What are the Barriers and Enablers for *Equity, Diversity and Inclusion* within the Creative Health Sector?

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Abstract

This study explores the barriers and enablers to equity, diversity, and inclusion (EDI) within the creative health sector, focusing on both workforce representation and the audiences engaging with creative health initiatives. The research addresses a gap in the existing literature by identifying a broad range of factors that influence access to and participation in creative health and providing recommendations for creating the conditions to promote EDI within the sector. The research employs a literature review and semi-structured interviews with sector professionals, analysed using reflexive thematic analysis, to answer the research question.

Findings highlight several barriers including a lack of awareness of creative health, socioeconomic barriers and lack of access to resources, and negative perceptions of creative health spaces as intimidating and unwelcoming. Structural issues within the sector, such as tokenistic practices, short-term funding, and disconnection between organisations and communities further adds to the challenges.

Despite these barriers, several enablers are identified, such as embedding lived experience into decision-making roles, fostering co-creation with communities and improving cross-sector collaboration. Other enablers include targeted outreach, increasing access to participation, context-specific approaches and tailoring offers, as well as long-term funding models, professional development opportunities, and support networks for creating sustainable careers and initiatives within creative health and promoting systemic change in the sector.

The study concludes with actionable recommendations for both the creative health sector and the National Centre for Creative Health, aiming to contribute to the development of a more equitable and inclusive sector that better reflects and serves diverse communities.

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Glossary

Creative Health: Arts, culture, community and creativity-based approaches and activities for health and wellbeing.

Diversity: Recognising people are different in many ways, including backgrounds and experiences in relation to race, ethnicity, gender, sexual orientation, socio economic status, age, disabilities, religious beliefs, caring status, and other characteristics. Respecting and empowering these differences and aiming to be representative of the wider society.

Equality: Ensuring everyone has the same opportunities and no one is treated differently or discriminated against because of their personal (or protected) characteristics.

Equity: Ensuring that everyone is treated fairly in accessing resources and opportunities, by removing barriers that some groups face in society. Recognising people have different backgrounds and needs, so focusing on “equal outcomes” by levelling the playing field.

Inclusion: Being proactive to make sure everyone is feeling welcomed, respected and valued for who they are, and everyone is fully able to participate in a space.

1. Introduction

Creative health is an emerging sector that explores how creativity, arts, culture and community-based approaches and activities can support our health and wellbeing. Despite the sector's growth, a lack of equity, diversity and inclusion (EDI), both in participation and workforce representation, was raised as an issue, and there is a gap in understanding how to address this problem. This study aims to explore the barriers and enablers to EDI within the creative health sector, and to make recommendations to ensure greater diversity and inclusivity as it grows.

The benefits of arts and creativity on our health and wellbeing has long been recognised, dating back to ancient civilizations where the arts were used as forms of healing (Fancourt, 2017). Yet, the evolution of modern science and healthcare, dominated by the biomedical model, has created a rigid separation between the arts and sciences, pushing arts and health initiatives to the fringes of healthcare. As a result, the integration of creative approaches into wider health and social care systems have often been overlooked. Therefore, the creative health field, otherwise known as "arts in health" or "arts and health", have struggled to gain acceptance and support from health and social care sectors.

In 2017, the All-Party Parliamentary Group on Arts, Health and Wellbeing published an influential inquiry report *Creative Health: The Arts for Health and Wellbeing,* presenting findings from two years of research and citing over a thousand resources evidencing the impact of arts on wellbeing (APPGAHW, 2017). The term "creative health" was adopted by this report. With the movement gaining momentum since then, several national organisations have taken up its recommendations, including the NHS England and the Arts Council England (Arts Council England, 2022; ACE & NCCH, 2022; Polley et al., 2023).

The increased recognition of using creativity for health benefits, leading up to the commissioning of the *Creative Health* report, was partially driven by a crisis in health and social care. Healthcare systems are under huge pressure with record numbers of people on waiting lists, combined with a lack of capacity and staff shortages in health and social care systems. Life expectancy in the UK is stalling and more people are living with major illnesses. Furthermore, there is a pressing social justice concern with the widening health inequalities, defined as "avoidable, unfair and systematic differences in health between different groups of people", that calls for urgent action (Dunn et al., 2023).

Health inequalities arise because of social inequalities. The World Health Organization (WHO) estimates around 50% of health outcomes are driven by the social determinants of health, the conditions in which people are born, grow, live, work, and age, shaped by

social, cultural, political, economic, commercial and environmental factors (The Health Foundation, n.d.; WHO, n.d.). The Commission on the Social Determinants of Health argues that the social determinants of health are responsible for a major part of health inequalities between and within countries (Commission on Social Determinants of Health, 2008).

The growing recognition of the social determinants of health and the unequal distribution of health across the social gradient, led to the commissioning of the Marmot Review (2010), which proposed evidence-based strategies for reducing health inequalities. Two of the six policy objectives were "creating healthy and sustainable places and communities" and "strengthening the role and impact of ill health prevention" with a focus on a community assets-based approach. These objectives suggested health and social care systems alone cannot tackle health inequalities, and a new whole systems approach is needed.

Creative health can play an important role in such an approach that is health-creating, preventative, person-centred and community-led. Six years after the initial report, the APPG AHW and the National Centre for Creative Health published the *Creative Health Review* (2023), with a focus on how policy can embrace creative health to tackle pressing issues, including health inequalities. By integrating creative practices into health and social care, some of the root causes of health inequalities can be addressed to support health promotion and prevention. Creative health initiatives can also address health inequalities by empowering individuals and communities, improving the environments in which people live, and providing culturally appropriate care that meets the needs of underserved communities.

For creative health to flourish it needs to be available and accessible to all. However, much like health inequalities, social disparities exist in access to arts and culture. A recent *State of the Nations* report found that social inequalities persist in who participates in arts, culture and heritage, and who gets the opportunity to work in the sector, with an overrepresentation of White middle-class people in the workforce (McAndrew et al., 2024). For creative health to not reinforce health and social inequalities, the barriers to access and inclusion need to be addressed.

1.1. Research Question: What are the Barriers and Enablers for EDI in Creative Health?

Despite the benefits of arts and creativity on health and wellbeing, the creative health sector faces challenges in achieving EDI. The Culture, Health and Wellbeing Alliance (CHWA) has conducted a state of the sector survey in 2023, gathering equality, diversity

and representation data. Based on this, the sector workforce overwhelmingly consists of white, British, middle-aged, non-disabled and heterosexual cisgender women (Tang, 2024). Lack of diversity and representation in the workforce and practitioners naturally leads to insufficient cultural competence in program design and delivery and a failure to reach diverse, marginalised, underserved audiences. Therefore, the underrepresentation of diverse voices in the creative health sector not only perpetuates health inequalities but also limits the potential impact of these programs. The lack of EDI within the sector has been raised as an issue in several influential reports (NCCH & APPGAHW, 2023; Tang, 2024a, 2024b; The Baring Foundation, 2021, 2024) Yet, there is a lack of comprehensive research that specifically addresses these barriers and explores the enablers that could foster a more accessible and inclusive environment for creative health practices, which can inform the development of effective strategies for diversity in the creative health sector as it develops. This research project aims to address this gap.

1.2. Partner Organisation: National Centre for Creative Health

This project is undertaken with the National Centre for Creative Health (NCCH). The NCCH was formed in response to the Creative Health inquiry report by the All-Party Parliamentary Group on Arts, Health and Wellbeing (APPGAHW, 2017).

> (The NCCH) advances good practice and research, informs policy and promotes collaboration, helping foster the conditions for creative health to be integral to health and social care and wider systems (NCCH, n.d.).

The NCCH is committed to encouraging EDI in the organisation and within the wider creative health community. This research will help NCCH to understand how to ensure that the creative health movement develops inclusively, with equality and diversity at its heart, and achieving its full potential to tackle health inequalities.

1.3. Research Aims and Objectives

The aim of this research project is to understand the current state of EDI in the creative health sector and to explore barriers and enablers to EDI. To achieve this objective, first, a literature review will explore and critically examine existing research and initiatives, identify key themes and gaps in knowledge regarding barriers and enablers to EDI in the field. Then semi-structured interviews will be conducted with sector professionals, such as organisation leaders, policy makers, researchers, practitioners, and funders to have in-depth conversations about their perspectives on EDI in creative health, which will then be thematically analysed.

Based on the findings of the research, this report will aim to provide actionable recommendations to NCCH to promote diversity within both the organisation and the wider sector.

The findings of this project are expected to have implications for policy, practice, training, and community engagement initiatives in the creative health sector. By identifying barriers and enablers, the project aims to inform strategies and interventions aimed to promote EDI in creative health, improving outcomes for both practitioners and participants. Additionally, the research will contribute to the broader discourse on health inequalities and the social determinants of health, highlighting the best practices for incorporating creative approaches into holistic, community-based health and wellbeing strategies. Ultimately, this study aims to inform the sector about the conditions that will create a more inclusive and equitable environment where the benefits of creative health can be experienced by all.

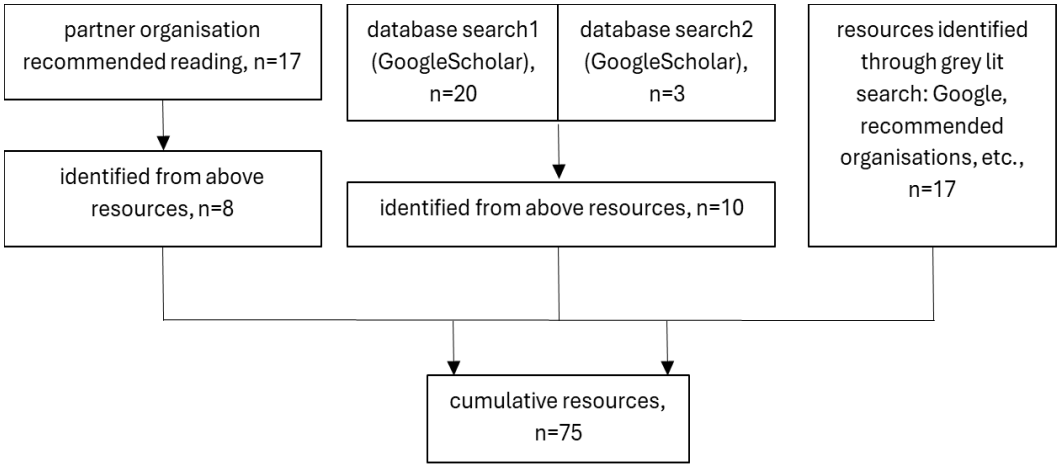
2. Literature Review

The current body of research largely emphasizes the benefits of creative health interventions and focuses on building the evidence base for the effects of arts on health and wellbeing (APPGAHW, 2017; Fancourt & Finn, 2019). However, there is a gap in research for understanding barriers to access and engagement with creative health and enablers to participation amongst marginalised groups (Dowlen, 2023). This literature review aims to synthesize existing research and resources to highlight the state of knowledge, as well as obstacles and strategies to promoting EDI in creative health.

There are no peer-reviewed articles directly looking at enablers and barriers, or strategies for promoting EDI in the creative health sector. Therefore, grey literature, such as websites, blog posts, organisation reports, roundtable overviews, etc., were included in the literature review, alongside peer-reviewed articles that were relevant to the research question. Furthermore, the scoping of resources was extended to include related research from adjacent sectors, such as enablers and barriers to access and participation in the arts and cultural or healthcare sectors, and how this can affect diversity or address health inequalities.

Scoping of literature was initiated with recommended readings from the NCCH. Google Scholar was used to cover a wide range of interdisciplinary studies, with Appendix 1. illustrating the Boolean strings and inclusion and exclusion criteria. Further resources were extracted from Google search engine, sources identified from the reviewed literature and recommendations from interviewees (see Figure 1). A table of the resources included, and the data extracted can be found in Appendix 2.

Figure 1. Summary of literature sourced, reviewed and included



Resources included in the literature search were reviewed to identify barriers and enablers for EDI within the sector. Findings were synthesised to be presented under two headings: *Barriers for a Diverse Creative Health Sector* and *Enablers for EDI within Creative Health*.

2.1. Barriers for a Diverse Creative Health Sector

Literature has consistently shown that specific socio-demographic groups are less likely to engage in creative activities for their health and wellbeing (Mak et al., 2020a, 2020b, 2021; Mak & Fancourt, 2021; Shaikh et al., 2021). These groups include marginalised ethnic groups, people from low socio-economic backgrounds and deprived areas, older adults, carers, and several other populations minoritised in relation to ethnicity, race, language and sexuality (Tymoszuk et al., 2021). Existing mental and physical health problems, which disproportionately affect most of these marginalised groups, create additional barriers to engagement with arts, culture, and creativity (Fancourt et al., 2020). Recent statistics show that the longstanding inequalities in the wider arts, culture and heritage sectors persist, with uneven representations of social classes and ethnic groups, and other dimensions of social inequalities both within workforces and audiences (McAndrew et al., 2024). While these disparities in access to creative health require urgent action, research on specific mechanisms and barriers creating these disparities are scarce. This literature review identifies barriers that make access to the creative health sector more difficult for certain groups, both within the workforce and as participants.

2.1.1. Discrimination

There are many creative health initiatives supporting individuals and communities that face discrimination (Daykin et al., 2020; Red Earth Collective, 2024; Shaw, 2019; The Baring Foundation, 2021). However, it is still important to emphasise that the systemic, structural and societal barriers in place that prevent certain groups of people from accessing and engaging in creative health practices, are rooted in discrimination. Discrimination can manifest in several ways: systemic biases within institutions, prejudiced attitudes from individuals, and exclusionary practices that fail to accommodate or respect cultural differences (Shannon et al., 2022). All of which can directly influence engagement from these groups.

While the ethos of creative health organisations is often centred around tackling inequalities, stigma and discrimination, people from marginalised groups who have historically faced discrimination from health and social care, or arts and culture sectors may be discouraged from engaging with creative health. Their mistrust in institutions that have failed them may extend to creative health initiatives, creating a barrier to EDI (Hemmings et al., 2021; McAndrew et al., 2024).

2.1.2. Socioeconomic Barriers

Socioeconomic factors are among the most cited barriers accessing creative health (Fancourt et al., 2022; Fluharty et al., 2021; Mak et al., 2020b; Shaikh et al.,2021; Waterson et al., 2024). People on low-income often face financial barriers that limit their ability to participate in creative activities. These barriers include the costs of travel, materials, and participation (Fluharty et al., 2021; Johnson & Monney, 2021). Moreover, individuals from deprived areas may have fewer opportunities to engage with creative health due to a lack of local cultural resources or programmes (Fanthome, 2023; Mak et al.,2020a, 2021; Waterson et al., 2024). Time constraints and other priorities, such as work and caregiving responsibilities, further compound these socioeconomic barriers, particularly for those already struggling with financial instability (Percy-Smith & Bailey, 2023b; The Baring Foundation, 2024).

Socioeconomic barriers also impact those wanting to work within the creative health sector. Financial barriers limit access to education, training, and professional development opportunities in the field. Individuals from low-income backgrounds may struggle to afford the necessary qualifications or may be unable to take unpaid internships or volunteer positions that are often the way into the non-profit sectors (Southby et al., 2019). Furthermore, the instability of funding within the creative health sector can lead to insecure employment, freelance or part-time positions, making it less attractive to those needing financial stability.

2.1.3. Systemic and Structural Barriers

Systemic and structural barriers stem from broader issues in society. There were several barriers relating to communication issues between services and to participants. One barrier is a lack of collaboration between healthcare services, cultural organisations, and community groups, which leads to fragmented and inaccessible services (Percy-Smith et al., 2023; Thomson et al.,2021). Additionally, the lack of awareness of creative health activities and opportunities is a barrier for certain groups, which points to insufficient outreach from organisations to engage diverse communities (McHayle et al., 2024; Percy-Smith & Bailey, 2023b). Similarly, language barriers, or difficulty understanding and navigating the system can create challenges for accessibility (Arts & Homelessness International et al., 2020; Public Health England, 2021; The Baring Foundation, 2021; Vougioukalou, 2022).

Furthermore, short-term funding models and the competitive nature of grant allocation contribute to the instability of creative health initiatives, limiting their reach and sustainability (McHayle et al., 2024; Percy-Smith et al., 2023; Shaughnessy et al., 2023).

Finally, a lack of support for networking, mentoring and cross-sector linkages, limits the development of community-driven solutions, inhibiting professionals from marginalised communities from gaining the support and connections needed to progress (and sustain themselves) within the field (Dadswell et al., 2024; Percy-Smith & Bailey, 2023a).

2.1.4. Lack of Representation and Cultural Sensitivity

A significant barrier to diversity within creative health is the lack of representation and cultural sensitivity. Creative health initiatives fail to be inclusive when they don't represent or cater to the needs of diverse groups (Percy-Smith et al., 2023; Shaw, 2020). This can lead to a disconnect between programmes and communities they aim to serve, limiting engagement. For those entering the workforce, lack of representation and the absence of role models sharing similar background or experiences can make the sector seem inaccessible and unwelcoming.

2.1.5. Stigma and Internal Barriers

Stigma, both external and internalised, creates another significant barrier to engagement with creative health opportunities (Dobson et al., 2024; McHayle et al., 2024; NCCH & APPGAHW, 2023; Stewart et al., 2018; The Baring Foundation, 2024). External stigma refers to the negative cultural or societal attitudes that devalue the arts and marginalise people with mental health problems. Internalised stigma refers to the shame and embarrassment or fear of being discriminated against, that prevents people from seeking help or participating in creative health initiatives (Gray, 2002). These internal barriers are often worsened by lack of confidence or self-esteem, as well as believing the arts "not for them". Lack of perceived social opportunities, and physical/psychological capabilities have also been reported to be a barrier for engagement with participatory arts, which can affect both audiences and those entering the workforce of creative health (Fancourt et al., 2020).

2.2. Enablers for EDI within Creative Health

Despite these barriers, several enablers have been identified that can promote diversity within the sector. It is important to note that these strategies already exist in several organisations, and they provide examples of good work that the rest of the sector can learn from.

2.2.1. Community-Centred Approaches

Place-based and community-led initiatives are frequently mentioned as examples of good practice (Ganga et al., 2022; NCCH & APPGAHW, 2023; Percy-Smith et al., 2023). Enabling communities to design and deliver creative health initiatives that reflect their specific needs and preferences is a powerful enabler for diversifying the sector. *Mobilising*

community assets to tackle health inequalities research programme facilitates this approach by funding local, community-based projects addressing health inequalities (UKRI, n.d.). By mobilising community assets, such as community centres, heritage sites, parks, these place-based approaches meet people where they are at, increasing accessibility and reach.

A main pillar of community-centred approaches is co-production, which incorporates lived experience voices into the design and delivery of services. Co-production and participatory methods empower communities to be active partners in creating initiatives that work for them, rather than being passive recipients of "solutions" by external agencies often lacking understanding of community context. Placing community narratives and lived experience voices at the core of programme development also ensures that interventions are culturally sensitive and tailored to the specific challenges and strengths of each community (Arts & Social Outcomes Network, n.d.; Red Earth Collective, 2022; Synergi Collaborative Centre, n.d.; Waterson et al., 2024).

