hence few such statements appear in the document.

g. Art therapist quotations include some from interviews and a focus group involving 18 art therapists with substantial experience of psychosis-related practice in the course of guideline preparation (Part 2).

h. This guide will need to be revised at intervals in the light of new evidence.

Service user ratings (where applicable): *** Essential; ** Quite important; * A bit important; ° Not important; xx Don't do.
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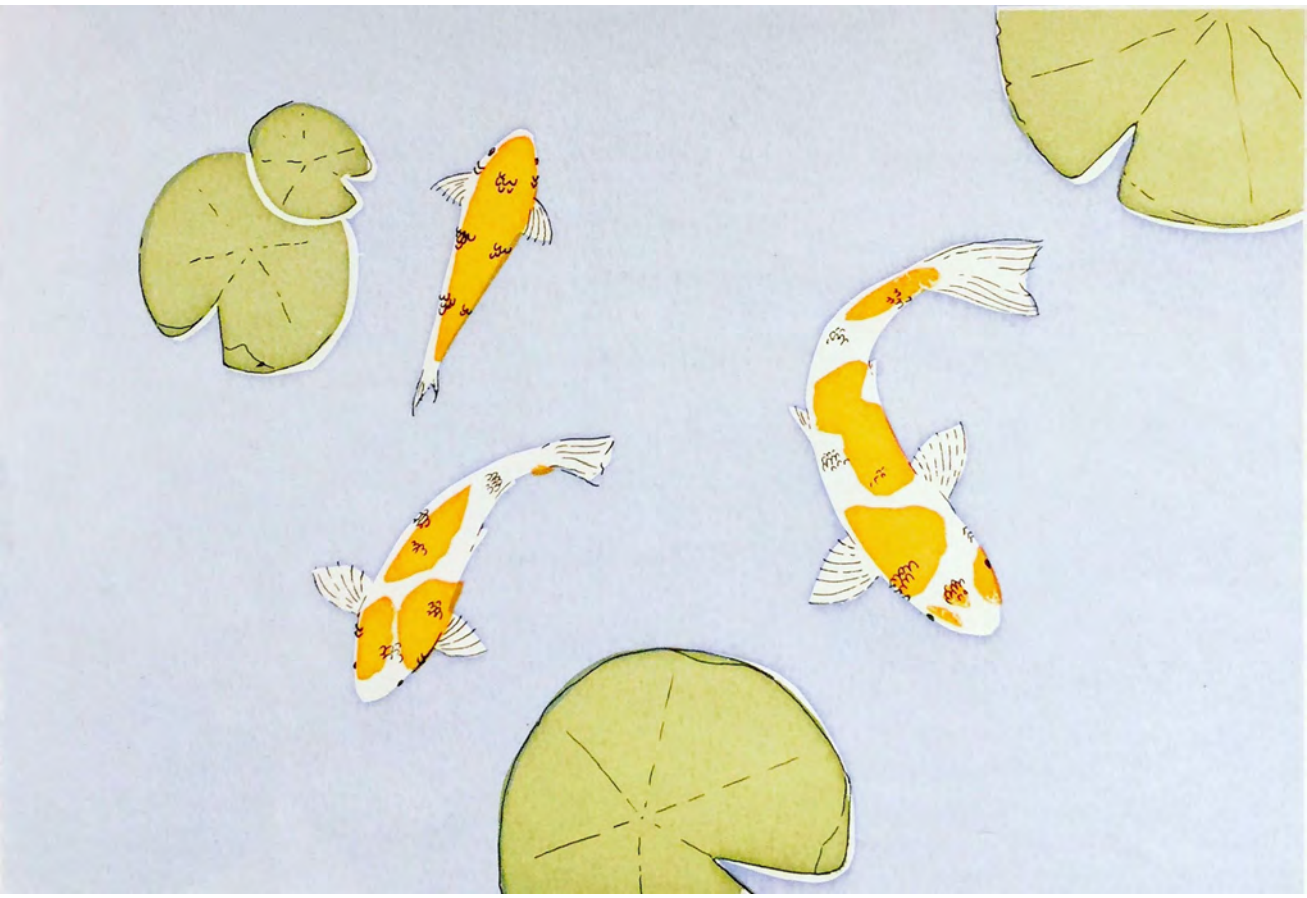

Nat Burgess. Koi Carp. Screen print on paper.

RECOMMENDED LENGTH OF THERAPY

In inpatient services length of therapy is generally limited to the length of admission. England's National Institute for Health and Care Excellence (NICE) recommends that any psychological therapy commenced during an admission is allowed to continue:

> "When psychological treatments, including arts therapies, are started in the acute phase (including in inpatient settings), the full course should be continued after discharge without unnecessary interruption." (NICE, 2014, p. 221)

However, no indication is given of how long this continuation may be. Ideally the art therapist would be able to tailor the length of therapy to the needs of the service user but depending on the service context, there may be limited choice as to what length of therapy they can offer. They will need to offer the most helpful possible interventions they can within such limitations. Formulation and the collaborative development of realistic therapeutic goals will be important. Attachment difficulties and practical obstacles (Section E, this document) may make it hard for some service users to attend fully and regularly. Art therapists may need to take this into account when making decisions about session length and length of therapy. Team support can be vital in facilitating service users to attend.

Where possible art therapists should work with other staff to advocate for service-users to have therapy lengths that are helpful. Some trials of art therapy for people with a psychosis-related diagnosis (e.g. Montag et al., 2014; Richardson et al., 2007) have reported positive results after 12-16 sessions, though this may be more than some services can offer and also some individuals may need substantially more. People whose trust has been severely damaged may need more than 16 to establish safety, enable formulation, and then work towards articulated goals. Due to the economies involved, group art therapy may enable a longer length of therapy than individual work.

ART THERAPISTS WORKING TOGETHER WITH OTHERS IN ORGANISATIONS

– Working with professionals and experts by experience

– Supporting service users to speak through art

Working in multidisciplinary teams enables art therapists to integrate what is unique about art therapy as well as keep informed on wider practice in psychosis. Increasingly, art therapists can also work alongside peer workers who have expertise by experience of psychosis and of attending art therapy. Art therapists can contribute to supporting service users to have a voice, sometimes with the help of their artwork. Art therapists can have important information about what is going on for a service user that may not be apparent to other professionals. Finally, art therapists may be in a position to offer art-therapy-based education, supervision and support to colleagues from different professions who are part of a team. They can assist with strategy for developing local service pathways and ensure art therapy is well signposted.

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A. ART THERAPISTS WORKING TOGETHER WITHIN ORGANISATIONS**

A1. Working with professionals and experts by experience

- Explaining art therapy to a range of people

An art therapist wishing to introduce a new art therapy service into community mental health said of England and Wales' national guideline recommending arts therapies (NICE, 2014): "That was a solid recommendation to present."

- Doing joint assessments with clinicians from other professions to help service users to make informed choices
- Contributing to professional meetings, ward rounds, care and recovery reviews, and risk assessments, shared with the service user
- Appreciating and drawing on user-led support, services and training, and peer workers (experts by experience)***

An art therapist on working with a peer worker: "I'm co-running psychoeducation workshops [...] with an ex-service user [...] and I think that's having a good effect on all my clinical work in terms of the experience of working side-by-side with a patient as a peer."

An art therapist on the UK's service user-led Hearing Voices Network (HVN) training described it as "the most helpful thing" for working with people with a psychosis-related diagnosis, "in terms of understanding psychosis." For current information on Hearing Voices Networks internationally, see InterVoice http://www.intervoiceonline.org/

- Suggesting how art therapy might contribute to the organisation, and working to keep art therapy available through the NHS***

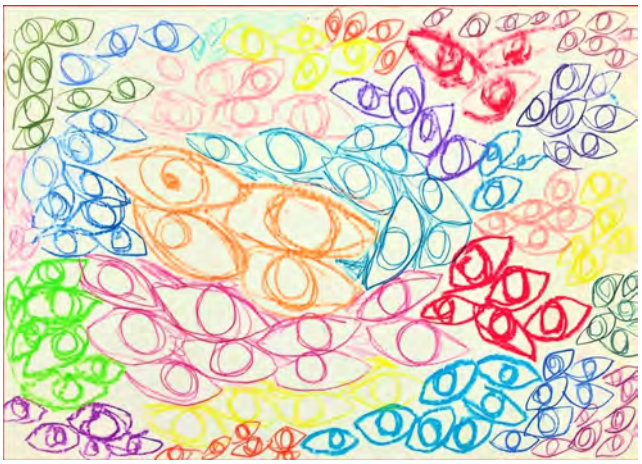
Service users said:

"That's definitely important!"

"If it's not in the NHS you won't get it!"

A2. Supporting service users to speak through art

This can be especially important where the service user finds verbal communication daunting.



Maria. What they See. Coloured pencil on paper. "I drew loads of eyes in different colours representing different people watching me and different opinions about me, so that was quite stressful but it feels nice to make actually, although the meaning behind it is quite sad – it's quite beautiful."

- Supporting service users to have a voice with other professionals, with the help of their artwork where appropriate

A service user said: "Externalisation [expressing things via artwork] also helps other people and society to understand the feelings and the narrative associated with the [service user's] trauma."

An art therapist talking about showing artwork to staff team members with the service user's permission: "It can really motivate people to help that person even more."

Service user ratings (where applicable): *** Essential; ** Quite important; * A bit important; ° Not important; ˣˣ Don't do.
Position of artworks and service user statements do not signify agreement with specific nearby practice statements.

B COLLABORATING WITH SERVICE USERS IN ART THERAPY

- Inviting service users into art therapy
- Supporting culturally specific art
- Enjoying art
- Creating a shared formulation

People who receive a psychosis-related diagnosis may have experienced psychological trauma (see Part 3). Experienced art therapists understand how to establish a therapeutic alliance with service users who may be experiencing great fear. Formulation may not be possible immediately.

Once sufficient safety has been established, it is important to develop a shared formulation: an explanation, arrived at collaboratively, which includes the service user's current difficulties, things that might be contributing to them and what might be helpful (Cooke, 2017). In art therapy this is done with the help of art materials, because together with discussion, this can make the therapeutic aims clear.

Art-based activities can support engagement in art therapy because of their inherently enjoyable aspects. It can also be helpful for alliance-building if the art therapist shows interest in artwork from a range of cultural traditions. Among recent innovations is the use of digital media, including stop frame animation (Gammidge, 2016), avatars (Leff et al., 2013), 'sensory integration' techniques (Peciccia and Donnari, 2017) and graphic novels. In secure and forensic units, where young male service users are in the majority, digital media may be particularly helpful. Although art therapy is different from art classes and therapeutic arts engagement, the art therapist can teach art skills to help raise service users' self-esteem, support focus and attentional control and enable emotional expression and the externalising of experience.

Service user ratings (where applicable): *** Essential; ** Quite important; * A bit important; ° Not important; xx Don't do.
Position of artworks and service user statements do not signify agreement with specific nearby practice statements.

Antony Perkins. Untitled. Oil pastel and pencil on paper. "I was imagining a summer's day and thinking about forms of attachment – the mother and 2 cygnets. It's about hope – hoping for a relaxing mood."

B. COLLABORATING WITH SERVICE USERS IN ART THERAPY

B1. Inviting service users into art therapy

- Establishing a therapeutic alliance while minimising the possibility of alienating service users who may be experiencing great fear
- Where service users are experiencing high levels of distress or communication difficulties, initially assisting them to orientate to the physical setting and the art materials (Bonneau, 2017)
- Explaining clearly to service users what art therapy is and what it is for, both at the start and again later if people have difficulty concentrating***

Service users:

"I think it is helpful in art therapy when the art therapist explains the reasons for different exercises, and gives information like handouts, that can be looked at later. Personally I found it helpful to know why we did things."

"I think it is helpful when the art therapist revisits the previous session at the beginning of the next, and when they go over the course at the end."

Art Therapist referring to a service user who seemed very anxious at first: "It was about being consistent in a simple way so, 'It's not an art class, it's a chance for you to use the materials. You can make whatever you like.' Consistently saying a small number of things every week."

Art therapist talking about learning to explain art therapy in an acute inpatient setting: "Being clear with people when they came in what they were coming into, regardless of whether they appeared to understand that. [...] What I experienced [on placement] was a consistent approach and it allowed people to respond to what was laid out for them."

- Doing or saying little things that will offer encouragement or hope to service users***
- Taking a 'side by side' approach to service users (Greenwood, 2017)
- Using joint attention while looking together at an individual service user's artwork while avoiding intrusion
- Going for a walk and observing using joint attention or 'looking together' (Isserow 2008)
- Helping people to overcome difficulties in beginning with art therapy***
- Considering meeting in a mutually agreed place to build up initial trust, for example a café, a garden or at home
- Understanding why it is sometimes difficult for service users to say what they feel or think during therapy***

Service user: "Let people decide how much time to spend on art making and how much on talking."

- Being willing to work out with the service user what to do if he or she has difficulty engaging in art therapy***

Service users:

"At first I could not speak and then gradually I gained confidence to be with them [art therapy group] while making art and then eventually I could speak."

"Give gentle encouragement to move forward but not if talking will cause anxiety or distress."

- Working to create a therapeutic alliance using sensitive communication skills and ordinary kindness

Service users on what art therapists should not do[xx]

"Not serve cold coffee."

"Not force the service user into doing things that are not helpful and so could be detrimental."

- Being interested in service users as people – their life, their interests, who they are**
- Being kind and welcoming***

Service user: "Put people at their ease."

Service user ratings (where applicable): *** Essential; ** Quite important; * A bit important; ° Not important; [xx] Don't do.
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B2. Supporting culturally specific art

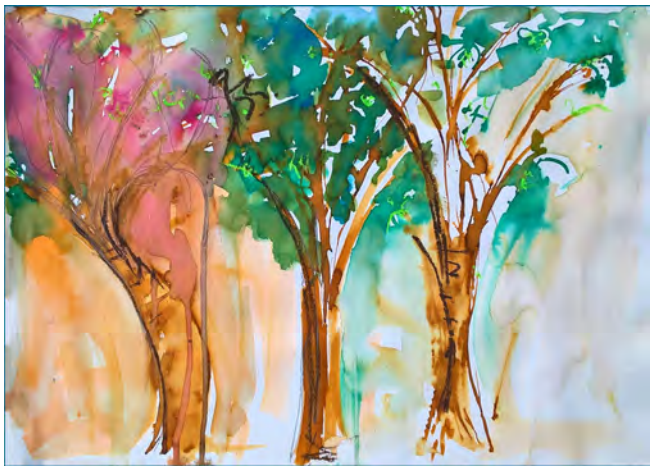
- Offering support and assistance if people want to use art that comes from their particular background or tradition**

Service users:

"Yes, it's all about that person's experience."

"It's respectful."

B3. Enjoying art



Sarah. Untitled. Ink and pastel on paper.

- Enabling all service users to play and enjoy the art materials where possible*

Service user in Lynch et al. (2018) in the context of first episode psychosis: "Just really doing it [art making] for the kind of joy, whereas when you are talking with people there is usually a question involved, but with art there's not really a question, it's more of a, just a, interpretation of something."

- Giving instructions or guidance to people if they have difficulties using art materials**

Service users:

"Teach us how to use oil paints and art materials."

"Showing us how to go on with making art work."

Art Therapist: "Teaching people to make simple pots can be containing when people have a problem with their imagination [...]. Making something practical is a way forward. And then with this guy who's at times been very paranoid and has some long admissions, beautifully he just started painting one of his pots in bright colours that were totally new to him, and he could see they were new, and he was smiling about it. It was a lovely moment."

- Employing active art therapy techniques and 'directives' as appropriate, for example art exercises, observational drawing, collaborative art making

Art therapist on observational drawing: "It can help individuals or groups practise using a curious or 'not knowing' approach to looking around them. In my experience it can also open up ways of talking about seeing things and feelings things that other people don't."

"Both our perceived world, and the drawings we make are a hybrid of projected and received information. They are a marriage of 'what we know', and 'what we see.'" (Maslen & Southern, 2011, p. 22)

- Making a range of art materials available, employing methods and materials that stimulate the senses, and being open to opportunities provided by digital media***

Art Therapist on digital media: "The 'My Story Group' took place in a medium secure service and used the medium of the graphic novel. Service users worked with an art therapist and a peer worker who had several graphic novels published to become the narrators of their own story. The books made in the group were published online and were then shared with family and friends as well as mental health professionals.

"Feedback suggested that service users particularly enjoyed using a mixture of traditional art materials along with digital media. They were also positive about the group being co-delivered by a peer worker, someone who had 'been there' himself and having built a successful life outside of hospital imparted a message of hope."

- Showing acceptance for service users' artwork***

Service user: "Recognise everyone has their own style."

- Using humour to help increase rapport and reduce shame when enough trust has developed in the therapeutic relationship, but also being prepared to acknowledge and explore situations where humour backfires

Service user ratings (where applicable): *** Essential; ** Quite important; * A bit important; ° Not important; ×× Don't do.
Position of artworks and service user statements do not signify agreement with specific nearby practice statements.

Service users:

"Essential to have laughter."

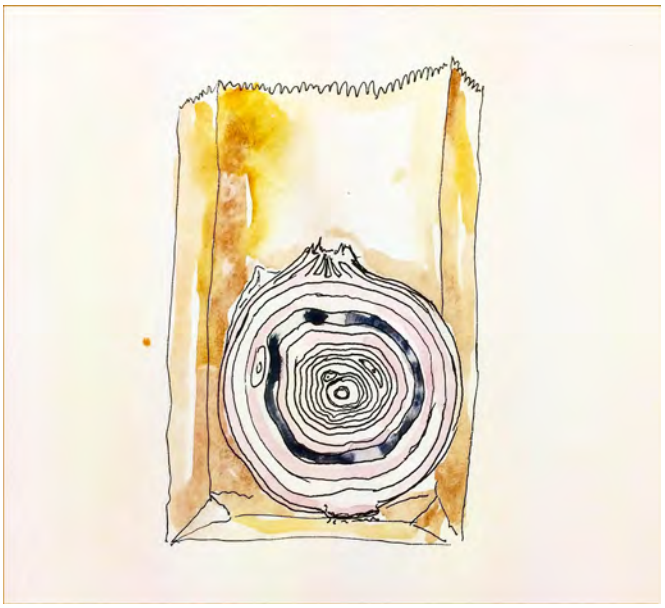
"Always wear purple socks and always allow for a sense of humour."

