



Article

The combined arts therapies team: Sharing practice development in the National Health Service in England

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ABSTRACT

The complex nature of many arts therapies interventions indicates a richness in practice development and the number of potential applications in the clinical, social and cultural sectors. There is greater opportunity to consider the overlap of shared models, skills, techniques and approaches in the arts therapies, and in a combined arts therapies team in the National Health Service (NHS) some early examples of interdisciplinary practice sharing have emerged. A number of practice-based examples are used to illustrate the work of a combined arts therapies team in the NHS in England. Combined practice developments are described, including shared therapeutic levels, shared observations, shared techniques and shared therapeutic work. It is hoped that these areas of shared development within a clinical context will lead to practice developments that support improved outcomes for clients.

KEYWORDS

arts therapies, practice development, practice sharing, intellectual disability, complex intervention

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ARTS THERAPIES AS COMPLEX INTERVENTIONS

Arts therapies are concerned with engaging people in creative processes and exploring the meaning of personal experience that bring about helpful psychotherapeutic changes for individuals or group members (Hackett 2012a). In January 2015 there were 3,574 arts therapists (art, music, drama) registered with the UK Health and Care Professions Council (HCPC) and 324 dance movement therapists registered with the Association for Dance Movement Psychotherapy UK (ADMPUK). Arts therapies are described by the National Institute for Health and Care Excellence (NICE) as “[...]

complex interventions that combine psychotherapeutic techniques with activities aimed at promoting creative expression” (NICE 2014: 217). Arts therapies emphasise expression, communication, social connection and self-awareness through supportive and interactive experiences (NICE 2014).

Complex interventions are defined by the Medical Research Council (Craig et al. 2008) as interventions that have,

- several interacting components;
- practical and methodological difficulties for successful evaluation;

- ❑ difficulty standardising the design and delivery of the interventions;
- ❑ sensitivity to features of the local context;
- ❑ organisational and logistical difficulty of applying experimental methods to service or policy change;
- ❑ length and complexity of the causal chains linking intervention with outcome.

The complex nature of many arts therapies interventions indicates a richness in practice development and the number of potential applications in the clinical, social and cultural sectors. There is greater opportunity to consider the overlap of shared models, skills, techniques, and approaches in the arts therapies and in a combined arts therapies team in the National Health Service (NHS) some early examples of interdisciplinary practice development have emerged.

COMBINED ARTS THERAPIES TEAM

The combined arts therapies team is based in the North East of England within Northumberland, Tyne and Wear NHS Foundation Trust. Northumberland, Tyne and Wear NHS Foundation Trust is one of the largest mental health and disability Trusts in England employing more than 6,000 staff, serving a population of approximately 1.4 million, providing services across an area totalling 2,200 square miles. The Trust has over 100 sites across Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside and Sunderland and provides a number of regional and national specialist services. Within the Trust arts therapies are based within psychological services. The combined arts therapies team model is one that includes all arts therapy modalities: art, music, drama, and dance movement psychotherapy. The team consists of four and a half full-time equivalent posts which are split between two full-time and five part-time staff. The team is made up of a Head Arts Therapist, an Arts Therapist Principal, four Arts Therapists (Art, Music, Drama, Dance Movement) and an Arts Therapies Assistant. Within this structure there are a number of benefits to the service delivery that are supported by shared practice and practice development. The combined arts therapies team allows for each therapy modality to be supported to deliver and develop their own practice for the benefit of clients but also encourages practice sharing that can strengthen and enrich each approach. Mechanisms for sharing and developing practice include monthly team

meetings that incorporate clinical case discussion and occasional 'away days' for detailed practice sharing. Combined therapy programmes or projects, for example art and drama therapy group work or music and dance movement therapy group work, have been developed by the team. The team works primarily in hospital wards that provide assessment, treatment and rehabilitation services to adults and young people with intellectual disabilities and/or mental health difficulties or risky and challenging behaviour. The specialist service provision includes work with young people with complex needs or psychotic illness; adults with autistic spectrum disorder and challenging behaviour (Wadsworth & Hackett 2014); adult offenders with intellectual and developmental disabilities (Hackett 2012a); and adults with intellectual disabilities and mental health difficulties that include community pilot projects for people who are at risk of a hospital admission (Hackett & Critchley 2012) or following their discharge from hospital (Hackett & Bourne 2014).