2.2.2. Cultural Sensitivity and Representation

Cultural sensitivity in practice looks like understanding and respecting the cultural, religious, social contexts within different communities, and delivering appropriate and meaningful activities to them (Brooks et al., 2019; Mukunda et al. 2019). Considerations around cultural sensitivity can involve language support, religious accommodations, and the implementation of culturally relevant creative practices. Representation and role models within the workforce are also important factors for fostering diversity (The Baring Foundation, 2024). Having practitioners with similar backgrounds and experiences to the communities they serve can help break down stigmas and make it a safer space for diverse groups by promoting a sense of belonging (CHWA, n.d.-a,b; Stewart et al., 2018; The Baring Foundation, 2021). Representation is important across all levels of an organisation's workforce. Increased representation within leadership and decision-making roles can lead to more inclusive policies and practices, further improving the sector's ability to address diversity issues (Arts & Social Outcomes Network, n.d.; Gordon-Nesbitt, 2022; Shaughnessy et al., 2021).

2.2.3. Workforce Development, Training, and Support

Workforce development and training are important enablers for diversity. Professional development programmes targeted towards specific demographics have been enabling people from underrepresented communities, who may face additional barriers for professional progression, to further their practice within the sector (see examples from London Arts and Health et al.; Counterpoints Arts, 2023). These programmes include

mentoring and networking, which enhance the skills and confidence of the practitioners. Furthermore, support networks for artists facing additional challenges are important in sustaining them within the workforce (Collard-Stokes & Irons, 2022; Percy-Smith & Bailey, 2023b; Shaughnessy et al., 2023; Wreyford et al., 2021).

Alongside professional trainings, several resources highlight the importance of having trainings around EDI, such as anti-racism, cultural competence or inclusive practices, for the workforce (NIHR, n.d.; Shaw, 2020; Vougioukalou, 2022). Instituting these trainings can tackle implicit biases and create a culture of inclusivity.

2.2.4. Cross-Sector Collaboration

Cross-sector collaboration is crucial for an integrated, whole-systems approach to diversity in creative health (Waterson et al., 2024). All successful initiatives and programmes identified uses collaborative methods, often across different sectors and disciplines. Recent studies on the successes and challenges of collaborative approaches will allow for opportunities for well-informed partnerships in the future (Fortier & Coulter, 2021). They conclude that collaborative approaches are crucial for addressing the complex challenges underlying health inequalities, and ensuring diverse populations have equitable access to creative health benefits.

2.2.5. Funding and Resources

Sustainable and dedicated long-term funding is a critical enabler for promoting EDI in the creative health sector. Long-term funding allows for the development of initiatives with a lasting impact, collaborations across different stakeholders, and resources to support practitioners (Percy-Smith & Bailey, 2023b; Shaughnessy et al., 2023). Whereas short-term projects are unlikely to sustain their momentum or attract practitioners needing financial stability (McHayle et al., 2024; Waterson et al., 2024). Furthermore, longer-term projects allow participants to build sustained relationships beneficial to health and wellbeing (Percy-Smith et al., 2023).

Funding for initiatives targeting marginalised communities ensures that these groups are not overlooked and get equitable access to creative health programmes (The Baring Foundation, 2020, 2021, 2024). Baring Foundation is a funder that takes this targeted approach creating grants focusing on diversity in specific areas to overcome the effects of discrimination and disadvantage.

Additionally, resources supporting collaboration between different sectors can help scale successful models and practices, making them accessible to a wider audience (Fortier & Coulter, 2021; Thomson et al., 2021). Sufficient funding also allows organisations to invest

in the infrastructure needed to support EDI, such as training programs, outreach efforts, and evaluation mechanisms. Therefore, with the necessary financial and material resources, creative health initiatives can become more inclusive (Percy-Smith & Bailey, 2023b; Shaughnessy et al., 2023).

2.2.6. Accessibility and Safe(r) Spaces

The *Queering Creative Health* report outlines how just having an accessible and safer space, where you are free from judgment and discrimination, can express yourself and create connections, makes people's lives more liveable (Jiang, 2023). Having these welcoming spaces, whether physical or online environments, allows the participants to feel respected, valued, and cared for (Fanthome, 2023; Hearst, n.d.-b). It is important also to consider providing diverse forms of engagements, such as online programs to help overcome geographical and physical barriers, or sensory adjustments for neurodivergent participants, which might otherwise prevent participation (Dowlen, 2023; Hearst, n.d.-a; NCCH, n.d.-a). Additionally, making creative health activities affordable or free removes financial barriers that can exclude those from low-income backgrounds (Percy-Smith & Bailey, 2023b). Access issues are mentioned often in the literature, so prioritising accessibility and the creation of safer spaces allows the benefits of creative health to reach diverse communities and improve wellbeing.

2.2.7. Education and Outreach

Education and outreach are necessary to raise awareness about the benefits of creativity on health and encourage participation among groups that might not otherwise engage (The Baring Foundation, 2024). There is a need for the evidence base and benefits of creative health to be included in the education of health and care professionals, and vice versa; to promote better collaboration between sectors (NCCH, n.d.-c). Furthermore, educational efforts highlighting the positive impact of arts and culture on health and wellbeing can help shift negative perceptions towards creativity and motivate individuals and communities to engage in creative health activities. Effective outreach should involve going beyond traditional communication methods to reach people in ways that can build trust, employing different forms to reach different groups—whether through community events, social media, or partnerships with trusted local organisations (Counterpoints Arts, 2023; NCCH, n.d.-a; Percy-Smith & Bailey, 2023b). Targeted outreach to underserved and underrepresented groups can dismantle barriers related to stigma, misinformation, or lack of awareness about available opportunities and resources, building a more equitable and accessible route to creative health (Fancourt & Steptoe, 2024; Kearney et al., 2021; Percy-Smith et al., 2023).

2.2.8. Evidence and Evaluation

The final enabler identified was having ongoing evidence gathering and evaluation (Gordon-Nesbitt, 2022; Waterson et al., 2024). While a large evidence base for the effectiveness of creative health have been identified recently, the current momentum of creative health might need further evaluation to understand what works for whom (Dowlen, 2023). Organisations that work with different communities will have different approaches and initiatives that work for them. Systemic evidence gathering and evaluation methods can help identify successful approaches in their diversity and recommend areas for improvement. This evidence can be used to refine programs, making them more adaptive and responsive to the needs of diverse populations (Percy-Smith & Bailey, 2023b). Moreover, evidence and evaluation help to build the case for continued investment in creative health by demonstrating its value to funders, policymakers, and the broader public (NCCH & APPGAHW, 2023). Evidence-based practice is also critical to scale up successful models and ensure they can be replicated in different contexts (Fanthome, 2023; Karkou et al., 2024; Percy-Smith & Bailey, 2023a). It is important to note that evidence and evaluation does not mean randomised control trials and systematic reviews. The literature on creative health is rich in creative approaches to research and evaluation; and arts-based, participatory, collaborative, community-informed and co-produced approaches should continue to be adopted for research (Fanthome, 2023; Jiang, 2023; Percy-Smith & Bailey, 2023b; Percy-Smith et al., 2023; Waterson et al, 2024).

2.3. Gap in Literature

While the above barriers and enablers were identified from the literature, there is a need for more exploration and an in-depth understanding of how the creative health sector can create the conditions to promote EDI within the sector, justifying the need for the following research to be carried out.

3. Methodology

This chapter outlines the methodological approach taken to identifying barriers and enablers for diversity within the creative health sector.

3.1. Design

A qualitative approach was chosen to gain in-depth knowledge from key stakeholders and sector professionals. Primary data were collected through semi-structured interviews with professionals in the creative health sector. Semi-structured interviews were chosen to accommodate the differences between organisations and job roles of the participants and provide flexibility to explore emergent themes or areas of significance in conversation; while ensuring that key topics related to EDI were addressed (Braun & Clarke, 2013). This approach was chosen over quantitative methods or structured interviews to allow participants to feel valued and listened to; promoting open engagement and meaningful communication.

3.2. Recruitment & Data Collection

Participants were selected using purposive sampling, based on their experience and expertise in creative health, particularly those with a focus on EDI, and based on existing relationships and contacts through project supervisors (Prof Helen Chatterjee and the NCCH). Nine participants were contacted and recruited directly by the NCCH via email. Snowball sampling was used to recruit four further participants introduced by the initial interviewees, resulting in a total of thirteen interviews. Participants represented different types of organisations, and several held various roles as follows:

Table 1. Participant Sample

Types of Organisations and Roles	**Number of Participants**
CH infrastructure/sector support organisation	5
Funding organisation	1
CH organisation + freelance practitioner	1
Creative and/or social action charity	3
Academic + lived experience network	1
Lived experience researcher + therapeutic arts nonprofit	1
Public health researcher at a cultural organisation	1
Social prescribing infrastructure + therapeutic arts nonprofit	1

Interviews were conducted remotely, recorded and transcribed automatically on MS Teams or Zoom, and stored in accordance with UCL Data Protection regulations on UCL

OneDrive, a data storage space only accessible by the researcher. Each interview lasted approximately 45 minutes to 1 hour.

3.3. Ethical Considerations

This study was granted low risk ethical approval by the UCL Arts&Health Local Research Ethics Committee (ID: 27405/001). Several ethical considerations were made throughout the study. Participants were sent a participant information sheet and consent form, alongside a copy of the interview topic guide beforehand to have the option to read the interview questions (see Appendices 3-5). Interviews were recorded and transcribed with informed consent. All data files were pseudo-anonymised and stored on UCL licensed and password protected storage spaces. They will be deleted after the dissertation hand-in date (23rd September 2024). Interviewees had the right to read through their transcripts upon request, add or extract comments, or withdraw their participation after the interviews. The interviewees also have the right to read the outcome dissertation paper post its submission.

Participants whose time was not financially covered by their organisation (e.g. freelance practitioners) and for whom this would be a barrier to participation were reimbursed for their time by the NCCH.

3.4. Data Analysis

Data from the interviews were analysed using the reflexive thematic analysis (RTA) approach, following Braun and Clarke's (2020) six-phase process (Table 2).

Table 2. Phases of Reflexive Thematic Analysis

Phase	Description
Familiarisation with the data	Reading and re-reading the transcripts, noting down initial ideas.
Generating initial codes	Generating labels (codes) that reveal important features of the data that are relevant to addressing the research question, collating codes across the entire dataset with relevant data extracts (i.e. quotes from transcripts).
Generating initial themes	Examining the codes and data, collapsing them together to develop broader patterns of meaning within the dataset (potential themes).
Reviewing potential themes	Checking the potential themes against the initial codes and the entire dataset to see if it tells a convincing story to address the research question, splitting or combining themes as necessary.
Defining and naming themes	Developing a detailed analysis of each theme by using a mind map, determining their scope and generating clear definitions and names for each theme.

Producing the report	Weaving together the selection of data extracts and the analytical narrative, synthesising them with the literature to answer the research question in a write up.

The analysis process started with familiarisation with the data, through reading and re-reading the interview transcripts. Each interview transcript was coded using an inductive approach and themes were derived from organising the codes around central concepts. The process of coding and theme development was conducted using the qualitative data analysis software NVivo 14.23.

A reflexive approach to thematic analysis recognises the subjectivity of the researcher and their active role in interpretation and knowledge production (Byrne, 2022). As such, I recognise that the results from this analysis presented in the next chapter is my own interpretation of the data and reflect my positionality.

4. Findings

Six themes were generated through the reflexive thematic analysis of interviews with sector professionals: *(1) Understandings of Creative Health, (2) Understandings of Diversity, (3) Lived Experience, Co-Creation, and Collaboration, (4) Outreach, Engagement, and Participation, (5) Strategies for Sector Support, Development, and Sustainability,* and *(6) Systemic and Structural Context* (see Table 3). Each theme relates to EDI within the creative health sector by capturing different aspects of how diversity is perceived, challenged and promoted in creative health.

Table 3. Reflexive Thematic Analysis Findings

Themes	Description	Subthemes
1. Understandings of Creative Health	*Definitions and conceptualisations of creative health, including the different terminology used, scope of the sector, its relation to other sectors, and discussions around who feels parts of the sector.*	Creative Health Definitions
		Terminology
		Sector Inclusion
2. Understandings of Diversity	*Understandings of diversity, discussions around the current lack of diversity both within the workforce and those who access creative health initiatives, recognition for the need for more EDI.*	Current State of the Sector
		Recognition for the Need for More EDI
3. Lived Experience, Co-Creation, Collaboration	*The importance of involving people with lived experience in the design and delivery of creative health programmes, the value of co-creation with communities and the current challenges, and the opportunities for collaboration between sectors to promote EDI.*	Lived Experience
		Co-Creation with Communities
		Cross-Sector Collaboration
4. Outreach, Engagement and Participation	*Challenges and strategies for reaching underrepresented groups in creative health, including discussions on targeted outreach, overcoming the psychological and social factors and the financial and logistical barriers that impact engagement and participation from diverse groups.*	Outreach
		Perceptions
		Access to Resources
5. Strategies for Sector Support, Development, and Sustainability	*Strategies to support the growth and sustainability of the creative health sector, including recruitment practices, training opportunities, funding models, support networks for practitioners and organisations, as well as research, policy and advocacy.*	Getting into the Sector and Recruitment Practices
		Training, Development and Support
		Support Networks
		Research, Policy, Advocacy
6. Systemic and Structural Context	*Broader systemic and structural issues that shape diversity within the creative health sector, including discussions on root causes of inequities, differing ideas on the infrastructure of creative*	Issues within Wider Systems
		Complexity of Diversity
		Infrastructure of Creative Health

	health, and the need for systemic change to create a more inclusive and accountable sector.	Accountability of the Sector

Findings were summarised and presented in a table that lists enablers and barriers to EDI identified within each theme, at the end of this chapter (see *4.7 Summary of Findings*).

4.1. Understandings of Creative Health

This theme explores definitions of creative health, discussions about the terminology, relations with other sectors and causes, and who feels part of the sector.

4.1.1. Creative Health Definitions

"Creative health is about using creativity for health benefits" (P11). In their definitions of creative health, participants emphasised the breadth of creative health activities falling under this term.

> It's a broad definition of creativity and quite a broad definition of health as well, so that we hope it can incorporate that broad and diverse range of activities. (P8)

> I think creative health is any creative or cultural activity that enhances our lives and our wellbeing and our day-to-day existence. (P4)

This breadth also extends to "incorporate creative approaches and different ways of thinking about healthcare services" (P8).

> Anything like co-designing with participants I would see as part of a creative health approach, and even though it's not always involving arts, something that you're doing which is trying to disrupt the culture of health can be a creative health approach. To be more equitable, to be more creative in problem solving. (P9)

One participant further emphasised the importance of individual and community agency in defining what "creativity" and "culture" means for them, rather than offering a set of predetermined creative and cultural activities.

> It's important that we don't give a definition of what constitutes a creative or a cultural activity, and that is entirely down to you. For some people that might be cooking a meal for their family, decorating their house, for others it might be very prescribed, structured or organised group or solo activities. (P4)

4.1.2. Terminology

Creative health has many names, "arts for health", "arts and health", "arts, health and wellbeing". Participants in this study were aware of the different terminology and had various perceptions of the terms or their relation to them.

Some participants noted their use of multiple terms. “It feels interchangeable in terms of terminology” (P2).

One participant said that although aware of the term “creative health” and feeling part of the sector, they choose to use the term “arts and health” in Wales as “it reflects that partnership between arts and health in line with the Wellbeing of Future Generations Act” (P1).

Other participants noted their view of the term “creative health” as being inclusive of various types of creativity.

> When we talk about the arts, it tends to just really focus on a few select specialties. It doesn't really scream nature, does it? Or the heritage side of things, which also been proven to have just as much impact. And they're all creative in their own way. (P12)

> The arts and health aren't always done by people who work with the arts or are artists or think of themselves as somebody who engages in the arts. So, I very strongly relate to the outsider arts movement where people use creativity because it's a compulsion, and it's something that they do naturally, they don't think of anything to do with art, culture, being part of a bigger system. They're just making, gardening, crocheting, or going for a walk. That's still a creative act. (P11)

“Creativity” being more inclusive than “arts” was echoed in other interviews, with one participant saying, “everyday creativity is democratic and relates to diversity in its true sense that everybody's creative and not just artists” (P6), suggesting that the creative potential in everyone should be supported and nourished. The connection of everyday creativity and wellbeing was identified as an under-explored area and a research priority in literature (Mansfield et al., 2024; Wright, 2022). A better understanding of everyday creativity and its health and wellbeing influence can inform creative health practices and their diversity.

Additionally, several participants said they use variations of the term creative health, such as narrowing it down to “creative mental health*” (P3)* -to be clear that their work and resources offered only extend to tackling mental health problems- or using it as a verb, *“queering creative health” (P6)* -to emphasise what they do is “a mutation of creative health”- and “self-define their interpretation of creative health.” This approach allows organisations or practitioners to pay attention to the wider context affecting the audiences targeted in the interventions.

> We've been exploring what creative health means in a specific time, place and context. (P6)

While the terminology around creative health has taken steps towards inclusivity, it might still be posing a hierarchy and excluding groups of people that are not aware of or think about creative health while engaging with their creative activities.

> For me creative health excludes the idea of people who are outsiders in the arts. In the hierarchy of terms, you've got the arts, then you've got creativity, and then you've got somebody who makes and does. And the person who makes and does, a mum bakes cookies for her kids, an elderly person goes and messes about in the garden, they're not thinking of themselves as doing creative health acts. (P11)

This issue was also brought up as a barrier for practitioners performing creative health work but are unaware of the sector, therefore not accessing the creative health community.

> There's a blockage somewhere, I skirted so close to this work for so long and did it but didn't know the term and didn't have access to this massive community. (P4)

The resulting lack of inclusion of people engaging in creative activities for health and wellbeing means they are not reflected within the creative health sector and contributing to its diversity.

4.1.3. Sector Inclusion

Combined with the lack of awareness of the terms, the perceptions around what creative health is, e.g. who creativity is for and therefore who creative health is for, poses a barrier to diversity within the sector.

> There can be a perception of art as middle-class people going to the ballet or the opera and that can be a barrier to people thinking that creativity is not for them and therefore creative health is not for them. If you view it in that way, then creative health becomes a narrow sector, but that doesn't mean it's not taking place. People are engaging in creativity and different cultural activities in a way they've always done within their communities, improving their health and wellbeing, but maybe they don't consider it to be part of creative health. Therefore, it doesn't get represented and we kind of perpetuate this idea that creative health is overwhelmingly white and female. (P8)

It is a challenge amongst "the increasing awareness of what creative health is" (P8), to determine who is included in this evolving sector. While striving for more inclusion would

diversify the sector, the sector should reflect on how inclusive it is before aiming to bring people in.

> If you are going to invite and encourage people to be part of this sector from diverse backgrounds, there is a responsibility to make sure that the sector is a good sector to work in, to make sure that there is fair pay, that there's many opportunities so that somebody can sustain a career within this space. I don't think we're there yet, but I think that's what we need to be working towards. (P1)

One participant noted not feeling part of the sector because of the lack of EDI.

