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ARTICLE

Foundations for change management in integrating the arts into healthcare: An empirical study

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ABSTRACT

The uptake of arts-based practices into health care has been slow despite drivers such as increasing awareness of value, policy initiatives, patient satisfaction and quality services. Approaching the issue from within the Consolidated Framework for Implementation of Research (CFIR), our study asked i) if experiences of staff influenced willingness to implement arts and health interventions, ii) about awareness of current music and visual-art programs within the hospital and iii) about staff perceptions of barriers to implementation of arts within healthcare. This mixed methods study used an initial quantitative online survey of staff recruited from a large metropolitan tertiary hospital (n=38) followed by a qualitative semi-structured focus group (n=6). Staff largely reported a willingness to improve integration of arts initiatives, not influenced by their personal experience of the arts. Staff seemed relatively unaware of successful instances of arts programs in their own hospital, unless they were directly involved in its delivery. Barriers to implementation were perceived to come from upper management, with successful programs resulting from individuals or individual team motivations. Results from this initial study suggest that understanding staff perceptions and providing carefully designed educational programs are likely to be key in promoting the change necessary for incorporating the arts into regular patient care.

KEYWORDS

arts and health
change management,
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BACKGROUND

Increasing attention has been paid to the contribution of the arts to the patient experience of health care in recent years, particularly related to psychosocial outcomes (Lambert, 2015). A wealth of evidence demonstrates that the use of various arts initiatives within health settings helps alleviate patients' stress, creates a more pleasurable and ambient environment, and offers a sense of familiarity in an otherwise foreign surrounding, for example in the emergency department, acute care and mental health care (Jensen & Bonde, 2018; Khan et al., 2016; Short et al., 2010; Silverman, 2018). The accumulation of such solid evidence has led to broad policy change across large health regions. One example of this is the Australian New South Wales (NSW) Health and the Arts Policy, which has in turn led to the establishment of various local and regional groups to foster connections between the health and the arts with the South Western Sydney Health and Arts Reference Group (https://www.swslhd.health.nsw.gov.au/innovation/index.cfm/pages/pHealthAndArts).

Despite local and policy initiatives like these, uptake is slow for incorporating more arts-based practices into health care with potential resistance to change. This apparent slow uptake contrasts with key drivers to integrating the arts within healthcare existing within organisational policy and governance as health services increasingly focus on patient and consumer-focused care. Health services typically search for ways to improve the context and experience of healthcare delivery for their patients, and the arts are generally seen positively by consumers. The importance of the patient's experience as a partner in their own care is enshrined within the Australian National Safety and Quality Health Service Standards (Australian Commission on Safety and Quality in Health Care [ACSQHC], 2017). The NSW Agency for Clinical Innovation, now known as the Clinical Excellence Commission, explicitly links person-centred care with evidence of benefits such as improved quality of life and satisfaction with care (Debono et al., 2013; Sarrami-Foroushani et al., 2012), with the arts typically contributing to quality of life for consumers. Continual improvement to ensure person-centred and effective care is mandated as a responsibility of health service organisations (ACSQHC, 2017) and the arts can engage patients in activities which support personalised care and individual identity. Additional economic benefits result from improvements in patient quality of life and consumer satisfaction (Chlan et al., 2018).

With policy and governance primed to further integrate the arts in healthcare, previous research has examined other contributing supports and barriers to running arts activities within health services in NSW (NSW Health, 2016). It was found that the majority of health facilities have the necessary space and facilities to incorporate arts but a perceived lack of funding may be a key obstacle. Further government initiatives (NSW Health, 2016) have resulted in the NSW Health and the Arts Taskforce, and Health and Arts Reference Group, calling for better integration of health and arts across all domains of psychosocial, mental and physical health care (Davies et al., 2016). With the apparent mismatch in government and policy support and despite the existence of adequate facilities,

challenges around the actual integration of arts activities on the ground in healthcare may depend on deriving new information to guide practices, particularly based on the attitudes of healthcare staff and their readiness for change.

Foregrounding person-centred care and moving away from a medicalised model requires ongoing development and change across the organisation (ACSQHC, 2017; Clinical Excellence Commission, 2018; McCormack et al., 2011). Staff attitudes are pivotal to the uptake and implementation of evidence-based changes in practice (Barbosa et al., 2012). Despite consumer interest and policy drivers, barriers still exist to the implementation of the arts for health in general hospital and public health contexts, including funding, time and staff turnover (Dimopoulos-Bick et al., 2019). This occurs despite reports of health professionals' overwhelmingly positive attitudes towards the use of arts in healthcare (Wilson et al., 2015) where artists are seen as valued members of an integrative health team (Sonke, 2017).

