Metro South Addiction and Mental Health Services

School of Medicine

Research Protocol

Arts on Our Mind: The effectiveness of creative activities in promoting mental wellbeing and reducing psychopathological symptoms in children of families with a mental illness

Version 5.0
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Amendment Summary to previous Research Protocol

Version 4.1	**Version 5.0** **(New amendments, including recommendations from the Confirmation Panel)**
Literature Review completed in 2015	**Literature Review revised and includes more recent article from within the last five years.**
Participants are recruited from previous participants in the OurSpace COPMI program	**Participants are recruited openly** This reduces the barrier for participants to take part in the research. This also reduces confounding factors that may contribute towards any changes to be observed.
Age range: 8-17 years old	**Age range:8-12 years old** The age range for the research was reduced to increase generalisability.
Sample size n = 100	**Sample size n = 120** Based on analysis of previous comparable studies, the targeted sample size of 120 participants appears to be sufficient to detect significant changes, allowing for an attrition rate of up to 15%.
Creative arts activities chosen at random to be included in the intervention	**Creative arts activities are based on a published book - "the Expressive Arts Activity Book" by Suzanne Darley and Wende Heath (2008).**
Key assessment Measures - Beck Youth Inventory 2nd Edition - CAMM (Child and Adolescent Mindfulness Measure) - RS-14 (Resilience Scale) - Y-OQ (Youth Outcomes Questionaire) - Ultra-brief Outcome Measures - Session Rating Scale (SRS); Outcome Rating Scale (ORS)	**Key assessment Measures** - The RS-14 replaced by RSCA (Resiliency Scales for Children and Adolescents), as the RSCA is deemed to be more applicable for the target population of this research. - Ultra-brief Outcome Measures – The ORS will involve using the Child Outcomes Rating Scale (more suitable for children) and also the Group Session Rating Scale (GSRS) was added.
Post intervention measure for longer term outcomes – three months after conclusion of the group intervention	**Post intervention measure for longer term outcomes – one month after conclusion of the group intervention** Shorter interval between conclusion of the group intervention and post intervention measure will reduce dropout rates.
When the waitlist group completed the initial research period with the experimental group, and subsequently provided with the creative arts intervention, their results was not to be recorded. This is because the aim is to compare the results between the experimental group (receiving the intervention) versus the waitlist group (not receiving the intervention).	**Waitlist group results from engagement in the creative arts intervention will also be recorded.** - This generates additional data sets for future comparison and analysis if required.

Abstract

Children of parents and families with a mental illness have an increased risk of psychopathology, medical problems, behavioural issues, and poor intellectual and social outcomes due to a combination of risk factors (Australian Infant Child Adolescent and Family Mental Health Association, 2004). According to Brockington et al, 2011, children of parents with mental illness, often abbreviated as COPMI, are more likely to be exposed to parenting difficulties, dysfunctional family dynamics, genetic predisposition to mental health problems and various environmental background factors such as financial constraints and social isolation.

Historically, this group of young people was considered 'forgotten' and 'neglected', as the support and healthcare were primarily targeted towards their parents or other family members with a mental illness (Cowling, 1999). Fortunately, in the last ten to fifteen years, there have been an emergence and a growing number of programs and resources developed to address the specific needs of the COPMI population. A variety of mental health promotion strategies can be used to enhance the resilience of young people in the general population and also for specific at-risk groups of young people such as the COPMI population. This includes the use of creative activities to promote mental wellbeing and reduce psychopathological symptoms that might be present or emerging in young people (Butler & Devenney, 2015). The use of creative activities may also allow them to express their creativity, generate new models of living, and develop a more integrated sense of self awareness and acceptance (Australian and New Zealand Arts Therapy Association, 2012). Such creative activities do not necessary need to be complex but can be simple, self-directed

activities that are accessible, flexible and replicable across different settings (Darley and Heath, 2008).

Currently, there are various types of research and evaluative evidence, derived from quantitative and qualitative methods (or both), linking creative arts exposure to health and wellbeing (All Party Parliamentary Group on Arts, Health and Wellbeing, 2017). Despite the available evidence, the efficacy and long-term outcomes of reported programs and approaches were usually not comprehensively examined or evaluated (Fudge, 2002), with variable quality and unevenly distributed across the field (APPG, 2017). Therefore, further research into the efficacy of programs, groups and other intervention approaches which uses creative activities as a tool is warranted. This research will aim to address some of the limiting factors identified in the literature to explore the link between creative activities and mental wellbeing, in group-based approaches. It will have a specific focus on the COPMI population, through a mixed method, pre- and post-intervention randomised controlled design that gathers data through quantitative assessments, semi-structured interviews and facilitator feedback.