> I don't feel part of the sector entirely, because the sector is very white, middle-class, lots of women, and they haven't got a clue what I'm doing. It's like I'm saying I'm doing voodoo. Because they are so far removed. (P11)

Other participants said they don't define their work as creative health, or feel part of the sector, because they don't focus on health and wellbeing. While their work might improve wellbeing, their direct focus is on creativity or social justice. One participant working at a creative ageing organisation said their focus on creativity is "a pushback against some of the ideology that is often behind the work within health and wellbeing."

> It's often seen that the process of ageing comes from a deficit and that it's an inevitable decline, and when you're focusing on health and wellbeing, it tends to be because people are unwell, ill, at end-of-life. But from our perspective, it's about focusing on an assets-based approach and creativity being part of people's human condition, whether they have a health condition or have poor wellbeing. Everybody should have access to creativity and culture, and that should be celebrated across the life course, not seen to decline at any point. (P5)

Another participant said although "health is an integral part of what [they] do and [their] primary outcome is to improve people's wellbeing," (P10) they would not use the term creative health for their work, as their work relates to issues around immigration and "wellbeing that's been messed up by the political sphere" rather than issues around health and healthcare.

These perspectives suggest that there are various reasons why some organisations might not feel part of the sector, and as Participant 6 suggested, it would be interesting to explore further why they might not want to be identified with it, what that means for EDI within the sector and what the sector can learn from this.

4.2. Understandings of Diversity

Participants' understandings of "diversity" varied (see Table 4). There was a consensus on the current lack of diversity within the sector, both in terms of the workforce and in who accesses creative health initiatives.

Table 4. Participants' Understandings of Diversity.

Participant	Definitions and understandings of diversity
P2	Diversity is recognizing all the different things that make us who we are, but how that's also connected massively with community, culture, what shapes us, and then the systems in society around us, and how that influences our sense of identity as well, and all sense of like resources, and all the things that have an impact on how we live our lives. All the things that shape us as individuals, the spectrum of that across a number of different aspects whether it's to do with age, sex, gender, religious beliefs, race, cultural backgrounds, all the things that have a significant influence on and shape the people that we are, and also how society responds to these aspects, too.
P4	I think for me, diversity means that every single person, regardless of their background, has access to arts and cultural activities for their wellbeing, as a participant, as a member of the workforce, if they want to that stuff is universally available. My understanding of diversity is that everyone comes with their own unique heritage, background, lived experience and in the context of health and wellbeing, the biggest thing that comes to mind is health inequalities and that we know certain groups are at bigger risk of issues with their health and wellbeing, are less likely to engage in what is currently the standard offer for many health conditions, but also there's a disproportionate treatment in a lot of areas of health and wellbeing for people from certain backgrounds
P5	I guess from our perspective, diversity is about protected characteristics, but it's also about those inequalities around poverty, class, place, all those intersectional layers that mean that a person either has more or less access to creativity and culture. But also, within how we contextualize creativity and culture from a white British perspective of how the institutions like Arts Council invest funding in projects that are not necessarily how other communities would define creativity and culture, and I'm not just talking about ethnicity or race diversity, I mean as in class as well and any of the other protected characteristics that the mainstream cultural offer can often miss. The complexity of unpicking that is in all our systems.
P6	I suppose diversity is the fullness of the world in all its splendour. And then it's how the world is and how the world should be reflected, because that nature is various, and diversity is like the reality of the world in its diverse forms that we're presented with, but often mean something very specific in terms of corporations and policy.
P7	I see it more from [institutional EDI] perspective, and that can apply to everybody in a sector. If we take this sector, to me it would mean the diversity of people that benefit from creative health, but also people that practice that and work in that space. So, it's really on any level of where people are in that space, whether there is diversity in terms of access, opportunities if

	you are a practitioner. And by diversity we mean with respect to protected characteristics, do we have enough representation of different groups or different characteristics, and people from different heritage, etc, within a sector within a space.
P8	I always understand it as making sure that the activities and services that are provided are inclusive and accessible to everybody in society and appropriate for a range of different backgrounds and characteristics, so different social backgrounds or different ethnic backgrounds. I think it also means making sure that the workforce that's involved in promoting that health and wellbeing is also diverse and represents all those different parts of society that the activities and approaches are trying to serve. It's making sure that everything that we're doing is accessible to all, all different backgrounds and everybody that we're trying to reach and that is also represented in the workforce that's providing those activities and approaches.
P10	Diversity, in a broad sense would mean people with a whole wide range of different backgrounds, different life experiences, different ways of looking at the world, and different ways of thinking about problems.

4.2.1. Current State of the Sector

All participants agreed that the sector currently lacks diversity, and in line with the findings from the *State of the Sector* survey, they identified the sector as predominantly consisting of white, middle-aged, and middle-class women (Tang, 2024wra). The lack of diversity came up as an issue in both the workforce and individuals accessing creative health initiatives.

The creative health workforce was found to be unrepresentative of the overall society. Participants have pointed out an underrepresentation of practitioners from global majority or ethnically diverse communities, men, and those from low-income backgrounds. Many initiatives exist to diversify the sector, including targeted funding, changing approaches to recruitment, training and workforce development, which are further discussed under theme *5. Strategies for Sector Support, Development, and Sustainability*.

As mentioned earlier, while undertaking diversifying initiatives, the sector should ensure that it is inclusive and accessible for people from diverse backgrounds to come and work in. One participant mentioned that it is within their organisational EDI policy to foster an inclusive workplace, alongside the initiatives taking place such as recruitment policy and trainings (P8).

The accessibility and inclusivity of sector events for the workforce - such as creative health conferences - was noted, where the lack of diversity is visible. One participant pointed to the space seeming intimidating for people starting out at the sector.

> Sometimes I wonder is [the presence of established, knowledgeable and experienced people] may be a bit intimidating for people or do people feel like there's space for them to contribute if they're going to these events and they're seeing the same faces or hearing from the same people. (P4)

Another participant noted certain groups of people don't know if they are welcome in these spaces.

> If we're seeing certain demographics not attending events, there's two things there -- they don't know the event exists, but also, they don't know they're welcome in that space. I was talking to a few people at the last event, the SHAPER event, who were one of five people of colour in the whole event, and they were talking about how they were feeling in the space, that this wasn't a space they'd realised they were allowed in had I not invited them. (P9)

Finally, one participant discussed how these sector support events might be unaffordable and therefore inaccessible for people working freelance in communities.

> The people at the grassroots who are doing the work, they only get paid if they're doing the work... people doing short-term freelance work in a community organisation, they only get paid per session. You can't spend all your time operating in these arts and health circles. It's just pointless. You won't get any work done. (P11)

Overall, this lack of accessibility of creative health events is a barrier to diversity in the workforce.

It was pointed out that diversifying the workforce would engage a more diverse audience for creative health, as the sector would be "more representative of the population [it] is intending to serve." (P8)

> We're focusing on creative practitioners now in the hope that we're going to have a more diverse workforce longer term so that our diverse communities will have opportunities to work with creative practitioners who look like them or represent their background. (P1)

Diversifying who accesses creative health initiatives requires diversifying the programmes offered by considering what they want and need.

> It's about deconstructing what the offer is and co-designing what that should be with the communities that we're working with. (P5)

> Ensuring that there is something for everyone. (P12)

In offering diverse programmes and activities catering to diverse communities, we must work and co-create with those communities, which is further explored in theme *3. Lived Experience, Co-Creation, and Collaboration.* Furthermore, the issues around accessibility and how to reach and engage underserved communities is discussed in theme *4. Outreach, Engagement, and Participation*.

4.2.2. Recognition for the Need for More EDI

There was an awareness of the lack of diversity and recognition of who is missing in the sector amongst the participant sample.

> There are other programmes and initiatives being developed to help [diversify creative health] and it's a priority area for a lot of people involved in creative health. (P8)

With this increased awareness, many individuals and organisations within creative health are tackling the issue by taking actions to improve.

4.3. Lived Experience, Co-Creation, and Collaboration

Lived experience, co-creation with communities, and cross-sector collaboration were identified as enablers in creating inclusive creative health practices and diversifying the sector. The challenges of all three are discussed along with their value.

4.3.1. Lived Experience

Participants outlined the value of having people with lived experience in different positions within the creative health sector, both as practitioners and decision makers in creating new offers and grant cycles. It was mentioned by participants that many practitioners come to do creative health work because of their own lived experience of being unwell and creative health being a lifeline (P2, P3, P11). This puts them in a unique position, as "they've got a greater depth of understanding to what's happening with the people they're working with" (P3).

Furthermore, participants commented on the importance of people with lived experience being involved in designing and diversifying creative health initiatives. One participant said that they recruited practitioners with lived experience "to disrupt the status quo and to challenge [them] to think differently about diversity" (P1), enabling them to have different offerings for different people. While the value of lived experience is widely recognised now (Arts & Social Outcomes Network, n.d.; NCCH, n.d.-a; Percy-Smith & Bailey, 2023b; Vougioukalou, 2022), participants highlighted that there is still much work needed to bring the voices of lived experience into strategic positions of decision making, and to avoid tokenistic practices which lead to mistrust. One participant suggested we should focus

more on “the positions of power and how much that is within lived experience” (P2). Another noted “it's really important that the people leading on [diversity] work are people with that lived experience [of being underrepresented]” (P4). Finally, another participant discussed the benefits of including people with lived experience in different aspects of the grant cycle.

> Something that I've been doing is working with the UKRI to empower lived experience experts to make grants, to review grants, to be on panels where they judge who should get the funding, and that's really successful. Those people working in the grassroots, before the projects are made to serve them, they should be writing the bids. (P11)

Alongside these opportunities, participants mentioned the challenges of working with people with lived experience and the considerations needed. The main challenge suggested by several participants was tokenistic practices when working with lived experience experts.

> From [the point of view of someone with lived experience in shaping projects and working with different organisations] I've experienced some bad tokenistic practices. I think that creates an increased mistrust of how organisations are approaching you as an individual. (P2)

Another participant emphasised lack of consideration of people’s experiences with these tokenistic practices.

> This is our human experience. We're not going to come in for you to tick a little box, then go into our hole and carry on living a life of misery, and you're like a white saviour. (P11)

Participant 2 further pointed out some of the considerations needed when co-creating with people with lived experience.

> There's a lot of tokenistic practices that are underdeveloped. There's funding that can be offered to work with certain communities or certain marginalised groups, and sometimes that work happens without enough consideration for how that's happening, who that’s happening with, who's leading on that, what voices are influencing, how those projects get shaped, the limitations on time... people really need to think through that. (P2)

Finally, Participant 2 highlighted the vulnerability in sharing one’s lived experience, and how -even if well intentioned and from an allyship position- bringing attention to prejudices

can lead to emotional responses. They gave the following example from an action plan for anti-racist work:

> A member of the team was really triggered by talking about that within the team, what her lived experiences of racism was day-to-day. She found it hard that suddenly all this attention being given to the experience of racism when there hadn't been before. There's this gesture of understanding, but at the same time not understanding. (P2)

As a response to this challenge, they recommended building more solidarity and support networks for people with lived experience.

> Sometimes just being able to talk to people that share some of the challenges of what it is to work within the creative health sector and know that there are prejudiced things that operate or barriers around the culture, things that can be difficult… I think building support systems and ways of strengthening how people with lived experience can become more empowered, which is what essentially happens through some good lived experience work, feels important. (P2)

4.3.2. Co-Creation with Communities

Building on working with people with lived experience, co-creation with communities was frequently described as an enabler for creating relevant initiatives and increasing diversity in the sector.

> I would say that the big move towards co-creation has been a huge positive. I know it's really challenging to get the funding for truly co-designed and co-created approaches, but I think that is the only way that we are going to increase diversity. (P5)

One strategy for practicing co-creation was having new roles or groups from the community to consult on projects and inform organisations about community needs and desires. Participants talked about a “community advisory panel” (P12), “community connectors” (P9) or a “co-creation hub” that is a subcommittee of an organisational board (P10).

> What are the community wanting and how can we make those things self-sustaining in the community with a bit of help from the community connector team to set it up. (P9)

Sustaining connections with communities were mentioned in several interviews as essential to co-creation.

> The co-design, co-created approach and working with communities for the long term, not parachuting and doing one project or one size fits all projects and hoping that people will connect to it. (P5)

Another aspect of collaboration noted was going into communities with no agenda.

> I think universities, funders and grant providers need to step out of their world and go into the community to make it more diverse and have no agenda. Be there without wanting. Be there with the intention that you want to see and learn and grow together, and connect, not because you want to take something out. (P11)

One participant mentioned that when partnering with communities, you should be open to not knowing where you will end up and take directions from the needs and desires of the communities.

> Funders and health partners and anybody who isn't feeling safe within these products need to be more positive towards risk, that you get results when you start from a place of not knowing where you're going to end up. (P5)

One of the main arguments for co-creation was to ensure organisations are not distant from people accessing creative health initiatives.

> To ensure that a charity isn't distant from the people that it's been set up to support, that people who it's set up to support are part of the charity, not just receiving its services. (P10)

Several participants argued that organisations are disconnected from community practices that benefit health and wellbeing through grassroots approaches. This manifests as a "lack of insight into people's experiences that is different from the people that are planning, funding, or organising a project" (P2).

> People with power don't understand the needs of people without power. They don't live in the same spaces or breathe the same air. So, they put on what they think is useful, but they don't have that knowledge of what works. (P11)

Therefore, in collaborating and co-creating with people already doing effective work within their communities, organisations should go in with the intention of learning from them.

> We're trying to avoid that dynamic of us coming in and going "This is what we can do for you", we don't want any kind of saviourism there. We want to learn from the people that we're not engaging with currently. We want to go to them and go "You're doing really interesting work and you're excelling in this area, or you seem to have

> built up a relationship with this community. Can we talk to you about how you've done that? We're really interested." (P4)

Finally, to build trust with the communities, organisations need to prove that change is happening, and there is an inclusive space for the communities to continue their work.

> You've got to make incremental steps to show change is happening, before people come on board and believe, you got to evidence that this is inclusive. This is supportive. And this is who's benefiting. (P11)

If these challenges can be addressed, co-creating with communities can be an important enabler to involve different groups in the creative health sector and foster more diversity.

4.3.3. Cross-Sector Collaboration

Under the theme of collaboration, participants also discussed the importance of collaborating across different sectors to create and support creative health initiatives.

Cross-sector collaboration in Wales was mentioned as a good example by several participants. One participant from Wales said due to its smaller size, multiyear funding, and policies driving public bodies to have common aims and goals, cohesive cross-sector partnerships exist within Wales.

> Wales is much smaller than England. And because we get multiyear funding from the Arts Council, and I have a full-time role and a team of freelancers working with me. We have capacity to do quite a lot. We are working very much in partnership with our funders and health boards, so we have a close working relationship with Arts Council of Wales and with the Welsh NHS Confederation… And I guess the key driver in Wales that influences the way that we work is the Wellbeing of Future Generations act, which means that all the public bodies have to work closely together to deliver on key priorities in Wales. (P1)

Furthermore, they mentioned collaborating with different stakeholders working for promoting diversity, such as "LBTQ+ networks" and "diverse Cymru." Another participant from England said that there are more opportunities for collaborating with diverse sectors, creating an ecosystem of support for people's wellbeing.

> As creative health grows there's more opportunities to make those links with sectors that we wouldn't have thought of linking up with before or might not have considered themselves part of this and really building up an ecosystem of different people doing work in slightly different areas that all come together to improve people's health and wellbeing with creativity as part of that. (P8)

Another participant suggested the creative health sector support organisations with these connections to different sectors should try to include people working within communities in their networks, so they can also makecross-sector collaborations.

> This is something for the creative health industry or movement at large, it's really relational work, so it is about who you know and so much of the work is like “oh this opportunity came up and I have to move so quickly that I don't have the time to do this outreach thing of finding different partners. OK well, I have this person and this person already.” So, part of my job is making sure people are connected into those networks so when funding comes up, they're being thought of, they're ready to be included into an application process. (P10)

> Creating spaces to bring people together to discuss and then forming links and linking people up that we know are doing work in different parts of the system. (P8)

4.4. Outreach, Engagement, and Participation

The fourth theme identified in the analysis was looking at strategies and engagement efforts to increase access to creative health activities for a wider population. Discussions involved outreach work, perceptions of people around creative health, and access to various resources.

4.4.1. Outreach

Participants argued that organisations involved in creative health have the responsibility to reach out to people and make the initiatives accessible to all.

> There are issues that we need to think about who creative health is reaching to improve our diversity and make sure that it is not just accessible to everyone, but that everyone is accessing it if they want to. (P8)

One participant suggested the way to reach out to diverse crowds is targeted work.

> When you do focused, deliberate, intentional, very thought through ways of attracting people in, it does work and it’s successful. There is often a lack of more targeted approaches. And when there are targeted approaches, they do yield good outcomes, and they do promote diversity. (P3)

Another important aspect of outreach discussed was listening to people’s needs and tailoring your approach to meet them to make your offer truly accessible.

> Sometimes [saying you’re accessible] is quite a lazy approach almost to go well, we've said that everyone's welcome. If people don't attend, it's on you and you have

> to meet people where they're at within what you can do, within the scope of whatever it is you're running. (P4)

This involves going into the places where the communities you want to work with are at, trying to understand which spaces they feel comfortable in and if engagement can be supported.

> You have to go to places where... if you're looking to engage people in a certain demographic or in a certain community or area. It's no good to just throw open the doors and say, well, I said people were welcome. You need to do the hard work of going "right, I really want to engage with these communities, what are the places that they feel comfortable? What are the places that are already part of their daily lives?" (P4)

One participant pointed out that there is often a focus on London-based initiatives, and a tendency to try and scale up these initiatives to elsewhere in the UK without first understanding the differences of the audiences in those places.

> I think there is a focus on the things that are called national projects that are exclusively London based, and I think London people that are based in London assume that they will then become a national project even when they do nothing to scale it up or to understand how the demographics of different places in the UK look. (P9)

Another participant argued that there are many instances where practitioners fail to take a targeted approach and attempts to work with communities solely based on funding opportunities. They don't consider the specific community's needs and desires and offering the skills and practices they want to offer.

> You decide the project. Say, I want to do a crochet project. Right? Say, okay, I run a company. I want to do crochet. Let's see where we get the funding. Oh, the funding says I have to work with poor people. Okay. So, I want to do crochet. Do poor people want to do crochet? No, poor people might want to do watercolours. So now my crochet idea is obsolete, but I'm going to force it and force it and force it until I find the right people. And then it's like you're just finding people for the sake of it, to say you've done a project. This is something that I'm seeing a lot. Companies get set up, and they've got people who want to make their art. They decide they want to do art, they want to make art. So, then they set up the company so that they can keep on doing their skill. Not for people who need that skill. (P11)

Overall, it was argued that outreach initiatives should be targeted towards specific communities and informed by them.

4.4.2. Perceptions

The second component that affected participation in creative health was the perceptions of creativity, health, and creative health. As previously discussed under the *Understandings of Creative Health* theme, some groups may not feel welcome in creative health spaces due to their previous experiences of exclusion from the arts or being discriminated against in healthcare services. These experiences shape the perception of what creative health is and can act as a barrier that stops people engaging with it.