"Know that humour is important".

"Not to blow things out of proportion."

B4. Creating a shared formulation with the service user

- Collaborating with the service user to create a shared formulation, perhaps using art materials to structure the work***



Nat Burgess. Onion. Ink on paper.

- Using a staged approach to formulation and making use of art materials and sensory modalities to help service users to feel safe and grounded (Campbell et al., 2016)

Two art therapists (RW and CO[1]) on formulation using art materials and 'found objects' (note CO's last comment in relation to past trauma):

RW: "Often we begin in individual sessions doing a piece of work which is about establishing a life line, a time line of the individual's experiences growing up, crucial moments in their childhood – particular events, relationships, and using art playfully, [...] whether it's the individual bringing photographs of specific items or using a variety of material to illustrate their timeline."

CO: "[...] It's that joint attention, and that sense of being together and paying respect to that person in a tangible, concrete way."

RW: "[...] Often their childhood might be full of negative experiences, but our stance is encouraging and validating." [...]

CO: "Being really mindful of trauma is key to my work [...]. Before we even start doing any work [...] we always look for ways to use art as a grounding technique: 'What's your favourite colour? What makes you feel safe?' [...] Lots of art around safe places."

Service user on what art therapists should not do [xx]

"Not focus on childhood issues until some sense of safety is achieved. Maybe only go into childhood at the end."

- Working out with the service user a clear therapeutic aim to support informed consent and for sustaining engagement
- When time in therapy is limited, finding priority areas to work on, underpinned by the formulation, for example addressing hearing voices, or coping with challenges of day-to-day living
- Still keeping the concept of formulation in mind in the context of brief engagement such as a short stay in an acute unit, wherein the encounter is part of a broader narrative of the client's life even if this cannot be known to the therapist

Not recommended

- If the art therapist adopts an aloof or judgemental stance this can be unhelpful to service users

Service user on what art therapists should not do [xx]

"Not judge people."

- A rigidly neutral, interpretive therapeutic stance is unlikely to support engagement and could be harmful through reinforcing feelings of exclusion and stigma
- Where service users have the capacity to make a choice, it can be unhelpful to insist that they always leave their artwork in the art therapy room

Art therapist talking about a service user: "He struggled with the whole idea that he would make things and leave them behind."

[1] Richard Whitaker and Claire O'Donoghue

Service user ratings (where applicable): *** Essential; ** Quite important; * A bit important; ° Not important; [xx] Don't do.
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C WORKING WITH FRIENDS AND FAMILY

- Welcoming family and friends
- Supporting relationships through art

It can be helpful to offer the option for friends or family members to accompany the service user to the initial sessions, or at intervals. This is particularly relevant to early intervention for psychosis (Baird et al., 2012; Parkinson & Whiter, 2016) but should also be considered in inpatient settings where family members and friends may appreciate help to stay in touch and address stress around admission (Stanbridge et al., 2009). However, service users need to be consulted on who they consider to be their important friends or family members.

Service user ratings (where applicable): *** Essential; ** Quite important; * A bit important; ° Not important; xx Don't do.
Position of artworks and service user statements do not signify agreement with specific nearby practice statements.

Alicia. My Mentalising Cultures. Oil pastels on paper. "I remember trying to think at first what the relation was with like friends and family and actually getting a bit sad thinking about the kind of relationship with my family. It kind of made me look into it more in depth which yeah was a bit unsettling and then I didn't know what to draw without you know saying too much. It's difficult getting it from your brain to paper without going over it in detail, kind of destroying the artwork by trying to put in too much detail. It's difficult – so you've got to mentalise on the actual art work itself."

C. WORKING WITH FRIENDS AND FAMILY

C1. Welcoming family and friends

- Speaking to carers (friends, relatives, partners) when a service user would like this***
- Explaining to carers (relative, friend or partner) why art therapy can be helpful and how they can support service users to make the most of it**

Art Therapist: "Her [client's] carer actually came along to a review meeting that she set up – she wanted him to come and see her work."

- Suggesting a trusted friend or family member accompany the service user initially

C2. Supporting relationships through art

- Where family or friends are taking part in group art therapy, facilitating interaction via talking and via art
- Recognising when a service user is having difficulty with a relative or friend, and supporting the service user's efforts to improve the situation**

A further potentially helpful practice

- The art therapist may, with appropriate training, employ family intervention (Madsen 2011; 2014)

Service user ratings (where applicable): *** Essential; ** Quite important; * A bit important; ° Not important; ×× Don't do.
Position of artworks and service user statements do not signify agreement with specific nearby practice statements.

D GROUP ART THERAPY

- Groups for different needs
- Facilitating creativity
- Connecting through artwork and discussion

A range of issues, including social stigma towards psychosis (Lim & Gleeson 2014), can make it difficult for people experiencing psychosis to connect socially. Working in a group context is both a challenge and an important way of facilitating therapeutic benefit.

The image making and viewing processes can make it easier for some people to be with and communicate with others. Image making in art therapy is often seen as a means of communicating implicitly, in contrast to more explicit verbal communication. The ability of images to prompt a range of thoughts and feelings without having to tie these down explicitly is a key resource of art therapy. In a group context, this can result in a rich range of responses to images that are viewed as well as important interpersonal interactions around image making. This can help people to understand more about their own communication and how they may be seen and heard by others (Gabel & Robb, 2017; Lynch et al., 2018).

Service user ratings (where applicable): *** Essential; ** Quite important; * A bit important; ° Not important; xx Don't do.
Position of artworks and service user statements do not signify agreement with specific nearby practice statements.

Anon. The Day Dream. Pencil on paper.

D. GROUP ART THERAPY

D1. Groups for different needs

- Trying to ensure that the group feels safe for everyone***

Service users:

"Keep the group friendly."

"Help people to be part of a community, like a family."

"Make sure everyone is accepted."

"Provide a safe environment, with no interruptions etc."

- Establishing a well-functioning group adapted to members' needs

Art Therapist: "There's plenty of space in the room and lots of people can have their own tables and space if they want to work. And it's very varied. I'm catering to different needs in the group."

On keeping the group functioning well: "If there's stuff going on at home, she [client] is more chaotic, [...] so can be loud in the group, quite vocal, and struggles with the boundaries sometimes. I need to be clear and direct with her sometimes."

- Where members' capacities allow (usually possible in outpatient art therapy groups), co-producing guidelines for the group and agreeing boundaries to help everyone feel safe and involved

Service users:

"Act in such a way that everyone uses the group in whatever way they can."

"We are all different but part of a living, moving group."

"Make sure we all talk about things that are important and have our opinions and sort things out, work things out."

Service user on what art therapists should not do [xx]

"Speech therapy [Talking therapy] just makes people worse. When you are listening to someone's horrible problems straight away you lose hope – I mean if this is done too quickly and with little understanding."

Service user ratings (where applicable): *** Essential; ** Quite important; * A bit important; ° Not important; [xx] Don't do.
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- Moving between implicit (non-verbal) and explicit (verbal) communication: sometimes it is not important not to spell things out and at other times it can be reassuring
- On acute wards and forensic inpatient units, setting up groups to allow service users to come in and out at will, and to have their own space for art-making, enabling them to be with others but not be compelled to interact directly

Service user: "It's good to have the art as a task."

Art Therapist Chris Wood: "When someone's thinking seems very troubled and even muddled, sometimes it can be helpful to persuade them to straightaway start making artwork, even though this might seem quite directive. Yet often it is as though while composing artwork they are able to compose themselves, and even after a short time of art making they might feel more able to talk and think coherently."

D2. Facilitating creativity

- Using art-based warm-up exercises where members' capacity allows, especially when a new group begins

Art therapist talking about a small art therapy group: "They also liked listening to music so we said 'Right you've got five' – literally counting down, 'On your marks, get set, go, right I want you to close your eyes and draw to the sound of this song.'"

Art therapist talking about mono-printing: "A lot of people would be rigidly drawing and enslaved to trying to make something look like something, and then finally they've allowed chance to happen and they can see something [in it]. [...] There's a sense of freedom."

Sarah. Untitled. Ink, pencil and oil pastel on paper

Service user ratings (where applicable): *** Essential; ** Quite important; * A bit important; ° Not important; xx Don't do.
Position of artworks and service user statements do not signify agreement with specific nearby practice statements.

D3. Connecting through artwork and discussion

- Where members' capacity allows, supporting them in connecting with each other through their artwork and facilitated discussion

Service users:

"Invite people to talk about their week."

"Art allows living beings to cooperate [...]."

"Art therapy using art is a form of communication to help people talk about what is important in their life."

"It helps to keep your brain active through group discussion and art."

- When looking together, modelling curiosity using your own work (where applicable) and each other's work

Service user: "I think it is helpful when the art therapist encourages you to discuss the exercise and what you have produced with other people [...] and when they also take part, as it helps to make you feel less self-conscious and more comfortable about other people looking at what you've done."

- Supporting service users' efforts to contribute to other group members***

Service user: "I think that's one of the main things that's helpful about art therapy – everyone helping each other, supporting one another."

- Being flexible regarding group boundaries, since social contact between group members outside the group can be supportive (Coles & Harrison, 2018; Lynch et al., 2018), and being prepared to help clients to manage any difficulties that may arise from such contact

- Helping service users see they are not alone in having psychotic experiences**

Service users:

"Before I was sectioned I was so alone [...]. Even standing next to someone is better – not even talking."

"When it's really bad I shut myself away."

"It's the shared thing. We've all had the same experiences, even though they are different."

"When chronically isolated and psychotic it's a really big hurdle to connect."

Service user ratings (where applicable): *** Essential; ** Quite important; * A bit important; ° Not important; ×× Don't do.
Position of artworks and service user statements do not signify agreement with specific nearby practice statements.

E WORKING WITH REAL-WORLD CONTEXTS

- Trauma-informed art therapy
- Working with mental health stigma
- Working with poverty and disadvantage
- Working with mental health systems

Experiences of bullying, prolonged stress, discrimination, deprivation and trauma as contributing to psychosis are well-documented (Bergström et al., 2019; Karlsen et al., 2005; Read et al., 2014; Romme et al., 2009). Poverty and disadvantage may make it difficult to attend community-based art therapy unless there is outreach support. Some service users may be fearful of clinical settings themselves due to previous experience of compulsory admission and treatment, or may struggle with overly strict therapeutic boundaries. Some also have negative experiences of antipsychotic medication (see Part 3). Finally, the mental health system and wider financial context may limit the length of therapy to fewer sessions than either the therapist or service user believe is needed.

Service user ratings (where applicable): *** Essential; ** Quite important; * A bit important; ° Not important; ×× Don't do.
Position of artworks and service user statements do not signify agreement with specific nearby practice statements.

E. WORKING WITH REAL WORLD CONTEXTS

E1. Trauma-informed art therapy

- Being aware how oppression, racism, abuse, deprivation, stress and trauma can contribute to the causes of psychotic experiences
- Being able to work sensitively with people who have experienced psychological trauma
- Offering a calm, alert and responsive presence***
- Working to manage possible triggers of traumatic memories
- Using trauma-informed techniques to enable clients to moderate fear and other emotions that undermine engagement (e.g. grounding and art warm-ups to counter passivity and fear)

Sam Rice. Help! Oil pastel and graphite on paper.

Art therapist: "All our therapists have had some trauma training and we readily recommend our therapists prescribe, 'Colouring in' books or using tactile sensory based objects that can be carried around [...] to help defuse disturbing thoughts and feelings that might be triggered."

- Using a staged treatment approach that adjusts to the circumstances of the service user and does not work with the trauma unless or until the service user and/or service can accommodate this safely

Service user on what art therapists should not do [xx]: "Not ask too many questions."

- Showing understanding of how a service user is feeling**

Service users:

"Emotional support from the therapist and from the group."

"If anyone is particularly distressed, think with them about what additional help they need."

E2. Working with the effects of stigma, prejudice and discrimination***

Service user: "Certain crowds can be very discriminating. Doctors can write what I think is bad and is viewed negatively; it weakens your chance of survival. If you don't work you don't survive – it's a harsh world. If someone's discriminating it means there's not much understanding."

- Developing skills for challenging stigma and social inequalities (Cooke, 2017, pp 113-115) within and outside of therapy

Service user: "Art therapists should avoid concentrating [...] on the individual in ways that seem to make the problems as only within the individual and not the society."

Maria. Feet in Conversation. Acrylic and pastel on paper. "I made this piece about different anxieties I had about socialising. [...] They're kind of like abstract feet. [...] facing each other and people standing opposite each other having conversations and it really helps me just think about how I can make socialising easier for myself and made me think about my past as well. So it was nice to make it but it was also a bit sad because I think at that point I was kind of struggling with socialising with my friends."

Service user ratings (where applicable): *** Essential; ** Quite important; * A bit important; ° Not important; [xx] Don't do.
Position of artworks and service user statements do not signify agreement with specific nearby practice statements.

E3. Working with poverty and disadvantage

- Taking an interest in people's real-world context that can affect their well-being or hinder attendance

Service users:

"People who are poor are afraid to talk about their poverty. The therapist has to acknowledge and work sensitively with the guilt and pre-conceptions about poverty."

"People who have committed crimes are often afraid to speak and again the therapist needs to work carefully and not hide away from the crimes."

- Drawing on other professionals to mitigate the effect of stressful life situations on people who experience psychosis, including problems with benefits***

Art therapist [1]: "At one point [the service user] was worried about benefit sanctions [...]. The GP was great. He just said this man needs the benefits."

- Where indicated, asking service users if it would be helpful to send a reminder to attend art therapy
- Understanding how someone's home or life situation can sometimes make it difficult to attend art therapy***

Service users:

"It is helpful to ask about physical health and how people are."

"Help people to remember to eat."

"Make sure everyone has something to eat and drink before so that they are fortified."

Service user on what art therapists should not do [xx]

"Understand that sometimes people can't get to the session every week and don't make them feel that they have failed."

E4. Working with mental health systems

Service users:

"Understand that our own control of our lives should be respected."

"You need freedom to overcome mental illness – not being interfered with."

"You can't force anyone to get well."

Art therapist: "There's another guy [...]. And we're circling round whether we might do some trauma work. And actually, identifying the trauma was his first admission. That's it."

- Both recognising when a service user finds medication helpful and understanding its less helpful effects, including on concentration, motivation and a person's ability to access their creativity***

Service users:

"An art therapist needs to understand that doctors treat people as though they do not have a brain by only offering drugs. They should acknowledge that some drugs don't work."

"An art therapist needs to understand what happens if you take medication and then stop: because after stopping when you look at the world again it looks worse and this needs communicating to the service user."

- Being prepared to advocate for a service user, for example regarding potential changes to or reduction in medication – supporting informed choice and good practice***

Service user: "[Support people to change or reduce their medication], not by telling them what to do but by helping them feel empowered."

- Where relevant, taking an active interest in sleep issues and thinking with service users and other health professionals about how to address problems sleeping, including reducing medication if it is causing excessive daytime sleepiness (Faulkner & Bee, 2017)
- Where sleep difficulty and daytime sleepiness mean service users may be unavailable in the mornings, discussing the time of the appointment and agreeing a mutually practicable time
- Advocating for the indicated length of therapy where feasible, and optimising it within mental health system constraints where necessary

Not recommended:

- It is best to avoid treating the person as a diagnosis and assuming this suggests what they will need
- It is important to avoid mistaking communication difficulties for lack of intelligence and lack of value

[1] Chris Wood

Service user ratings (where applicable): *** Essential; ** Quite important; * A bit important; ° Not important; [xx] Don't do.
Position of artworks and service user statements do not signify agreement with specific nearby practice statements.

Asa. Untitled. Oil pastel on paper. "This shows personal development with the flower starting to open and bloom. It also shows a sort of tiredness because the sky is either morning or early night. It reflects my problems with sleeping."

5 ADAPTING AND ATTUNING ART THERAPY TO SERVICE USERS' NEEDS

- Adapting to changing needs
- Holding boundaries but not rigidly
- Relief through art
- 'Concrete' art and craft
- Going deeper when it's time

Service users' needs can fluctuate from day to day and moment to moment. It is important to hold boundaries but not so rigidly that they impede therapy. They may need carefully considered flexing, in response to the specific therapeutic aims and the service user's needs at a particular time. Clinical supervision can help in decision-making around this.

An important factor determining how art therapists need to adapt their approach will be the setting in which people are seen. These include early intervention, community mental health teams (CMHTs), acute inpatient, psychiatric intensive care units (PICUs), rehabilitation, and forensic mental health units.

Service user ratings (where applicable): *** Essential; ** Quite important; * A bit important; ° Not important; xx Don't do.
Position of artworks and service user statements do not signify agreement with specific nearby practice statements.

F. ADAPTING AND ATTUNING IN ART THERAPY

F1. Adapting to service users' changing needs

- Waiting for the right time for formal procedures

Art therapist in a forensic inpatient unit: "You get people who are very unwell and they can't necessarily consent to treatment. They don't know what they're consenting to. They wouldn't be able to say 'I am consenting to art therapy, I understand it might be emotionally difficult for me.' They can't say all that."

- Recognising that some clients will find formulation easier to engage in than others and being prepared to revisit and develop it throughout the therapy
- Where it is not possible for the service user to engage in an explicit formulation, being guided by your own sense of the formulation and being ready to discuss this with the service user when he or she is ready
- Responding quickly to service users' changing needs during therapy***
- Adapting to where people are in terms of their needs – allowing people to go at their own pace***

Service user: "I think that's essential – if you're in a different place to your therapist it's not going to go together."

- Supporting people when they experience high levels of fear or distress due to their mental health***

Service users:

"Yes, that's why they're in therapy, in the session."

"If someone's in fear it means they're close to their psychosis."