Importantly, the research will focus on exposing participants to simple creative activities, without psychotherapeutic and psychoeducation elements embedded in the interventions. In contrast to most other research that explores the link between mental health and creative activities, the distinctive approach of this particular research is that it aims to exclusively explore the effect of creative activities exposure on mental wellbeing and psychopathological symptoms. It attempts to minimise any possible confounding effects from psychotherapeutic or purposeful psychoeducation elements. Therefore, this research is not about the development of a particular therapeutic

approach or program, but simply to examine whether exposure to creative arts activities makes any significant differences in the mental wellbeing and levels of psychopathological symptoms in individuals.

Participants will be randomly assigned to an Experimental Group, where they will take part in a five-week (3-hour session per week) group entitled, Art On our Minds (AOOM), which exposes them to a variety of simple creative activities, or alternatively to the Waitlist Control Group. Participants assigned to the Waitlist Control Group will not take part in AOOM initially but will be provided with the opportunity at a later time. Quantitative data will be gathered before (pre) and after (post) the intervention using three assessment measures. Three other ultra-brief measures will also be used during each session to measure the participant's perceived psychosocial outcomes, the feedback on the different art forms used in each session and the group process itself. Qualitative information will also be obtained through semi-structured interviews and facilitator self-reports. The qualitative feedback will provide further insight into the unique and subjective perspectives and experiences of the group participants.

The quantitative data will be analysed using a repeated measures model with potential covariates being investigated - such as gender, age, types of mental illness within the family and the types of creative activities used (Rutherford, 2011). Deductive direct content analysis will be conducted to explore any common or significant themes gathered from the qualitative measures, particularly in relation to the yielded quantitative data (Creswell, 2006).

Literature Review

One in five people in Australia will experience a mental disorder at some point in their lives (ABS, 2014). It is estimated that there are approximately one in four Australian children who live in families where at least one of their parents has or previously had a mental illness (Mental Health Council of Australia, 2012). This indicates that there are over a million young people who are 'children of parents with a mental illness' (Maybery, Reupert, Patrick, Goodyear & Crase, 2009). When siblings and other close family members with a mental illness are also included, the prevalence rate is almost certain to be even higher. COPMI, for the purpose of this study, will denote 'children of parents/families with a mental illness', to be inclusive of families where it may not be the parents that have a mental illness, but may involve other significant members in the family as well such as siblings.

Growing up and juggling with school and learning, navigating social relationships and finding their place in the world can be a very difficult and challenging experience for many children and young people. Young people, particularly adolescents, are also going through a period of drastic physical, physiological and psychological changes that can bring additional challenges to their wellbeing (Lougher, 2001). Families in which at least one parent with a mental illness are at a much greater risk of experiencing more physical, emotional and financial problems when compared with other families (Fraser & Pakenham, 2008). Longitudinal studies in the literature have shown that the risk of developing mental disorders among children whose parents have a mental illness ranges from 41% to 77% (Hosman, Van Doesum & Van Santvoort, 2009). This is likely to be a combination of genetic predisposition, relational factors, psychosocial disadvantages and the reduced capacity for the family

to meet the children's emotional and physical needs, particularly in the acute phase of mental illnesses (Reupert, Marybery & Kowalenko, 2012). Therefore, children of parents and families with a mental illness experiences far greater risk than other children to develop emotional or behavioural problems, school difficulties and mental illness (Fraser & Pakenham, 2009).

The COPMI population often assumes the caregiving role for their parents and younger siblings, in a process called 'parentification', a situation in which young people takes over the parental roles and responsibilities (Fraser & Pakenham, 2008). This brings additional psychological, social and physical burden to the young people who may found themselves missing out on attending school or pursing their hobbies, as well as reduced involvement in other social opportunities because they felt that they need to stay at home to care for their parents or siblings. The stigma of mental illness also causes many young people to feel isolated and alone (Pretis & Dimova, 2008), particularly when many of them already lacked social and extended family support. They are often disengaged from school and the community, with poor awareness and access to professional support services (Reupert et al, 2012).

With the COPMI population, there is a varying level of mental resiliency, coping mechanism and other significant environmental protective factors such as a supportive school or community that forms. These protective factors provides a plausible explanation as to why some of the young people in this at-risk group demonstrate better coping mechanisms whilst others can become much more negatively affected and develop psychosocial problems such as substance abuse or post-traumatic stress disorder, even when faced with similar challenges (Cogan,

Riddell & Mayes, 2005). Resiliency is a protective factor that can be promoted or enhance through mental health promotion and early intervention, reducing the impact of difficult experiences and the emergence of psychopathological symptoms (Fraser & Pakenham, 2008).