This current study investigates staff attitudes to the use of the arts in health care and their perspectives about implementation in the context of a large urban teaching hospital. In doing so, it provides a missing link connecting the implementation of arts and health initiatives with an in-depth understanding of change management related to increased use of arts approaches. Using a systematic research approach, we derive further information about staff readiness from the individual staff themselves.

Change related to implementing arts in the health sector

The way that change is managed strategically within organisations and within the health sector is based on a range of factors such as environmental needs, existing policy, key leaders of change, a supportive organisational culture, relations between clinicians and management, co-operative inter-organisational networks, the fit of the proposed change to the local context, and clear organisational goals and priorities (Nuño-Solinís, 2018). Further, a sense of readiness for change must be addressed as a key issue. Although not commonly measured, *organisational readiness for change* (ORC) is important for the success of proposed changes and implementation of evidence-based practices (Nuño-Solinís, 2018). High ORC is linked to staff motivation for overcoming barriers and challenges in change endeavours, and helps reduce the research-practice gap (Nuño-Solinís, 2018). Focusing on underlying theoretical concepts, Damschroder and colleagues (2009) sought to further understand organisational readiness for change by comparing and integrating previous research, in turn creating the Consolidated Framework for Implementation Research (CFIR). This model posits five domains within a pragmatic structure designed to guide the building and subsequently evaluating of implementation knowledge into practice. The five domains of the CFIR are: 1) intervention characteristics, 2) outer setting, 3) inner setting, 4) characteristics of the individuals involved, and 5) the process of implementation. Generally, the outer setting refers to the overarching economic, political, and social context within which an organisation is situated, whereas the inner setting refers to structural, political, and cultural contexts which may directly inform implementation (Damschroder et al., 2009). Within each of these domains, further constructs have been identified. This model has been widely applied across healthcare systems to gain an in-depth understanding and assessment of practitioner experiences (Kirk et al., 2015; Miake-Lye et al., 2020), including emergent qualitative

understandings of patient needs and voices (Safaeinili et al., 2020). Personal attributes of staff are of great importance with regard to organisational readiness for change, as is the implementation climate and organisational culture, and a multitude of relevant assessment approaches have proliferated (Miake-Lye et al., 2020). It is clear that detailed stakeholder input and analysis is necessary in preparation for the change process, including stakeholder interests and levels of influence, and that gaining the perspectives of the stakeholder groups is essential (Allen, 2016). This includes applications in a range of settings, such as aged care (Hebert et al., 2018) and primary care (Keith et al., 2017).

Typically, there may be conflicting opinions, assumptions, experiences and value judgements in relation to the arts, which may be associated both explicitly or implicitly with diverse positions regarding aesthetics and the role of the arts in society (Juslin, 2013). Such a potential diversity of positions is explained by Damschroder's model within the construct, "characteristics of individuals" (Damschroder et al., 2009, p. 9), since individual behaviour changes are the basis for organisational change. Individual attitudes and beliefs related to the intervention/ change are of key importance, with positively and negatively valued affect responses having an influence on forming a precursor to actual change. Therefore, information about the beliefs and attitudes of staff towards implementation of arts and health initiatives are seen as critically important. The pragmatic need for this was put forward in the current study by the aforementioned reference group seeking to foster further implementation of arts and health initiatives across a large health district.

In addressing organisational readiness for change, assessment approaches may be quite diverse in nature and are typically designed to fit the specific context (Miake-Lye et al., 2020). Given the interface of the perceptions of the arts in health with organisational readiness for change, researchers in this study created a uniquely relevant survey form in several sections in order to fully understand the knowledge, experience and assumptions that stakeholders bring to the issue of improving the uptake of the arts in healthcare practice.

Research aims and questions

This study sought to uncover characteristics of the individual staff involved in implementing further arts and health initiatives (specifically music and visual art) into healthcare across all levels of a tertiary teaching hospital. The individual attributes of participants were sought specifically in relation to their perceptions/attitudes in the change process, and the influence of any previous experiences with the art forms under consideration. Our research questions asked i) whether the experiences of staff influenced their willingness to implement such interventions, ii) if staff were aware of current music and visual-art programs within the hospital and iii) staff perceptions of barriers to implementation of arts within healthcare.