"Art therapy needs to throw people a lifeline, especially people whose problems endanger themselves and others."

Service user on art therapy in Lynch et al. (2018) in the context of first episode psychosis: "It's given me a life vest where I know if it is getting really bad just go and do a bit of art therapy, explore it and do that [...]. It's given that understanding of what works for me and what doesn't."

Service user on what art therapists should not do [xx]

"So not dismissing people who are considered dangerous or particularly vulnerable."

- Recognising crisis as a window for engagement on acute admission wards

F2. Establishing and holding boundaries without being too rigid

Art therapist: "When I first trained I would be, 'Oh well we have to do this properly, the session's an hour' [...], the idea of keeping to the frame [...] thinking that that was important above all else."

- Where it would be helpful to service users, supporting them in taking their art work home or to the ward, or in exhibiting artwork from their sessions
- Encouraging service users to make art outside the session either spontaneously or by agreement between art therapist and client, and viewing it in sessions
- Being willing to sometimes use email or phone between sessions to help people to keep going and keep attending art therapy**

Art therapist: "She [client] would rarely make images in therapy, and establishing trust in that way was hard, but we got into a rhythm of her sometimes bringing actual images she'd made, sometimes bringing them on her phone, sometimes emailing them to me at work. And we had some important email exchanges about her artwork at times when she couldn't attend therapy, or sometimes even between sessions. [...] And she seemed to have an instinctive respect for the boundaries of that, and email was an important part of our relationship."

Service user ratings (where applicable): *** Essential; ** Quite important; * A bit important; ° Not important; [xx] Don't do.
Position of artworks and service user statements do not signify agreement with specific nearby practice statements.

- Allowing session times to be made outside fixed intervals and at locations other than the therapy room, for example going for a walk and observing the environment

Art therapist talking about a client: "Sometimes [being in the room is] just intolerable. [...] And I suggested, 'Let's just go for a walk and see where we end up. We're gonna have to stay within an hour, but let's just see where we go.' What was useful about that was both being able to see things outside the rigid confines of the room. [...] It helped her relax. It's very simple but it also changed the conversation – what we were talking about. So then we were able to go back and make something about what we'd seen."

F3. Enabling relief through art

- Where appropriate, enabling art-making for temporary relief or escape. The effect of service users being able thus to compose themselves can be cumulative***

Service user: This works like meditation.

- If it would assist service user engagement, making and talking about your own artwork in relation to the session while maintaining appropriate boundaries

Art therapist: "I think it can be a great relief, that if that happens in the right way and if they see the therapist getting interested in their own artwork and not thinking just about them. [...] I'm thinking, with one guy who's got psychosis-related problems in my studio group, [...] he can suddenly get interested in something that you're doing and it can become an inspiring thing.

F4. Enabling 'concrete' art and craft where appropriate

- In forensic settings that allow for a longer period of therapeutic engagement, or where a service user is not ready to engage in symbolic art-making, sometimes enabling 'concrete' art or crafts

Art therapist describing work with a client in a secure forensic setting: "What was important about the card making, [...] there's a sorting, filtering, assessing, cutting out, sticking together and choosing kind of process. And it was very calming for her."

F5. Going deeper when it's time

- Being aware that exploring the meaning of service users' artwork is not always helpful

Art therapist: "I don't think he [client] would have felt [interpretation] as feeling very safe, or else it would have just been too confusing."

"[The service user was] frustrated about something concrete [...] and I tried to make something more interpretive out of it and [the service user] said 'I just want the bloody door open.' [...] And I thought yes fair enough."

- Being thoughtful when talking about a service user's artwork, and sometimes being prepared to hold back commenting on it**

Service user on what art therapists should not do [xx]

"Not interfere."

- Being prepared to sensitively explore difficult thoughts and emotions when appropriate

Service user on what art therapists should not do [xx]

"[...] not work in ways that are superficial. So not to avoid distressing problems. An art therapist should not try to disguise the 'hell' that is in people's lives."

Not recommended

- Whilst boundaries are important regarding such issues as time keeping, contact outside the session or therapist's disclosure, it is advisable to avoid making them excessively firm
- Art therapy is not a 'one size fits all' intervention. It requires adaptation to individuals' mental state, abilities, preferences and cultural identity

Service user ratings (where applicable): *** Essential; ** Quite important; * A bit important; ° Not important; [xx] Don't do.
Position of artworks and service user statements do not signify agreement with specific nearby practice statements.

Sarah. Bugging Me. Pencil and ink on paper.

C SUPPORTING RECOVERY THROUGH ART THERAPY

- Enabling expression in art and words
- Making sense of psychosis
- Supporting personal agency and recovery
- Supporting everyday coping

Facilitating expression through the use of art materials is a core component of art therapy irrespective of a person's diagnosis. Expression enables distressing or confusing mental contents to be externalised and then potentially discussed enabling increased self-understanding and others' understanding of the work's creator (Czamanski-Cohen & Weihs, 2016; Gabel & Robb, 2017). Tailored psychoeducation can enable art therapists to share understandings of psychosis while respecting service users' own expertise by experience. Art materials can help service users to communicate difficult experiences and thereby enable art therapists to tailor information to their needs. The formulation process can also achieve this.

Facilitating exploration of art materials and in art-making can help build personal agency. Where capacity allows, art therapists can also consider working with individuals or groups in museums and art galleries (e.g. see Allan et al., 2015; Coles and Harrison, 2018). Such visits can be ideal opportunities to practice 'Looking together' (e.g. Isserow, 2008), and may also support self-esteem, social participation and recovery through engaging with mainstream community facilities (All Party Parliamentary Group on Arts, Health and Wellbeing, 2017; Colbert et al., 2013; Stevens et al., 2018). Finally, people may come to art therapy with a number of difficulties in day-to-day coping, and these can be a focus of art therapy and the use of art materials.

Service user ratings (where applicable): *** Essential; ** Quite important; * A bit important; ° Not important; xx Don't do.
Position of artworks and service user statements do not signify agreement with specific nearby practice statements.

G. SUPPORTING RECOVERY THROUGH ART THERAPY

G1. Enabling expression in art and words

- Encouraging service users to use art materials to express feelings, thoughts, life experiences or psychotic experiences

Service user: "People can express themselves through art."

Art therapist: "Going for a walk with a guy and he was quite amused 'cause every now and then I stopped and scribbled something and he said, 'What are you doing?' And I said, 'I'm writing down what we said.' And I wrote down 'I'm writing down what we said.' And at the end of the day we made a poem out of it – cut it up and moved it around and turned into a poem. But that was because he was quite an ill man and the conversation [...] had been a wild dialogue, but it became a narrative in a way that described the things we'd seen on the walk. And we did make some pictures later on."

- Enabling processing of thoughts and feelings via images and words, with due attention to service users' readiness to approach the most difficult material***

Service users:

"Their art work can help them see things from the outside and this reduces the trauma. [...] The process of externalising changes the feeling by allowing other perspectives. Also it allows a different intellectual understanding or narrative."

"It' a way of understanding experiences."

G2. Making sense of psychosis

- Helping people understand how past or recent stressful events may have contributed to their psychosis**

Service users:

"Stress is a big part of it."

"Mental illness can come from outside things e.g. if you live in smog and traffic."

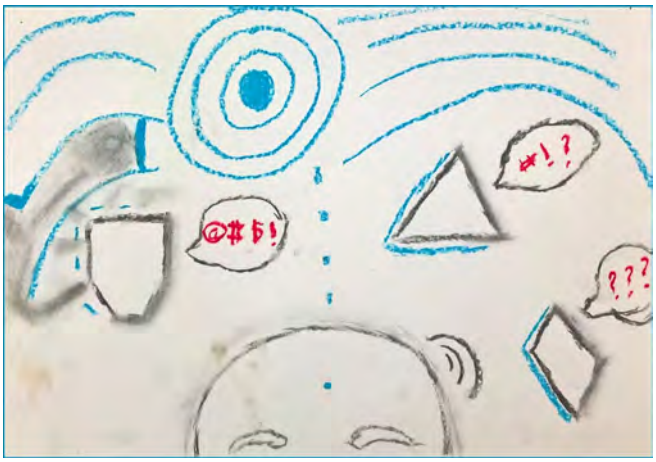
Art therapist: "I could map it out [formulation] with [the client] and at the end of the work together she was able to think some of this made sense to her."

- Being aware of other ways of understanding psychosis e.g. religious, spiritual, cultural, and respecting these
- Helping service users to value some experiences that others do not, if it makes sense to those service users (Hanevik et al., 2013)**

Service users:

"It might help to have some meaning attributed to [psychotic experiences]."

"Do you mean 'make sense'? That's important."



Alicia. What my Voices Look Like. Charcoal and oil pastel on paper. "The bit on the forehead – starts with my inner voice and it goes – the dotted line – up to the big blue circles and they're like emotions that are like trying to calm and block the voices."

- Helping people to cope with psychotic experiences*

Service user: "Teach people practical ways of dealing with and understanding their condition, e.g. we should teach everyone to breathe slowly as a way of managing anxiety."

- Considering using psychoeducational interventions where service users have capacity, and employing art methods as part of these

Art therapist: "Our 20-week psycho-education group began with a regular "fun" warm up exercise. Each group member and facilitator would perform a physical gesture or dance move and say their name, circulating clockwise and anti-clockwise, speeding up and slowing down until it came to a natural end with everyone laughing and helping each other remember their movements and whose turn it is".

"Each psycho-ed group would begin by the therapist outlining the material we would be covering in that day's session and why the material might be helpful, inviting participation."

Service user ratings (where applicable): *** Essential; ** Quite important; * A bit important; ° Not important; ×× Don't do.
Position of artworks and service user statements do not signify agreement with specific nearby practice statements.

- Being appropriately open and genuine in sharing thinking with service users: Being able to say, for example, when seeing something in a different way to how a service user sees it*

Service users:

"The art therapist's communication needs to be open with no pre-conceptions."

"The therapist needs to work at being honest."

Art Therapist talking about being able to challenge paranoia in a respectful way: "The mentalisation [CPD training] gave me a certain way of [...] emphasising the fact that there are two minds here, and that I've got my own mind and I might be right and I might be wrong."

G3. Supporting personal agency and recovery

- Showing commitment to supporting service users' hopes and dreams***

Service users: "Help people show and know they have value."

- Supporting service users to do things that they themselves know from experience will help**

Service users:

"The therapist needs to work at seeing service users as being as clever as the professionals so then it is possible to allow service users to have solutions within themselves."

"I think it's also good if they let you come to your own conclusions at [..] times, or let you think about why something might be useful before telling you why they think it is."

- Enabling varied uses of art materials to foster different therapeutic aims depending on service users' needs
- Appreciating how important education, work or training can be to people irrespective of diagnosis (Baksheev et al., 2012; Bond & Drake, 2008).
- Considering agreeing art-therapeutic exercises for service users to undertake between sessions

Service user: "I think it is helpful when the art therapist gives you suggestions for exercises to do outside the session. Although I didn't do many of these at the time, I have started doing some more recently and have found them very useful."

Art therapist: "We encourage home 'work' in between sessions; it might be an art exercise in order to learn to 'switch off' an over active mind. The opposite is also true, the homework may be used in order to reboot an inactive mind. Similarly you might [...] ask a service user when they go out and about that they 'take note' of the trees, clouds and chimneys, [...] and come back and tell their therapist about their experience of this."

- Supporting service users to look after their general health: e.g. sleep, diet and activity levels
- Considering working in museums and with third sector and community arts groups (Coles & Harrison, 2018)

Service user: "I found discussing art made by artists very interesting, particularly visiting a gallery exhibition. I had only been to exhibitions alone before and had always felt like I had to rush through them."

G4. Supporting everyday coping

- Supporting service users with everyday coping, not just with psychosis***

Service users:

"It's not all about psychosis is it?"

"A big part of recovery is getting back into doing ordinary everyday things. Help move on."

Art Therapist: "Because I know I have less time to work with people I'm often thinking in a much more practical, brief way. What keeps them safe? Have they got enough wherewithal to just live? [...] And I'll be linking with other staff to do that. But also I'm thinking, [...] 'How can they have an ordinary life, with social networks?' [...] People often come with things that are really distressing them, so I'd get them to use the art-making to help them see that they have ways of processing very distressed upset feelings. But I'd also be thinking about these other elements."

Service user ratings (where applicable): *** Essential; ** Quite important; * A bit important; ° Not important; ×× Don't do.
Position of artworks and service user statements do not signify agreement with specific nearby practice statements.

Asa. Untitled. Oil pastel on paper. "I did this to show how things can go well – like the tree growing – while at the same time the tree is susceptible to disaster. It is precariously placed on the side of a cliff."

ENDING ART THERAPY

- Facilitating expression about ending
- Enabling evaluation
- Supporting bigger goals

Art therapists are advised to make themselves familiar with arts and cultural resources in their local area and make links with local agencies, and museums and galleries that offer art courses or other arts participation opportunities – somewhere people might begin to go during art therapy and continue afterwards if they discover that art or arts might help sustain them or meet their future goals, or other ways to become more connected with people who share an interest (Coles & Harrison, 2018). This could include recovery colleges where they exist (Stevens et al., 2018). Audio Image Recordings (www.baat.org) offer a means for clients to look back at a completed course of therapy through three key images and to think about what has changed for them.

Service user ratings (where applicable): *** Essential; ** Quite important; * A bit important; ° Not important; xx Don't do.
Position of artworks and service user statements do not signify agreement with specific nearby practice statements.

H. ENDING ART THERAPY

H1. Facilitating expression about ending

- Reminding people when therapy is due to end, and encouraging them to express how they feel about it***

Service users:

"Let people be involved in the decision about how long they will be attending for."

"Give people a letter at the end of art therapy, summing up what they have got out of attending."

Art therapist on service users' feedback on ending letters: "They all mentioned that that had been really important, and that was something they'd come to reflect on in time. [...] A year later that's still been really important and people have talked about showing it to their family and carers [...]. It says that they'd achieved something by coming to art therapy."

H2. Enabling evaluation

- Encouraging people to say what they find helpful and less helpful about art therapy, especially towards or after the end of therapy***
- Employing formal art-based methods for reviewing the progress of and the experience of therapy – this may include Audio Image Recordings (AIRs) (Examples at www.baat.org)

H3. Supporting bigger goals

- Making links with community resources, including museums, galleries and recovery colleges, to support service users' goals after art therapy

Service user in Allan et al. (2015, p. 22):

"Being in the Arts Centre is a huge boost. It made me feel proud to come in and out – I felt like an artist, not a mental health patient."

- Being willing to refer people to another therapy (if available) if art therapy doesn't help**
- Signposting people to opportunities in the community to carry on doing or seeing art after the end of art therapy*

Art therapist: "I encouraged [my client] to go to a community arts session and he made much more art, and joined an art group that I had nothing to do with [...]. I began to see him less frequently because he was getting much better. [...] But when I first saw him he was [planning to end his life]. [...] But now, because he's making all this art, and I think, because he's made social networks, he's just saying to me 'I want to be around as long as I can.'"

Service user ratings (where applicable): *** Essential; ** Quite important; * A bit important; ° Not important; ×× Don't do.
Position of artworks and service user statements do not signify agreement with specific nearby practice statements.

ART THERAPISTS' REFLECTION AND WELLBEING

- Using supervision
- Reflective art-making
- Maintaining self-awareness
- The art therapist's self-care

Like any other mental health professional, art therapists need to be aware of their professional power and to use it with care. Reflection through regular introspection and art-making can be helpful. In light of the depth of distress they can encounter, and the way in which this can sometimes manifest as anger, hostility, withdrawal, highly pressured communication, and other factors that mean that hard work is required to establish rapport, art therapists also need to monitor their own wellbeing and use supervision. Sometimes, especially when relatively new to their profession, therapists can doubt themselves (Rønnestad & Skovholt, 2003). Art therapy may not be the right fit for a client at a particular time (Lynch et al., 2018), and it can take courage to accept this. Also some work settings entail pressures, such as for shorter work, which occasionally may appear in conflict with an individual client's needs. Whilst good team working (Section A) can help art therapists to advocate for a client's needs, there are some situations that can be outside one's control.

I. ART THERAPISTS' REFLECTION AND WELLBEING

I1. Using supervision

- Making use of supervision to address the challenges of the work, including the impact of service users' distress

Service user: "Therapists need to be well supported ... so it's not all on them."

Art therapist: "One has to be mentally available and attuned to the work." [...] In frustrating or distressing situations, it's important [...] to have this kind of support [supervision] to enable you to put things into context – what you are experiencing."

- Accepting when art therapy is not right for someone.

Art therapist talking about a client who dropped out: "It felt important to be able to be confident enough to say that – 'This isn't for everybody, and that's OK.' I guess that was a bit that I had to find within me to be able to articulate that to other people."

I2. Reflective art-making

- Engaging in art-making to remain open to the creative process and to one's own issues

Art therapists:

"it's only when you're doing your own art that you realise all your own anxieties."

"I have my own art-making practice [where] I process things on a different level."

I3. Maintaining self-awareness

- Being careful not to add to the powerlessness service users sometimes feel in the mental health system***
- Valuing one's own difficult life experiences

Art therapist: "Having had a psychotic experience, it has never felt alien."

- Being able to judge when, if and how to share personal experiences and avoiding over-identifying
- Developing capacity for awareness of your own internal responses to service users, including when these are uncomfortable, and using these to inform your work with people

I4. The art therapist's self-care

- Considering attending psychotherapy for wellbeing, self-awareness or processing difficult feelings

Art therapist talking about art therapy training: "Having to have your own therapy – its effect can be useful. So that informed me a bit about myself, and that's an on-going project isn't it till I die."

Maria. Vulnerability Bucket. Acrylic paint and coloured dough. "I was thinking about the stress vulnerability model and I was thinking about the different people who make me stressed or that help me manage my stress – that kind of thing ... I used lots of different colours to represent different people."

Service user ratings (where applicable): *** Essential; ** Quite important; * A bit important; ° Not important; ˣˣ Don't do.
Position of artworks and service user statements do not signify agreement with specific nearby practice statements.