There are many mental health promotion strategies that can be used to enhance the resiliency of the COPMI population. They include psychoeducation and peer support interventions, as well as the use of the creative arts and related activities. A scoping study conducted in 2012 with disabled young people and those facing mental health complexity in the United Kingdom, has found a significant evidence base which links visual arts practice to individual and community resilience (Macpherson, Hart and Heaver, 2013). A recent rapid review of the literature by Zarobe and Bungay (2017) also concluded that there is evidence which shows that participating in arts activities, such as in a group setting, can help build resilience which ultimately contribute to positive mental wellbeing of children and young people.

In addition to resilience, creative activities are also considered to enhance mindfulness in individuals (Coholic, Lougheed & Cadell, 2009). Mindfulness is defined as the state in which a person is paying undivided attention to how things are in the present moment, and it is believed that such a state is helpful for stress reduction, reduce pain symptoms and enhance wellbeing and performance (Davis, 2015). A recent thesis by Fogo (2017) from The University of Tennessee at Chattanooga, presented results through an experimental survey with 140 participants which illustrates that engagement with the visual arts, whether it is simply through making, viewing or teaching about visual arts, increases mindfulness.

Perhaps it was due to recognition of the linkage between creative activities and mental wellbeing by healthcare providers through firsthand experience and anecdotal evidence, the use of creative activities has always been incorporated within mental health practice and service delivery in many parts of the world (Leckey, 2011). Mental healthcare providers such as Occupational Therapists have used creative arts activities as a therapeutic tool since the inception of their profession in the early Twentieth centuary (Lougher, 2000). As illustrated by the various evidence describced earlier, there are increasing research, development and recognition in the potential of the creative arts to improve health and wellbeing within the academic and clinical communities, particularly in the past decade (Tischler, 2010). A review of the literature by Perruzza and Kinsella (2010), demonstrated the effectiveness of the use of creative arts in therapeutic practice, with benefits such as enhanced perceived control, building a sense of self, gaining a sense of purpose and building social support particularly when a group-based approach is used. Creative activities can also enhance the motivation and rate of participation in the creative arts across all ages (Mental Health Foundation and Baring Foundation, 2011), promoting overall wellbeing (Fenner, Rumbold, Rumbled, Robinson & Harper, 2012), and reducing psychopathological symptoms and the need to access health services (Butler & Devenney, 2015).

Creativity can be defined as originative or productive engagement in activity, or simply ‘inventiveness’ (Stevenson, 2010). Creative activities can be defined as any purposeful activity involving active participation using imagination and creative skills (Cynkin & Robinson, 1990). It is important to note that there are many different types of practitioners, approaches and schools of thinking in relation to the utilisation

and application of the arts and creative activities in healthcare and community settings, as well as with different individuals and groups. For example, there are art therapists of various disciplines who are qualified professionals trained in both mental health and specific art disciplines, equipping them with the knowledge and skills to use art processes for assessment and diagnosis across various settings (Case and Dalley, 2014). There are also healthcare providers, artists and educators who regularly use simple and inexpensive creative activities such as drawing and creative writing across diverse settings such as hospitals, clinics and schools to engage and assist participants to develop their resilience and capacity to manage challenging life circumstances (Darley and Heath, 2008).

Whilst creative art activities can be delivered to different target groups from various demographic backgrounds on an individual basis, there are evidence which suggests that group-based interventions are particularly beneficial for young people (Tischler, 2010). According to Lougher (2001), group interventions provides opportunities for peer support and learning, enhance knowledge of social skills and behaviours, promotes a sense of belonging and mutual support through shared experiences, provision of a more predictable and safe environment away from home, opportunity to make new friends and form relationships, as well as the chance to develop new skills, coping strategies and attain a sense of mastery over challenging situations (Rosal, 1993). Group facilitators can also provide mentorship, positive modelling and act as additional support networks for the young people. Lastly, groups can reach a larger amount of people compared to individual approaches and maybe more resource efficient (Coholic, Laughed & Lebreton, 2009). Specific reports in the literature on the effectiveness of creative art-based groups includes the research by Camilleri (2007) on the mental wellbeing of students suspended from school, in young people

who are coping with grief issues (Rogers, 2007), as well as with children living in foster care (Coholic, Laughed & Lebreton, 2009).

The following table highlighted thirteen publications in the literature, with timeframes spread across thirty years, which explored the use of creative arts groups or programs with children. The participant types, group formats, research methods and outcomes are briefly described.