In this paper I will draw from a number of practice-based examples that illustrate the combined arts therapies team work towards (1) shared therapeutic levels, (2) shared observations, (3) shared techniques, and (4) shared therapeutic work. It is hoped that these areas of shared development within a clinical context will lead to practice developments that support improved outcomes for clients.

ARTS THERAPIES SHARED PRACTICE

There are overlapping areas in all arts therapies that give a clear rationale for therapeutic work with a wide range of people with social and communication difficulties including those with psychosis and intellectual and/or developmental disabilities (Karkou & Sanderson 2006). Arts therapists working with these client groups can support (1) engagement in a therapy that has non-verbal capacity, (2) encourage communication and self-expression, and (3) help relational and/or social connection. There has been longstanding recognition of the role that creative arts can have in clinical and health settings "[...] the creative arts are uniquely suited to the task of preserving and maximising the sense of self in patients with mental disorders, mainly because they are non-verbal modalities which encourage self-expression and socialisation" (Johnson 1992 cited in Staricoff 2004: 26). Arts therapies have been identified as a helpful approach for people with intellectual disabilities

who may also have communication problems (Royal College of Psychiatrists 2004). There are wide ranging examples of how arts therapies can engage people at a non-verbal level and support engagement. Music therapy is well established in work with children with autistic spectrum disorder and there is evidence for specific benefits to communication (Gold & Wigram 2006). Music therapy research for adults with autistic spectrum disorder is an emerging area with clinical benefits being indicated in case studies and small trials (Kaplan & Steele 2005). Arts therapies have great relevance for individuals with autistic spectrum disorder due to the accessibility of the non-verbal medium. Music therapy also provides opportunities for relationship building and the sharing and expression of feelings and emotions (Watson 2007). Practice-based research in music therapy featuring a child with Rett Syndrome has also shown positive outcomes for functional skills such as turn-taking and holding an object (Hackett, Morison & Pullen 2013).

Dance movement therapy is a therapeutic intervention which combines verbal and non-verbal methods in its application (Payne 2006). Dance movement psychotherapy is described as “the psychotherapeutic use of movement and dance through which a person can engage creatively in a process to further their emotional, cognitive, physical and social integration” (ADMP UK 2015). Improvisational movement and dance is used with the emphasis being placed on deeper expressiveness and self-exploration (Koch et al. 2015). A single-case study of dance movement therapy with an adult with autistic spectrum disorder gives an account of early practice-based observations (Wadsworth & Hackett 2014). Observational studies of this kind offer the potential to make progress towards developing specific research questions and larger scale studies.

Group drama activity has been seen to enable individuals with learning disabilities to express themselves with other group members and raise their current concerns. The use of drama activities has been observed to encourage cognitive, emotional and social skill development in groups (Price 1999). More specifically in groups of people with learning disabilities and mental health needs the use of psychodrama approaches has been seen to increase social competence (Tomasulo 2006). Drama and participatory arts are reported to provide enjoyment, active participation and self-development which may then contribute to personal benefits like confidence building, improved self-esteem, and skills development. Social benefits

may include relationship building, conflict resolution and social inclusion (Stickley, Crosbie & Hui 2011). The Get Going Group (Hackett & Bourne 2014) has been developed within the combined arts therapies team. The Get Going Group runs once a week for 12 weeks with group members having the opportunity to continue as facilitators in subsequent groups. It takes place in a central (non-NHS) community venue that is accessible by public transport. The group is welcoming to paid support staff who often work with group members in the community and joint participation is encouraged. The two NHS facilitators are both inpatient therapy staff, a dramatherapist and a nurse psychological practitioner, who work alongside a service user with an interest in drama. The Get Going Group has incorporated ‘mutual support’ and ‘peer support’ within its approach and ethos. Mutual support is a model of peer support by and for people with learning disabilities with involvement of non-disabled people as allies. Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility and mutual agreement of what is helpful (Keyes & Brandon 2012).