J CONTINUING PROFESSIONAL DEVELOPMENT

- Seeking further skills and knowledge
- Learning new art-making techniques
- Keeping up to date

Using experience of theory and practice learnt at art college or other creative courses is important to keep active. 'The Drawing Project' is a useful example of an accessible, contemporary and practical source of art exercises and dialogue on everyday art practice in developing sensual, emotional and cognitive skills through drawing (Maslen & Southern 2011). However, a range of cultural and arts experiences may be drawn upon for maintaining creativity and understanding a wide range of forms of human experience, as eloquently expressed by Salom (2011; 2015).

Service user ratings (where applicable): *** Essential; ** Quite important; * A bit important; ° Not important; xx Don't do.
Position of artworks and service user statements do not signify agreement with specific nearby practice statements.

J. CONTINUING PROFESSIONAL DEVELOPMENT

J1. Seeking further skills and knowledge

- Being aware of the overlap between the different arts therapies
- Being prepared to learn from other professionals within and outside mental health

Art therapist: "Working as part of a team [with clinical psychologists] was amazing [...] working with people and coming around a bit to their way of thinking, and also exposing them to my way of thinking."

J2. Learning new art-making techniques

- Using experience of theory and practice learnt at art college or other creative courses to keep active

Art therapist: "Part of my CPD is art-making. I've enrolled in a formal art training."

- Engaging in dialogue on everyday art practice in developing sensual, emotional and cognitive skills through drawing

J3. Keeping up to date

- Being familiar with national guidelines on treatment for psychosis
- Being up to date on research about mental health***

Service user: "Be up to date on research on mental health in order to have a better understanding and maybe challenge and improve what we are doing."

- Being up to date about research on the effects of things that happen in people's childhood***
- Being up to date on developments in service user movements

Service user ratings (where applicable): *** Essential; ** Quite important; * A bit important; ° Not important; ×× Don't do.
Position of artworks and service user statements do not signify agreement with specific nearby practice statements.

PART 2: HOW WE DEVELOPED THESE GUIDELINES

2.1: THE NEED TO CLARIFY ART THERAPY PRACTICE

Prior to 2012 there had been two controlled trials of art therapy with people with a psychosis-related diagnosis published in English (Green et al., 1987; Richardson et al., 2007). England's National Institute for Health and Care Excellence (NICE) guidelines (2010) recommended that people with a diagnosis of psychosis or 'schizophrenia' be offered arts therapies. They based this on the few available trials of art therapy, music therapy, dance movement therapy and drama therapy, but they also reported from interviews with people who had experience of mental health treatment for psychosis or 'schizophrenia' that they appeared to value creative activities. Then a large randomised, controlled trial called MATISSE (Crawford et al., 2012a, 2012b) reported that art therapy showed no benefit over and above either usual care or a control condition offering activity groups. Crawford et al. (2012a) challenged the NICE (2010) recommendation, specifically in relation to art therapy. The MATISSE trial, however, suffered from low participant attendance at both art therapy and control activities (Holttum & Huet, 2014; Kendall, 2012; NICE, 2017; Wood, 2013). The revised NICE guidelines (2014) still recommended offering arts therapies, and a subsequent update (NICE, 2017) also maintained the recommendation.

Nevertheless, there have been on-going questions about the evidence for art therapy in relation to psychosis. For example, Attard and Larkin (2016, p. 8), when reporting on their narrative review of research in this area, stated that "comparison across studies was difficult because art therapy had various theoretical approaches, definitions, titles and structures, which were not always clearly defined." They suggested a need for the BAAT to define art therapy more clearly.

Holttum and Huet (2014) had also suggested that art therapy practice was unclear in the MATISSE trial, consistent with a similar suggestion by Patterson et al. (2011) that there was a lack of a clear model for art therapy with people diagnosed with 'schizophrenia'. Patterson et al. (2011) carried out their qualitative study in parallel with the MATISSE trial (Crawford et al., 2012) and concluded that the "integration of art therapy within the spectrum of care [...] will require clear articulation of theory and practice." Drawing on the Medical Research Council (MRC, 2008) evaluation guidelines in their critique of Crawford et al. (2012a, 2012b), Holttum and Huet (2014) suggested the need for a clear theory of change based on a theoretical understanding of psychosis and of art therapy mechanisms. Although the MATISSE trial incorporated fidelity checks of art therapy, Holttum & Huet (2014)

questioned their utility given that the trial's own process evaluation (Patterson et al., 2011) demonstrated a lack of clarity about practice and theory at the time. Because of this need for clarity, in 2015 the BAAT Council set up a task group with a remit to produce new guidelines, underpinned by research evidence and a change theory. In future when research is conducted on art therapy in relation to psychosis, we wanted it to be clear what the practice is, and for that practice to reflect what art therapists do.

2.1.1: Steering a path through some pros and cons of pinning down practice

In making the attempt to describe practice clearly in relation to psychosis, it was important to the BAAT task group that art therapists would feel supported by the new guidelines rather than feeling that we were dictating practice in an unhelpful way. Art therapists have practice-based training and ideally continue into posts with ongoing supervision, usually of a specialist nature with experienced art therapists who work with the same client group (Holttum et al. in preparation). We wanted to reflect art therapists' expertise in working with people who have a psychosis-related diagnosis, which is recognised as going back a long way (Hogan, 2001; Patterson et al., 2011; Wood, 1997). This entails recognition of art therapists' autonomy to vary their practice in accordance with the needs of individual service users and specific contexts. The importance of variation and adaptation was recognised by the MRC (2008) guidelines and was also acknowledged in the MATISSE trial (Crawford et al. (2012b). However, there was still an unanswered question about how much and what type of variations still constitute art therapy and for whom these are expected to be helpful. In developing these guidelines we aimed to:

a) Cover variations of practice by drawing on examples from experienced art therapists interviewed about their practice, and especially looking at what they did in given practice situations with specific service users;

b) Reflect a range of practices service users find helpful;

c) Ensure that the recommended practices have an evidence base and an underlying theory of change; and

d) Present the guidelines in a way that is accessible to a wide range of people.

2.2: BUILDING ON EARLIER GUIDELINES

The first published practice guidelines on art therapy with psychosis were by Brooker et al. (2007), based on work within a single UK National Health Service trust. The task group aimed to build on these and did so in parallel streams of work (Figure 1). A core stream involved a Delphi process (Figure 2) with 30 art therapists from around the UK, and with input from service user consultations (Figure 1). This led to the first national professional consensus guidelines (Holttum et al., 2017), which was a positive new landmark for UK art therapists.

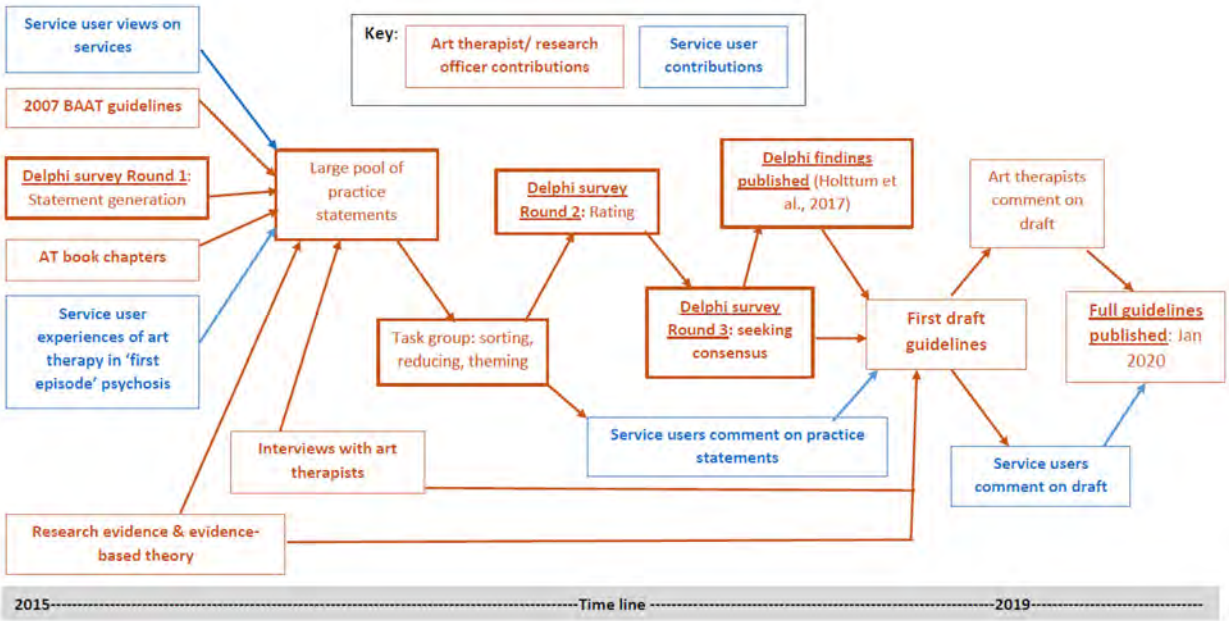


Figure 1: Flow-chart showing main components of guideline development process

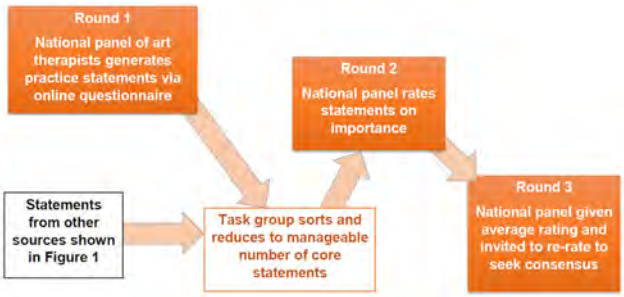


Figure 2: The Delphi survey process

In parallel with the Delphi process, the task group decided that more detailed guidelines were required to address both how psychosis may be understood and the specifics of appropriate art therapy practice, with illustrative examples. This was in part because a Delphi survey is based on practice consensus and may not fully reflect the evidence base. In addition, the Delphi process itself does not generate detailed illustrations of practice tied to specific contexts and client difficulties.

The detailed guidelines build on and supplement the BAAT professional consensus guidelines that the Delphi process generated (Holttum et al., 2017), which in turn built on those of Brooker et al. (2007). The practice items listed by Holttum et al. (2017) formed the core of the framework for the current guidelines. However, the final set of 10 principles was arrived at following three further processes:

i. In-depth interviews and a focus group with 18 art therapists about what they do when working with people who have a psychosis-related diagnosis and their observations of service users' responses (Holttum et al., in preparation);

ii. Service user focus groups, using statements from the consensus guidelines as an initial framework and inviting comments and additions;

iii. A review of the evidence on art therapy in relation to people with a psychosis-related diagnosis.

Data from the service user focus groups have been incorporated into these guidelines (Part 1). Groups of service users based at three different NHS trusts in England were involved, and their ratings of specific practice statements are shown in Part 1 as well as quotations from these consultations. In the next section we illustrate how the new guidelines reflect the evidence base. For ease of reference the 10 principles (from Part 1) are shown in Table 1.

2.3: DRAWING ON THE EVIDENCE

The purpose of assessing the research evidence went beyond establishing what evidence there is now for art therapy for people with a psychosis-related diagnosis. As previously explained, we also wished to develop a theory of change or programme theory. The programme theory development process drew from Pawson and Tilley (1997) and Pawson (2013), who have outlined an approach to research and evaluation that enables the constructing of evidence-based programme theories, comprising context, mechanisms and outcomes (CMO). The context influences how the mechanisms of a programme work in that context, which may be different to other contexts and can lead to different outcomes. This CMO approach is gaining traction in understanding what the Medical Research Council (2008) calls complex interventions. An example of a recent paper utilising this approach is Baker et al. (2019) reporting on their work to improve the implementation of a new system for enhancing care received by people with severe mental health diagnoses in primary care.

We carried out our systematic search of the literature in five databases: PsycINFO, MEDLINE, ASSIA, CINAHL and Cochrane. We included mixed method and qualitative studies as well as quantitative, since this would increase the variations and detailed description that would be available to build a programme theory showing how and why art therapists might use particular practices.

Table 1: The 10 principles of the new guidelines on art therapy for people with a psychosis-related diagnosis

A) Working together in organisations – Working with professionals and experts by experience – Supporting service users to speak through art	**F) Adapting and attuning art therapy** – Adapting to changing needs – Holding boundaries but not rigidly – Relief through art – 'Concrete' art and craft – Going deeper when it's time
B) Collaborating with service users – Inviting service users into art therapy – Supporting culturally specific art – Enjoying art – Creating a shared formulation	**G) Supporting recovery through art therapy** – Enabling expression in art and words – Making sense of psychosis – Supporting personal agency – Supporting everyday coping
C) Working with friends and family – Welcoming family and friends – Supporting relationships through art	**H) Ending art therapy** – Facilitating expression about ending – Enabling evaluation – Supporting bigger goals
D) Group art therapy – Groups for different needs – Facilitating creativity – Connecting through artwork and discussion	**I) Art therapists' reflection and wellbeing** – Using supervision – Reflective art-making – Maintaining self-awareness – The art therapist's self-care
E) Working with real world contexts – Trauma-informed art therapy – Working with mental health stigma – Working with poverty and disadvantage – Working with mental health systems	**J) Continuing professional development** – Seeking further skills and knowledge – Learning new art-making techniques – Keeping up to date

Table 2: Search terms for systematic evidence search and how they were combined

trial OR experimental OR evaluation OR outcome* OR assessment* OR review OR qualitative OR grounded theory OR thematic OR hermeneutic OR phenomenol* OR narrat* OR mixed method* OR mixed design OR case*
AND
Art therapy OR art psychotherapy
AND
Psychosis OR psychotic OR schizo* OR paranoi* OR halluc* OR hearing voices OR voice hearer*

Note: * used to enable words with different endings to be sought, such as outcome and outcomes. Thesaurus terms were also used where available.

The search terms are shown in Table 2. In addition, due to the observation that some relevant papers in art therapy journals did not appear in initial searches, the contents pages of the UK and USA art therapy member association journals were hand-searched back to the year 2012: International Journal of Art Therapy and Art Therapy: Journal of the American Art Therapy Association. The year 2012 was chosen because it was the year that the most recent major trial of art therapy was published (Crawford et al., 2012a, 2012b). Research on art therapy thus far was sparse and relatively well documented. There was also a hope that studies carried out since that trial and reported in the art therapy journals of the two longest-established art therapy professional associations (American Art Therapy Association and BAAT) and in other journals might have the potential to report on more clearly defined art therapy interventions.

The inclusion criteria for papers were as follows:

- English language.
- Peer reviewed journal article.
- Clinical trial or intervention or evaluation study.
- Systematic case studies.
- Qualitative studies or art therapy interventions using a systematic method.
- Reviews were studied for reference to new studies not already identified.
- Published in any year since records began (or since 2012 for the hand-searches).

The exclusion criteria were:

- Unsystematic case studies, theory and discussion papers.
- Study not specifically focusing on psychosis or no evidence that a significant proportion of participants had a psychosis-related or schizophrenia diagnosis.
- Staff/therapist questionnaire surveys with no service user data.
- Conference abstracts – insufficient detail to review study.
- Editorials, commentaries, letters, and book reviews.
- Art therapy as part of a package of interventions with no separate evaluation.
- Trial protocols with no trial results identified.

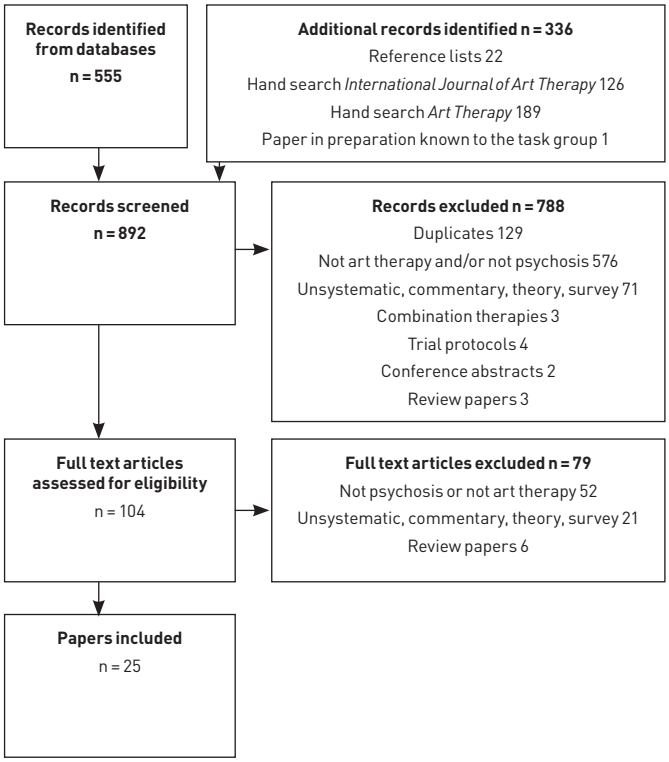


Figure 3: Flow chart of papers screened during systematic search

Figure 3 shows the flow chart of papers identified, included and excluded. The studies are listed in Tables 3-7. There were 10 quantitative papers (covering 8 separate studies), 12 qualitative (covering 11 studies) and 3 employing mixed methods. The quality of the quantitative studies was assessed using the NICE (2012) quality appraisal checklist for quantitative interventions. Main strengths and weaknesses only are shown in the tables. The qualitative studies were assessed using the Critical Appraisal Skills Programme (CASP) checklist for qualitative studies (CASP, 2018). Mixed-design studies were assessed using both NICE (2012) and CASP (2018) checklists. Two independent raters rated all papers. Disagreements were resolved through discussion.