AUTHORS	PARTICIPANTS	GROUP FORMAT	RESEARCH METHOD	OUTCOMES
Quinlan, Schweitzer, Khawaja& Griffin, 2016	42 students of refugee backgrounds	Creative arts therapy over the course of a school term	Controlled trial of creative arts therapy – pre and post intervention with control and intervention group	Significant reduction in emotional symptoms found for the treatment group. Empirical support for school-based creative arts therapy intervention specific to refugee young people

Butler & Devenney, 2015	Adolescents attending a Child and Adolescent Mental Health Service.	Eight weeks program, two hours each session/week	Mixed methodology - two quantitative outcome measures; qualitative self/parental feedback	Small sample size of 15. No randomisation. Significant positive changes on both quantitative scales.
See & Kokotsaki, 2015	Pre-school and School-aged children (ages 3-16)	Various formats – utilising traditional fine arts (e.g. visual arts, music, dance, performing arts, theater and dance) as well as hip hop, poetry and creative writing	Literature review – 199 relevant studies identified from eleven databases	Some art activities such as music have shown consistent positive results on students' learning and wider outcomes. Methodological weaknesses and sampling limitations were noted in a majority of the studies.
Cortina & Fazel, 2014	Young people aged 5-16years	Selective group intervention – students attend The Art Room for one or two sessions a week, for at least one term (10 weeks)	Pre and post intervention measures completed by participants and teachers	Improvement demonstrated on a range of social and emotional difficulties for students. No comparison group, varied enrolment time and follow-up periods.

Bungay & Vella-Burrows, 2013	School-aged children	Music, dance, singing, drama and visual arts activities in community/ school based settings	Rapid review of Literature, 20 papers (6 quantitative, 8 qualitative, 6 mixed-method studies.	Some evidence that creative activities promotes self-esteem, confidence, and empowerment. Methodological weaknesses and sampling limitations were noted in a majority of the studies.
Khadar, Babapour & Sabourimoghaddam, 2013	Elementary School Boys (7-12 years old) in Iran	Painting therapy – 12 sessions twice per week, 40 minutes per session	Experimental, pretest-posttest control group design	Experimental group demonstrated a significant decrease in the symptom of ODD while the control group showed no significant difference.
Coholic, D., Eys, M. & Lougheed, S., 2012	20 boys aged 8–13 years and 16 girls aged 8–14 years (drawn from local child protection agency and mental health service)	Twelve Weeks (2 hours) program - Holistic Arts-Based Group Program (HAP), arts and crafts group, waitlist group	pre-post test, comparison (waitlist and control group)	Self-reported lower emotional reactivity (a resilience measure). No changes for perceptions of self-concept.

Wurzel, 2011	Aged 9-12 experiencing academic, family, social or health stressors	15 weeks, 90 minute session/week	Pre-post test, self report scale	No significant changes for outcome, variables in Experimental group. No significant difference between Experimental and control group.
Kim, Kirchhoff & Whitsett, 2011	Aged 11-13 Adjustment issues, mild oppositional or disruptive behaviours, or ADHD	8 weeks, 75 minutes/week	Facilitator observations	Active engagement in group, social skills building, interpersonal learning

Coholic, Lougheed & Cadell, 2009	Aged 8-15, Poor self esteem, blame and poor future outlook	6 weeks changed to 12 weeks, 2 hour/week	Semi-structured interview	Enjoyment of group, increased confidence, improvement in family and friend relationships, increased self-awareness
Pifalo, 2002	Aged 8-17, Victims of sexual abuse	10 weeks, 90 minute session/week	Pre-post test, self report, Trauma checklist	Significantly reduced anxiety, PTSD symptoms and dissociative symptomatology
Kozlowska & Hanney, 2001	Aged 5-8 Symptoms of PTSD	7 weeks, one hour/week	Facilitator observations	Safe/supportive environment; acknowledge positive changes; more positive future expectations

Rosal, 1993	Aged 8-12 behavioral problems	10 weeks, 50 minutes session twice a week	3 pre-post test measures evaluated	Both treatment groups showed significant improvement in diagnosis

Despite the popular use of creative activities in mental health promotion and practices, limited research has been conducted for the child and adolescent population and even less so for children and adolescent from families with a mental illness. Additionally, whilst many of the qualitative designs and single case studies were able to demonstrate potential positive outcomes relating to the use of creative activities at least in specific circumstances and situations, the gathering of robust quantitative data is limited (Butler and Devenney, 2015). Most research design to-date to explore the link between creative activities and mental health are often limited by small sample size, self-report measure biases, a lack of control groups for comparison or a combination of these factors, which reduce their capacity to provide statistically significant evidence of efficacy (Leckey, 2011).