Art therapy studies have reported that people with learning disabilities increased pro-social behaviour during art psychotherapy sessions (Pounsett, Parker, Hawtin & Collins 2006). White, Bull and Beavis (2009) have also shown that a client became less reliant upon community learning disability team resources following art psychotherapy. Research conducted within Northumberland, Tyne, and Wear NHS Foundation Trust forensic services as part of a PhD programme has found art psychotherapy treatment effects in reducing self-rated anger and observed aggression in repeated single-case studies of offenders with intellectual and developmental disabilities (Hackett 2012a). Measures of process identified components of art psychotherapy that were influential upon participants’ negative maladaptive schemas linked to repeated patterns of interpersonal conflict with others (Hackett 2012a; Hackett, Porter & Taylor 2013). Findings from these early studies showed that male participants found making drawings a useful and accessible means of processing various historic and interpersonal difficulties. Improvements in behavioural outcomes for aggression were measured by the Modified Overt Aggression Scale (Oliver et al. 2007).

Few published research papers evaluating combined arts therapies appear in the literature but one notable example describes dance/movement and music therapy with young adults diagnosed

with severe autism (Mateos-Moreno & Atencia-Dona 2013).

AUDIT OF COMBINED ARTS THERAPIES TEAM SERVICE DELIVERY

An audit of two years of combined arts therapies team activity from 2011 to 2013 showed that an annual average of 1030 direct therapy sessions were provided to patients (this figure does not include cancelled or unattended sessions). The delivery of therapy sessions is split between 50% group work, 46% individual therapy with 4% unattended. The percentage of unattended sessions reflects the complex nature of the services the arts therapies team work in, such as inpatient assessment and treatment units and nationally commissioned specialist services. Work with adults with intellectual disabilities and mental health problems amounts to 50% of the team's work with 30% provided to children and young people. The remaining 20% of provision is split equally between work with offenders with intellectual and developmental disabilities and work in a specialist hospital unit for people with autistic spectrum disorder and challenging behaviour. Equally important as direct therapeutic work with patients is close multidisciplinary team working and all members of the combined arts therapies team work within a full clinical team in their service area.

SHARED THERAPEUTIC LEVELS

By articulating therapeutic levels it is possible to deliver tailored interventions in a specific and targeted way that can be appropriate for different client groups and the aims of specialist health services. Examples of levels of therapy in arts therapies have been discussed by Wheeler (1987) and Chesner (1995) used the metaphor of the 'dramatherapy tree' to describe components of therapy that can be considered as therapeutic levels. Within the combined arts therapies team therapeutic levels have been developed in clinical practice so that they can be applied to single session interventions or to a full programme of group work with a targeted focus. This practice based approach to articulating therapeutic levels has primarily been developed with clients who have intellectual disabilities and/or autism but it has potential for wider application across client groups. The levels described below are flexible in that they consist of the basic building blocks of therapy and can be interchangeable. Whilst there is a 'person

centred' bias in the components forming each level, the aims of this simple framework for practice-based arts therapies can be applied in a pan-theoretical and multimodal way.

Level 1: Building trust

Aim: To establish a positive working relationship.

Components: Be welcoming, provide basic information; give clarity about roles and responsibilities; actively support positive engagement; offer specific choices; identify and respond to individual needs; work collaboratively with the client; seek to reduce anxiety through giving direction and setting parameters such as a defined start and end or structuring the therapy session by providing source material/subject or theme or introducing an exercise or game for a group.

Level 2: Using and developing skills

Aim: Confidence building.

Components: Provide opportunities for skills to be used and encourage the development of skills; give constructive feedback in the session; skill development can be broad and client-focused and may encompass physical skills, social skills, or psychologically-based skills that reduce personal distress; appropriate to the client group some games and tasks for basic skills like turn-taking may be used to encourage interaction and communication.

Level 3: Engaging with creative work

Aim: To create and develop personal material.