Table 3: Quantitative studies included in the literature review

Authors	Study design	N	AT offered	Main strengths and weaknesses	Favoured condition	Reported improvements
Green et al. 1987; USA	RCT: AT vs TAU	47	10 group sessions	Randomisation and acceptable measures.	AT	Attitude to self and getting along with others
Richardson et al. 2007; UK	RCT: AT vs TAU	90	12 group sessions.	Randomisation and good retention pre-post, valid measures and 6 month FU.	AT	'Negative symptoms'
Schmid & Wanderer 2007; Switzerland	Comparison 'phantasy therapy' vs AT	205	Not clear	Not randomised and high contamination between conditions.	Phantasy therapy	Therapist-rated functioning
Crawford et al. 2010; 2012a; 2012b; MATISSE UK trial	RCT: AT vs activity groups vs TAU	417	Weekly groups for a year	Randomisation and mostly valid measures but severe attrition.	Activity groups	'Positive symptoms'
Leurent et al. 2014; UK	Analysis of P variables in MATISSE	417	As above	As for Crawford et al. and also key measures not validated.	None	No significant results
Montag et al. 2014; Germany	RCT: AT vs TAU	58	12 groups over 6 weeks	Randomisation; valid measures; intention-to-treat analysis	AT	'Positive symptoms' and awareness of others
De Morais et al., 2014a; Brazil	Group comparison post-test only, clay therapy vs TAU	24	8 sessions of group clay therapy	Valid measures of anxiety and depression, but not randomised, small N and no pre measure	Clay therapy	Depression and a trend for anxiety
Qiu et al., 2017; China	Comparison AT vs TAU waiting	120	32 or 48 weeks of group AT	Mostly valid measures but randomisation uncertain and compliance measure not validated.	AT	By 8 weeks for anxiety, depression, 'negative symptoms' and compliance. By 16 weeks also for anger

Notes: AT art therapy; FU follow-up; RCT randomised controlled trial; TAU treatment as usual; P participant

2.3.1 Quantitative studies

As shown in Table 3, three of the four randomised, controlled trials favoured art therapy and all of these tested art therapy along with usual care versus usual care alone. Two (Green et al., 1987; Richardson et al., 2007) were in outpatient services and one (Montag et al., 2014) inpatient. The fourth (Crawford et al., 2012a; 2012b) tested art therapy against activity groups and 'treatment-as-usual' for outpatients with a "mean length of illness" of 17 years (Crawford et al., 2012b, p. 38). This trial was much larger and longer than the other three. Although the activity groups were slightly favoured in it, there was severe attrition from both art therapy and activity groups, with only 31% and 21% of assigned participants respectively attending at least 10 in total of the weekly sessions offered over 12 months. Outcome was examined using an 'intention-to-treat' (ITT) analysis, which meant that data were collected from over 80% of participants at post (one year) and follow-up (two-year) points irrespective of whether they had received the intervention. If there had been any effects of art therapy, they may thus have been rendered undetectable because the majority of participants did not "take the medicine" (Kendall, 2012, p. 1).

It could be argued that the low attendance might be because art therapy as offered in the Crawford et al. (2012) trial lacked efficacy. However, the similar lack of attendance at the control condition's activity groups might suggest something else was at play. This provides perhaps one obvious programme mechanism (not unique to art therapy), represented in Figure 4 (the programme theory) as AM1 and AM2. That is, service users have to be able to attend art therapy, and thereby attend a sufficient number of sessions to benefit from it. At this point, however, we have not yet explained why service users may not attend. We come to this later after considering more of the evidence.

Leurent et al. (2014) carried out a secondary analysis of data from Crawford et al. (2012a; 2012b) in order to test whether specific subgroups of participants had more favourable outcomes than others for art therapy, and reported that none did. However, this reanalysis suffered from the same problems as the original trial. Perhaps especially notable is that Leurent et al. (2014) did not examine outcome only for participants attending the majority of offered art therapy sessions versus those not offered art therapy, i.e. a 'per protocol' analysis (Hernan & Hernandez-Diaz, 2012). Also, few of the measures used were validated. No rationale was provided for dividing participants into those who had been in contact with services for 10 years or more versus under 10 years. A rationale could be made that the cut-off should be no more than three years versus longer, given that the three years after first experiencing psychosis are generally seen as critical for preventing decline and that many people seen in early intervention for psychosis (EIP) services fare worse when discharged into usual care too early (Baird et al., 2012).

Montag et al. (2014) tested art therapy plus usual care versus usual care alone in an acute inpatient setting. Randomisation was done by an independent agent, valid measures were used, as was ITT analysis. 'Positive symptoms' reduced more with art therapy than in usual care alone from pre to post and at six month follow-up according to both 'per protocol' and ITT analyses. Awareness of others on the Levels of Emotional Awareness Scale (LEAS, Lane et al., 1990) increased after art therapy compared to usual care (shown under the umbrella term 'connection' in OC1 in Figure 4). Participants had access to a range of other therapies under usual care, including medication, other psychotherapies, occupational therapy and excursions. This makes it unlikely that the effect of art therapy could be explained as due to almost any therapy being better than usual care alone. Along with Green et al. (1987) it suggests a possible role for the service context (C1 and C2 in Figure 4). In Green et al. (1987) the service context had an explicit focus on service users' strengths and aim of increasing connection with social networks. In Montag et al. (2014) there was a wide range of other therapies, and excursions and sports available to all participants whether in art therapy or not. We hypothesise that a wider service context in which there is a range of therapies and support and/or a focus on strengths (C1, C2) may help service users to attend art therapy, or indeed any therapy (AM1). After describing and appraising the other quantitative studies, we examine the four RCTs in greater depth and further explicate the programme theory.

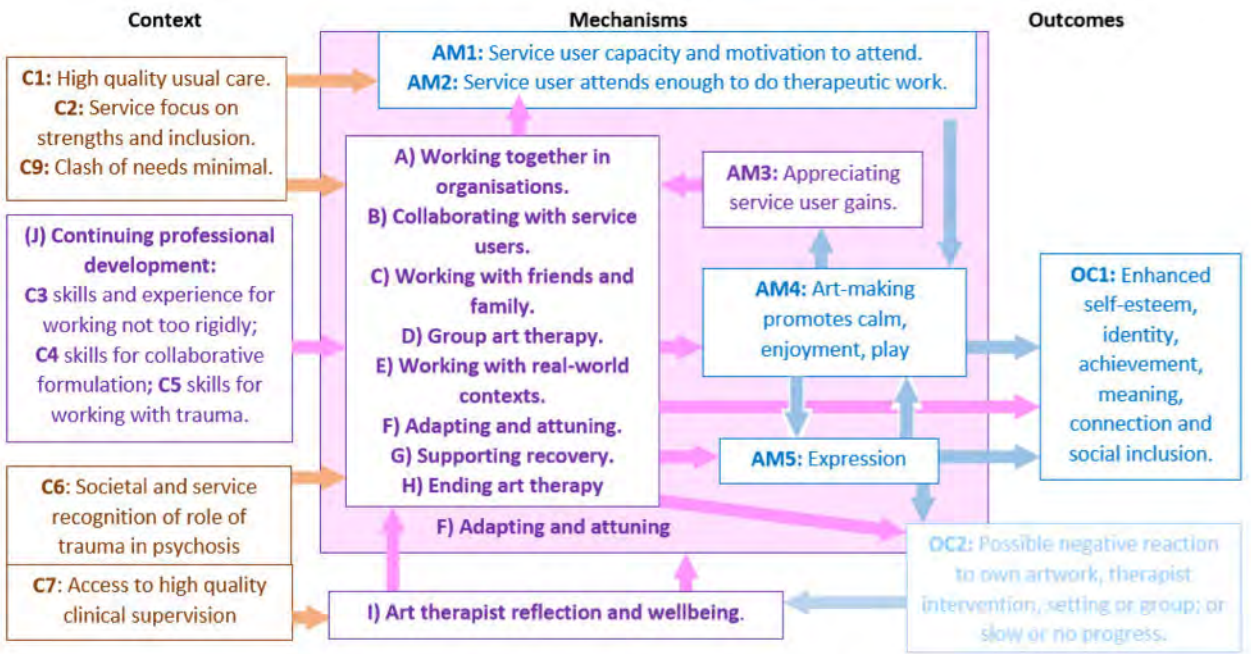


Figure 4: Synthesised programme theory

Notes: OC outcome; C context; AM additional mechanism; service and societal context; art therapist; service user; ➡ influences

Qiu et al. (2017) compared outcomes for forensic inpatients attending art therapy versus those waiting to attend. Although the authors mentioned randomisation it also appeared that allocation to art therapy or waiting was according to residence in one of two "prisons" (p. 1069). Lack of randomisation might leave the findings open to bias if other conditions differed between the two settings. Qiu et al. (2017) reported positive changes within eight weeks of starting art therapy (compared to waiting with only usual care) in anxiety, depression, 'negative symptoms', and compliance with staff of the institution. These changes were reportedly maintained at 16 weeks, and in addition anger and anger control were reported to have significantly improved compared to waiting. After waiting 16 weeks, art therapy was provided in total for 32 weeks in the waiting group compared with 48 weeks in the intervention group, and gains were reportedly maintained up to the end of therapy.

The study by Schmid and Wanderer (2007) was intended to test a new therapy ('phantasy therapy') against usual care, and art therapy and weekly ward meetings were two of the usual 'treatments'. However, there was no randomisation and many participants experienced more than one of the intended interventions simultaneously. The study was based in acute inpatient care, and no one experienced more than four sessions of art therapy, phantasy therapy or ward meetings. Art therapy was not described. It is therefore difficult to draw any firm conclusions from this study.

De Morais et al. (2014a) investigated whether participants in clay therapy (a specific form of art therapy) fared better on depression and anxiety than those not in clay therapy (a majority in each group having a diagnosis of schizophrenia or psychosis). However, there was no randomisation and no pre-therapy test, so post-therapy scores favouring clay therapy in terms of lower depression may have been due to factors other than the intervention.

Next we examine the type of art therapy provided in the studies reporting more versus less favourable outcomes for art therapy in the higher quality trials. The nature of art therapy provided in the four RCTs is shown in Table 4. Two of the trials that favoured art therapy (Green et al., 1987; Montag et al., 2014) had structured groups, involving time spent making art and then time talking about the art. Both of these could be described as supportive in that the art therapist supported art-making as needed, and encouraged (but not required) interactions between group members, consistent with Principle D of the new BAAT guidelines, i.e. providing group art therapy tailored to different needs, and focusing on creativity and safe connection with others via artwork and discussion (see Figure 4).

Table 4: Type of AT in the higher quality quantitative studies

Authors	Participants, setting and other services	Aims of service	Aim of art therapy	Frequency	Format	Principles
Green et al. 1987; USA	'Chronic' outpatients. Supportive psychotherapy & medication monitoring	Strength- focus, reducing hospital, social support	Increase self-esteem and relating; mastery and resolution	10 sessions every other week for 90 minutes. 12 in a group.	Relaxation exercise; art-making to a theme; invited to talk about their art	Self-expression, not drawing out conflicts; supportive not 'uncovering'
Richardson et al. 2007; UK	Chronic' outpatients in deprived inner city. CMHT care and CPA reviews; medication checking	Not stated	Facilitate learning about one's distress-causing behaviour via art	12 sessions weekly 90 minutes	Brief group interactive AT	Group interactive; art as buffer for relating and container for difficult feelings
Crawford et al. 2012; Patterson et al. 2011; Patterson et al. 2015; UK	'Chronic' outpatients in 4 locations. Care co-ordination, medication & other services as needed	Not stated	Enable exploring relationships in group; facilitate understanding of group processes; process- not goal-orientated	Weekly for 1 year, 90 minutes, up to 8 in a group	Range: studio (1:1 in a group); structured group (art-making, talk about the art); hybrid	Free expression; support, empathy; art as buffer; individual needs; mainly not interpreting; protected place; anything can be a communication
Montag et al. 2014; Germany	Acute inpatients. Support, medication, other therapies, OT, outings	Not stated	Support art-making and to understand the art	Twice a week 6 weeks, 90 minutes, up to 6 in a group	Art-making then invite to talk about their art; encourage to interact	Non-directive – find own image

Notes: OT occupational therapy; CPA care programme approach; CMHT community mental health team

Green et al. (1987, p. 989) specifically refer to "a supportive rather than uncovering orientation", consistent with Principle F, namely adapting and attuning art therapy to individual and changing needs, enabling 'concrete' art or craft, and relief through art, and only 'going deeper' (such as exploring past trauma) at an appropriate time. Green et al. (1987) included an initial relaxation exercise, which is not a standard component of art therapy but is also consistent with providing a safe group environment, and therefore broadly consistent with Principle D.

Richardson et al. (2007), which also favoured art therapy over only usual care, specified group interactive art therapy, based in here-and-now interactions and enabling participants to understand how others perceive them, through their art and discussion of it (Principle D). Thus three RCTs showing a favourable result for art therapy were all based on group art therapy with the opportunity but no pressure to interact.

Crawford et al. (2012), which produced a null result, also made reference to this approach. However, Patterson et al. (2015) suggested, from their interviews with clients and therapists involved in the Crawford et al. (2012) trial, that there was a range of approaches used by different therapists: (a) a studio set-up where people effectively have one-to-one therapy in a group, (b) structured sessions involving art-making and then talking about the art, and (c) a hybrid version of these, wherein interaction may occur at any time.

Clearly if the setup is one-to-one therapy in a group, then group interaction and processes cannot be a focus or change agent. Although Patterson et al. (2015) stated that this approach only applied to a minority of the art therapists in Crawford et al. (2012), the very low attendance may also have meant group art therapy was not well realised even where it was intended. In addition to a potential loss of therapeutic effects of group interaction, this may have had a negative effect on attendees who came expecting and desiring a group format. Thus, a positive outcome for service users in art therapy, and especially connecting more with others (OC1) may depend on there being opportunity for safe interaction with others (Principle D).

Table 5: Mixed method studies included in the literature review

Study and design	Participants	Measures and analyses Art therapy mode	Quantitative findings	Qualitative findings[1]	Main strengths and weaknesses
Brady et al. 2017, Eire; Post treatment survey	35 staff and 11 clients, acute MD mental health service	Group and one-to-one, acute admissions unit, length unknown. Qr; thematic analysis of written answers to questions.	Staff wanted more AT & more evidence. Clients pre to post session less stressed. Most wanted more.	Client themes: enjoyment; expression, communication, self-understanding, achievement, absorption	Small & biased samples. Qr not validated. Thematic analysis unclear. No quotes for specific themes.
Allan et al. 2015; UK; 1-group pre-post. Interviews and FG	Qrs and interviews 17 clients. FG with 5 still in AT.	Weekly group in ward then arts venue, at least 8 months. Pre-post qrs: distress, wellbeing and social inclusion.	Significant reduction in psychological distress; increase in wellbeing.	Being in a group (e.g. sharing); art-making (e.g. artist identity), wellbeing (e.g. motivation), what helps (e.g. safe space); plans (e.g. more artwork)	Independent FG facilitator. Independent coding. 2 of 3 qrs valid. Reason for loss of post-qrs unclear.
Coles & Harrison, 2018; UK; 1 group pre-post. interviews.	7 young adults, severe diagnosis	18 weekly sessions group AT in 2 museums: art-viewing then making and discussing. Themes from therapist notes, NHS staff email observations, Ps' self-set goals, mood and self-esteem.	Large mean positive effect size on goals (5 better, 2 worse). Self-esteem less change (3 better, 4 slightly worse), mood generally positive post-sessions	Self-understanding via object-handling and art-making. Relating via exhibits, shared resonances, informal meetings. Inclusion via context & accessibility. Creativity via inspiring contexts & exhibits.	Valid qrs. Interviews not audio-recorded; qualitative analysis unclear; small sample with low statistical power; mood qr only post-sessions.

Notes: 1 themes are paraphrased; Ps participants; MD multidisciplinary; FG focus group; qrs questionnaires; FU follow-up; AT art therapy

Table 6: Qualitative study characteristics

Authors	Design	Participants	Analysis	AT mode
Van Lith et al. 2009	Interviews	3 therapists	Phenomenology	Supportive, expressive group AT
Patterson et al. 2011	Interviews and focus groups	24 therapists	Grounded theory	Group, 1:1, more & less structured, 1 year
Teglbjaerg 2011	Interviews pre, post and 1 yr FU	5 psychosis & 5 non-psychosis clients	Modified grounded theory	1 year weekly group AT
Patterson et al. 2013	Interviews and 1 focus group	23 clients in Crawford et al. 2012	Grounded theory	Weekly group AT for 1 year
Colbert et al. 2013	Interviews	7 clients, 2 gallery staff, 2 NHS staff	Narrative analysis	4 weekly art gallery sessions.
Hanevik et al. 2013	Systematic case: therapist notes & interviews	5 women with psychosis	Testing propositions	Weekly group AT 10 months
De Morais et al. '14b	Interviews	16 day patients	Content analysis	7 sessions clay therapy
Patterson et al. 2015	Interviews, focus groups & obs during RCT	RCT clients and therapists	Grounded theory	Weekly AT offered for 1 year
Van Lith 2014; 2015	Longitudinal qualitative single case	12 AT clients	Phenomenology	Varied, group and 1:1
Lynch et al. 2018	Interviews	8 (6 eligible for EIP)	Grounded theory	Mainly group, also 1:1.
Holttum et al. in prep	Interviews	18 art therapists	Grounded theory	Range of modes

Notes: AT art therapy; FU follow-up; RCT randomised controlled trial; EIP early intervention for psychosis; RV respondent validation; obs observation

In line with the original NICE (2010) guideline recommendation concerning arts therapies more generally, a tentative conclusion from the high quality trials in terms of the art therapy approaches used, is that supportive and expressive art therapy, with some structure and support (but no pressure) for interaction appears helpful, with "less emphasis on the use of 'uncovering' psychoanalytic approaches", as originally emphasised by NICE (2010, p. 252). As well as Principle D, this is reflected in Principle G on supporting recovery in terms of facilitating expression in art and (where possible) words, making sense of psychosis, and supporting personal agency and everyday coping, and Principle F in that this incorporates not using an 'uncovering' approach, but enabling relief through art-making, concrete art and crafts, and only going deeper, if at all, when the time is right. Next we discuss the mixed method and qualitative studies and see what further light may be shed on the conditions for a positive outcome.