METHODS

This mixed-methods study approach followed a sequential explanatory design (Creswell et al., 2003), where an initial quantitative online survey conducted at a major tertiary teaching hospital was followed up with a qualitative semi-structured focus group. Results from the initial survey contributed to

formulating the focus group questions, in order to gain a deeper level of interpretation of the quantitative findings. This project was co-designed with industry representatives in line with mandated inclusivity policies and practices required within the hospital work setting.

Participants

In this study, staff recruited from a large metropolitan tertiary hospital completed an anonymous online survey via a weblink advertised within a regular hospital email from the General Manager. Employees at the hospital in this very multicultural location were proficient in English for understanding the consent and survey information. More details regarding participant incentives and attrition appear in Appendix 1.

Materials

The purpose designed survey for this study was delivered online via the Qualtrics platform (https://www.qualtrics.com). The survey consisted of 56 questions in three main sections: i) demographics, ii) personal experiences and beliefs (music, visuals arts), and iii) existing initiatives, support and barriers (music, visual arts). Sections ii) and iii) were completed once each relating to the role of music and the role of visual arts. In order to remove potential bias caused by the order of focus on 1) music and 2) visual arts, the occurrence of these blocks in the survey were randomised across all participants via the Qualtrics platform. More details about the survey questions can be found in Appendix 1.

The subsequent focus group followed a semi-structured interview guide of questions about perceptions of benefits and barriers around the integration of music and visual art in their departments, using the main trends within the survey data to stimulate discussion within this mixed method explanatory design. Information about the data analysis techniques used can be found in Appendix 2.

Ethics

All participants gave informed consent under ethics approval from the ethics committees of the South West Sydney Local Health District and Western Sydney University (approval number HREC/17/LPOOL/227), and all participants gave informed consent to participate in this project.

RESULTS AND DISCUSSION

Demographics and participant experience

A total of 38 participants completed the online questionnaire (30F, 7M) with a median age range of 45-54 years. The professional workgroup/discipline focus of participants included nursing (34.2%), allied health (26.3%), medical (18.4%) and administration staff (18.4%). A further two staff worked in research, and one was a hospital language interpreter. Two of the participants chose not to provide information about their discipline work group within the survey. Resulting from the survey, a total of

six participants attended the focus group; all were female and five of these participants were from the palliative care department, and one from a speciality clinical service. Participants from palliative care reported experiencing successful music and visual arts programs in their department.

The majority of participants reported that they did not have personal arts experiences: did not play a musical instrument (55.3%); did not create any visual art (57.9%). However, most participants had engaged with the arts for entertainment and leisure purposes within the past 12 months (see Table 4 in Appendix 3; Table 5 in Appendix 4).

Participants were asked about their willingness to support integration of health and arts, and the results confirmed that participants' experience with playing a musical instrument did not significantly affect their willingness to support the further integration of music listening within the hospital (Mann Whitney U = 167.5, p = 0.75). Likewise, the experience of creating visual art also did not significantly affect participants' willingness to support more visual art being displayed at the hospital (Mann Whitney U = 152.0, p = 0.492). In addition, participants' discipline work area did not influence their willingness to support further integration of music (Kruskal Wallis tests: X2(4) = 1.594, p = 0.81) or visual art (X2(4) = 4.000, p = 0.406).

Awareness of existing programs and support

Approximately two-thirds of the respondents were not aware of any current music listening (65.8%) or visual art programs (63.2%) in the hospital. Approximately one-third of respondents provided specific examples of how music and visual art were currently used in different areas of the hospital. Despite a lack of awareness of current programs, a majority of the staff believed that there were adequate facilities/space to encourage more visual art (68.4%), with 14 participants particularly citing the endless amount of corridor space available to display artworks. Fewer staff believed adequate facilities were available for music (42.1%); just over approximately one-third were unsure (34.2%).

Table 1 reports the frequency with which each barrier to implementation was selected, its mean rating (where 1 is most important), and the standard deviation of ratings amongst participants. Lack of support by upper management and lack of funding were the two highest rated (and amongst the three most frequently selected) barriers for both music and visual art. Lack of resources and government support were the third and fourth most important barriers perceived by healthcare staff. Table 1 is also supported by Table 4 in Appendix 3.