Components: Be supportive; promote periods of self-directed work and/or use a collaborative approach; give praise and encouragement; support the use of imagination and how ideas can be flexible, changed, or adapted: support sensory work by offering opportunities to explore movement/materials/instruments and asking questions about the 'here and now' and the clients' immediate experience.

Level 4: Self-development

Aim: To support positive change such as reduced distress/increased independence/improved ways of relating to others/developing resilience.

Components: Show empathy, provide opportunities to consider what can be learnt from

the creative work; support the client to make links or associations between their creative work and life or own experience; use a positive approach to explore how things can change/improve/be managed/be supported (Hackett 2012b).

It is important that all arts therapy modalities remain focused on building safe therapeutic relationships that support access to creative processes or art forms. One benefit of using the shared therapeutic levels within a team or service is in providing a common language regarding therapeutic work. The levels have also enabled some arts therapy interventions to be targeted at a specific level. For example, providing a 'drop-in' group for children and young people with acute psychotic illness in an inpatient setting which is focused primarily upon level 1 - 'building trust'. Other interventions may encompass all levels such as individual art psychotherapy which seeks to address negative interpersonal behaviours (Hackett 2012a). Identifying levels within therapy also allows for consideration to be given to the outcomes and observations that are expected as a result of the level of therapeutic work being carried out.

SHARED OBSERVATIONS

Due to the overlapping nature of therapeutic aims across many arts therapy modalities, devising and validating observational tools that allow practitioners to record the progression of their clients is an area for development. The 'Creative Arts Therapies Session-Rating-Scale' (CAT-SRS) is a therapist observational tool developed in clinical practice in the combined arts therapies team (see Appendix 1). It provides a range of descriptors for arts therapists to choose from based upon their observation of the client within each therapy session. The CAT-SRS is based upon goal attainment scales which have a long history of use in mental health services to assess a patient's individual goals and whether they have been achieved (Hart 1978; Kiresuk & Sherman 1968). As yet this tool has not been used in any formal research studies and requires further reliability testing. There is one published example of its use in an observational single-case study (Wadsworth & Hackett 2014). The CAT-SRS has been developed primarily for observation of work with children and adults with intellectual and developmental disabilities and provides observational descriptors within four areas, (a) '*Communication: Use of the person's primary method of communicating: i.e. verbal language, non-verbal signs/gestures and vocalisations*'; (b)

'Social skills: Use of listening, turn-taking, eye contact, appropriate body language, tone of voice'; (c) '*Motivation/participation: Motivation to engage actively throughout the session*'; (d) '*Linking: Ability to make links between personal experience and material that arises in therapy*'. For example, descriptors in the communication component are (1) responds to verbal and non-verbal communication initiated by the therapist only; (2) expresses basic wants and needs; (3) uses basic communicative function to gain and hold attention, to request items of information, to reject/protest, to express basic feelings; (4) uses advanced communicative function which include giving instructions, negotiating, speculation, describing own or others' feelings/reactions/opinions; (5) uses higher level communication to develop ideas, plan, predict, reason, evaluate, explain, argue/debate. With further testing the CAT-SRS has potential to be broadly used in arts therapies evaluation and offers an unobtrusive means of recording therapy observations and monitoring areas of therapeutic development.

SHARED TECHNIQUES

Across all modalities in the arts therapies there are a wide range of techniques and approaches that are utilised routinely in clinical practice. Some of the approaches are driven by a particular theoretical model or modality and others can be generally applied to support engagement or for a specific therapeutic purpose. Within the combined arts therapies team we routinely hold practice sharing meetings where a therapist will present their clinical work to the team. This has led to a number of therapeutic approaches and techniques being adopted and included in the arts therapy 'toolbox' for all modalities in the team. One such example is a creative narrative approach called the 'six part story' (Lahad, Shacham & Ayalon 2013). The origin of the six-part story is rooted in work supporting positive coping strategies and resilience in people experiencing ongoing stress (Lahad, Shacham & Ayalon 2013). This structured approach requires the client to generate narratives about a situation where a character faces an obstacle and requires some help. Each story includes (1) a character, (2) a place or land, (3) a task, (4) an obstacle, (5) some help (to overcome the obstacle), and (6) an outcome or ending (Lahad, Shacham & Ayalon 2013). The six-part story method is very accessible to the majority of the clients the team works with and can be adapted