2.3.2 Mixed method studies

Table 5 shows the three mixed method studies. There was some discussion as to whether to include Coles and Harrison (2018) because there was no specific statement about participants having psychosis-related diagnoses. However, they were all designated as having "severe and enduring mental illness and complex needs" (Coles & Harrison, 2018, p.116). All three of these studies lacked a control group, but two of them included both pre- and post-therapy measures (Allan et al., 2015; Coles & Harrison, 2018). This can evidence whether there was change but cannot establish its cause.

Both of these latter studies were innovative in that art therapy was offered in public arts venues, and both reported positive change. However, Coles and Harrison's (2018) study lacked statistical power due to the small sample size, so although mean effect size for participants' self-set goal attainment was large, it may not have been statistically significant (not reported). Brady et al. (2017) only included both pre and post measures for mood before and after individual sessions, and did not report any statistical analysis on these. They also gave few details about the questions on their questionnaire, which was not validated.

The themes of service user benefit reported in these three papers are reflected in Principle G of the current guidelines (supporting recovery), and are broadly consistent with the aims and principles stated in the four RCTs: expression, learning about oneself, art-making and artwork as a vehicle for safe communication and relating, and achieving something. Although they are described as self-reported outcomes in the mixed method studies, they are shown under both mechanisms and outcomes (AM4, AM5, OC1) in Figure 4. This is because, as defined by Pawson (2013, p. 26), "mechanisms capture the way in which the programme's resources impinge on the stakeholders' reasoning." In our programme theory we propose that the therapist's facilitation in the art therapy room enables art-making, which may promote calmness

and/or constitute or enable expression of something important to the service user, which in turn produces and enables therapeutic outcomes.

In addition, arts venues (Allan et al., 2015; Coles & Harrison, 2018) seemed to add a new dimension of stimulus and variety, normalisation and availability of nearby facilities for informal meeting for refreshments, enhancing the potential for gains in everyday coping and social inclusion (Principle G, OC1). Exhibits in the museums could also become vehicles for communication via shared resonances (Principle D, connecting through artwork and discussion). For those able to attend, this use of public arts spaces might help provide important bridges to greater participation and social inclusion following the completion of therapy, which potentially could help address the stigma and discrimination often experienced by people who receive psychosis-related diagnoses (Schizophrenia Commission, 2012; 2017). Combating stigma is a feature of Principle E of the current guidelines (working with real-world contexts).

2.3.3 Qualitative studies

There were 12 qualitative papers representing 11 studies since Van Lith (2014; 2015) appeared to report on the same study (Tables 6 and 7). Three were closely related to the Crawford et al. (2012) trial (Patterson et al., 2011; Patterson et al., 2013; Patterson et al., 2015) but we examine them separately as they addressed different questions. All except two of the qualitative studies (De Morais et al., 2014b; Teglbjaerg, 2011) appeared relatively high quality in terms of their systematic approach and employment of quality criteria such as triangulation of interview and focus group data with therapist notes, and carrying out respondent validation (asking participant to comment on the findings).

Table 7: Qualitative study findings, strengths and weaknesses

Authors	Qualitative findings[1]	Main strengths and weaknesses
Van Lith et al., 2009	Therapist skills and approaches; transformative art-making; transcending self	Systematic analysis; with RV, but small sample
Patterson et al., 2011	Art as buffer; safe space to connect; being seen; feeling alive; artist identity; understanding self; acceptance; mastery; agency; processing; unique to each P	Systematic; saturation; diverse sample, but no theoretical model presented; quality checks unclear
Teglbjaerg, 2011	Here-and now presence; new meaning; being oneself; acceptance by others; playfulness	Triangulation and FU at 1 year but selection unclear; reflexivity missing; few quotes.
Patterson et al., 2013	Engagement; dabbling; opting out; never attended. Engagement followed by no or specific change, or life-changing	Diverse sample; saturation reached; systematic analysis, but quality checks unclear
Colbert et al., 2013	Psychosis narrative; modified narrative; validation; empathy; joining in; commonality; recovery; achievement; distraction; bonding; inclusion	Systematic, with independent audit & RV but sample small, with limited diversity
Hanevik et al., 2013	Coping with psychosis; feeling valued	Systematic, with triangulation & RV but only women (1 man dropped out early)
De Morais et al., 2014b	Feelings (e.g. energising; emotional release). Effects (e.g. hope; improved social life).	Negative cases and persuasive quotes but analysis and quality checks unclear
Patterson et al., 2015	3 AT approaches: modified studio; phased group; potentially interactive. 9 values, processes and practices	Range of data with triangulation but quality checks unclear and few service user quotes
Van Lith, 2014; 2015	Role of art (e.g. self-discovery, achieving, art as safe place, art to cope); necessary conditions (e.g. feeling supported)	RV & diverse sample
Lynch et al., 2018	Unpressured atmosphere facilitates expression & connecting with others, pleasure, and new experiences	Systematic, with negative case & RV but small sample
Holttum et al. in prep	More and less supportive service context; what client brings; finding a way to relate; supporting service user's journey; supporting agency and inclusion; working to contain self	Systematic, with negative cases and RV

Notes: 1 themes paraphrased; AT art therapy; FU follow-up; RCT randomised controlled trial; EIP early intervention for psychosis; RV respondent validation; obs observation; P participant

Teglbjaerg (2011) used few quotes to illustrate codes and categories, and despite interviewing participants three times over the course of a year and drawing from grounded theory, did not present a model illustrating changes over this time period. De Morais et al. (2014b) did not describe their analysis process and therefore it was difficult to judge how systematic it was. Several studies had quite small samples (Colbert et al., 2013; Hanevik et al., 2013; Lynch et al., 2018; Van Lith et al., 2009) but appeared to be carried out systematically and with good attention to quality. What they lack in empirical generalisability is compensated by their analytic generalisability, since a strength of these qualitative studies is their ability to examine participants' experiences in depth to help us understand processes and mechanisms of change.

Three studies presented theoretical models grounded in their data (Holttum et al., in preparation; Lynch et al., 2018; Patterson et al., 2013). Lynch et al. (2018) focused on people who had received a diagnosis of 'first episode psychosis'. Their model suggested that when participants experienced the "unpressured atmosphere" of group art therapy (Lynch et al., 2018, p. 4) they were able to express themselves via art (AM5). Consistent with art therapy aims in Richardson et al. (2007) and Crawford et al. (2012), the art-making and focus on artwork were reported to have a buffering effect from the intensity of direct interaction, enabling enjoyment and play (AM4), in turn enabling participants to interact and make connections with other group members (Principle D), which in some cases continued as new friendships and further shared activities (OC1). Art therapy was experienced as enjoyable and participants were able to experience themselves and their emotions in new ways, fostering enhanced sense of identity (OC1). There were also instances of participants feeling that art therapy was not the right fit, for example if they felt too frightened or unwell. For one participant, one-to-one therapy had felt too intense at the time. This is represented in Figure 4 as OC2, and we return to it later.

What was less clear from Lynch et al. (2018) is what the art therapist did. Holttum et al. (in preparation) set out to explore in detail what art therapists reported doing, and the responses they observed in service users. It is a report of a systematic qualitative study of art therapists' experiences of delivering art therapy for people with a psychosis-related diagnosis. It produced a model of art therapy for this service user group that again shares features with many of the studies already reviewed here. Specifically, it also supports Green et al.'s (1987) taking more of a supportive than psychoanalytic 'uncovering' approach (Principle F). Indeed, several of the more experienced of the 18 art therapists who took part talked about having had to modify their approach from a more rigid psychoanalytic one because the client's level of distress or fear could mean they reacted negatively to an interpretation, or were unable to stay in the room for more than a few minutes early on in therapy. This suggests that one contextual factor (C3) is the art therapist's skill and experience for working within a therapeutic frame but not too rigidly (Principle F). Skill and experience in this case seemed to come from continuing professional development (Principle J), including learning from one's clients.

Thus, creating a safe space was paramount, and offering structure could be helpful, sometimes including offering themes for artwork. In Figure 4 this is represented by both Principles D and F, but adapting and attuning (F) is shown both as a specific set of practices and as a general approach within which other practices occur, because it appeared central in Holttum et al. (in preparation). Along with a supportive service context, we hypothesise that adapting and attuning is the other key mechanism that enables service users to develop trust and thereby to attend for a sufficient length of time in any given session and to attend enough sessions to do therapeutic work (AM1, AM2).

Flexibility (or not being too rigid) in Holttum et al. (in preparation) could include going for a walk outside in a natural landscape but staying within the hour, or introducing the art materials and the art therapy room without necessarily expecting the service user to speak. This approach is also reflected in Principle B, collaborating with service users, and illustrates that collaboration may need to begin with an invitational approach (Van Lith et al., 2009), whereby the art therapist enables orientation to the art therapy room and art materials and explains the options available. Some service users, especially in inpatient settings, may only be able to tolerate group art therapy if they can have their own art-making space and are not required or even encouraged to interact with others, but the art therapist might hold hope that in time they would be able to do so (Holttum et al., in preparation). Whilst this studio approach appeared to be used by some art therapists in the Crawford et al. (2012) trial (Patterson et al., 2015), it was unclear how much opportunity there was for those service users able and ready to interact with other group members to do so. Holttum et al. (in preparation) reported that art therapists saw service users' ability to interact verbally with the therapist or other group members initially as depending on how distressed or disturbed they were on entry to art therapy, again emphasising the importance of adapting and attuning (Principle F).

Holttum et al. (in preparation) reported art therapists as stating that once service users were able to make art, they would often experience a calming effect from the activity (AM4). This could then enable them to be calm enough to talk about things that were troubling them, and process difficult thoughts, feelings and memories. It may not be until after such processing that they could think about goals other than relief from distress (Principle G, OC1).

More than one art therapist in Holttum et al. (in preparation) talked about drawing from reading or further training in using formulation (context element C4 in Figure 4) to help them to support some service users' need to understand the origin of their psychotic experiences (Principles B and G). In some cases it seemed possible to collaboratively come to an understanding of these in relation to difficult life experiences, which then enabled the service user to feel more settled and to begin considering broader life goals. Interestingly art therapists did not routinely link formulation to goal-setting. This may indicate that formulation can have more than one function, and in art therapy and in relation to psychotic experiences, it may have as much of a stigma-reduction function (Principle E) as aiding therapeutic goal-setting. That said, collaborative setting of achievable goals that take people nearer to their desired life is in keeping with service-user-defined recovery principles (Perkins et al., 2012) and our Principle G, and was present in other studies (Coles & Harrison, 2018; Hanevik et al., 2013).

One pair of art therapists in a joint interview in Holttum et al. (in preparation) talked about work they did that specifically drew on trauma-informed approaches, and they built an initial phase into their art therapy programme that specifically enabled service users to establish safety. This trauma-informed approach is reflected in Principle E, working with real-world contexts. One of these two art therapists had received prior training in trauma-informed work, and the other was learning from her (C5 in Figure 4). Both the addition of formulation and of specifically trauma-informed work can be attributed to continuing professional development (Principle J in Figure 4)

An important feature in Holttum et al. (in preparation) was that the service and broader societal context within which art therapy was provided was seen as making a difference. For example, some art therapists experienced pressure for shorter therapy than service users appeared to need, or conversely, support for relatively long therapy in some secure forensic settings. This aspect of service context, which fits within a broader theme in Holttum et al. (in preparation) of a 'clash of needs' between those of service and service user (C9) has a hypothesised impact on service users' attendance at and benefit from art therapy (AM1, AM2), and may also contribute to the art therapist's capacity or opportunity to work with others in the organisation (Principle A). More general movements in society, and in service-user-led training that recognised the role of trauma in psychosis, were experienced as supporting trauma-informed work (C6 and Principle E in Figure 4).

Principle A, working together in organisations, highlights how team working may help ensure that service users receive all the support and therapies that may assist them in their recovery journey, and is consistent with the service setting reported by Green et al. (1987) and Montag et al. (2014), in both of which trial participants received a range of other supports. This also coheres with Allan et al. (2015), de Morais et al. (2014b) and van Lith (2014; 2015). These provisions appear superior to standard care in the UK as documented in the Schizophrenia Commission report (2012), and which was the context of the MATISSE trial (Crawford et al., 2012a, 2012b).

Arguably, although similar conditions may have pertained in the Richardson et al. (2007) trial, that trial was conducted prior to the period of austerity that began in the UK following the 2008 global economic downturn. This supports our hypothesis that one possible contributor to the favourable art therapy outcomes in three of the RCTs compared to the MATISSE trial's null result was a comparative lack of comprehensive and integrated services in MATISSE. This may have contributed to the low attendance in the two active arms of that trial. High quality usual care (C1, C2 and not too much of C9 in Figure 4, enabling AM1 and AM2) is hypothesised to facilitate service user attendance of art therapy in a number of ways, which may include helping to raise service users' overall wellness, raising hope and motivation, and service needs not conflicting with art therapy. An alternative explanation could be that had the other RCTs been as long as MATISSE they also might have shown less positive outcomes due to dropout. However, this possibility seems less likely given that Montag et al. (2014) reported better outcomes for art therapy compared to usual care as long as six months after art therapy even using ITT analysis (correcting for dropout).

Two art therapists in Holttum et al. (in preparation) talked about showing artwork made by a service user (with their consent) to other members of the mental health

team and how this appeared to increase empathy for and understanding of the service user's needs. This is captured in Principle A as supporting service users to speak through art, although it also signifies the enhancement of service users' verbal communication capacities through first beginning to communicate within art therapy via art (Holttum et al., in preparation).

Availability of experienced supervisors was reported to be helpful (Holttum et al., in preparation), especially when service users were struggling or disengaged, and this is reflected in Principle I, art therapists' reflection and wellbeing. Service users' slower-than-anticipated progress or disengagement is shown in Figure 4 (OC2) as contributing to the art therapist's use of supervision and self-care. In turn, the availability of clinical supervision is shown as part of the service context (C7), although art therapists often seek and receive supervision outside their immediate service if it is not available there (Holttum et al., in preparation). Use of supervision then leads to new ways of accommodating service users' needs (F).

Holttum et al. (in preparation) also reported art therapists as feeling reward when they observed service users' progress (AM3). Even when it was slow or only after a period in which it seemed that nothing was happening, service users' gains and at times direct expression of appreciation to the art therapist could contribute to the art therapist's continuing commitment to supporting service users' sense-making, agency and coping (Principle G).

Patterson et al. (2013) presented a grounded theory model of engagement with art therapy in the Crawford et al. (2012) trial. It suggested that those who engaged with art therapy experienced it positively and continued to attend (AM2), with one of three outcomes. They could experience no change (OC2), specific change or find it life-changing (OC1). Participants who engaged felt attached to the therapist and felt they gained skills and a sense of achievement from the art-making or by managing to interact with others, reflected in Principle G (supporting recovery) as a mechanism leading to these outcomes (OC1) in Figure 4. Buffered interaction via art-making and artworks, and enjoyment of art-making (Principles B and D), was consistent with Lynch et al. (2018), and negative forms of voice-hearing experiences faded into the background during art-making (AM4), consistent with Montag et al. (2014). According to Patterson et al. (2013, p. 7), participants who experienced transformation "had identified and pursued personal goals with therapists, with a view to 'recovery'." This echoes the allusion to personal goals in Coles and Harrison (2018) and is reflected in Principles B and G. It is inconsistent with a view of art therapy reported by Patterson et al. (2015) as not goal-orientated, discussed next.

Patterson et al. (2015) reported qualitative findings drawing on an impressively large range of data including interviews and focus groups with clients and therapists, and observations during the Crawford et al. (2012) trial. The different approaches to art therapy reported in the latter have been mentioned already. In addition Patterson et al. (2015, p. 35) listed nine "common values, processes and practices" including provision of a protected space, providing emotional containment, supporting the use of art materials as a buffer from direct interaction with therapist or other group members, great caution as to voicing psychoanalytic interpretations to participants, and, as already mentioned, focusing on processes rather than service users' goals. One drawback of Patterson et al. (2015) was the relative lack of quotations from service users. This may have been to avoid duplication but was in contrast to Patterson et al. (2013), who reported service users feeling transformed and pursuing personal goals.

The inconsistency between Patterson et al. (2013) and Patterson et al. (2015) about whether or not art therapy is or can be goal-orientated may be due to different practices by different art therapists. However, the subjectively reported positive outcomes where participants had set goals (not captured in the quantitative findings from Crawford et al. 2012), suggests that supporting service users to set achievable goals in art therapy that take them nearer to their valued lives may be advisable where service users have capacity to engage in doing so. It is also consistent with principles of personal recovery (Perkins et al., 2012), and is reflected in Principles B and G of the current guidelines. Holttum et al. (in preparation) reported that a common positive end point was that a service user was able to embark on training or education that had previously felt impossible, and also that their social connections with others outside therapy were enhanced (OC1).

As shown in Table 7, many of the themes identified from interviews and focus groups with art therapists by Patterson et al. (2011) were echoed by service users in later qualitative studies (Colbert et al., 2013; Lynch et al., 2018; Patterson et al., 2013; Patterson et al., 2015). Colbert et al.'s (2013) systematically conducted though small study of an art therapy based intervention in an art gallery setting included the dimension of joint viewing of gallery

artworks, with participant themes resembling some reported in Coles and Harrison's (2018) mixed method study, including the specialness of the setting adding something to the sense of validation and social inclusion (Principle G leading to OC1), and helping to provide alternatives to the "dominant narrative of psychosis" (Colbert et al., 2013, p. 252) (Principle E). Stevens et al. (2018) have provided further evidence that a range of creative activities offered in public arts venues can enhance mental health service users' sense of value and social inclusion.

Hanevik et al. (2013) reported on a small study of art therapy with women who had psychosis-related diagnoses, using qualitative systematic case methodology. They reported the participants as stating that they felt better able to cope with psychotic experiences, and felt more valued (OC1). Illustrating the detailed depth possible in such studies, for one participant the art-making seemed to help her to differentiate some experiences (seeing angels) as helpful because these had long-standing positive connotations and valued religious meanings, and others as unhelpful and signals to seek help from a key worker.