> When we're thinking about health and wellbeing, these issues of trust are related sometimes to historical experiences of health and care services where people have experienced discrimination or racism in some way and therefore maybe become more reluctant to engage in health and care services. I think these perceptions of what creativity is and previous experiences of a healthcare service can then also be barriers to people accessing creative health and understanding the benefits that creativity can have for the health and wellbeing and then interacting with us as a sector. (P8)

4.4.3. Access to Resources

Lack of resources and barriers to access deter people from engaging with creative health, and participants discussed the strategies they use to tackle them. The first barrier identified was the cost of creative health activities or financial barriers to accessing initiatives. One participant representing a funding organisation said that for everything they fund, participation would be free, eliminating the financial barriers for participants (P3).

Another participant (P2) said that they use “pay-as-you-can” or “pay-as-you-feel” approaches in their offers to reduce financial barriers.

Participants also outlined geographical barriers, with the lack of offers in rural areas (P3). Furthermore, the physical accessibility of creative health offers in rural areas was discussed, and considerations to make these offers more accessible, such as funding transport or using various community venues to bring the offers to the communities.

> There's a lot of people that are more socially isolated, so they live in quite rural communities around where we are. So, there's a lot of consideration to how people can access the workshops for the creative activities that we run. So, a lot of our funding is around transport, supporting people to get to the venues. (P2)

> We try and do things in different venues, whether it's from pubs to car parks to arts venues, or community centres or youth centres. We work across lots of different venues, which I think can help support as a place of access, and especially more local people we get to. (P2)

Finally, they mentioned the psychological barriers of walking into a creative health activity or workshop that may seem intimidating for some people due to negative perceptions or previous experiences of being excluded from similar offers and spaces.

> Assuming that someone will be able to even just walk to a workshop, or to be able to go into that building without actually that being hugely intimidating to go into certain buildings, or what the vibe is when you go in a certain room, and I think these things are often under thought about. (P2)

All these factors should be considered when aiming to make creative health offers accessible to diverse communities. As Participant 4 pointed out, “access isn't just lifts and ramps, it's psychological barriers, logistical barriers, and socioeconomic barriers too.”

4.5. Strategies for Sector Support, Development, and Sustainability

The fifth theme that emerged was related to the barriers to get into or sustain oneself as a practitioner in the sector, and strategies that support and enable workforce and sector development, including both practical initiatives and policy.

4.5.1. Getting into the Sector and Recruitment Practices

Participants discussed the socioeconomic barriers, including training costs and lack of opportunities getting into the sector. Participant 6 pointed out how there is a class division in the cultural sector, and it is much harder to gain access to cultural industries and higher education for people from low socioeconomic backgrounds, making it harder to get into sectors such as creative health.

> We find that the economic conditions really impose some of the most anti diverse instances due to the costs involved. (P6)

Several other participants mentioned how higher education, and the opportunity to pursue a creative degree is a privilege that not everyone has (P1, P9, P11), and not being able to go into higher education acts as a barrier for people trying to gain experience and work in the creative health sector. One participant mentioned how the charity sector relies heavily on volunteers (P10). As the creative health sector widely consists of charities and community interest organisations (Tang, 2024b), the same problem can occur where volunteering

“privileges people who've got time and can afford to volunteer” and provides them the experience to work in the sector.

The final challenge mentioned preventing certain groups from joining the workforce, and restricting sector diversity was the tightening immigration policies and Brexit, which make it harder to get international practitioners or staff due to visa complications (P6).

Participants mentioned outreach efforts to bring people from diverse backgrounds into the sector.

> If [a diverse range of people] don't know [the creative health sector] exists and they don't know it's an option, the chances of them stumbling across it are much less… the more you have people coming into the sector and then in a few years maybe taking on leadership roles and more senior roles, the more those rooms will start to change hopefully. (P4)

Another argued that the sector is not always inclusive, and much of the work done is relational, depending on the contacts you already have and people you know, making it harder for new practitioners or organisations to get involved with the work.

> [There is an] unashamed lack of inclusion practices. We went to a conference last week and in one of the presentations where they were talking about a multimillion pound project, and when they were talking about how they decided which creative organisations to work with, it was like “oh well, I was friends with this guy, and then I met this other person at this one event, and then so and so recommended this one” and there was no procedure to asking people to apply. And so, anyone that wasn't already connected to those people just didn't have an opportunity. (P9)

One strategy mentioned to increase opportunities for diverse groups was commissioning artists from underserved communities who may have additional barriers, increasing representation in the workforce.

> We work with an organization called Unlimited who support disabled artists to commission new works, so we collaborate with them. And I think commissioning is a significant part of supporting artists that can be more representative of the communities that are underserved. That is an important way to focus on supporting artists that maybe have additional barriers or challenges to access. (P2)

An important factor suggested by several participants for equitable access to the sector was recruitment practices. The first consideration pertaining to this was where to advertise the opportunities and job roles to reach different audiences (P6, P13). Beyond this, one participant argued that we should think about the entire recruitment process end-to-end,

not just where the roles are promoted and who gets to see them. They outlined that there are different ways of doing things, and organisations need to think about "what [they] are really trying to communicate, what really matters, what are the things that [they] really need, and which of the things that [they] often say [they] need but don't" (P10). They mentioned when reflecting those considerations on the recruitment process for a senior role, they got the most diverse applicant pool they have ever had.

> We paid a lot of attention to the language we used. There was no detailed job description…[or] person specification… We explained where we wanted to go as an organisation, and we asked people to come forward if they wanted to be involved in that, or if they thought they could help lead it. We had some broad statements about what we were looking for. So, we did have some kind of essentials and desirables, but they were quite broad… We called them must haves and good to haves. We made some very clear statements about wanting to diversify the team and being very interested in recruiting people with lived experience… We did it substantially differently. And we had a high proportion of people from global majority applying, we had a high number of people with relevant lived experience. And so, we had the most diverse field that we've ever had. (P10)

Other participants also discussed the importance of reflecting on recruitment experiences (P12) and ensuring those reflections feed into policies (P8) to enable inclusive recruitment practices and diversity.

4.5.2. Training, Development and Support

An enabler for diversity mentioned by most participants was training, workforce development opportunities, and support networks. One participant said that "time, opportunity and cost were all barriers for many practitioners working in this space… unable to find a foot in the door" and to tackle these barriers, "supportive training programs that are funded" are needed (P1).

Participants mentioned two training and professional development programs as examples happening right now: the Artists' Represent Recovery Network run by London Arts and Health, Raw Material and Arts & Health Hub, supporting artists with ethnically diverse backgrounds who've faced systemic racism, and the Stepping In programme by Wales Arts, Health & Wellbeing Network supporting practitioners from minoritised communities. With these examples, participants emphasised the importance of "targeted training programs" and "wrap around support" for underrepresented artists and practitioners (P1).

> It's not just about the training. Whether that's formal or informal, it is the wrap around support that makes the difference, offering childcare, paying a bursary, we

> paid a £1500 bursary to each of our mentees so that they could attend the residential and some kind of training around that, because that made the difference between them taking part or not. (P1)

The wrap around support that mentioned can involve many things, examples included bursaries for people from diverse background to join training programmes, conferences and related strategic spaces (P9), funding to establish career pathways (P9, P13), funding to support freelance artists and practitioners to have the space to explore and build relationships with other stakeholders (P7), and supporting people from different communities working at grassroots level to "access fundings to do what they already do well" (P11).

Funding is also important for the sustainability of creative health work. One participant mentioned that for many people, especially freelancer workers, the creative health sector is not always sustainable, and "there is a lot of drop off" (P4). Another supported this claim by saying practitioners are worried about the sustainability of a career in creative health, wondering whether "there is enough money there for somebody to sustain themselves as a freelancer", which can steer them away from working in the sector (P1). The sustainability of creative health programmes with short-term fundings were also discussed, with practitioners "having to put time and energy into rejigging or rebranding [their programmes] every time funding pools change" (P12), which one participant described as "a funding model that is not working" (P13). These perspectives emphasise the importance of funding for early career support, especially for freelancers, and long-term, sustainable funding models for creative health programmes.

Another barrier for sustainability linked to funding is the mental load of the work (P2, P3, P4, P11).

> I also think it's about the mental load that comes with this work and is that sustainable, because we know that a lot of people come into this work through their own lived experience. So, they might have additional responsibilities outside of the work that they need to do to take care of themselves. Whether that's a health condition, caring responsibilities, there are so many other things that people juggle that we know when they're going through this work and the precariousness of the work and the funding, but also the emotional labour of delivering projects or running organisations where the work is quite emotionally charged and has a big social impact, can be really draining, and it might get to the point where people just can't do it anymore and also manage those other areas of their lives. And I think that is as big a problem as funding potentially and funding feeds into that, the hell of that

> repetitive project grants and tiny bits of money and closing projects down left, right and centre, it's hard. (P4)

4.5.3. Support Networks

A recommended strategy to overcome this barrier is support networks that allow people to connect with and talk to others in similar positions.

> There's also something to be said for how networks can support each other, [being] more connected to people that are doing good work or [knowing] who to talk to about it sometimes. (P2)

As well as peer support, participants talked about the importance of supportive mentors and funders who provide flexibility when working with practitioners with lived experience of having mental health problems or other protected characteristics.

> I can't do my work in a linear way, because I don't know what's going to happen with my mental health. I have to have enough space around me, for if something collapses, then I need to have backup. So, an enabler for my company to rise was that there were supportive mentors around me that were guiding me to do my work, and I had people volunteering to act as directors in my company when I was very unwell. I had other people to share responsibility, so it helped me to work through the mental illness, and to continue with the company. I was facing so much discrimination or structural barriers and issues; I wouldn't have been able to cope with those and having that protected characteristic of being severely mentally ill. (P11)

Participant 11 further discussed that another enabling factor of a supportive mentor was connecting them with other people who might want their service or benefit from working with them. As previously mentioned under collaboration, several participants talked about the importance of being part of networks due to the relational nature of the work. Networking creates a support system of people who do similar work and understand the challenges. There are several examples of supportive networks within the sector. One is supportive funders who enable networking with other practitioners.

> When Baring Foundation set [the diversity] grant up, they brought everyone together who got the grants twice in two years. We all got together and showcased what we're doing. We had group activities. We had networking opportunities. They had some case studies speaking about their work. In doing that, we learned what was going on in other parts of the country. We got contacts, we got ideas, and we didn't feel so alone, so it felt like there was a nurturing funder recognising “Hey, you've got

> a shit deal. We're going to give you some money to help you, and we make it easy with a reporting process." … It made us feel valued and like we're part of something, because we're in that space where there's not many people like us, seeing nationally a picture of successful work, and having people encourage you to keep going. (P11)

Another example is a community of practice between UK creative health networks and organisations piloting programmes relating to diversity. Participant 1 said that "[they've] set up the community of practice to check in with each other regularly and to support each other in a peer learning way."

4.5.4. Research, Policy, Advocacy

The final factor supporting the development of the sector is regarding research and evidencing, reflecting on practices, policy development and advocacy for sharing knowledge and good examples.

Participants mentioned that there is already much work being done around evidencing the value of creative health (P13), and inclusion of lived experience voices in deciding which creative health programmes get funded (P9). Moreover, participants mentioned that one opportunity for promoting EDI would be further research exploring new ways, methodologies, and models (P7, P8). They discussed that future research should look at the enablers for incorporating communities into healthcare systems (P8) and into creative health research by evidencing what communities value (P12).

Participants argued that diversifying the workforce and widening engagement with creative health initiatives should be a key priority for creative health networks, funders and organisations, and strategies should be put in place to address this priority. These strategies include EDI policies for accountability (P2, P13), but also "EDI at the centre of everything [they] do" (P8). Several participants mentioned that their organisations are in a reflective period where they are "trying to put in place a new exploratory approach to EDI" that is informed by ongoing conversations with underrepresented communities, practitioners and organisations, such as global majority artists or disability led organisations (P4).

Finally, participants talked about the importance of sharing knowledge and examples of good practices that are happening in different places. One participant said that when they asked people if they could only do one thing to increase the number of underrepresented communities and creatives, what would that one thing be,

> overwhelmingly, people said that they wanted to know what works in different places, and to see role models. The idea of if you can see it, you can be it, and more diverse communities, individuals, leaders being profiled and given a voice and visibility so that the work that happens in these pockets of places that everyone knows happens all over the place is given more platform. (P5)

Another participant said that currently everyone in the sector is very busy doing the work and not always have the time to talk about it (P4), which is a barrier that needs addressing to "learn from what's been done and share that learning" (P8) to inform practices and approaches to EDI.

4.6. Systemic and Structural Context

The final theme is around the systemic and structural context that enable or pose a barrier to EDI in the creative health sector. Discussions included issues within wider systems, complexity of the problem, infrastructure and accountability of the sector.

4.6.1. Issues within Wider Systems

Participants argued that within the current systems, there is a lot of short sightedness focusing on problems that surface rather than tackling root causes and trying to influence culture for sustained change (P7, P10, P13). This is often because "there are cultures within organisations that are quite established, and it's hard to assert things to be different in certain ways" (P2). Several participants outlined the need for systemic change to address and shift these existing cultures and subconscious biases influencing the EDI of the sector (P5, P6, P11).

> People are working within a structure that is already failing. So if you try and change that structure altogether and start again, you might get some good results but they're constantly trying to build into a system that doesn't work and the more you look at it, the more it seems tokenistic, because the higher up you go, the less money there is for you to be included.
>
> We need to have a whole shift in the thinking about how we're doing this work. A whole shift in what the work involves and who it's for. (P11).

4.6.2. Complexity of Diversity

Another challenge is the complexity of diversity and intersectionality. Most participants talked about the importance of intersectionality in understanding and advocating for diversity. People are more than one thing, and there are various characteristics and issues affecting people's lives. One participant emphasised that when trying to do a work around promoting diversity, the complexity that comes with intersectionality can be a challenge.

> As soon as you start maybe doing a big round table and you're focusing on different protected characteristics, you're completely missing the point that most people's lives are complex, and they span more than one protected characteristic. (P1)

One enabler for addressing this challenge is being context specific and adapting your approaches and offers to the issues of the specific demographics you are working with. For example, one participant working with people going through the immigration system said that in their context race is a big issue since a large proportion of the people going through the immigration system are people of colour or from the global majority, so "if you don't look at immigration systems through a lens of race, you would miss some important things about its history, how it works, and its effects" (P10). Another participant talked about the targeted work of the public health team in Birmingham, who for example, instead of saying "here is a service for all people of colour", work specifically with Nigerian men who have mental health issues, or older LGBTQ+ people experiencing bereavement (P9). Making targeted creative health offers is important to account for the nuances of intersectionality.

4.6.3. Infrastructure of Creative Health

Creative health work exists within the context of complex wider systems and issues. When considering how these issues manifest within the creative health sector and what sort of infrastructure is needed to address the current lack of diversity, two points, scalability and institutionalising, prompted differing perspectives.

Participants had differing views on scalability of the projects. Some of them believed it is important to scale up creative health practices that work well so that they can be accessed more widely (P9, P12). Whereas others were wary of scalability, "because sometimes the desire to have a product that can be replicable means the nuance of connecting with local people can be lost" (P1). This relates to how creative health should be applied in specific times and places, rather than being a generalised good, as one participant pointed out, "specific aspects of the work that apply in [one] context can actually go against more generalised ideas" (P6). Therefore, while there are advantages of "setting up things like social prescribing and packaging up creativity as an intervention for making it understandable to those who are in a health and wellbeing context, by doing that it reduces the amount of flexibility and diverse responses that people can put through" (P1). And mainstreaming these practices often end up putting on offers for a particular audience and exclude some of the others that may already be underrepresented in creative health.

Participants also held differing views on the institutionalisation of creative health. There are extensive efforts to embed creative health into systems and to understand how government policies can embrace creative health (NCCH & APPGAHW, 2023). Several

participants suggested that formalising the sector through things such as “appropriate referral pathways” or “routes to set up connections with healthcare providers” would be helpful for the sector’s growth (P12, P13). While these incentives are important to make creative health offers more accessible, it is difficult to ensure that those offers will be inclusive for diverse populations. Some participants believed that institutionalising creative health offers could be a barrier to diversity, as they reinforce a power imbalance between larger organisations and grassroots people working within communities.

> Not necessarily providing financial support for people to come *into* a university or *into* a conference where there's totally different people. In my ideal world, there'll be people mixing together within the communities that they're aiming to serve, rather than going to an arts and health event or being part of a big national panel or a network. All those things are quite high up on the hierarchy of arts and health. (P12)

There is a consensus between the participants in this study and the wider literature that co-creation with communities is an enabler for diversity in the sector. Some participants made a point of extending the ethos of co-creation and collaboration into the infrastructure of the creative sector by not having a linear “bringing people in” approach to feed the system but a more equitable exchange (P11).

4.6.4. Accountability of the Sector

The final point made relating to EDI was regarding the accountability of the sector. Firstly, in terms of the sector reflecting on how it operates, looking at the bad sides as well as the good, allowing there to be space for public discourse and open discussions (P6). Building on the institutionalisation debate, participant 6 suggested that there should be more examination of creative health institutions, how they were brought up and how they operate.

Second point on accountability was in terms of the sector responding to current political issues.

> Thinking a bit of bigger world view in terms of priorities. There's some really shit things going on in the world at the moment in terms of people that suffer massive inequalities. And I think there's always more that can be done to recognise the place of creative health in some of those wider political conversations or the circumstances of people. (P2)

Several participants (P2, P6) pointed out that what’s going on in the public (e.g. the humanitarian crisis in Gaza or the anti-trans media during the political lead up to the UK

elections), has an immediacy, and creative health can be more vocal, join up with these conversations and advocate for equity against basic human rights violations.

4.7. Summary of Findings

A summary of enablers and barriers to EDI within the sector identified for each theme is presented in the below table.

Table 5. Enablers and Barriers to EDI within the Creative Health Sector.