Focus group thematic results

Thematic analysis of the transcribed focus group responses produced two main themes: i) Benefits, and ii) Support and Barriers. "Benefits" was sub-categorised into *Relaxation and Healing*, *Communication* and *Staff Perceptions, and Benefits*. Table 2 contains example quotes belonging to each sub-theme. Participants noted the many benefits of music and visual art programs in the hospital, that these were therapeutic for the patients, a good distraction from pain and a way to relax within the hospital environment. Staff particularly noted that arts programs enabled them to communicate better with patients, that it would often help to start conversations and could also help patients connect with each other and their families. Staff also noted the benefits for themselves with these programs, of changing the atmosphere on the ward.

Barrier	n	*M*	*SD*
Music:			
Lack of support by upper management	32	2.19	1.62
Lack of funding	30	2.70	1.77
Lack of resources	32	3.41	1.70
Lack of government support	27	3.70	1.93
Lack of support by healthcare professionals (colleagues)	28	4.29	2.30
Lack of time	26	4.65	2.37
Lack of adequate training for implementation	29	4.79	2.01
Lack of support by patients	23	6.87	1.84
Other	5	7.20	4.03
Visual Art:			
Lack of funding	33	2.03	1.40
Lack of support by upper management	32	3.22	1.98
Lack of resources	33	3.27	1.46
Lack of adequate training for implementation	30	5.17	1.70
Lack of government support	29	3.62	2.09
Lack of time	29	3.90	2.24
Lack of support by healthcare professionals (colleagues)	25	5.04	1.99
Lack of support by patients	22	7.05	1.76
Lack of adequate training for implementation	30	5.17	1.70
Other	6	6.00	4.29

Table 1: Ratings of berries for implementation of music and visual art in healthcare.[1]

Sub-theme	Example quotes
Relaxation and healing	"It's very healing for the soul" "It relieves the pain, they forget their symptoms for that moment"
Features and products	"So, there's something strong about our - maybe there's a memento part of <art> that music can't give you ' cause music's fleeting in the moment. Art does last…" "Even if you don't particularly like music then you have a wedding or a funeral as a rule, there is music, isn't there?" "yes, it's embedded into our culture isn't it?"
Communication	"that makes a big difference I think in conversation and finding out, getting to know people." "it brings together not only the patient but the family, other families come to start the conversation" "then they come to talk and they find there's so much of commonality in what they are doing and their suffering"
Staff Perceptions/ Benefits	"because it's good for them. It benefits the student" "it's not only just the families and the patients but the staff got a lot out of it as well"

Table 2: Sub-themes and example quotes from the main theme Benefits

[1] For each barrier, the number of participants rating this barrier is reported, as well as the mean value of importance (where 1 is most important) and the standard deviation of importance ratings.

The "Support and Barriers" theme was sub-categorised into *Raising Awareness/Changing Attitudes*, *Colleagues' Support,* and *Facilities and Funding*. Table 3 contains example quotes belonging to each sub-theme. Participants noted that colleagues across the organisation had limited knowledge of the benefits of music and visual art within healthcare, unless they had a personal experience of a friend or family member who had taken part in one of the existing programs. Reference was made to the integration of health and arts being low down in priority for a lot of staff; attitudes towards the arts were that it took focus away from clinical concerns, rather than complementing them. Success was achieved when participants had the support of one or two key colleagues, with someone able to drive the arts programs in that department. A perceived lack of facilities and money to sustain these types of programs were reported.

Sub-theme	Example quotes
Raising awareness/ Changing attitudes	"they don't have enough knowledge of the research to prove that how the benefits of having it."
	"Because you go there and the clinical stuff takes priority, and that has to be. But at the same time, we can also talk about these things, to sort of complement the clinical side of it. Because it does make a difference."
	"You're on the lowest rank of all the priorities in the hospital, but, but I push for it with all my managers"
	"that's when things change when people have a personal experience"
Colleagues' support	"You've got to change the culture…you've got to have people willing to drive it, maintain it, sustain it."
	"I have a good team supporting and backing me and taking it up, escalating it, that's why it happens"
Facilities and funding	"they just don't have the time"
	"Space is also a problem like to [where to] keep your instruments … So when you build these purposeful, say in dedicated inpatient unit, that is not taken into consideration."
	"Until like the Ministry of Health decides we have money to put into that, to invest into that, which is important as well…"

Table 3: Sub-themes and example quotes from the main theme Support and Barriers

GENERAL DISCUSSION

This project sought to contribute to the first stage of change management in healthcare, by committing preparatory time and attention to understanding and analysing the current situation (Allen, 2016); in this case undertaking a systematic and empirical study of stakeholder attitudes of staff towards increased use of the arts in healthcare. Placing this within an ORC and CFIR framework (Damschroder et al., 2009), the characteristics of the staff involved needed to be addressed, especially staff attitudes towards the arts generally as well as towards proposed implementations in the hospital context. It was expected that pre-existing staff experiences of music and visual art may influence their

attitudes and willingness to support the implementation of arts interventions within a healthcare organisation.