The group art therapy in Hanevik et al. (2013) shared core characteristics identified by Patterson et al. (2015). However, some features were distinctive, including all participants setting goals (Principles B and G) in individual meetings with the art therapist before starting the group, and that there were built-in phases within the therapy programme, the first being depicting a safe place, followed by sessions in which clay, movement and writing were employed to depict psychotic experiences, and then later sessions being focused on thinking about hopes for the future (Principle H). There was an overall strength-based framework (Principle G). Although Hanevik et al. (2013) do not mention trauma specifically, their approach could be seen as consistent with the framework of trauma-informed therapies, in that the initial phase of depicting a safe place and "establishing confidence" (Hanevik et al., 2013, p. 314) is consistent with the phase-based therapeutic approach to 'complex post-traumatic stress disorder' recommended by Cloitre et al. (2012) in their expert consensus guidelines. In Part 3, we explain why psychological trauma is likely to be relevant for a significant proportion of people who receive psychosis-related diagnoses. In this respect, art therapy practice in Hanevik et al. (2013) resembles the specifically trauma-informed practice (Principle E) mentioned by some art therapists in Holttum et al. (in preparation).

The studies reported by Van Lith et al. (2009), and Van Lith (2014; 2015) again point to certain core elements shared by other studies, such as the role of art-making in creating a sense of safety and role of the art therapist in creating a safe therapeutic space (Principles F and D). Consistent with Hanevik et al. (2013), van Lith (2015) emphasises the importance of a spiritual dimension in that some participants made connections between their artwork and spiritual or religious beliefs and values. This is expressed as finding new meaning in OC1 (Figure 4). Although we did not identify any papers specifically discussing the ethnicity of art therapy participants with psychosis-related diagnoses, Salom (2015) discusses valuing and drawing on cultural art traditions of displaced ethnic minority women in Colombia in brief art therapy aimed at aiding their adaptation to their new surroundings. This, together with some art therapists' experiences reported in Holttum et al. (in preparation) led to the inclusion of supporting culturally specific art in Principle B (collaborating with service users). Despite some shortcomings, Teglbjaerg (2011) and De Morais (2014b) also reported findings broadly in keeping with other qualitative studies, in terms of the processes and mechanisms of art therapy for people with a psychosis-related diagnosis.

2.3.4 Summary of programme theory

On the basis of this literature review, it is possible to suggest core features of art therapy for people with psychosis-related diagnoses and how they are helpful. Figure 4 illustrates the three classes of process and how they are hypothesised to interact based on the current evidence review of art therapy for people with a psychosis-related diagnosis. Consistent with the CMO approach, some aspects of context are in the service setting and wider society, and some are about therapists' prior training and experience. Service users' prior experiences are not shown directly as context, although they are relevant and implied (e.g. trauma experience), because what is of interest here is how the actions and influences of the setting and therapist take these into account and interact to facilitate service user outcomes. A broader discussion of the service user aspect of context is provided in Part 3 of this document.

It appears that one contextual necessity may be a service context (C1, C2, minimal C9) in which there is a range of other supports and services and/or a focus on service users' strengths and resources and minimal clash of needs, at least as experienced by the art therapist. This

positive context is shown in Figure 4 as contributing to service users having capacity and motivation to attend art therapy and thereby (AM1) receiving an adequate number of sessions (AM2). Low perceived levels of conflict between service needs and needs of service users (C9) may contribute to both service users' and therapists' motivation and hope for the service user, and may contribute to art therapists being able to work together more effectively with others in the host organisation (Principle A), and to more easily implement recovery-focused art therapy practices described in Principle G.

Other important contextual factors are the art therapist's prior training and experience. Art therapists without substantial placement experience of working with people who have psychosis-related diagnoses may need a certain amount of post-qualifying experience and continuing professional development (J) to work sensitively with service users who are extremely fearful and may have been traumatised (C5). These skills enable art therapists to work according to Principles B, D, E and F (Figure 4). For some, this may include learning through experience to temper what might feel to be a certain level of practice rigidity (C3) in order to adapt to the level of fear, distress and disturbance with which service users with psychosis-related diagnoses may arrive. This is particularly reflected in Principle F (adapting and attuning art therapy), which includes not holding boundaries so rigidly that it can be counter-therapeutic, and great care in offering psychoanalytic interpretations, or indeed not offering them, and only exploring deeper issues at the appropriate time (Principle F). Skills in using a trauma-informed approach (C5, Principle E) may also be needed.

In terms of therapeutic mechanisms, art therapists' skills for working with distress enable them to create a physically inviting and psychologically safe space for service users to enter, with the hope that they may be able to remain long enough and continue attending long enough to engage in therapeutic work: AM1 and AM2 and again Principles B, D, E and F as shown in Figure 4. As was illustrated in several studies reviewed here, safety may be created in a number of ways, including: the use of trauma-informed approaches as mentioned already; having structure such as the use of themes; specific relaxation-inducing exercises, or music; for very vulnerable service users their own space in a group to do their artwork and no expectation of immediate interaction with therapist or other group members; and going outside and walking in a natural environment (where accessible) to shift the focus away from social interaction and onto the surroundings.

As an interim outcome and therapeutic mechanism, the therapist's creation and maintenance of safety (Principles B, D, E and F) enables service users to express aspects of self, emotions, or psychotic experiences in art, words or both (AM5), with art-making and the focus on the artwork as a buffer to reduce the intensity of the face-to-face interaction with the art therapist or other members of an art therapy group (D). The buffering effect of art-making was featured in many of the studies reviewed here. Service users' expressions then may enable them to process distressing or difficult emotions (AM4), and thereby gain relief. It seems likely that in addition to providing a buffer for interactions, the act of art-making itself is calming (AM4), with the result that service users are more able to talk in individual or group art therapy after some engagement in art-making and to consider other goals (Principles B and G, OC1).

Other mechanisms entail the art therapist facilitating service users in their creative efforts, including by supporting the development of art-related skills and encouraging playful use of art materials (Principles B and G). Art therapists may suggest particular art-making approaches that facilitate playfulness, and may use music and movement. The therapist's support for service users' art-making or to achieve collaboratively set goals (Principles B and G) may in turn lead to service users feeling a sense of achievement, increased self-esteem, and for some, a new artist identity (OC1). Supporting connection may go beyond art therapy group members to include social inclusion more broadly (OC1), for example by the art therapist supporting the service user to attend either a bridging activity such as arts activities provided for service users, or move directly to mainstream arts activities or other courses for which they had an interest or aptitude (OC1), illustrating Principle H (ending art therapy). Social inclusion may also be facilitated by providing art therapy in a museum or gallery, either from the start or later in therapy.

Service users' gains in art therapy can feed back into art therapists' commitment to their recovery journey (AM3) as the art therapist observes and appreciates these gains. Conversely, service users can also react negatively to their own artwork, to a therapist intervention, to the setting or other service users, and may disengage or not make hoped-for progress (OC3). Access to high quality clinical supervision from therapists experienced in working with psychosis may be invaluable (C7) to enable art therapists to work to contain their difficult feelings, and to problem-solve and try different ways to adapt to a service

user's needs (Principle I). This may lead to service users re-engaging. Other than the brief mention of a participant dropping out in Hanevik et al. (2013), Holttum et al.'s (in preparation) inclusion of examining disengagement and dropout is unique in the art therapy literature, and sheds important light on how less positive service user responses can occur and how they might be (a) reduced and (b) addressed.

None of the reviewed papers mentioned any role for involvement of friends and family directly in the therapy process. However, the guidelines (Baird et al., 2012) for early intervention services for psychosis (EIP) recommend engagement with and support for people's families, including therapies for the family. The Open Dialogue approach to severe mental health difficulties sets out to help people involved in a crisis situation to engage in dialogue together with their families and social networks (Seikkula et al., 2011). Holttum et al. (in preparation) reported that some art therapists were becoming aware of Open Dialogue and were inspired by its possibilities for opening up different ways of understanding people's difficulties and supporting recovery. There is more information about this in Part 3, but it illustrates how not only family members but members of people's wider social network may be invited to participate in enabling an understanding of how things have come to crisis point and thinking of ways forward. Communication with family or friends was endorsed by art therapists in the consensus guidelines (Holttum et al., 2017), and occasional direct involvement in art therapy was mentioned by art therapists in Holttum et al. (in preparation), for example a service user asking for a spouse to attend an interim review session. Such direct involvement of family or friends may require additional training for some art therapists beyond their qualifying training, but it is expressed in Principle C.

2.3.5 Conclusions

The ability to adapt to individual service users' needs (Principle F) is core to art therapy (Crawford et al., 2012; Holttum et al., in preparation; Teglbjaerg, 2011; van Lith, 2014). Whilst this can mean that each service user experiences art therapy uniquely, it does not preclude the specification of a broad and evidence-based framework with such adaptations specified as they are here and in more detail in Part 1. To the extent that art therapy practice in relation to psychosis is clearly specified, this should enable appropriate fidelity checking for future research trials. Finally, the programme theory presented here is open to testing by further research aimed at examining specific elements and interactions described in it.

2.4 AREAS NOT ADDRESSED IN THESE GUIDELINES

We do not focus exclusively on the use and role of art materials because this would draw a false cut-off between elements of practice that are part of a holistic approach, with some exclusively art-related, and some less so or not at all but integral to the overall approach (Springham & Huet, 2018). Nonetheless there are many areas of general good practice that are not covered in the guidelines but are covered under other policy and guidance. Art therapists in the UK are expected to work in accordance with the Health and Care Professions Council (HCPC) Standards of Professional Practice and Standards of Conduct, Performance and Ethics, the BAAT Code of ethics and any other relevant guidance. They are expected to work in accordance with relevant legislation and to comply with local policies and procedures instituted by their employing organisation.

PART 3: UNDERSTANDING PSYCHOSIS

3.1 THE PHENOMENON OF PSYCHOSIS

The Task Group undertook a detailed examination of the literature on how psychosis is understood, including recent advances in understanding contributors to psychotic experiences, studies on the experiences of service users, and The British Psychological Society's *Understanding Psychosis and Schizophrenia* (Cooke, 2017).

The experiences that are called psychosis form a continuum. This ranges from the fleeting and relatively untroubling to the regular and overwhelming. At one end of this continuum are experiences shared by many that result in no need for psychiatric or therapeutic support (Beavan et al., 2011). At the other end, psychotic experiences can cause great distress to those experiencing them and sometimes to those around them and make it hard to sustain education, employment, relationships and independence. Those affected in these ways often have contact with psychiatric services, sometimes over a long period.

The British Psychological Society (BPS) has published a helpful description of the sort of experiences that are usually thought of as 'psychosis', underlining that these experiences often occur at times of stress and may be linked to other distress including depression and anxiety, or problems resulting from trauma:

- "Hearing voices speaking when there is no one there."
- "Holding strong beliefs that others around you do not share."
- "Difficulties with thinking and concentrating."
- Appearing "inexpressive, withdrawn, listless, apathetic or unmotivated" (Cooke, 2017, pp 10-11)

Although we use the term 'psychosis' for brevity we view the term as potentially making a diverse and hard-to-define set of phenomena appear more coherent and concrete than they are. In keeping with widely accepted aims to challenge stigmatising and discriminating attitudes (Cooke, 2017; Baird et al., 2012; NICE, 2010) we would challenge the use of terms (referring to people) such as 'psychotics' or 'schizophrenics' because they depersonalise experience, may imply permanence that is unwarranted, and impose a division between people that is usually unhelpful.

We do not see psychosis as 'something you've got', like a cold or an infection and we question the utility of attempts to understand this range of experiences within any single framework, such as that of medical diagnosis. It is also important to note that, in line with the continuum mentioned above, some people with mental health diagnoses such as 'depression' and 'emotionally unstable personality disorder' (EUPD) may have some psychotic experiences.

3.2 NEUROPSYCHOLOGICAL ISSUES

Many people who receive a psychosis-related diagnosis have experienced psychological trauma or prolonged stress in childhood or later (Bergström et al., 2019; Read et al., 2014; Romme et al., 2009). Early, attachment-related trauma can severely reduce trust in others (Debbané et al., 2016) and evoke fear, which may be expressed as anger or hostility at times. Such levels of understandable fear and mistrust can render direct contact with others highly challenging, and in keeping with Principles B, D, E and F of the present guidelines, interacting with art materials is thought to provide a buffer that may enable people to be in a room with a therapist and perhaps other service users when they might not manage it otherwise (Czamanski-Cohen & Weihs, 2016; Holttum et al., in preparation; Lynch et al., 2018; Richardson et al., 2007). People who are unable to engage verbally may be able to use art materials (Brooker et al., 2007). NICE (2010; 2017) recommends that clinicians consider offering arts therapies to people, particularly to help with 'negative symptoms'.

Our understanding of the evidence is that most people given a diagnosis of psychosis or 'schizophrenia' do not have something 'wrong' with their brains. The brain has been shaped by evolution to respond in certain ways to environmental challenges and we see psychotic phenomena in this context. Psychotic states and experiences entail changes to brain functioning, but this does not mean that psychosis should be viewed as an 'organic disease'. When we consider the biological we believe it is important to be aware of how this interacts with the psycho-social. Growing evidence, as discussed in this document, suggests that a great proportion of psychotic experiences can be understood as responses to the psycho-social environment. There are some organic conditions that can cause psychotic experiences and other experiences and difficulties (see next section) but these are not the focus here.

Due to the brain's plasticity, changes can go in both directions i.e. the brain can adapt into and out of disturbed states (Cozolino, 2017; Johnstone et al., 2018; Read, et al., 2014). Early intervention for psychosis (EIP) guidelines (Baird et al., 2012) note that structural brain changes occur very early on in the experience of psychosis. They avoid a discussion of whether these are the cause of or are caused by psychotic experience or indeed life experience, and simply commit to curtailing the changes as soon as possible (Baird et al., 2012). To put this in context, it is worth noting that changes in the brain occur all the time in the general population in response to life. They occur in learning such as when black-cab drivers learn 'the knowledge' of London's streets (Woollett & Maguire, 2011). They occur in children who have been abused or neglected (Read et al., 2014). One study has shown that a 10-session art class held in a museum was followed by beneficial changes in the brains of older people (Bolwerk et al., 2014).

Experiencing psychosis can entail changes to bodily awareness. Recent work (Reininghaus et al., 2016) on excess salience of sensory input (which includes that from one's own body) offers one possible way of understanding this. First, an individual's sensitivity to stress may have been increased by adverse experiences. Associated with a state of hypervigilance, unusual salience is likely in itself to have an impact on an individual's perceptions and thinking, such that sensations originating both from outside and inside the body can contribute to the sense that one's experiences are unusual and disturbing, over and above real-world threats.

Psychosis may be a response to many of the same psychological issues as occur in the general population. People who receive a psychosis-related diagnosis may hear voices or see things others cannot hear or see, but they can also experience fear, distress, depression, shame, low self-esteem, low motivation, inability to find words for feelings (alexithymia), difficulties in expressing what is on their mind, confusion, disconnectedness, blankness and difficulties in connecting thoughts together (Cooke, 2017).

3.3 CAUSES OF PSYCHOSIS

Despite evidence suggesting that both genetic and environmental factors may contribute to the development of a range of mental health problems, these sources of influence are often seen as a dichotomous 'nature versus nurture' split (Cooper, 2001). While in this guideline we have chosen to focus mainly on the psycho-social, our intention has not been to play into this split. We cannot say that psycho-social factors constitute all the causes of psychotic experiences, but they are the areas of most immediate importance to art therapy practice. Having said this, we consider it important for art therapists to have an awareness of biological influences on the issues service users bring to therapy. In addition, we view art therapy as one of the ways of creating the conditions for our brains to heal (Cozolino, 2017), especially in cases where the causes of psychotic experiences are largely psychosocial.

3.3.1 Socio-economic and psychosocial factors

Evidence suggestive of socio-economic influences on mental wellbeing is broad ranging. Some research shows a correlation between low socio-economic status and psychosis: for instance, Warner (1994) and McKenzie (2017). Warner's seminal book discussed international evidence of the impact of economic recession on the incidence of psychosis, on hospital admissions, and on social and clinical recovery. Epidemiologists Wilkinson and Pickett (2009) used international data sets to show how inequalities in different countries are frequently correlated with health problems for people with both low and high economic status. They reported correlations between societal inequalities and poor outcomes for everyone's health. In societies with greater social and economic inequality, the following factors are significantly worse: physical health, mental health, drug abuse, education, imprisonment, obesity, social mobility, trust and community life, violence, teenage pregnancies, and child well-being. Although correlation does not necessarily imply causation or tell us about the direction of causation, many of these issues affect the lives of people with a psychosis-related diagnosis.

In answer to the question about whether inequality causes mental distress or mental distress causes people to drift down into poverty, Read (2010, p.7) argues that:

> "An evidence-based resolution to the longstanding debate between 'social causation' and 'social drift' explanations is that the former perspective explains how poverty is a major cause of psychosis and the latter explains how poverty is involved in its maintenance."

Whatever the range of views regarding a direct causal link between conditions of inequality and psychosis, we think that it is important for practitioners to be mindful of the possible effects of service users' socio-economic conditions, currently and in their history (e.g. Watts et al. 2018; Wood, 2011). This underlines the importance of Principle E in this document (working with real-world contexts).

There is evidence to suggest that people belonging to Black and minority ethnic (BAME) groups are disproportionately given a diagnosis of schizophrenia (Stewart-Brown et al., 2015) and are perceived as being more dangerous. BAME individuals are more likely to be detained under the Mental Health Act (MHA) than white service users (Morgan et al., 2004). Gajwani et al. (2016, p. 1) suggest a "complex and multi-faceted relationship between ethnicity and detention."