Themes	Enablers	Barriers
1. Understandings of Creative Health	Breadth of activities and approaches Having own definitions of "creativity" and "creative health" Everyday creativity Reflections on sector inclusivity	Hierarchy of term – arts, creativity, the person who makes and does Lack of awareness of creative health and the sector Lack of inclusion and representation of people doing the work outside the sector Perceptions of "creativity" and "creative health" Various reasons for not feeling part of the sector
2. Understandings of Diversity	Ensuring accessibility and inclusivity Organisational EDI policies, trainings, recruitment policies Diversifying the workforce and the programmes are enablers for engaging a more diverse audience	Intimidating space for people starting out at the sector Not feeling welcome in CH spaces Sector events being unaffordable and inaccessible
3. Lived Experience, Co-Creation, Collaboration	Lived experience in different positions, including decision making and leadership roles Solidarity and support networks for people with lived experience Co-creation with communities Sustained connections Having no agenda and learning from communities Cross-sector collaboration	Tokenistic practices Lack of consideration for people's experiences Disconnection between organisations and communities Lack of insight into people's experiences
4. Outreach, Engagement and Participation	Outreach by targeted work, listening to people's needs and tailoring approaches to engage different communities Free or pay-as-you-can offers Funding transport, using community venues	Scaling up London-based initiatives without consideration of differences Shaping offers based on funding opportunities and not community needs Negative perceptions and experiences Financial barriers – cost of participating Geographical barriers – lack of offers in rural areas

		Psychological barriers – intimidating space, negative perceptions
5. Strategies for Sector Support, Development, and Sustainability	Outreach Commissioning artists from underserved communities Reconsidering recruitment practices Training and professional development programmes Wrap around support including funding Support networks and networking Flexibility Research and evidencing Reflections on practices and policy Sharing knowledge and examples of good practices	Socioeconomic barriers – training costs and lack of opportunities getting into the sector, access to higher education, volunteering Tightening immigration policies Lack of inclusion practices – relational work Short-term fundings Mental load of the work
6. Systemic and Structural Context	Systemic change Being context specific and adapting approaches and offers to the issues of specific demographics *Scaling up* – widening access* *Institutionalisation* – formal routes for sector growth* Accountability – reflections on how the sector operates and responding to current political issues	Not tackling root causes – focus on problems that surface Challenges of changing cultures Complexity of the issue *Scaling up* – disconnection from local people, mainstreaming offers don't favour underrepresented communities* *Institutionalisation* - reinforce power imbalance between larger organisations and communities*

**Italicised points indicate areas of differing opinions.*

5. Recommendations

5.1. Recommendations for the Creative Health Sector

1. Build long-term partnerships with communities through co-creation. Funders and organisations should allocate resources to sustain community advisory panels, co-design hubs, and roles like “community connectors”, allowing communities to drive the direction of the creative health initiatives on offer (see 4.3.2).
2. Organisations should employ targeted outreach strategies by collaborating with communities and delivering programmes in culturally relevant and accessible spaces (see 4.4.1). Geographic disparities should be addressed by bringing creative health offers to rural and isolated areas (see 4.4.3).
3. There should be more efforts on building trust within underserved communities and ensuring inclusivity of services before expecting them to join in on your offers (see 4.1.3 and 4.3.2).
4. Introduce financial support initiatives for participation like travel stipends, free or pay-as-you-can participation models, and grants specifically aimed at low-income or geographically isolated participants (see 4.4.3). Workforce development should be backed with bursaries for training, mentoring programmes, and targeted recruitment (see 4.5.1 and 4.5.2).
5. Advocate for and implement long-term, flexible funding streams that allow organisations to build sustainable programmes with consistent staffing and deeper community engagement (see 4.3.2 and 4.5.2).
6. Implement organisation or sector-wide Equity, Diversity, and Inclusion (EDI) policies that not only focus on recruitment but also on retention and promotion. Policies should also include regular reviews of current practices to monitor progress through transparent reporting structures (see 4.5.1 and 4.5.4).

5.2. Recommendations for the National Centre for Creative Health

1. Develop a creative health framework, similar to the Creative Health Quality Framework, that is specifically for promoting EDI, which can include guidance on recruitment practices, inclusive programming, inclusive creative practices, cultural competence, and how to support practitioners from underrepresented communities.
2. Provide and/or advocate for targeted funding streams for grassroots organisations and practitioners from marginalised backgrounds. Similarly, offer and/or advocate for more training, mentoring, and networking opportunities to build capacity and

ensure these groups can effectively participate in and contribute to the creative health sector (see 4.3.2 and 4.5.2).

3. Continue fostering the conditions for cross-sector collaboration by establishing partnerships between creative health organisations, healthcare services, community groups, and policymakers (see 4.3.3). Create collaborative platforms that bring together diverse sectors to share knowledge, develop joint initiatives, and advocate for the systemic inclusion of creative health (see 4.5.4). Create spaces for small-scale organisations or freelance practitioners to join in on these partnerships (see 4.3.3).
4. Facilitate the creation of networks where practitioners from diverse backgrounds can access mentorship, peer support, and professional development opportunities. These networks should offer spaces for reflection and connection, addressing the mental and emotional load of creative health work (see 4.3.1, 4.5.2, and 4.5.3).
5. Create space (e.g. a platform) to share case studies, success stories, and lessons learned from creative health projects that have successfully addressed EDI (see 4.5.4). Regularly convene accessible events or webinars to showcase good practices and inspire broader adoption of inclusive approaches across the sector (see 4.2.1 and 4.5.3). Additionally, create space to reflect on the bad sides that allow for criticism and recommendations for growth (see 4.6.4).

6. Conclusion

This dissertation aimed to explore the barriers and enablers to EDI within the creative health sector. Through a combination of literature review, examples of current good practices, and reflexive thematic analysis of interviews with sector professionals, this study aimed to provide a comprehensive understanding of how diversity is perceived, facilitated, and impeded within the creative health sector.

The findings revealed significant barriers in both access to creative health services and diversity within the workforce. Marginalised and underrepresented groups face a range of barriers from socioeconomic constraints and lack of access to cultural insensitivities and systemic exclusion. Furthermore, the creative health workforce consists predominantly of White middle-class women, with limited representation of diverse voices in decision-making roles. These challenges highlight the urgent need for sector-wide policies and practices that are more inclusive and responsive to the needs of diverse populations.

Despite these barriers, several enablers for EDI were identified. The importance of co-creation and lived experience in the design and delivery of creative health programmes was emphasised by participants, as well as the need for long-term funding models, targeted outreach, and professional development and support initiatives. These enablers allow for the creation of sustainable, self-supporting practices and networks, facilitating engagement of underrepresented communities with creative health opportunities. Cross-sector collaboration was also identified as a key enabler, with partnerships between healthcare providers, community organisations, and cultural institutions seen as critical to creating more inclusive and sustainable programmes.

The recommendations developed from these findings are actionable and focused on systemic change. They include the need for comprehensive EDI policies, enhanced recruitment and training practices to respond to the barrier of access, and the provision of sustainable funding models that support the growth of a diverse creative health workforce and sector. Sector support organisations, such as the NCCH, have an important role to play in advocating for these changes and providing guidance on inclusive practices.

Despite the barriers to achieving EDI within the creative health sector, there are numerous opportunities for change and growth. The sector can hold a more inclusive space for everyone by continuing to foster a culture of collaboration, co-creation, and equity. Future research should continue to explore strategies and policies to promote EDI within the sector and evaluate the effectiveness of these initiatives specifically in relation to the barriers identified, as well as generally. This ongoing work will be crucial to ensure that creative health truly reflects and serves the diverse communities it aims to support.

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Appendices

Appendix 1: Literature Review Search Terms

Appendix 2: Literature Review Resource Table

Appendix 3: Participant Information Sheet

Appendix 4: Consent Form

Appendix 5: Interview Topic Guide

Appendix 1: Literature Review Search Terms

Boolean string for database search 1: "creative health" OR “arts and health” AND "diversity" OR “equality” OR "equity" OR "inclusion"

Boolean string for database search 2: "creative health" AND "diversity" OR "equity" OR "equality" OR "inclusion" AND "barriers" OR "enablers"

Inclusion criteria: since 2017 (after the publishing of the APPG Creative Health Report)

Exclusion criteria: COVID-related, only talking about effectiveness of creative health initiatives with no mention of barriers or opportunities for access and engagement

Appendix 2. Literature Review Resource Table

Source ID	Author(s)	Organization/Institution or Journal	Year	Title	Type of Source	Keywords/Focus	Abstract/Summary	Relevance to RQ	Methodology	Findings/Conclusions	Barriers to Diversity	Enablers to Diversity	Recommendations	DOI/URL	Identified from
1	Tang, J.	Culture, Health and Wellbeing Alliance	2024	Creative health: UK state of the sector equality, diversity, and representation report	Report	state of the sector	The aim of the State of the Sector Equality, Diversity, and Representation Survey is to help us better understand the current landscape of the creative health sector in the UK.	data for current state of diversity in CH	survey	creative health practitioner tends to be: • Within the age range of 50-64 years old • White British • Heterosexual cisgender female • Married / in a civil	N/A	N/A		https://www.culturehealthandwellbeing.org.uk/sites/default/files/DiversityReport_20240201.pdf	partner organisation recommended reading
2		London Arts and Health, Raw Material and Arts & Health Hub	2023	The Artists' Represent Recovery Network	professional development programme	ethnically diverse artists, participatory or community setting, tarining, skills development	A professional development programme for 10 London-based, freelance, ethnically diverse artists who have faced systemic racism, and who are working in arts & health in a participatory or community setting.	professional development initiative for ethnic diversity in CH				professional development programme for a specific underrepresented group		The Artists' Represent Recovery Network – London Arts in Health Forum (londonartsandhealth.org.uk)	partner organisation recommended reading
3		The National Centre for Creative Health (NCCH) and All-Party Parliamentary Group on Arts, Health and Wellbeing (APPG AHW)	2023	Creative Health Review: How Policy Can Embrace Creative Health	Report	evidence for CH, Integrating CH into a whole system approach to health and social care, policy recommendations	Highlights the potential for CH to help tackle pressing issues in health and social care and more widely. The Review has gathered evidence that shows the benefits of CH in relation to major current challenges, and examples of where this is already working in practice.	pages 56-65 on health inequalities and page 100 on diversifying CH -- overview, case studies						https://ncch.org.uk/creative-health-review	partner organisation recommended reading
4		Baring Foundation	2021	Creatively Minded and Ethnically Diverse	Report	arts and mental health, ethnically diverse backgrounds, challenges and barriers to access	Improving creative opportunities for people with mental health problems from ethnically diverse backgrounds. Exploring the challenges and barriers to access to the arts for people with mental health problems from ethnically diverse backgrounds, and draw out and suggest some good practice.	explores challenges and barriers to accesing arts for people with mental health problems from ethnically diverse backgrounds	op-eds and case studies		stigma and discrimination lack of representation (within who participats and the workforce), cultural barriers, socioeconomic disparities, disproportionately affected by mental health problems,	Place-based approach – enabling communities to design and deliver initiatives that work best for them can be the most effective way , culturally appropriate ways to engage specific communities, making sure activities are accessible and culturally sensitive, community informed and using community assets, dedicated and protected funding, link between healthcare professionals and	themes of best practice: - co-production and participant led, - cultural sensitivities, - locality, - employing artists with LE, - safe spaces, - working with refugees, - challenges to hierarchies, - intersectionality, - the language that we use	https://baringfoundation.org.uk/resource/creatively-minded-and-ethnically-diverse/	partner organisation recommended reading
5	Amedume, V.	Baring Foundation	2021	The response to our grant round 'Creatively Minded and Ethnically Diverse' and what we did next	Blog post									https://baringfoundation.org.uk/blog-post/the-response-to-our-grant-round-creatively-minded-and-ethnically-diverse-and-what-we-did-next/	partner organisation recommended reading
6		Baring Foundation	2020	On diversity and creative ageing	Report	creative ageing	This short report includes eleven case studies of creative ageing projects which set out to engage sections of the older population that might feel and be under-served by arts and cultural organisations.	diversity in age, increasing access to arts and culture and their benefits for older people						https://baringfoundation.org.uk/resource/on-diversity-and-creative-ageing/	partner organisation recommended reading
7		Baring Foundation	2022	Creatively Minded: The Directory	Report	arts and mental health, mapping	listing around 320 UK organisations working in arts and mental health.	mental health (protected characteristic)	mapping	N/A	N/A	N/A	N/A	https://baringfoundation.org.uk/resource/creatively-minded-the-directory/	identified from initial resources
8		Baring Foundation	2024	Creatively Minded Men	Report	men, mental health, arts	Exploring men's participation in arts and mental health activities	men are not equally engaged in creative mental health initiatives	op-eds and case studies		stigma around mental health, time constraints and prioritising other responsibilities, lack of male role models, lack of cultural sensitivity, internal barriers (belief that art is not for them, embarassment, masculinity, fear, stigma, etc)	safe space bridging arts and mental health, flexibility, education on benefits of arts on health, recruiting male community champions,	male specific workshops, male role models and champions, outreach and promotion, flexibility in schedule, community engagement, cultural sensitivity	https://baringfoundation.org.uk/resource/creatively-minded-men/?gad_source=1&gclid=CjwKCAjwk8e1BhALEiwAc8MHiD3R6NWlwOBTI2do1pFS1SaYuR2XpMJ4D4BxvGs_3ZYMWGQ2K6E11hoCPzYQAvD_BwE	identified from initial resources
9		CHWA	2022	Black History Month 2022	Blog post	Black History Month, activites, racism, mental health	highlighting a few activities led by CHWA members and regional champions for Black History Month.	including ethnically diverse artists and audiences					highlighting initiatives or organisations directly tackling racial inequalities -- increased awareness and representation	https://www.culturehealthandwellbeing.org.uk/news/blog/black-history-month-2022	partner organisation recommended reading
10		CHWA	2023	Why queer creative health?	Blog post	queer creative heatlh	exploring what it means to queer creative health, information about Queercircle and their program	creative health in context for LGBTQ+ communities					not talking about 'community' too generally, noting the importance of social or political context	https://www.culturehealthandwellbeing.org.uk/news/blog/why-queer-creative-health-guest-blog-frances-williams	partner organisation recommended reading
11		CHWA	2023	Focus on Black History Month 2023	Blog post	Black History Month, events, racism, mental health	highlighting CH events going on for Black History Month	including ethnically diverse artists and audiences						https://www.culturehealthandwellbeing.org.uk/news/blog/focus-black-history-month-2023	identified from initial resources
12	Hearst, J.	NCCH		The Place of Creative Health in LGBTQIA+ Personalised Care	Blog post	LGBTQIA+ mental health care, areas of improvement, integrating CH in personalised care	Internalised mental health disorders disproportionately affect LGBTQIA+ individuals. The blog talks about areas of improvement for mental health care and how integrating CH in personalised care can be effective.	integrating CH into personalised care for LGBTQIA+ individuals, how CH can address inequalities in susceptibility to mental health problems				person-centred design	incorporating creative health into personalised care plans	https://ncch.org.uk/blog/the-place-of-creative-health-in-lgbtqia-personalised-care	partner organisation recommended reading
13		NCCH		Synergi-Leeds - The Journey to Racial Equality in Leeds Mental Health Services	News	racial equality, mental health, collaboration, co-production, lived experience, "creative spaces"	Synergi-Leeds is a partnership between the NHS, Public Health, and the local community and voluntary sectors to tackle the long-standing overrepresentation of people from Black, Asian and minority ethnic communities admitted to crisis mental health services or detained under the Mental Health Act.	great example of whole system approach and using collaboration and coproduction to tackle racial inequties						https://ncch.org.uk/case-studies/synergi-leeds	partner organisation recommended reading
14		NHS Leeds and York Partnership	2023	Leeds mental health racial equality partnership shortlisted for two prestigious national awards	News	Synergi-Leeds shortlisted for the NHS Race Equality Award, and for Mental Health Innovation of the Year.						specific grants programmes, championing community and lived experience narratives		https://www.leedsandyorkpft.nhs.uk/news/articles/racial-equality-partnership-shortlisted-two-national-awards/	identified from initial resources
15		Synergi Collaborative Centre		Creative Spaces	Webpage	collaboration, co-design, reducing ethnic inequalities in mental health	A systems approach to reduce ethnic inequalities in severe mental distress and improve experiences and outcomes	example of a systems approach to tackle health inequalities				solution-focused dialogue, collaborations, and co-designed approaches, infomred by lived experience		https://legacy.synergicollaborativecentre.co.uk/connect/creative-spaces/	identified from initial resources
16		Bedlam Festival and Red Earth Collective	2022	Bedlam Festival 2022	News / CH initative	collaboration, mental health and arts, lived experience, creative programmes	Bedlam Festival invites The Red Earth Collective to deliver creative programmes in medium-secure mental health settings across Birmingham	collaborative CH initiative from a black-led organisation and delivered from practititioners with LE in mental health settings				collaboration with artists with lived experience		https://www.redearthcollective.org.uk/post/bedlam-festival-2022	partner organisation recommended reading
17		Bedlam Festival and Red Earth Collective	2024	Red Earth Collective to join the BEDLAM Festival 2024	News / CH initative	partnership, creative workshops, secure mental health settings, training for artists	The Red Earth Collective is pleased to be a main partner on this year's Bedlam Festival where we will be delivering creative workshops for patients in some of Birmingham's secure mental health settings.	similar to above, secure mental health settings are underserved by arts festivals				placed-based initiatives, training for artists		https://www.redearthcollective.org.uk/post/red-earth-collective-to-join-the-bedlam-festival-2024	identified from initial resources
18		NCCH	2023	Roundtable on Education and Training: Creative Health, Workforce Development & Wellbeing	Roundtable overview			workforce development					evidence base and use of arts and health to be included in the education of health and care professionals, arts institutions to develop courses and professional development modules dedicated to the benefits of the arts on health and wellbeing,	https://ncch.org.uk/blog/roundtable-on-education-and-training-creative-health-workforce-development-wellbeing	partner organisation recommended reading