We set out to investigate individual characteristics construct of the CFIR framework. What our results implied was that the individuals' perceptions of the inner and outer settings also affected their readiness for change. In cases where there was a mismatch between the individual perception and the outer setting (for example, in the case of policy initiatives that encourage integration of arts and health), it may be that these contributed to further resistance within the inner setting. To enable further discussion of these results, we will refer to these in the constructs of *individuals, inner setting and outer setting.*

Individuals

Interestingly, we found no evidence to suggest that previous individual musical/visual arts experience had an effect on staff willingness to support implementation of such interventions within the hospital context. This suggests that instead of familiarity with the actual intervention content (music, visual arts), it is beliefs and knowledge about these interventions within healthcare that may be important for organisational readiness to change. The CFIR model outlines that individual beliefs may be driven by the strength/quality of evidence surrounding the implementation at hand. This evidence can be based on research literature, clinical experience and patient experience. With this in mind, our survey participants' lack of awareness of current interventions within the hospital represents an opportunity for educational change. Through direct experiences in the palliative care unit, many focus group participants were familiar with the benefits that the arts could provide as a consequence of witnessing existing programs in action, and this may have motivated them to participate in this current project. From the focus group results it is therefore apparent that there were successful music programs in the hospital, but it appears that these were not widely publicised; raising staff awareness is discussed as a potential solution.

Promotion of current successful initiatives may influence readiness to change for both the direct network of staff (often inter-departmental) required in the implementation, and the larger context of the organisation for future programs. Much like developing the broader culture of person-centred care, more is needed to translate the motivation and experience of these individual healthcare professionals (exemplified by the focus group participants) so that the 'moments' of successful integration of health and arts become part of a more sustained ethos and model of care across the organisation (McCormack et al., 2011). This can have implications for the involvement of different levels of staff: for instance, as is exemplified in our results, the perception of staff is that once upper management have a personal connection to these success stories, the programs are more likely to find support within the hospital. This is in line with findings by (Hebert et al., 2018) where role-modelling by leaders was suggested to assist in implementation of wider music in health initiatives. An increased effort to better evaluate existing programs quickly and efficiently (Fancourt & Poon, 2016; NSW Health, 2016) may also bring increased support from upper and middle management.

Inner setting

In considering the CFIR construct of the *inner setting*, specifically the readiness for implementation of an arts and health program, both the survey responses and the experiences from the focus group participants confirmed a perception of numerous barriers, namely from a perceived lack of support from upper management and available funding and resources. This echoes findings from studying the implementation of a personalised music listening program (Hebert et al., 2018) where health system regulations and staff perception of roles presented challenges to overcome (particularly staff hesitancy that the music program may just be the current flavour of the month, only to dwindle away afterward). However, success came about when staff collaborated to "flex the rigid system," often inspired by videos of the process (Hebert et al., 2018). Findings from Dimopoulos-Bick et al. (2019) also regarding personalised music listening across acute, sub-acute and primary healthcare settings in NSW, Australia also mentioned perceived barriers in the lack of funding, or lack of sustained funding for these types of interventions. Conversely, our study supports and echoes the previous NSW Health survey (NSW Health, 2016), with many of our survey respondents agreeing that existing facilities would enable these services to be implemented.

Outer setting

Our findings revealed a potential disconnect between the outer setting (government-auspiced initiatives) and the inner setting (here taking the perceptions of individual hospital staff as an indication of the inner environment as a whole). Although it is not known exactly how many healthcare staff across the levels of the organisation were aware of the specific government initiatives to integrate health and arts, lack of support at government level was a highly reported barrier (music: 27, visual arts: 29), with a medium level of importance attached (music: median = 3.70, visual arts: median = 3.62, 1 is highest importance). Focus group participants also did not mention specific government support initiatives, but noted that the success of programs required the government to allocate funding. Those who were involved in running some of the existing arts initiatives in the hospital mentioned having support from one or two key colleagues, but they found pushing these programs to be problematic with upper management, and ensuring sustainability was particularly difficult. This clearly reflected a connection between inner and outer values, beliefs and applied setting, and influenced the further possibilities of change in promoting engagement in the arts for patient benefit.