for groups and individual work. We have introduced the six-part story in therapeutic work across a range of client groups including people with autistic spectrum disorder (Wadsworth & Hackett 2014) and people with learning disabilities and mental health problems (Hackett & Bourne 2014). It has been successfully used in an adapted manner in clinical practice with children and young people and in work with adult offenders with intellectual and developmental disabilities. The six-part story approach can also be used alongside the therapeutic levels described earlier leading to work in levels 3 (engaging with creative work) and level 4 (self-development). Potentially, the therapist observations of the client can also be recorded and monitored using the CAT-SRS in areas like 'item 4 - linking' when the client makes 'links or associations between' their six-part story and 'their own experiences'.

There are many techniques and approaches that are specific to the different arts therapy modalities requiring a trained and competent clinical practitioner. Outside the scope of this practice there are also areas that can be adopted and adapted across the arts therapies with broad appeal to clients and potential for generalised therapeutic benefit. Such areas require further investigation. This could initially take place through practice-based sharing and evaluation that progresses towards well-designed clinical research. The 'causal chains linking intervention with outcome' (Craig et al. 2008) in arts therapies are a rich source of research and evaluation which have not as yet been fully explored.

SHARED THERAPEUTIC WORK

Shared therapeutic work is possible in a combined arts therapies team and we routinely offer programmes of group work that draw from collaborative approaches. This has included an art and dramatherapy group programme for patients admitted to an assessment and treatment unit for adults with intellectual disabilities and mental health problems. The 12-week programme explores six themes including, turn taking, trust and friendships, noticing and sharing feelings, personal space, communicating, and celebrating achievements. A combination of dramatherapy and art therapy approaches is used to introduce and explore the themes within each group. For example, art therapy techniques used to explore the theme of 'trust and friendship' include asking clients to draw a safe place and then talking about why it is safe, drawing a supportive person and talking about how they

make the client feel good. The group members are then led to discuss 'the importance of placing themselves in a safe situation within different places and with different people'. The dramatherapy techniques used to help explore the theme of 'trust and friendship' include asking clients to walk around the room and nod and smile at different group members as they pass, then shaking hands and saying hello in different ways. This is followed by playing trust games and other games such as 'counting 1, 2, 3 and looking at a person; if their eyes meet, they swap seats with that person'. The games then lead on to sharing and discussion regarding a story about trust (Critchley & Bourne 2014).

CONCLUSION

Within this paper I have attempted to set out and illustrate some examples of shared practice development within a combined arts therapies team working in the NHS in England. The combined arts therapies team model is not unique but it is still rare within many areas of service delivery. This shared approach also retains the important and unique skills found in the training and competencies of the separate arts therapies. Without compromising the unique skills of each modality, finding some shared ground in practice such as shared therapeutic levels, shared observations, shared techniques, and shared therapeutic work is a positive interdisciplinary approach. It is my personal view that arts therapies have a great deal more to offer and demonstrate therapeutically within diverse clinical, social and cultural sectors. Whilst it has been important for the arts therapy professions to incorporate and adapt various therapeutic models and areas of evidence-based practice, there is further work that can be done to demonstrate the specific arts therapy techniques that are being utilised and developed in practice. Developing the evidence base around component parts of arts therapy approaches will offer further insights into the 'active ingredients' of our interventions. Ultimately this will enable interventions to be delivered in a more sophisticated and targeted way for the maximum benefit of our clients. Arts therapies have had diverse applications in the UK NHS and remain available on a limited basis. The value of arts therapies in supporting positive therapeutic gains for some client groups warrants further investigation and research. In many ways arts therapies research in clinical practice is an 'open field'. There is space for in-depth study of 'process' within all of the arts therapies that can

lead to rigorous investigation of the causal chains linking intervention with outcome. The areas of shared practice reported in this paper are still within early stages of development with greater potential for testing and validation. The combined arts therapies team can support arts therapy practitioners to deliver and develop their work whilst contributing towards important collaborative practice development.

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