											different forms of initiatives such as online and digital activities, establishing a new narrative between cultural institutions and those with lived experience of exclusion, funding specifically to encourage participation in arts and culture in the most marginalised communities, outreach activities in communities least likely to access arts and culture, communities, co-production and person-centred approaches				
19	NCCH	2023	Health Inequalities Roundtable	Roundtable overview										https://ncch.org.uk/blog/health-inequalities-roundtable	identified from initial resources
20	NHS England		Inclusion health groups	Webpage	inclusion health							ICSs' are asked to consider approach to improve support for inclusion health groups that include:		https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/what-are-healthcare-inequalities/inclusion-health-groups/	partner organisation recommended reading
21	NHS England	2023	A national framework for NHS – action on inclusion health	Long read	inclusion health, principles for action, examples of good practice	A framework to plan, develop and improve health services to meet the needs of people in inclusion health groups.			Inclusion health principles: 1. Commit to action on inclusion health 2. Understand the characteristics and needs of people in inclusion health groups 3. Develop the workforce for inclusion health 4. Deliver integrated and accessible services for inclusion health 5. Demonstrate impact and improvement through action on inclusion health			joined up action to mitigate universal policies which can disproportionately affect the most excluded and marginalised groups building trust with people and communities; communicating in a way that allows people to understand and use information to make decisions about their own health and ultimately respect their choice. improved compassionate care which is personalised, trauma informed strengths-based care that treats people with humanity and compassion working with people with lived experience and local partners, particularly the voluntary community and social enterprise (VCSE) sector to evaluate and improve how people in inclusion health groups are supported – taking services to people where it is necessary promoting the message that everyone	https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/	partner organisation recommended reading
22	Public Health England	2021	Inclusion Health: applying All Our Health	Government Guidance	inclusion health, guidance	This guide is part of 'All Our Health', a resource that helps health and care professionals prevent ill health and promote wellbeing as part of their everyday practice. The information below will help front-line health and care staff use their trusted relationships with individuals, families and communities to take action on inclusion health.				People may: - have difficulty understanding and navigating the system - have had past experiences of being turned away from services or being badly treated - not speak the language or be able to read or write - be afraid of punitive action after accessing services		This 'All Our Health' inclusion health information has been created to help all health and care professionals: understand how the concepts of inclusion health and social exclusion can be useful for your professional practice know about the health issues that socially excluded people living in your area are more likely to encounter understand specific activities and interventions that all health and care professionals can do to support the health and wellbeing of inclusion health groups consider the resources and services available in your area that can help people from inclusion health groups	https://www.gov.uk/government/publications/inclusion-health-applying-all-our-health/inclusion-health-applying-all-our-health	partner organisation recommended reading
23	National Institute of Health and Care Research (NIHR)		Resources and Training (topic: Inclusive Opportunities)	webpage for relevant resources and training	inclusive opportunities		inclusion practices in health and social care research - how can this apply in CH?							https://www.learningforinvolvement.org.uk/search-content/?searchv&date=DESC&topic=inclusive-opportunities&search_contributor=false	partner organisation recommended reading
24	Centre for Mental Health	2024	Pursuing Racial Justice in Mental Health	Report	racial equity, mental health, voluntary sector		EDI approaches (specifically for racial equity) in the voluntary sector			limited resources - funding and grants from multiple and diverse sources, each with different conditions and reporting mechanisms, competitiveness of commissioning, power imbalances, lack of knowledge about services on offer Lack of knowledge and awareness from both service users and health professionals about what is available. • Lack of "ambassadors" in communities - limited word of mouth experiences "Needs more advertising so people are aware of what's happening". • NHS professionals not trained to appreciate the value of creative activities. • Language can be a barrier- and culture matters -	mobilising community assets - Provide funding to help community organisations to engage and connect. Make good use of community centres, schools and church halls. Websites where stuff can be hosted electronically. Use a council building that's doing nowt. Dedicated organisation to 'glue' groups together. Discounts for hire of art studios for people on benefits/ low incomes. Better outreach services - Services going out to people and accessing groups. Mobile activity bus? Using an asset-based approach. We need to	Influencing key statutory organisations in addressing issues relating to the 'big picture' determinants of mental health – poverty, institutional racism, housing, and transport Uniting to find a shared vision for its delivery of services as a critical element of the wider transformation of the mental health system in Bradford Better connectivity between specialist, community-driven services in neighbourhoods, services in primary care, and hospital settings, with the longer-term objective of agreeing established pathways and integrated provision Developing and building partnerships between communities, providers, and commissioners to improve outcomes for the population Engaging with communities in all their diversity – hamessing technology to make it as easy as possible – to constantly refresh what is known about the needs of the communities they serve, and to listen to their ideas about how services could be better delivered Challenging the mental health stigma and 1. Change funding "metrics" - it should be about the journey and the impact on people. 2. Improve communication/visibility about what's available and how creativity can help. 3. Work together in funding consortiums, developing coherent local strategies. 4. Mentoring/buddying for PWLE and socially isolated people. 5. Improved connectivity with primary care and across sectors. 6. Develop a network of "champions" and a centralised database of offerings. 7. Ensure equality and diversity in provision using appropriate/sensitive language 8. Longevity and continuity of funding – support needs to be sustainable. 9. Ensuring safe spaces in all neighbourhoods for all groups to seek support.	https://www.centreformentalhealth.org.uk/wp-content/uploads/2024/01/CentreforMH_PursuingRacialJusticeInMH.pdf?mc_cid=e72cfecfe4&mc_eid=d7a9e8bb8d	partner organisation recommended reading
25	University of Huddersfield (The Creating Change Project)	2023	The value of creative health: Perspectives from people with lived experience	Research briefing	lived experience, enablers and barriers to access and impact for CH initiatives	This briefing provides important evidence of perspectives from People with Lived Experience about the value of creative health approaches in improving health and wellbeing and what is needed to enable people to live well in their communities.	perspective of people with lived experience on factors that effect accessing CH initiatives, recommendations for change and improvement	participatory action inquiry approach		Limited diversity in organisations, lack of cultural/ religious/faith knowledge, neurodiverse-friendly approaches. • Lack of equal/fair access for all groups, ethnic				https://pure.hud.ac.uk/ws/files/80252370/The_Value_of_Creative_Health_003_.pdf	SC1

26	Percy-Smith, B., Bailey, R., Stenberg, N., Booth-Kurpnieks, C., Munt, D., McQuillan, D., & Towns-Andrews, L.	University of Huddersfield (The Creating Change Project)	2023	Creative Health in Communities: Supporting People to Live Well in West Yorkshire	Report	community-based, place-based, co-production, creative/cultural/community assets	How creative health can reach communities and neighbourhoods to address health inequalities in place (West Yorkshire)	great example of assets-based approach that is co-produced, examples of what works well	collaborative action inquiry approach		inequalities in access - geographical and economic disparities, short term funding - not sustainable, lack of collaboration between cultural organisations, healthcare services and community groups	community-led approaches, co-production and co-creation - involving people with lived experience in the design and implementation, local and accessible spaces to improve social relationships	sustainable funding models, building partnerships, inclusive spaces	https://pure.hud.ac.uk/ws/files/76683690/Creative_Health_in_Communities_Final.pdf	SC1
27	Fanthome, J.C.	The School of Medicine Keele University	2023	Creative community groups as catalysts for health and wellbeing: An ethnographic study of arts participation in Stoke-on-Trent (UK)	Thesis	experiences of community creative participation	This ethnographic study aimed to understand the significance of participation within specific creative group projects, framed by the wider health and wellbeing agenda. Research took place in the city of Stoke-on-Trent, England, an area of multiple deprivation. It consisted of 12 months of participant observation among a women's craft group and a men's creative project. After 6 months of in-situ fieldwork participant observation moved online due to the COVID-19 restrictions. All data, including open-ended interviews and participants' diaries, were analysed thematically. The findings showed that people were motivated by an interest in the creative activity which functioned as a catalyst for social connection, transformation and feelings of belonging. Some engaged with these groups as an alternative to the healthcare system, others alongside it. Most recognised the wellbeing benefits, keen to advocate them to the wider community. The groups were designed to be inclusive, safe spaces intended to meet the wellbeing needs of the community and there was a system of governance and accountability in place. Challenges to the creative organisations were the need for personal and financial support to sustain their projects. This study provides key insights of the characteristics of creative community practice and participation for policymakers, social prescribing models and arts and health initiatives. The findings could be transferable to similar communities and contexts, particularly in areas of social and health	provides key insights of the characteristics of creative community practice and participation for policymakers, social prescribing models and arts and health initiatives, outlining motivators and barriers to involvement	ethnographic study					https://keele-repository.worktribe.com/preview/515586/FanthomePhD2023.pdf	SC1
28	Stewart, V., Roennfeldt, H., Slattery, M., Wheeler, A. J.	published in: Mental Health and Social Inclusion, Vol. 23 No. 1	2018	Generating mutual recovery in creative spaces	Peer-reviewed article	peer support, mental health, creative arts, self stigma	Participation in creative activities have been linked with increased personal agency. The purpose of this paper is to address critical considerations in the development of community-based creative workshops for people experiencing severe and persistent mental illness and explores participant experiences of these workshops.	Creative activities can promote positive self-identity and reduce self-stigma for people experiencing mental illness. It supports the use of peer mentoring in group creative processes.	workshops and focus group	The creative workshops supported the recovery of participants. The inclusion of peer mentors in the workshops was an important in facilitating connectedness.	N/A	indicates that peer mentors might be an enabler for people feeling more connected in the CH initiatives (representation)	N/A	https://www.emerald.com/insight/content/doi/10.1108/MHSI-08-2018-0029/full/html?casa_token=wLxutT0vjswAAAAA:lv3klGM9zHtmcpdBmxjkn5nM14TaQW3l6Ak242MtEgsSYP2zP4DhclPVOSi2fofQVDr_wjGwhlBu0n7BiUFYCfSau0AzX6VWpllr28xaftC0bpe1Vm0	SC1
29	Kearney, L., McCree, C., & Brazener, L.	South London and Maudsley NHS Foundation Trust, Centre of Parent and Child support, published in: Advances in Mental Health	2021	Making it together: a service evaluation of creative families: an arts and mental health partnership	Peer-reviewed article	Mental health; art; collaboration; preventative; early help	Evaluation of a collaborative intervention between an art and health service. The project's impact is understood in the context of the participants' personal and social circumstances, many were living with complex problems and seen as being hard to reach. The research indicates a need for inter-agency and preventative interventions.	engaging "hard to reach" participants,	Evidence-based self-report questionnaires and interviews	low level, inter-agency, preventative interventions as a solution to engage marginalised groups. supports the notion of finding creative, interagency collaborations to help mitigate the current over flooded mental health care system.				https://www.tandfonline.com/doi/pdf/10.1080/18387357.2019.1684828?casa_token=bgY46YMGJd8AAAAA:BOYegWcxtj9EPjmgPH3-5jgNY9ARw-S8psAxkyf7lpjo3e_x6-_P2Zyb7pZjF9MT1XJJ6foTtNRi	SC1
30	Corbin, J. H., Sanmartino, M., Urke, H. B., & Hennessy, E. A.		2021	Arts and Health Promotion: tools and bridges for practice, research, and social transformation	Book										SC1
31	Vougioukalou, S.	Cardiff University, Health Arts Research People	2022	Equality, diversity and inclusion in arts and health: insights from the Health Arts Research programme	policy briefing	EDI in arts and health, policy, practice, Wales	Applicability of arts and health interventions to different demographics. The research consisted of series of in-depth interviews on the process of embedding the arts within health and social care systems. As part of this research, participants were asked about their views about how the arts integrated within health and social care systems and served minoritised populations in relation to ethnicity, race, language and sexuality.	summary of research on EDI in arts and health and its relevance to policy and practice in Wales	interviews	Drawing on observations, interviews and questionnaires with 4 innovation facilitators and 44 participants in 17 arts and health projects that were part of the HARP innovation programme, it was clear that minoritised groups could be effectively engaged through the creation of safe spaces by artists who shared their lived experiences.		lived experience - "a key characteristic was that most of the artists had lived experiences that matched those of the participants. This assisted in recruitment as well as co-production."	1. EDI training: Ensure that healthcare workers including link workers are trained in EDI and understand the social model of disability, inclusive language and cultural competence. 2. Safe spaces: Create spaces that safeguard the emotional safety of under-represented groups through smaller tailor-made events with paid facilitators who share similar lived experiences. 3. Organisational commitment to EDI: Ensure that organisations that offer arts and health services also have publicly available EDI statements and audit/complaints processes where experiences of discrimination can be reported. 4. Diversity in the workforce: Value and encourage diversity among the workforce and draw on lived experiences to support innovation. 5. Community consultation: Consult diversity-led third sector organisations regarding creative activity that might not be labelled as social prescribing among under-represented groups.	https://orca.cardiff.ac.uk/id/eprint/156605/1/HARP%20research%20briefing5_EDI%282%29.pdf	SC1
32		Health Arts Research People - innovation and research partnership between Arts Council of Wales, Nesta and Cardiff University's 'Y Lab'		Recommendations	Webpage for recommendations	recommendations	recommended key actions people can take to support and enable people-powered innovation in arts and health. Includes recommendations for researchers and evaluators, policymakers, network facilitators, health and care leaders and investors	recommendations for a network facilitators (roles within a network, national centre or alliance, that supports and convenes people working on arts and health projects					Key Overall Recomendation ➔ support practitioners and the sector to make the links to big picture health strategies and priorities, and advocate for their work. further recommendations on Groundwork, Test, Invest and Scale	https://healthartsresearch.wales/harp/recommendations	identified from source 31
33	Thomson, L. J., Gordon-Nesbitt, R., Elsden, E., & Chatterjee, H. J.	published in: International Journal for Equity in Health	2021	The role of cultural, community and natural assets in addressing societal and structural health inequalities in the UK: future research priorities	Peer-reviewed article	health inequalities, cultural/natural/community assets,	Research demonstrates a clear need to assess the impact of cultural and natural assets in reducing inequality. Collaborations between community groups, service providers, local authorities, health commissioners, GPs, and researchers using longitudinal methods are needed within a multi-disciplinary approach to address societal and structural health inequalities.	identify future research priorities to address UK societal and structural health inequalities	An expert opinion consultancy process comprising an anonymous online survey and a consultation	Survey questions identified the main areas of inequality as 'health' (58%), 'social care' (54%), and 'living standards' (47%). The first research priority was 'access to creative and cultural opportunities' (37%), second, 'sense of place' (23%), and third, 'community' (17%). Approaches seen to benefit from more research in relation to addressing inequalities were 'health/social care' (55%), 'advice services' (34%), and 'adult education/training' (26%). Preferred evaluation methods were 'community/participatory' (76%), 'action research' (62%), and 'questionnaires/focus groups' (53%). Survey				https://link.springer.com/article/10.1186/s12939-021-01590-4#Sec11	SC1

34	Dow, R., Warran, K., Letrondo, P., & Fancourt, D.	published in: The Lancet Public Health	2023	The arts in public health policy: progress and opportunities	Peer-reviewed article	policy, intersectoral approach	WHO has called for governments to take an intersectoral approach, both within and across traditional areas of policy, to realise the potential of the arts for public health. To explore what global progress is being made towards this aim, we present examples of arts and health policy development from diverse government areas: health, arts, local governments, and cross government. These examples, which have been selected from a scoping review of 172 relevant global policy documents, indicate that many health and arts policy makers view the relationship between arts engagement and improved health in quite general terms, although some are investing in more targeted applications of the arts to address specific public health issues. The most promising and concrete commitments are happening when health and arts ministries or agencies work together on policy development.						work to improve accessibility must come with a special focus on improving provision for people who currently have the least access to arts and culture, to avoid exacerbating health inequalities. Also of note is the emerging area of local policy making, which recognises that cultural provision in local areas is one of the structural determinants of health and, as such, must be protected and receive investment.	https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(22)00313-8/fulltext#seccestitle108	SC1
35	Mak, H. W., & Fancourt, D.	published in: PloS One	2021	Do socio-demographic factors predict children's engagement in arts and culture? Comparisons of in-school and out-of-school participation in the Taking Part Survey	Peer-reviewed article	socio-demographic factors, barriers to arts and culture engagement, children	There is evidence on the health, social and developmental benefits of arts and cultural participation for young people. While there is a known social gradient across adult arts participation where socially advantaged individuals are more likely to engage in the arts, it remains unclear whether socio-economic factors also affect child participation either in school or out of school. This study analysed cross-sectional data from 1,986 children aged 11–15 in the Taking Part Survey interviewed from 2015–2018. It focused on three aspects of children's participation: (i) performing arts activities, (ii) arts, crafts and design activities, and (iii) cultural and heritage engagement. Results show a social gradient across all three activities for out-of-school engagement, but not for in-school engagement. Arts and cultural activities provided by schools are therefore important to ensuring universal access to the arts amongst young people.	equity access to arts and cultural activities in young people		a social gradient across all three activities for out-of-school engagement, but not for in-school engagement	socio-demographic factors	in-school activities	arts and cultural activities provided in school	https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0246936	identified from source 34
36	Mak, H. W., Coulter, R., & Fancourt, D.	published in: BMC Public Health	2021	Associations between neighbourhood deprivation and engagement in arts, culture and heritage: evidence from two nationally-representative samples	Peer-reviewed article	neighbourhood deprivation, engagement in arts	Engagement with arts is socially and geographically patterned. The aim of this cross-sectional study was to robustly disentangle associations between geographical deprivation and arts engagement from the individual socio-demographic factors that tend to correlate with residential locations.This study is the first to apply a robust PSM technique to examine the association between neighbourhood deprivation and arts engagement using two nationally-representative samples.	barriers to engagement with the arts	Propensity score matching (PSM) to two representative surveys	Results show that neighbourhood deprivation may act as a barrier that could prevent people from engaging in the arts, which in turn may exacerbate social and health inequalities. This highlights the importance of place-based schemes that focus on increasing individual motivation and capacity to engage in arts and cultural activities, especially in areas of high deprivation.	neighbourhood deprivation	place-based schemes that focus on increasing individual motivation and capacity to engage in arts and cultural activities		https://link.springer.com/article/10.1186/s12889-021-11740-6	identified from source 34
37	Mak, H. W., Coulter, R., & Fancourt, D.	published in: Public Health	2020	Does arts and cultural engagement vary geographically? Evidence from the UK household longitudinal study	Peer-reviewed article	area deprivation, geography, engagement in arts and culture	The aim of this study was to examine the association between geographical factors (spatial setting and neighbourhood characteristics) and arts and cultural engagement amongst adults in the UK.The study demonstrates a gradient for arts engagement across area deprivation. Arts engagement varies based on neighbourhood characteristics. Spatial setting has less influence on levels of arts engagement. Interactions are found between individual and geographical factors and engagement.	barriers to engagement with the arts	longitudinal study	results show that there are geographical differences in participation independent of individual demographic and socio-economic backgrounds. In particular, there was more evidence for differences in the participation based on neighbourhood characteristics (e.g. level of area deprivation). We also found some interactions between individual and geographical factors for cultural engagement but not for arts participation.	geographical differences, level of area deprivation			https://www.sciencedirect.com/science/article/pii/S0033506203013497#sec9	identified from source 34
38	Fluharty, M., Paul, E., Bone, J., Bu, F., Sonke, J., & Fancourt, D.	published in: PloS One	2021	Difference in predictors and barriers to arts and cultural engagement with age in the United States: A cross-sectional analysis using the Health and Retirement Study	Peer-reviewed article	barriers to arts engagement, age	Arts engagement constitutes health-promoting behaviour in older age. However, there are no large-scale studies examining how the predictors of arts engagement vary with age.	barriers to engagement with the arts with age	cross-sectional analysis	certain factors become stronger predictors of arts and cultural engagement and barriers to engagement as people age. Further, there appear to be socioeconomic inequalities in engagement that may increase in older ages, with arts activities overall more accessible as individuals age compared to cultural engagement due to additional financial barriers and transportation barriers	socioeconomic inequalities increase in older age -- financial barriers and transportation barriers			https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0261932	identified from source 34
39	Tom Dobson, Abi Curtis, Jane Collins, Paul Eckert & Paige Davis	published in: English in Education	2024	Envisaging intergenerational spaces for cocreating creative writing: developing reflective functioning for positive mental health	Peer-reviewed article	co-creation, creative activities, young people	In this paper, we take an ecological view of children's development to argue that preventive interventions should move beyond separating the microsystems of school and home to create new intergenerational spaces for nurturing mental wellbeing.	discusses barriers to co-creation and participation in creative activities			barriers to participation: (1) negative experiences and connotations that school and creative writing hold (2) stigma around creativity / not seeing oneself as creative (3) cultural and financial barriers for socially disadvantaged groups			https://doi.org/10.1080/04250494.2024.2370576	SC1
40	Sayers. T., Stickley, T.	published in: Mental Health and Social Inclusion	2018	Participatory arts, recovery and social inclusion	Peer-reviewed article	participatory arts, mental health, social inclusion, theoretical framework	There is growing evidence of the contribution participatory arts practice may make towards mental health recovery. The purpose of this paper is to examine this phenomenon by critically reviewing the relevant literature in the light of the CHIME theoretical framework that identifies the components and processes of mental health recovery.	what works in participatory arts for mental health recovery	critical realist review method	"By participating in such activities, people connect with one another and form significant positive relationships that inspire hope. By developing new abilities and strengths, participatory arts activities can break down barriers between service users, professionals and family members. Thus, more relationships that are positive emerge leading to a positive individual and social identity, a stronger sense of belonging, and improved self-efficacy. Membership of an arts group, with resulting creative artworks, can foster positive social unity, an important aspect in increasing social capital and social inclusion. People experience "safe" environments where				https://www.emerald.com/insight/content/doi/10.1108/MHSI-04-2018-0015/full/html	SC1
41	Mak, H. W., Coulter, R., & Fancourt, D.	published in: Public health panorama: journal of the WHO Regional Office for Europe	2019	Patterns of social inequality in arts and cultural participation: Findings from a nationally representative sample of adults living in the United Kingdom of Great Britain and Northern Ireland	Peer-reviewed article	social and health inequalities, arts and cultural participation	A significant amount of literature indicates the health benefits of arts engagement. However, as this engagement is socially patterned, differential access to and participation in the arts may contribute to social and health inequalities.This study aimed to uncover the patterns of participation in arts activities and engagement with culture and heritage among adults in the United Kingdom of Great Britain and Northern Ireland, and to examine whether such patterns are associated with demographic and socioeconomic characteristics.	social gradient in the arts and cultural engagement			demographic and socioeconomic disparities			https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7613129/	SC1