Limitations

This study is limited in focusing on one hospital and its relatively small sample: 38 participants for the survey and one focus group of 6 participants. Research reflection suggested that the length of the survey and associated time commitments influenced response rates (survey: approximately 20 minutes; focus group: one hour). Approximately 11 participants took up to 20 minutes to complete the full survey. Metrics indicated that the maximum completion time for the survey was 388 minutes. It is assumed that in this case, the internet browser was kept open during an interruption to completion of the survey.

Such a small group may have been susceptible to demand characteristics. However, the responses from one single hospital within the local health district of South Western Sydney provide a cross-sectional example of perceptions of the arts in health. This is expected to prompt a broader reflection across the local health districts in Australia for strategies to ensure the future success of integrating the arts within healthcare settings. In addition, a further exploration of the role of cultural experiences in affecting uptake of arts initiatives would be helpful in the future, including the way that music's floating intentionality may influence personal experiences of the musical context (Cross, 2014). This study supports the accumulation of knowledge surrounding how arts and health interventions are implemented across disparate healthcare contexts, and the constructs that may help, or hinder, sustainability for arts and health programs.

Conclusions

This study sought to investigate individual staff characteristics related to readiness for change in the implementation of arts programs at a tertiary teaching hospital, stemming from evidence in the literature that points towards a multitude of benefits for the patient experience by integrating arts initiatives with healthcare. We found that health professionals at the tertiary teaching hospital largely reported a willingness to see further integration of arts initiatives, and were not influenced by personal experience of the arts. We note that these same professionals seemed relatively unaware of successful instances of arts programs in their own hospital, unless they were directly involved in its delivery. Barriers to implementation were perceived to come from upper management, with successful programs resulting from individuals or individual team motivations.

Our study suggests that staff education is pivotal in translating successful one-off instances of arts integration into a wider culture change. These include the provision of concrete examples of success, and the diminishing of perceived barriers to implementation. Increasing awareness of existing government policy initiatives can be supported and extended by health-based reference groups guiding strategic policy planning and implementation. An example of this is the success of the South Western Sydney Health and Arts Reference Group which has been established for more than six years with 50% of the members being practicing artists/art therapists. The agenda of the Reference Group is guided by a well-established and collaboratively developed Health & Arts Strategic Plan (South Western Sydney Local Health District et al., 2018). Underpinning this is the need for more evidence of successful health and arts integration. Not only this, but a clearer understanding of roles within the delivery of arts programs can assist with delivery, for example the recently developed Music and Health Continuum (Short & MacRitchie, 2022; Short, MacRitchie et al., , 2019). Further examples of arts programs delivered within hospitals can be used to educate staff regarding the benefits to patient experience, and combat perceptions of barriers to this form of practice. In turn, this linkage reduces disconnects and enhances the role of the arts in supporting an integrated model of patient care aimed at increasing quality and patient satisfaction in clinical care.

This study built on previous conceptions of the change process and applied this to implementing arts and health initiatives in the hospital setting. The individual characteristics, perceptions and attitudes of staff were empirically investigated in terms of organisational readiness for change as part of the change management process. Results from this initial study suggest that understanding staff

perceptions and providing carefully designed experiential educational programs are likely to be key in promoting the change necessary for incorporating the arts into regular patient care for improved satisfaction and quality care within the health system.

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APPENDIX 1 – PARTICIPANTS AND SURVEY QUESTIONS

All staff on the hospital mailing list were included and participants were offered the chance to enter a draw for a $100 shopping voucher. This incentive was offered to encourage uptake and completion by staff with a wide range of interests, not only those familiar with music and visual art. A total of 54 participants commenced the survey, with considerable attrition resulting in 38 completed surveys. Via the survey, participants were invited to attend an optional in-person focus group. This focus group then occurred at a pre-arranged booked session time within the educational facilities at the hospital.

The entire participant survey consisted of 56 questions, with some questions appearing based on previous answers (for example, "do you play a musical instrument", "do you create any visual art"). The minimum completion time was approximately 10 minutes with the majority of participants expected to complete the survey in 15-20 minutes.