Being diagnosed with a psychotic disorder is correlated strongly with urban living, at least in developed, Western societies. A study by Veling et al. (2014) reported that the risk of experiencing psychosis was higher for people living in socially disorganised environments. Newbury et al. (2016) reported that children living in urban environments had twice the normal risk of having psychotic experiences at the age of 12 years. They reported causal links to low social cohesion and crime victimisation. Bourque et al. (2011) found that people who have migrated to a new country have higher rates of psychosis-related diagnoses than those who are native, in various countries where this has been studied. Karlsen et al. (2005) reported links between experiences of racism and experience of psychosis in members of BAME communities in England.

Social networks can become impoverished for people experiencing psychosis, but it is not clear whether it is a cause or a consequence of diagnosis, or both. However, in a longitudinal study Wright et al. (2000) reported that people discharged from mental hospitals experienced significant social rejection on top of internalised stigma. Individuals who have a history of experiencing psychosis may find their non-verbal language and social functioning is disrupted as a consequence of psychotic and other adverse life experiences (Debbané et al., 2016; Li et al., 2017). This may also contribute to their social isolation.

"Although professional support can be helpful, often the most important source of help and support is our network of relationships: friends, family and community" (Cooke 2017, p.63).

Offering information, psychoeducation, help and support in the form of family interventions has been a key development in recent years. In the UK this has tended to be behavioural family interventions. An alternative model, built on the systemic approach of family therapy is the Finnish programme of Open Dialogue, active in parts of the UK, which sets out to help people involved in a crisis situation to engage in dialogue together with their families and social networks (Seikkula et al., 2011). There is growing evidence for the efficacy of this approach (Bergström et al., 2018; Seikkula et al., 2011). Whilst best practice in terms of involving people's social networks may require further training, we include in the present guidelines Principle C (working with friends and family).

3.3.2 Early trauma and adversity

"The most profound realisation dawns on her gradually, becoming apparent incrementally over time and then one day she suddenly knows what she has always known. Her voices are more than just voices. They are many different selves, [...] dissociated selves that became internal representations of her external world. Rather than trying to eradicate these different parts of her even though they sometimes frighten her, she [...] begins to listen to them and understand them and to greet them with compassion and understanding. To her delight, they begin to teach her the mysteries of healing, alchemy and magic." (Dillon, nd)

The quote from Jacqui Dillon's story is part of her explanation of how she gradually came to understand her voice-hearing and paranoia in the context of prolonged abuse during her childhood. Early adverse life experiences and trauma are reported by several researchers as prominent factors in the development of psychosis (Longden & Read, 2016; Read at al., 2005; Read et al., 2014; Romme et al., 2009), underpinning the need for trauma-informed art therapy, part of Principle E, and for the shared formulation subsumed under Principle B.

"Several psychological and biological mechanisms by which childhood trauma increases risk for psychosis merit attention. Integration of these different levels of analysis may stimulate a more genuinely integrated bio-psycho-social model of psychosis than currently prevails. Clinical implications include the need for staff training in asking about abuse and the need to offer appropriate psychosocial treatments to patients who have been abused or neglected as children" (Read et al., 2005, p. 330).

Childhood adversity such as poverty, abuse and neglect can have a significant effect on people's attachment strategies (Debbané et al., 2016). Causation can be bi-directional, since early attachment problems may create further vulnerability. Attachment difficulties and trauma can lead to problems with mentalising (understanding one's own and others' minds) and consequently to problems in relating to others (Couture et al., 2006). Cozolino (2017) has summarised evidence on the adverse effects of lack of nurturing on the brains of numerous animals during their early years. Unlike in human studies, ethics committees allow researchers to manipulate the experiences of animals so that cause-effect relationships can be demonstrated.

Human studies are observational, but the findings closely resemble the animal studies (Read et al., 2014). Adverse childhood experiences including physical, psychological and sexual abuse have been found to have a dose-response relationship with both poor mental and poor physical health in adulthood (Felitti et al., 1998). Read et al. (2014) also pointed to a dose-response relationship, such that a higher number of childhood adversities was associated with a higher likelihood of receiving a psychosis-related diagnosis as an adult. Alongside these links, numerous changes in the brain have been documented (Read et al., 2014), with suggestions of links to epigenetic changes, that is, when the action of certain genes is switched on or off according to the environment that is encountered. The gene itself stays the same, but it is activated or deactivated, and this appears to be at least partly reversible (Read et al., 2014).

Notwithstanding the above, it is important not to assume that parents or primary care-givers are the perpetrators of abuse. It is possible, but so is abuse by trusted others, or members of institutions into which our children are entrusted. Equally, families do not exist in isolation but in environments (Western, privileged or otherwise) that may cause stress to all members, sometimes hampering the capacity for nurturance of children.

3.3.3 Drugs and other substances

Harmful use of drugs and alcohol is common amongst people with psychotic experiences. The NICE guideline CG120 (NICE, 2014) states that approximately 40% of people with psychosis-related diagnoses misuse substances at some point in their lifetime, at least double the rate seen in the wider population. There is also evidence to suggest that cannabis can play a role in causation for some people (Casadio et al., 2011; Gage e al., 2016). Coexisting substance misuse is associated with significantly poorer outcomes than for individuals with a single diagnosis (NICE, 2014). Also according to NICE (2014), non–prescribed substances are often used to cope with psychosis and in a third of people this amounts to harmful or dependent use. Substances may worsen psychosis as well as hampering treatment.

3.3.4 Other factors

Other conditions and disorders can create vulnerability to psychosis, for example dementia, Korsakov's syndrome as a result of alcohol dependency, and very rare genetic syndromes. Problems with general health issues such as sleep (Cozolino, 2018; Ettinger, 2014; Walker, 2017), nutrition and immune system functioning need to be taken into account as possible causative and sustaining factors in psychosis. Research has found significant sleep disruption to precede first psychotic experiences and getting a diagnosis of a 'psychotic disorder' (Davies et al, 2017; Reeve et al., 2015). Research also suggests that sleep difficulties are often overlooked in people once they are in the mental health system (Faulkner & Bee, 2017; Rehman et al., 2017). This highlights the aspect of Principle E that is about working with mental health systems, which do not always provide the optimal array of supports (Schizophrenia Commission, 2012; 2017), and which may contribute to what service users bring to art therapy (Holttum et al., in preparation).

3.4 RECOVERY – A PERSONAL JOURNEY

The word 'recovery' is used in diverse ways. 'Clinical' recovery is defined as no longer meeting diagnostic criteria for psychosis or 'schizophrenia', while 'personal recovery' is a more person-centred concept promoted by Anthony (1993), and by service users themselves (Deegan, 1987; Leamy et al., 2011; Perkins & Slade, 2012). The incidence, prevalence and clinical recovery rates for psychosis have been debated, but some research has suggested that clinical recovery is more common than was previously thought (Bergström et al., 2018; Harding et al., 1987; Seikkula et al., 2011).

World Health Organisation (WHO) studies in 1969 and 1978 have been described by Jablensky et al. (1992), and by Leff et al. (1992), and further follow-up work was carried out by Hopper and Wanderling (2000), and Harrison et al. (2001). In these WHO studies it was reported that full recovery from 'schizophrenia' is more likely in poorer countries. Jablensky and Sartorius (2008, p. 254) concluded:

> "The sobering experience of high rates of chronic disability and dependency associated with schizophrenia in high income countries, despite access to costly biomedical treatment, suggests that something essential to recovery is missing in the social fabric."

Subsequent 20-year longitudinal research in the USA by Harrow et al. (2014) suggests, more specifically, that there may be a negative impact of antipsychotic medication on recovery rates. There is also evidence of significant unpleasant subjective effects of taking it (Moncrieff et al., 2009; NICE, 2010), and some serious physical 'side effects' that can include weight gain, diabetes, and effects on the muscles, hormones and cardiovascular system (NICE, 2013). A review of evidence by Harrow and Jobe (2013, p. 964) suggested "extensive evidence of samples of medication-free schizophrenia patients with favorable outcomes." It is important for art therapists to keep this evidence in mind alongside some service users' positive experiences of medication (NICE, 2010).

Authors such as Slade (2009) and Deegan (1987) explore 'personal recovery', the socio-political concept at the heart of the user-led recovery model. Warner's (1984) notion of complete recovery and social recovery also make it clear that these may fluctuate. Incidence reported in studies fluctuates depending on what is going on in economies; prevalence is collected differently in different places.

Nonetheless, recovery rates for first episode psychosis are higher than initially thought, and early intervention philosophy (Baird et al., 2012) contributes to challenging views about psychosis. Early intervention in psychosis has been shown to be cost effective (McCrone et al., 2009). Baird et al. (2012) advise:

- Challenging stigmatising and discriminatory attitudes so that young people are not disadvantaged by their experience and are truly included in their local communities;
- Generating optimism and expectations of positive outcomes and recovery so that all young people with psychosis and their families achieve ordinary lives;
- Seeing the family as an important resource.

We consider it important to make a distinction between clinical recovery and the recovery vision that was initiated by service users (Repper & Perkins, 2003) and is supported by an extensive review by Leamy et al. (2011). The latter emphasises the uniquely personal quality of recovery and that it is not exclusively (or sometimes not at all) focused on 'symptom reduction' or simply another word for 'cure'. It may usefully be conceptualised, as:

"a personal journey of discovery. It involves making sense of, and finding meaning in, what has happened; becoming an expert in your own self-care; building a new sense of self and purpose in life; discovering your own resourcefulness and possibilities and using these, and the resources available to you, to pursue your aspirations and goals" (Perkins et al., 2012, p. 2).

This is clearly different from a simple eradication of symptoms (McGregor et al., 2014).

The authors of the present guidelines do not see 'mental health professionals' and 'mental health service users' as essentially discrete categories. Identities may be multiple or overlapping and individuals may move between categories. While mental health problems can for many individuals have a significant impact on social functioning, there are many examples of people who have received a psychiatric diagnosis who function well as mental health professionals (Boyd et al., 2016; Richards et al., 2016). The development of a more collaborative approach to mental health with roles such as peer support worker (Mental Health Foundation, 2012) seems likely to increase the prevalence of such dual experiences. This is included in Principle A (working together) as working with professionals and experts by experience.

3.5 SERVICES FOR PEOPLE WHO RECEIVE A PSYCHOSIS-RELATED DIAGNOSIS

People who are given a psychosis-related diagnosis may be treated across a range of contexts. These include primary care, early intervention services, crisis teams, acute and psychiatric intensive care units (PICU), community mental health services, rehabilitation, secure and forensic mental health services. Common interventions are medication, nursing interventions, social work, occupational therapy, cognitive behaviour therapy and the arts therapies.

One principle across all service contexts and interventions is the importance of a hopeful attitude (Boardman 2018; Baird et al., 2012; Perry et al., 2009). If professionals give the message that the individual has a life-long illness, this may reduce people's hope of succeeding in work, education and training, and cause prejudice that can make these more difficult to attain and maintain (Corrigan et al., 2004). Good practice in all services helps to instil hope in service users, and this underpins Principle G, supporting recovery.

All interventions or forms of treatment, including art therapy, can be harmful to service users if they are not applied appropriately or if the mental health professional misuses their power. We acknowledge that there is a range of evidence on and diverse and strongly held views about the benefits and problems of psychiatric medication (touched on earlier). The politics of the pharmaceutical industry is part of this landscape (Moncrieff, 2009). We recognise a complex relationship between service users and psychiatric medication and we support informed choice for service users and point to the good practice standards for EIP services (Baird et al., 2012). Considering children and young people, we support the NICE recommendation against prescribing antipsychotic medication in certain cases:

"For psychotic symptoms or mental state changes that are not sufficient for a diagnosis of psychosis or schizophrenia, or with the aim of decreasing the risk of psychosis. [2013]" (NICE, 2013, p. 12).

For a small minority of individuals, psychosis can contribute to the commission of crimes, sometimes of a serious nature. This may lead them to enter forensic psychiatric services. However, in general people with mental health difficulties are more likely than the rest of the population to have crimes perpetrated against them (Glied & Frank, 2014; Pettit et al., 2013; The Shaw Mind Foundation, 2019).

People in forensic services are doubly stigmatised, often with repeated or prolonged contact with the criminal justice system in addition to mental health problems. It can be particularly hard for people to achieve a sense of control over their lives and build a life 'beyond illness' when faced with stigma, part of which can be low expectations from those around them (Corrigan, 2002; Corrigan et al., 2004). Also, because of the increased focus on risk and containment in any situation where there is compulsory detention or treatment, it can be particularly important that efforts are made to afford service users some control and uphold their human rights. Independent mental health advocates (IMHAS) in England have a role in this respect, but service users do not always know about them (Newbigging et al., 2015). They may, however, be one of the other groups with whom an art therapist might work together if the need arises (Principle A).

3.6 CONCLUSIONS

In writing these guidelines, the authors have drawn on a range of literature, but we would like to particularly recommend art therapists read and watch accounts by service users of their experiences (e.g. Romme et al., 2009; Longden, 2013). In terms of art therapy, we recommend therapists look out for Audio Image Recordings (AIRs) by service users talking about their artwork in relation to psychosis eg:

https://m.youtube.com/watch?feature=youtu.be&v=c7NHyJXwNyM

https://www.youtube.com/watch?v=jaySpQfWKs0&feature=youtu.be

Further short films can be found on the BAAT website **www.baat.org.**

We also recommend the BPS document *Understanding Psychosis and Schizophrenia* (Cooke, 2017) and Johnstone et al. (2018) *The Power Threat Meaning Framework*. Additionally work such as the YouTube film produced by King's College London, Compassion for Voices: a tale of courage and hope can sometimes be helpful to show service users within sessions. These resources are from clinical psychology. However, whilst we value the work of other professions the focus of this document is articulating how art therapy can be helpful.

In these guidelines we have attempted to take into account the range of service contexts in which art therapists may work with people with a psychosis-related diagnosis. Art therapists have worked with this client group for many years, and can work closely with individual service users, sometimes over extended periods. They work with a range of colleagues and often in contexts where priorities may differ and the approach to service users may at times feel constrained, but with the recognition that the wellbeing of service users is the first priority. We hope that the practice statements and illustrative examples in Part 1 may give a flavour of some of the huge range of art therapy practices that are appreciated by service users and that art therapists have reported as helpful in terms of supporting personal recovery, agency and personal goals beyond mental health services, for people who have been described as having a diagnosis of an "abandoned illness" (Schizophrenia Commission, 2012). People who are in the midst of great distress can often connect with art materials, and that can be the start of connecting again, safely, with another human being, and a step on the road into a life they want for themselves.

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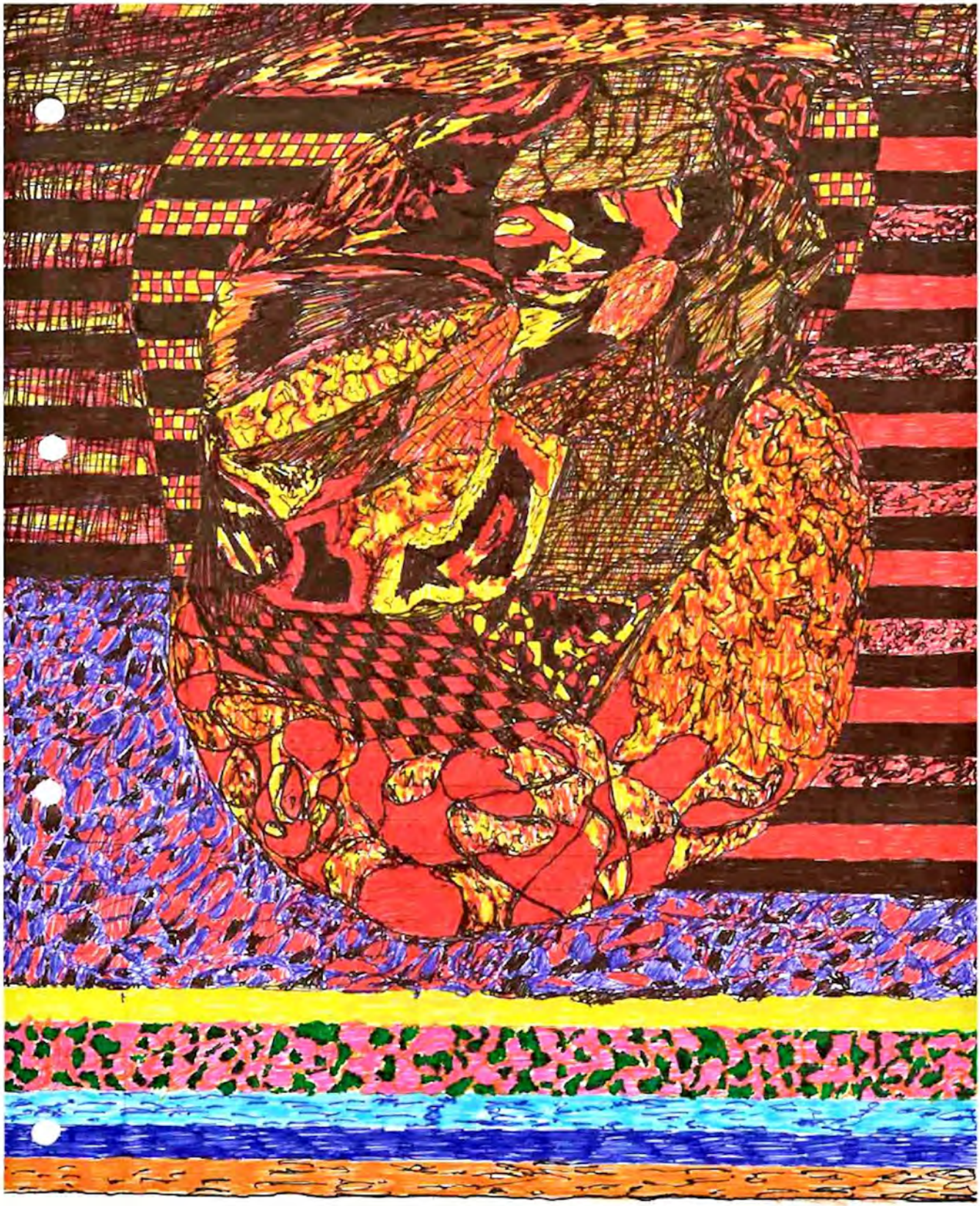

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