42	Fancourt, D., & Steptoe, A.		2024	Can social prescribing reach patients most in need? Patterns of (in)equalities in referrals in a representative cohort of older adults in England	Preprint	social prescribing, social and healht inequalities	the aim of this study is to incorporate bespoke novel questions on social prescribing into a nationally-representative cohort study to assess whether SP is truly reaching individuals most in need.	access to social prescribing routes		In this analysis of a nationally representative cohort study of 7,283 richly-phenotyped adults aged 50+ living in England, SP was offered most to individuals experiencing socio-economic adversity with health needs including depression, diabetes, chronic pain, multiple long-term conditions, and those who were physically inactive.Meaning: Promisingly, older adults with highest socio-economic need and most long-term health conditions particularly appear to be receiving support through social prescribing.				https://www.medrxiv.org/content/10.1101/2024.03.26.24304891v1.full-text	identified from source 41
43	Shaikh, M., Tymoszuk, U., Williamon, A., & Miraldo, M.	Public Health	2021	Socio-economic inequalities in arts engagement and depression among older adults in the United Kingdom: evidence from the English Longitudinal Study of Ageing	Peer-reviewed article	socio-economic inequalities, arts engagement, depression	Arts engagement has been positively linked with mental health and well-being; however, socio-economic inequalities may be prevalent in access to and uptake of arts engagement reflecting on inequalities in mental health. This study estimated socio-economic inequality and horizontal inequity (unfair inequality) in arts engagement and depression symptoms of older adults in England. Trends in inequality and inequity were measured over a period of ten years.	socio-economic inequalities as barriers to access	longitudinal study	Our findings suggest that while socio-economic inequality in arts engagement might appear to have reduced over time, once arts engagement is standardised for need, inequality has actually worsened over time and can be interpreted as inequitable (unfair). Relying on need-unstandardised estimates of inequality might thus provide a false sense of achievement to policy makers and lead to improper social prescribing interventions being emplaced.	socioeconomic inequalities		Relying on need-unstandardised estimates of inequality might provide a false sense of achievement to policy makers and lead to improper social prescribing interventions being emplaced. -- research needs to need-standardise to measure inequalities	https://doi.org/10.1016/j.puhe.2021.07.044	SC1
44	Taylor, M.	published in: Cultural Trends	2016	Nonparticipation or different styles of participation? Alternative interpretations from Taking Part	Peer-reviewed article	participation in cultre	In England, the Taking Part Survey is the dominant source of information on participation and its relationship with social stratification. Existing work that investigates state-supported culture implies often large groups of people "not currently engaged" in culture. The scope of this survey allows us to identify not only what else those "highly engaged" are doing, but also whether those "not currently engaged" are active elsewhere. Using this survey, I use hierarchical cluster analysis to identify relationships between variables, and kmeans cluster analysis to identify patterns of participation. The analysis suggests, consistent with other work, that about 8.7% of the English population is highly engaged with state-supported forms of culture, and that this fraction is particularly well-off, well-educated, and white. Over half of the population has fairly low levels of engagement with state-supported culture but is nonetheless busy with everyday culture and leisure activities such as pubs, darts, and gardening. Only about 11% of the population is detached from mainstream pastimes and social events outside of television. The results challenge the basis of policies seeking to manage cultural and leisure participation: current policies aimed at increasing participation in state-sanctioned activities are likely to target those with already busy cultural lives.	information about cultural participation might have alternative explanations, those reported as non-participants maybe participating in different sorts of activities (non-state)			implies that diversity in cultural and arts activities need to be considered to attract diverse groups	state-sanctioned activities are not likely to attract underreached groups in arts and cultural activites -- alternatives need to be explored	https://www.tandfonline.com/doi/pdf/10.1080/09548963.2016.1204051	identified from source 43
45	Tymoszuk, U., Spiro, N., Perkins, R., Mason-Bertrand, A., Gee, K., & Williamon, A.	published in: PloS One	2021	Arts engagement trends in the United Kingdom and their mental and social wellbeing implications: HEartS Survey	Peer-reviewed article	arts engagement trends									https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0246078	identified from source 43
46	Johnson, H., & Monney, N.	published in: Forum: Qualitative Social Research	2021	Using the Arts to Support the Arts: A Creative, Community-University Partnership Approach to Building Arts Inclusivity in Economically-Deprived Communities	Peer-reviewed article	arts-based research, community, collaboration, participatory research, arts and health	There is robust evidence supporting the positive impacts of the arts on health and wellbeing; however, researchers suggest that the poorest in society are significantly less likely to engage with the arts than the wealthy. In this article, we describe a creative, community-university partnership between the Hangleton & Knoll Project and the University of Brighton, where we aimed to investigate and tackle this "participation gap." Using the participatory arts-based method of collaborative poetics, we found that, contrary to claims in the literature, local residents valued and engaged with a wide range of art forms; however, their access to the arts was limited by issues including money, travel and illness. By communicating these findings creatively to a broad range of stakeholders, we were able to stimulate greater investment in the arts locally, with steps taken towards the establishment of a dedicated community arts venue. In this article we reproduce some of the arts-based outputs we created, using these to criticize the reductionist understanding of the arts that lies beneath "participation gap" claims and to demonstrate the enormous potential that can be unlocked when universities and local communities collaborate creatively as equal partners.		participatory arts-based method	collaborative poetics approach	money, travel and illness	collaboration between community and university			SC1
47	Gemma Collard-Stokes & J. Yoon Irons	published in: Research in Dance Education	2022	Artist wellbeing: exploring the experiences of dance artists delivering community health and wellbeing initiatives	Peer-reviewed article	Arts for health; social prescribing; dance artist wellbeing; community dance; personal narratives	The article examines the experiences, practices and professional development of dance artists/practitioners providing community dance programmes with a particular focus on enhancing participants' wellbeing.	practitioner wellbeing	qualitative	Three themes emerged – barriers to wellbeing, isolation and support networks. Four crucial areas of concern were highlighted. 1) Clearer distinctions between social prescribing, arts in primary/secondary care and participatory, community arts programming. 2) Improved dialogue between dance artists/practitioners, employers/commissioners, communities and training providers. 3) Action to address the lack of affective support and training for dance artists/practitioners working in a health and wellbeing context, and 4) Recognition. The independent dance sector still has work to do in order to provide dance			affective support and training for artists, improved dialogue between artists/practitioners and employer organisations	https://doi.org/10.1080/14647893.2021.1993176	SC1

48	Karkou V, Omylinska-Thurston J, Thurston S, Clark R, Perris E, et al.	published in: PloS One	2024	Developing a strategy to scale up place-based arts initiatives that support mental health and wellbeing: A realist evaluation of 'Arts for the Blues'	Peer-reviewed article	scaling up	In this study we make a unique contribution to knowledge about scaling up place-based arts initiatives that support mental health and wellbeing through focusing on the example of 'Arts for the Blues', an arts-based psychological group intervention designed to reduce depression and improve wellbeing amongst primary care mental health service users in deprived communities.	how to scale up place based initiatives	realist evaluation	we recommend that to scale up place-based arts initiatives which support mental health and wellbeing: (i) the initiative needs to be adaptable, clear, collaborative, evidence-based, personalised and transformative; (ii) the organisation has to have a relevant need, have an understanding of the arts, has to have resources, inspiration and commitment from staff members, relevant skillsets and help from outside the organisation; (iii) at a policy level it is important to pay attention to attitude shifts towards the arts, meet rules, guidelines and standards expected from services, highlight gaps in provision, seek out early intervention				https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0296178	SC1
49	Shaughnessy, C., Perkins, R., Spiro, N., Waddell, G., & Williamon, A.	published in: Cultural Trends	2023	Cultivating progressive development in the cultural industries: challenges and support needs identified by the creative workforce in the United Kingdom	Peer-reviewed article	creative workforce, challenge, development	The impacts of the COVID-19 pandemic in the creative and cultural industries have been closely tracked by researchers, professional bodies, and arts organisations. In the period of recovery that has followed, emphasis has moved towards building a more inclusive and sustainable industry. Yet beyond the headline statistics, accounts of the support needs of creative workers– as identified in their own words– are less forthcoming. This paper reports on open responses collected during April-May 2021 as the United Kingdom began to lift lockdown restrictions. T	challenges for the creative workforce	thematic analysis	Thematic analysis of responses identified three overarching themes identified by respondents as central to sustainable recovery: (i) Financial Infrastructures; (ii) Artistic communities; and (iii) Future-proofed professional landscapes. The findings support previous research that has emphasised the need for recovery to prioritise supporting individual artists and the importance of freelance voices at all stages of policy and decision making to ensure equitable development for the future.	"Particular attention has been drawn to the financial infrastructures which limit accessibility and inclusion of both entry into, and retention of, diversity within the sector" "Remove financial precarity through long term funding models that directly support the individual worker. Providing this financial stability will further help to promote diversity in the sector and allow artists to take more creative risks and build their businesses with less financial jeopardy."	long term funding	supporting artists and practitiones, including them in decision making	https://www.tandfonline.com/doi/full/10.1080/09548963.2023.2227850	SC1
50	Wreyford, N, O'Brien, D, and Dent, T	All Party Parliamentary Group for Creative Diversity	2021	Creative Majority: An APPG for Creative Diversity report on 'What Works' to support, encourage and improve diversity, equity and inclusion in the creative sector.	Report	creative diversity, EDI, what works				5 areas complimented by 26 policy recommendations			These five As should act as benchmarks for anyone wanting to see results in equity, diversity and inclusion (EDI). 1. Ambition reflects the need for EDI to be addressed by everyone, at every level, and put at the heart of business, funding and commissioning plans. 2. Allyship provides the conditions for EDI to flourish and ensures all voices are heard. 3. Accessibility provokes questions about who is not able to participate and why. 4. Adaptability provides practical tools for the application of effective practices. 5. Accountability promotes ways to ensure change happens, lessons are learned and shared, and actions are adapted accordingly.	https://www.kcl.ac.uk/cultural/resources/reports/creative-majority-report-v2.pdf	identified from source 49
51	Gordon-Nesbitt, R.	Greater Manchester Integrated Care Partnership	2022	The Greater Manchester Creative Health Strategy	Strategy report		Greater Manchester has committed to becoming a creative health city region. This means that GM will be the first city region in the world to realise the power of creativity, culture and heritage in addressing inequities and improving the health and wellbeing of its residents.	some recommendations/ areas of work identified to make GM a creative health city for all			leadership, knowledge, evidence, commissioning, workforce development, communication		https://gmintegratedcare.org.uk/wp-content/uploads/2022/11/gm-creative-health-strategy-exec-summary.pdf	Google search
52		University of Huddersfield	2023	Developing creative health provision	policy briefing				community-based action research and systemic action inquiry		Access to core funding is problematic with a lack of resources to support networking and cross-sector linkages. Priority (in funding) is given to NPO holders and high arts which tend not to be appealing or accessible to poorer communities, yet the majority of providers connecting with communities are small scale and existing hand to mouth. Poor communication and information sharing means that often communities and providers are unaware of what is available and language can be stigmatizing. Limited NHS capacity is used to justify arts not being		funding and sustainability, communication and visibility, culture and system change, capacity, skills and support (actions listed)	https://pure.hud.ac.uk/files/80251857/Developing_Creative_Health_Provision_003_.pdf	Google search
53	Fancourt, D., Baxter, L. & Lorencatto, F.	published in: BMC Public Health	2020	Barriers and enablers to engagement in participatory arts activities amongst individuals with depression and anxiety: quantitative analyses using a behaviour change framework	Peer-reviewed article	barriers and enablers to arts engagement, mental health	This study used a behaviour change framework to explore barriers to engagement in participatory arts activities amongst people with either depression or anxiety.	having mental health problems is a protected characteristic itself, furthermore people from marginalised backgrounds are disproportionately affected by mental health problems	citizen science experiment	Individuals with depression and anxiety felt they would be more likely to engage in arts activities if they had greater psychological and physical capabilities, more social opportunities, and stronger automatic and reflective motivations to engage. However, they did not feel that more physical opportunities would affect their engagement. Covariates explained only 8–37% of the difference in response amongst those with and without anxiety and depression.	poor mental health (marginalised groups disproportionately affected) – lack of psychological and physical capabilities, social opportunities and motivation		proposes interventions that focus on increasing perceived psychological and physical capabilities, providing social opportunities, and reinforcing both automatic and reflective motivations to engage.	https://link.springer.com/article/10.1186/s12889-020-8337-1#Sec13	SC1

54	Dadswell, A.; Wilson, C.; Bungay, H.	published in: Sustainability	2024	Sustainable Creative Practice with Older People: A Collaborative Approach between Arts and Care Sectors	Peer-reviewed article	sustainable creative practice, care homes, older people, collaboration	This article reflects on qualitative findings from the Artists' Residencies in Care Homes (ARCH) programme led by Magic Me, which paired four leading arts organisations with four care homes in Essex who worked together over four years to deliver creative arts for the residents. Building trusted relationships and collaborative working between the artists and care home staff was essential for the success of the residencies and for generating and embedding sustainable creative practice in the homes. This article argues that for creative practice to become sustainably embedded in care homes, arts organisations and the arts and culture sector need to embrace interprofessional collaborative practice in health and social care.	what works for creative health programs in care homes to be sustainable	qualitative	show how the focus on and support around building trusting relationships from the R&D phase and throughout the residencies enabled collaboration between artists and care home staff that, in turn, supported the embedding of creativity in the care homes. This builds on our previous research [26] by elaborating on how artists and care home staff can foster such trusting and collaborative relationships that subsequently lead to more sustainable creative practice. We discuss how these findings align with the collaboration and sustainability principles in relation to the recently published Quality Cycle		cross-sectoral collaboration		https://www.mdpi.com/2071-1050/16/9/3587	SC1
55	Fancourt, D.; Warran, K.	Wellcome Open Research and UCL - the social biobehavioural research group	2024	A fRAmework of the Determinants of Arts aNd Cultural Engagement (RADIANCE): integrated insights from ecological, behavioural and complex adaptive systems theories	Peer-reviewed article	arts and cultural engagement, population health, determinants		determinants of arts and cultural engagement (including barriers)	Drawing on the theoretical bases of ecological systems theory, ecosocial theory and complex adaptive systems science, we conducted a review and iterative theorising process	identified 35 different factors that can act as determinants of ACEng across micro, meso, exo, macro and chrono levels. We broadly categorised these as social (i.e. a primary feature being the interaction of people), tangible (i.e. a primary feature involving physical assets or resources or the production of physical assets), and intangible (i.e. constructs that do not have a primary physical basis but instead have a virtual or imaginary basis).				https://wellcomeopenresearch.org/articles/9-356/v1	interviewee suggestion
56	Fancourt D, Bone JK, Bu F, Mak HW, Bradbury A.	UCL - the social biobehavioural research group	2022	The Impact of Arts and Cultural Engagement on Population Health: Findings from Major Cohort Studies in the UK and USA 2017	Report	arts and cultural engagement, population health, access		has a subsection on access to arts outlining barriers		socioeconomic and demographic barriers (men, ethnic minorities, carers less likely to engage), geographical barriers (deprived areas), health barriers (people with poorer health perceive themselves as less capable of taking part in arts activitie)		1. arts engagement in school, 2. strengthening the link between clinical and community care, 3. preventative public health, 4. using the arts to reduce population health disparities (e.g. place based schemes), 5. enhanced longitudinal and complex research	https://sbbresearch.org/wp-content/uploads/2023/03/Arts-and-population-health-FINAL-March-2023.pdf	Google search
57		Arts Council England		Guide to producing Equality Action Objectives and Plans for NPOs: Putting equality and diversity into action	Action guide	equality action, equality and diversity	The Putting Equality and Diversity into Action section offers readers a practical guide to developing their equality objectives and action plans. It supports organisations to look at how they can respond to the Creative Case for Diversity through their arts and cultural programmes as well as how they can work towards diversifying their audiences and workforce.	equality action plan guidance for the arts and cultural sector (also relevant to CH)					https://www.artscouncil.org.uk/equality-action-plan-guidance#t-in-page-nav-2	Google search
58		NHS England	2023	NHS equality, diversity, and inclusion improvement plan	Plan	EDI, improvement plan	The aim of this plan is to improve equality, diversity and inclusion, and to enhance the sense of belonging for NHS staff to improve their experience. Therefore, while we refer to the protected characteristics as defined in the Equality Act 2010, the actions set out here are intended to positively impact groups and individuals beyond these terms and definitions.	EDI improvement plan for the healthcare sector					https://england.nhs.uk/long-read/nhs-equality-diversity-and-inclusion-improvement-plan/	google search
59		Counterpoints	2023	Our Plan 2023-27	Business Plan			includes aims, actions and ambitons to make arts inclusive and change perceptions of displacement and migration through arts-centred approaches			Curating, producing and commissioning work across art forms and genres • Talent development and mentoring programme for artists, including ongoing support, advice and connections • Developing Partnerships and networks including leading on the production of the national Refugee Week festival and Platforma networks • Learning a reflective layer that enables us to do the difficult thinking around the work • Pop culture and social change harnessing TV/film and comedy to shift the way we talk about		https://counterpoints.org.uk/wp-content/uploads/2023/03/Counterpoints_report_Business-Plan_2023-27_WCMH_01_CA-20.03.23.pdf	identified from recommended organisation
60	Jiang, Y.	Queercircle	2023	Queering Creative Health: A Community Informed Evaluation of Queercircle's Health and Wellbeing Programme	Evaluation Report							need to be context specific	https://website-artlogicwebsite020b.artlogic.net/user/library/documents/main/queering-creative-health-report_web.pdf	
61	Waterson, H., Thomson, L.J., Mughal, R., Manley, K., Coulter, A. & Chatterjee, H.J.	Mobilising Community Assets to Tackle Health Inequalities Research Programme, UCL	2024	Working with communities to reduce health inequalities: Interim findings from the UK Research and Innovation Mobilising Community Assets to Tackle Health Inequalities Research Programme	Findings Report	community assets, health inequalities				drivers to inequality: socioeconomic context and deprivation	enablers for success: cross-sectoral collaboration, co-production and incorporating lived experience, funding, evidence		https://nccph.org.uk/uploads/MCA-Interim-Report.pdf	
62	Fortier, J. P., & Coulter, A.	published in: Public health	2021	Creative cross-sectoral collaboration: a conceptual framework of factors influencing partnerships for arts, health and wellbeing	peer-reviewed article	arts and health, collaboration, organisational behaviour		collaboration has been identified as an enabler for diversity in other literature, therefore what influences collaboration is relevant	participatory action research				https://doi.org/10.1016/j.puhe.2021.05.017	SC2
63	Thomson, L. J. M., Waterson, H., & Chatterjee, H. J.	published in: International Journal for Equity in Health	2024	Successes and challenges of partnership working to tackle health inequalities using collaborative approaches to community-based research: mixed methods analysis of focus group evidence	peer-reviewed article	partnership working, collaboration, community-based research, health inequalities		collaboration has been identified as an enabler for diversity in other literature, therefore what influences collaboration is relevant	focus groups				https://link.springer.com/article/10.1186/s12939-024-02216-1	SC2