Participants were asked in detail about their active involvement in the arts (playing a musical instrument, creating visual art), and their attitudes and beliefs were accessed by rating their agreement with statements on the effects of engaging with the artform for themselves in their personal lives, their patients and colleagues. Development of this attitudes and beliefs survey section was guided by previous studies of the perceived value of the arts (Throsby & Zednik, 2008), and the functions and perceived importance of music (North et al., 2000; Schäfer et al., 2013). Statements taken from music-centric surveys were adapted where possible to also examine visual arts (for example, "music/ visual-art helps me understand myself better"), examining beliefs about the respondent's beliefs about use of arts in personal use and the healthcare context (for example, "music/ visual-art helps me communicate with my patients better"). Participants were asked to rate their level of agreement using a 5-point Likert scale (1 – Strongly Disagree, 5 – Strongly agree).

In particular, an understanding of existing initiatives, support and barriers was accessed by four questions about music and visual arts:

1. Are you aware of any current (music/visual arts) programs at the hospital (examples of potential programs given). If yes, please specify.
2. Would you like to see (music/visual arts) become more prominent at the hospital?
3. Do you believe that there is adequate space and existing facilities for (music/visual arts) opportunities at the hospital?
4. Thinking about the barriers that may be preventing the integration of (music/visual arts) with healthcare, which (if any) of them do you believe need to be addressed? A checklist of possible barriers were provided for this last question, including lack of funding, government support, time, resources; lack of support by patients, upper management, healthcare professionals/colleagues; lack of adequate training for implementation, and participants were asked to rank these in order of importance.

APPENDIX 2 – DATA ANALYSIS

Data from the Qualtrics online research platform (https://www.qualtrics.com) was downloaded and analysed via a range of mainly non-parametric tests (Mann Whitney U and Kruskal Wallis tests), depending on the type of question and using SPSS software (https://www.ibm.com/uk-en/analytics/spss-statistics-software).

Factor analyses were attempted to reveal underlying factors contributing to the perceived value of arts interventions (general value, communicative value, value for patients etc), but due to small participant numbers, the results are not robust.

The audio recorded focus group qualitative data were transcribed and thematic analysis was conducted by the third author using a six-step approach by Braun and Clarke (2006): 1) familiarisation with the data, 2) generating initial codes within the data, 3) searching for themes within the codes, 4) reviewing the themes, 5) defining and naming the themes, and 6) producing a report of the results. The coding and subsequent allocation of themes was confirmed independently by the supervising author to ensure trustworthiness.

APPENDIX 3 – RESULTS: TABLE 4

Barrier	n	*M*	*SD*
Music:			
Lack of support by upper management	32 (10:22)	2.19 (2.5:2.05)	1.62 (1.72:1.59)
Lack of funding	30 (11:19)	2.70 (2.64:2.74)	1.77 (2.16:1.56)
Lack of resources	32 (11:21)	3.41 (3.09:3.57)	1.70 (1.51:1.81)
Lack of government support	27 (9:18)	3.70 (4.22:3.44)	1.93(1.86:1.98)
Lack of support by healthcare professionals (colleagues)	28 (9:19)	4.29 (4.0:4.42)	2.30 (2.5:2.24)
Lack of time	26 (8:18)	4.65 (4.62:4.67)	2.37 (2.45:2.40)
Lack of adequate training for implementation	29 (10:19)	4.79 (5.0:4.68)	2.01 (1.5:2.26)
Lack of support by patients	23 (7:16)	6.87 (7.29:6.69)	1.84 (1.50:2.00)
Other	5 (2:3)	7.20 (9:6.0)	4.03 (0.0:5.20)
Visual Art:			
Lack of funding	33 (14:19)	2.03 (1.86:2.16)	1.40 (1.51:1.34)
Lack of support by upper management	32 (13:19)	3.22 (3.69:2.89)	1.98 (2.39:1.63)
Lack of resources	33 (12:21)	3.27 (3.33:3.24)	1.46 (1.23:1.61)
Lack of adequate training for implementation	30 (12:18)	5.17 (5.50:4.94)	1.70 (1.88:1.59)
Lack of government support	29 (13:16)	3.62 (4.00:3.31)	2.09 (2.08:2.12)
Lack of time	29 (11:18)	3.90 (4.09:3.78)	2.24 (1.45:2.65)
Lack of support by healthcare professionals (colleagues)	25 (9:16)	5.04 (5.33:4.88)	1.99 (2.29:1.86)
Lack of support by patients	22 (9:13)	7.05 (7.11:7.00)	1.76 (1.90:1.73)
Other	6 (2:4)	6.00 (4.50:6.75)	4.29 (4.95:4.50)

Table 4: Ratings of berries for implementation of music and visual art in healthcare.[2]

[2] For each barrier, the number of participants rating this barrier is reported, as well as the mean value of importance (where 1 is most important) and the standard deviation of importance ratings. Numbers in brackets are broken down for those participants who have answered that they are aware of current uses of this art form in the hospital versus those who were not.

APPENDIX 4 – RESULTS: FREQUENCIES OF ATTENDANCE AT ARTISTIC EVENTS/ VENUES

	< 1 week ago	< 1 month ago	< 6 months ago	< 1 year ago	> 1 year ago	Never
Visit an art gallery	2.9%	7.9%	34.2%	18.4%	28.9%	7.9%
Attend a play	0%	7.9%	18.4%	18.4%	39.5%	15.8%
Attend an opera or musical	2.6%	7.9%	15.8%	18.4%	42.1%	13.2%
Go to a live performance of music (e.g. a concert)	2.6%	21.1%	21.1%	18.4%	31.6%	5.3%

Table 5: Frequencies of attendance at artistic events/ venues

Ελληνική περίληψη | Greek abstract

Θεμέλια για τη διαχείριση της αλλαγής στην ενσωμάτωση των τεχνών των τεχνών στην υγειονομική περίθαλψη: Μια εμπειρική μελέτη

Jennifer MacRitchie | Alison Short | Stella Dion | Josephine SF Chow

ΠΕΡΙΛΗΨΗ

Η υιοθέτηση πρακτικών που βασίζονται στις τέχνες εντός του χώρου της υγειονομικής περίθαλψης εξελίσσεται αργά παρά τους παράγοντες όπως είναι η αυξανόμενη συνειδητοποίηση της αξίας, οι πρωτοβουλίες χάραξης πολιτικής, η ικανοποίηση των ασθενών και η ποιότητα των υπηρεσιών. Προσεγγίζοντας το ζήτημα υπό το πρίσμα ενός Ενοποιημένου Πλαισίου Εφαρμογής της Έρευνας (Consolidated Framework for Implementation of Research, CFIR), η μελέτη μας διερεύνησε i) εάν οι εμπειρίες του προσωπικού επηρέασαν την προθυμία για εφαρμογή παρεμβάσεων τεχνών και υγείας, ii) την ευαισθητοποίηση ως προς τα σύγχρονα προγράμματα μουσικής και εικαστικών τεχνών εντός του νοσοκομείου, και iii) τις αντιλήψεις του προσωπικού ως προς τα εμπόδια για την εφαρμογή των τεχνών σε πλαίσια υγειονομικής περίθαλψης. Για την παρούσα μελέτη μικτών ερευνητικών μεθόδων χρησιμοποιήθηκε ένα αρχικό διαδικτυακό ερωτηματολόγιο ποσοτικών δεδομένων για το προσωπικό ενός μεγάλου μητροπολιτικού νοσοκομείου τριτοβάθμιας υπηρεσίας υγείας (n=38) και στη συνέχεια διεξήχθη μία ημι-δομημένη ομάδα εστίασης (n=6). Το προσωπικό, ως επί το πλείστον, εξέφρασε προθυμία να βελτιώσει την ενσωμάτωση των πρωτοβουλιών για τις τέχνες, χωρίς να επηρεάζεται από την προσωπική τους εμπειρία με τις τέχνες γενικότερα. Οι εργαζόμενοι φάνηκε να μην έχουν επίγνωση περιπτώσεων επιτυχημένων προγραμμάτων μέσω

των τεχνών στο νοσοκομείο τους, εκτός κι αν είχαν κάποια άμεση εμπλοκή με αυτά. Τα εμπόδια στην εφαρμογή θεωρήθηκε ότι προέρχονται από την ανώτερη διοίκηση, με επιτυχημένα προγράμματα να προκύπτουν από ατομικά κίνητρα ή κινητοποίηση μεμονωμένων ομάδων. Τα αποτελέσματα αυτής της αρχικής μελέτης υποδηλώνουν ότι η κατανόηση των αντιλήψεων του προσωπικού και η παροχή προσεκτικά σχεδιασμένων εκπαιδευτικών προγραμμάτων μπορεί να αποτελούν το κλειδί για την προώθηση της αλλαγής που απαιτείται για την ενσωμάτωση των τεχνών στην τακτική φροντίδα των ασθενών.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

τέχνες και υγεία, διαχείριση αλλαγής, ετοιμότητα για αλλαγή, νοσοκομειακές υπηρεσίες, Αυστραλία