64	Daykin, N., Gray, K., McCree, M., Willis, J.	published in: Arts & Health	2017	Creative and credible evaluation for arts, health and well-being: opportunities and challenges of co-production	peer-reviewed article	co-production, evaluation, methodologies		collaboration has been identified as an enabler for diversity in other literature, therefore what influences collaboration is relevant	mixed methods	Co-production between stakeholders is needed to strengthen evaluation practice and support the development of the arts and health sector. Effective co-production can be undermined by structural and cultural barriers as well as unequal stakeholder relationships. The paper discusses recent initiatives designed to support best practice.				https://www.tandfonline.com/doi/pdf/10.1080/17533015.2016.1206948	SC2
65		Arts & Social Outcomes Network		Power and change: leadership, lived experience and coproduction	blog post	power, lived experience, coproduction	Our organisations have been built on the idea that power dynamics can change. Like many of you, we want to work out how to share what power we do have. As networks we are also all about collaboration. Thinking about what we might usefully do together, we realised that we shared a desire to ensure that the work is led by the people who understand the need for it best. A shorthand for this might be 'leadership by lived experience'. Our first step was to explore where we are all at with this work – and to share an example of an organisation or project we feel is leading the way. This blog describes what we discussed and is a way for us to share our own messy experiences as we try to build or change our organisations.	list of organisations that are working to change power dynamics through coproduction and lived experience in leadership		lived experience, coproduction		https://www.culturehealthandwellbeing.org.uk/news/blog/power-and-change-leadership-lived-experience-and-coproduction	identified from organisation
66		Arts & Homelessness International		The Jigsaw of Homeless Support	holistic coproduced model	holistic support, coproduction	The Jigsaw of Homeless Support is a holistic model that illustrates the multiple needs that people experiencing homelessness have. It was co-created with people from Manchester who were homeless. The Jigsaw diverges from the hierarchical models that focus only on the most urgent, practical needs, like housing.	cocreated model for creative health delivery		coproduction	nonhierarchical / holistic support	https://artshomelessint.com/what-we-do/advocacy/ligsaw/	identified from organisation
67		Arts & Homelessness International		Cultural spaces' responses to homelessness Training	training	training, inclusivity, homelessness, cultural spaces	a training program for cultural spaces to work more closely with homeless people, including a report and a toolkit	how can cultural spaces be more inclusive for a specific demographic				https://artshomelessint.com/what-we-do/training/cultural-spaces-responses-to-homelessness/	identified from organisation
68	Shaw, P.	Arts & Homelessness International		Open House: Cultural Spaces' Responses to Homelessness	report	homelessness, cultural spaces, coproduced review	A review of practices with coproduced questions, containing case studies of 40 cultural spaces and the journeys they have gone through to work more closely with homeless people.	how cultural spaces can address homelessness		Cultural spaces that are working to respond to homeless share these characteristics □ Their commitment to responding to homelessness is written down. □ They recognise the complexity of homelessness and are working with other organisations and individuals and pool their resources, to achieve more. □ They know that it takes time to build relationships and achieve change. □ Homeless or not, every visitor has access to the facilities, programme and opportunities on	recommendations for cultural spaces based on the enablers identified	https://artshomelessint.com/wp-content/uploads/2021/04/2020-02_Cultural-Spaces-Responses-to-Homelessness.pdf	identified from organisation
69		Arts & Homelessness International, Museum of Homelessness, Manchaster Museum and Tate Modern		Cultural Spaces Homelessness Toolkit	toolkit		The toolkit offers guidance to people working in cultural spaces that can help equip staff and volunteers to make the space as welcoming as possible for people who are or have been homeless and increase their involvement in the life of the cultural space. It begins with 7 practices and values which the cultural spaces in our Review all share. We have expanded each of these areas with other sharable examples of practices that are proving effective. Most importantly, we include detailed information about training packages available in order to help anyone interested take the next steps in their learning.	toolkit for making cultural spaces inclusive for homeless people			EQUITY: The welcome, The attitude & behaviour WRITTEN COMMITMENT AND TOOLS: Homeless policy, Safeguarding & boundaries, Signposting tools, Posters TRAINING: WOV's training modules PARTNERSHIPS: Find a homeless centre, People as partners CONSISTENCY: Language, Treatment IT TAKES TIME: Homeless lead, Working group, Peer learning MEMORY: Checklist	https://artshomelessint.com/wp-content/uploads/2021/04/2020-02_Cultural-Spaces-Responses-to-Homelessness-Toolkit.pdf	identified from organisation
70		Arts & Homelessness International		Participatory Democracy through Legislative Theatre	creative programme that democratices decision-making in policy		The LT process involves groups of homeless people and council workers staging improvised plays together which explore blockages in the systems. These plays are performed in front of an audience made up of members of homelessness services and policy makers. The audience can suggest changes to the narratives and resulting solutions are voted on and passed into legislation. In both Coventry and Haringey this has led to new policy being embedded into the Rough Sleeping Strategies and the homeless people involved being paid to remain on Scrutiny Groups within the council to ensure that the policy changes are being implemented. We are now going through the same process in Medway.	how creativity can be used to influence policy and practice, and inform decision making processes	participatory democracy methodology - Legislative Theatre			https://artshomelessint.com/what-we-do/advocacy/legislative-theatre/	identified from organisation
71		Arts & Homelessness International		Training	website for training programs on offer	training, homelessness, social justice, culture	AHI offers a wide range of in-person and online training for people, projects and policy in the homelessness, cultural, social justice sectors and corporate settings					https://artshomelessint.com/what-we-do/training/	identified from organisation
72		Arts & Homelessness International		Co-Produced Arts and Homelessness Practice Guide	guide		A co-produced guide which offers suggestions, good practice and values when working in participatory arts and creative projects with people who are or have been homeless				Before a project 1. Co-producing 2. Setting clear aims 3. Creating a safe space During a project 4. Promoting positive perceptions 5. Accessibility 6. Celebrating different ways of working 7. Adapting and reacting 8. Amplifying voices and agitating ears What next? 9. Evaluating and documenting 10. Building regularity and legacy	https://artshomelessint.com/wp-content/uploads/2021/04/2020-07_Co-produced-Arts-and-Homelessness-Practice-Guide.pdf	identified from organisation
73	Daykin, N., Mansfield, L., Meads, C., Gray, K., Golding, A., Tomlinson, A., & Victor, C.	published in: Arts&Health	2020	The role of social capital in participatory arts for wellbeing: findings from a qualitative systematic review.	peer-reviewed article	social capital, participatory arts,	Studies often cite positive impacts of bonding and, to a lesser extent, bridging social capital. However, reported challenges suggest the need for a critical approach. Forms of linking social capital, such as reframing and political engagement to address social divisions, are less often cited but may be important in participatory arts and wellbeing.					https://doi.org/10.1080/17533015.2020.1802605	identified from source 45
74	Ganga, R., Davies, L. and Wilson, K.	What Works Wellbeing	2022	Arts & Wellbeing - A review of the social value of place-based arts interventions.	review	place-based interventions						https://whatworkswellbeing.org/wp-content/uploads/2022/12/Arts-Wellbeing-A-review-of-the-social-value-of-place-based-arts-interventions-updated-30.01.2023.pdf	SC1
75	Mansfield, L., Daykin, N., Golding, A., & Ewbank, N	published in: Annals of Leisure Research	2024	Understanding everyday creativity: a framework drawn from a qualitative evidence review of home-based arts	peer-reviewed article	everyday creativity		everyday creativity regarded as a democratisation of arts					

Appendix 3. Participant Information Sheet

PARTICIPANT INFORMATION

UCL Research Ethics Committee Approval ID Number: 27406/001

YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM

Title of Study: Enablers and Barriers to Diversity and Inclusion within the Creative Health Sector

Department: UCL Arts and Sciences

Name and contact details of Researcher: Buse Kanber

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1. **Invitation**

   You are invited to take part in a research project. Your participation is voluntary and before you decide if you would like to consent to take part in the research, we would like you to understand fully why the project is being carried out and what participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask us if there is anything that is not clear or that you would like more information about. Take time to decide whether or not you wish to take part in the research study. The project is part of a MASc Creative Health dissertation project. Thank you for reading this.

2. **What is the purpose of the project?**

   The aim of this research project is to understand the current state of equality, diversity, and inclusion (EDI) in the Creative Health sector, to identify barriers to the sector becoming more diverse and inclusive, and to determine enablers that could promote diversity and inclusion. The objective of the research is to carry out interviews with sector professionals (practitioners, organisation leaders, policy makers) who are happy to take part in an interview about their perspectives on the current state of the sector, challenges they face around EDI, and policies and strategies they implement to promote diversity. Research findings will be evaluated and translated into a report freely available at the end of the project.

3. **Why have I been chosen?**
   You have been chosen to take part in the study because of your current job role in an organisation whose work is related to Creative Health, which can be defined as arts, culture community, and creativity-based approaches to health and wellbeing.

4. **Do I have to take part?**
   Your participation in the study is entirely voluntary and it is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep (and be asked to sign a consent form). You can withdraw from the research at any time up to one month after the interview, without giving a reason. If you do decide to withdraw you will be asked what you would like to happen to any data you have provided up to that point.

5. **What will happen to me if I take part?**
   You will be asked to participate in a brief interview that will last around 20-30 minutes. This interview will take the form of a relatively informal conversation, although the interviewer has a list of topics that they would like to ask you about your work and EDI practices. However, you are welcome to ask any questions or have anything clarified to you (as well as stop the interview) at any point.

6. **Will I be recorded and how will the recorded media be used?**
   If you choose to take part in the interview, an audio recording will be made of the conversation between yourself and the researcher. We will ask for permission for audio recording on the consent form. Recorded audio from the interview will be made pseudo-anonymous (using your initials) and they will be deleted once transcribed to be used only for analysis. No other use will be made of them without your written permission, and no one outside the project will be allowed access to the original recordings.

7. **What are the possible disadvantages and risks of taking part?**
   There are no direct risks or disadvantages involved in participating. However, we will be talking about diversity and inclusion, which might touch upon the topics of health inequalities and discrimination. You will only be asked to talk about these topics in the context of your work and not your personal experiences, but should you feel unwell or would prefer to discontinue or move onto a different question at any point, please feel free to say so.

8. **What are the possible benefits of taking part?**
   There are no direct benefits to you in participating in this research, however findings from this research will inform organisations of strategies to promote diversity and inclusion in their practices. For participants not currently considering themselves as

part of the "Creative Health sector", they will get a chance to learn more about how they can be included in the networks of National Centre for Creative Health (NCCH) and Culture, Health and Wellbeing Alliance (CHWA), and how these networks can support them (including reimbursements for their times in CHWA's research).

9. What if something goes wrong?

Should you wish to raise a complaint about the research/researchers, you should contact the Principal Investigator, Prof Helen Chatterjee, at the contact details above. If you feel that the complaint has not been handled to your satisfaction, then you should contact the Chair of the UCL Research Ethics Committee ethics@ucl.ac.uk.

10. Will my taking part in this project be kept confidential?

During the interview you will not be asked any questions concerning personal details about you and we would like you to try not to provide too much personal information about yourself. We are primarily interested in your opinions on the topics being discussed. Having said that, any information that you may provide about yourself during the interview will be kept strictly confidential. Moreover, the recording will be kept on a secure, encrypted and password protected computer, pseudo-anonymised (using initials) during transcription and will be destroyed once it has been transcribed. This means that you will not be identifiable in the report or any presentation or publications that will be produced based on this research.

11. Limits to confidentiality

Confidentiality will be respected unless there are compelling and legitimate reasons for this to be breached. If this were the case, we would inform you of any decisions that might limit confidentiality.

12. What will happen to the results of the research project?

The results of the research will be included in a MASc Creative Health dissertation. If you would like a copy of the report, you will need to ensure that you have left your contact details with the researcher for this purpose (and there is space for this at the end of the consent form). You will not be identified in the report or in any other publication.

13. Local Data Protection Privacy Notice

Notice: The controller for this project is University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data and can be contacted at data-protection@ucl.ac.uk. The information that is required to be provided to participants under data protection legislation (GDPR and DPA 2018) is provided by both the 'local' and 'general' privacy notices. This 'local' privacy notice sets out the information that applies to this particular study.

Further information on how UCL uses participant information can be found in the 'general' privacy notice https://www.ucl.ac.uk/legal-services/privacy/general-privacy-policy.

The lawful basis used to process your personal data is performance of a task in the public interest, and 'Research purposes' for special category data.

Your personal data will be processed as long as it is required for the research project. If we are able to anonymise the personal data you provide, we will undertake this, and we will endeavour to minimize the processing of personal data wherever possible. If you are concerned about how your personal data is being processed, or if you would like to know more about your rights, please contact UCL in the first instance.

14. Who is organising the research?

The project led by UCL in partnership with National Centre for Creative Health (NCCH) and Culture, Health and Wellbeing Alliance (CHWA).

15. Contact for further information

For further information, please contact Buse Kanber at UCL: buse.kanber.18@ucl.ac.uk

Thank you for reading this information sheet and for considering participation in the research study.

Appendix 4. Consent Form

CONSENT FORM

UCL Research Ethics Committee Approval ID Number: 27406/001
YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM

Title of Study: Enablers and Barriers to Diversity and Inclusion within the Creative Health Sector

Department: UCL Arts and Sciences

Name and contact details of Researcher: Buse Kanber
buse.kanber.18@ucl.ac.uk

Name and contact details of Principal Investigator: Prof Helen Chatterjee
h.chatterjee@ucl.ac.uk

Name and contact details of UCL Data Protection Officer: Alexandra Potts
data-protection@ucl.ac.uk

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the explanation already given to you, please ask these before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

I confirm that I understand that by ticking / initialling each box below I am consenting to this element of the study. I understand that it will be assumed that unticked / un-initialled boxes means that I DO NOT consent to that part of the study. I understand that by not giving consent for any one element that I may be deemed ineligible for the study.

		Tick Box
1.	I confirm that I have read and understood the Participant Information Sheet for the above study. I have had an opportunity to consider the information and what will be expected of me. I have also had the opportunity to ask questions which have been answered to my satisfaction.	
2.	I understand that I will be able to withdraw my data up to one month after the interview.	

3.	I consent to participate in the study. I understand that the information I will provide will be used for the purposes explained to me. I understand that according to data protection legislation, 'public task' will be the lawful basis for processing, and 'research purposes' will be the lawful basis for processing special category data.	
4.	I understand that any information I provide will remain confidential and that all efforts will be made to ensure that I cannot be identified. While it is not part of the project to record personal information any such information I offer will be stored anonymously and securely.	
5.	I understand that my information may be subject to review by responsible individuals from University College London and/or one of the partner organisations (National Centre for Creative Health) for monitoring and audit purposes.	
6.	I understand the potential risks of participating and the support that will be available to me should I become distressed during the course of the research.	
7.	I understand the potential benefits of the research.	
8.	I understand that the information I have provided will be included in a MASc Creative Health dissertation.	
9.	I wish to receive a copy of the report and be updated about any ensuing publications. (Please circle Yes or No)	Yes/ No
10.	I consent to my interview being audio recorded and understand that the recordings will be stored anonymously, using password-protected software, and destroyed following transcription.	
11.	I hereby confirm that I understand the inclusion criteria as detailed in the Information Sheet and explained to me by the researcher.	
12.	I understand that I can withdraw my consent at any point and without penalty, repercussions or negative consequences and know who I need to contact to do so.	
13.	I am aware of who I should contact if I wish to lodge a complaint.	

14.	I voluntarily agree to take part in this study.	
15.	I consent to other authenticated researchers from partner organisations (National Centre for Creative Health and Culture, Health, and Wellbeing Alliance) having access to my pseudo-anonymised data.	
16.	I confirm that I have read and understood the Participant Information Sheet for the above study. I have had an opportunity to consider the information and what will be expected of me. I have also had the opportunity to ask questions which have been answered to my satisfaction.	

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Name of researcher	Date	Signature

If you would like your contact details to be retained so that you can be emailed a copy of the report at the end of the study by researchers at UCL, please provide these below:

Email (optional): _____

Appendix 5. Interview Topic Guide

Topic Guide for Semi-Structured Interview

1. Introduction and Background:
    a. Introduce myself and the project I'm doing for my dissertation, including the purpose/objectives. Giving information about my partner organisation – NCCH.
    b. Participant information sheet and consent form.
    c. Asking for **brief** information about participant's organisation/work they do
        i. What do you call your sector?
2. Understanding Creative Health:
    a. Asking the participant about how they relate to the term "Creative Health" -- if they've heard of it/if they use it/if they feel like a part of the creative health sector.
        i. (*If they are an organisation from NCCH network they will know the term, if not I should give them a definition beforehand (in the initial email -- "arts, community, and creativity-based approaches to health and wellbeing"*)
3. Understanding Diversity:
    a. What do you understand by the term diversity in the context of promoting health and wellbeing?
    b. What's your approach to Equality, Diversity and Inclusion (EDI)/what work are you doing around it?
        i. Any particular methods for inclusion?
        ii. Any of these works and methods use creative approaches?
    c. Can you share your perspective on the current state of diversity within your sector?
        i. Workforce + target audiences
4. Barriers to Diversity:
    a. What do you think are the key barriers or challenges for promoting diversity within the Creative Health and related sectors?
5. Enablers for Diversity:
    a. Are there any initiatives or strategies that you've seen or been involved in that have successfully promoted diversity within the Creative Health and related sector?
    b. What is your view on collaboration between different stakeholders, such as healthcare professionals, artists, educators, and policymakers as a means to increasing diversity?

6. Future Directions:
    a. Looking ahead, what do you see as key priorities or opportunities for promoting diversity and inclusion?
    b. Are there any specific recommendations or actions you would propose for fostering diversity within the creative health sector? What do you think NCCH could be doing?
7. Closing:
    a. Is there anything else you would like to add or discuss that we haven't covered?
    b. Are there any people or organisations whom you think we should speak to in relation to this study?
    c. Thank the participant for their time and insights.
    d. Clarify any follow-up steps or further communication, if necessary.