Additionally, many of the research conducted involved psychotherapy and psychoeducation elements in conjunction with the use of creative art activities, such as explicitly teaching mindfulness skills through the facilitation of arts-based methods, or incorporating various psychotherapy approaches such as Gestalt therapy in the creative arts program delivery (Butler & Devenney, 2015). Subsequently, it can be difficult to deduce whether any significant changes in the participants are independent results from the effects of engagement in the creative activities, or if they

are influenced by the psychotherapy or psychoeducation components. Therefore, interventions which focus exclusively on exposing participants to a variety of simple creative activities, without incorporating elements of psychotherapy or psychoeducation are recommended. This will assist in reducing confounding variables such as the effects of psychotheraputic elements, to ensure that any significant results from the intervention can be more accurately correlated with the creative activities. This is particularly important if the objective of a research is to examine whether there is a true correlation between exposure to creative activities against levels of mental wellbeing, resilience and mindfulness.

In summary, there is a need for more empirical research in order to examine the efficacy of creative activities, including in its simplest modes of application, in reducing psychopathological symptoms and the promotion of mental wellbeing by enhancing levels of resilience and mindfulness within individuals. The effective use of creative activities that is accessible, flexible and easily replicated for high-risk groups like the COPMI population would be invaluable tools to improve mental wellbeing in this group. A mixed method design to capture quantitative impact as well as the unique, qualitative experiences and subjective perspectives of participants will assist to yield more robust and comprehensive results.

Research Design

This research aims to examine the link between engagements in various creative activities using a mixed method, randomised experimental and control group design to explore changes in psychopathological symptoms, as well as levels of resiliency and mindfulness in the COPMI population. Participants of the research will be young people identified to have a family member with a mental illness, living in the Metro South Health catchment region. Referrals may include self-referrals, referrals from mental health clinicians or other stakeholders such as youth workers, school staff or primary healthcare providers. Participants may or may not be currently experiencing a mental illness themselves. Exclusion criteria applies to those who are currently at risk of harming themselves or others, experiencing a psychotic episode or abusing illicit substances, as they may not be able to participate safely in the group. Participants with severe cognitive impairment are also excluded as they may have difficulties following directions and participate fully and meaningfully in the group.

Eligible participants will be randomised into either the Experimental Group that will take part in the 'Arts On Our Mind' (AOOM) creative arts group (which is the research intervention) or the Waitlist Control Group, in which the participants will not be taking part in AOOM during the initial research period. However, they will be offered the opportunity to take part in AOOM after the initial research period to ensure equal access to the program. Therefore, there will be two sets of data collected for the Waitlist Control Group, which includes the initial data set collected when acting as a control for the experimental group, as well as the subsequent data set collected when engaged in the AOOM after the waitlist period is over.

For the purpose of this study, participants will be exposed to simple, accessible, inexpensive and common creative activities usually deemed to be fun and engaging to young people, such as painting, drawing, drama, dance and movement, music and creative writing (Darley and Health, 2008). This research will use quantitative assessment tools to conduct pre-group and post-group measures of mental resilience, mindfulness and levels of psychopathology across the experimental and control groups. Ultra-brief assessments will also be used at the conclusion of each session to measure group and session effectiveness and outcomes. Qualitative data from semi-structured interviews and facilitator feedback mechanisms will provide further insight into the efficacy of the creative activities in promoting mental resilience, mindfulness and reducing psychopathology in the COPMI population.

The Repeated Measures model with potential covariates being investigated - such as gender, age, types of mental illness within the family and the types of creative activities used, will be the chosen analysis technique for the gathered quantitative data. (Rutherford, 2011). Deductive direct content analysis will be conducted to explore any common or significant themes gathered from the qualitative measures, particularly in relation to the yielded quantitative data (Hsieh & Shannon, 2005).

Ethics approval was approved by both the Metro South Human Research Ethics Committee (Reference Number: HREC/13/QPAH/499) and the University of Queensland (Approval Number: 2014000620). The Specific Site Approval for the amended design is currently being processed. The previous approval reference number was SSA/15/QPAH/151.

Methodology

Intervention - 'Arts on Our Mind'(AOOM) Creative Group

The 'Arts on Our Mind' or AOOM creative Group is a scripted, manualised approach for participants to be part of a group process whilst experiencing simple activities associated with a number of the key creative arts disciplines. It will be run over five weekly sessions, with three-hour duration for each of the session. There will be up to a maximum of twelve participants per group. The reason for the scripted and manualised approach is to promote replicability, uniformity and universal applicability on the types of activities chosen and the delivery of the group instructions. This also helps to minimise confounding factors such as facilitator bias that may influence the research results.

The creative activities for the AOOM are icebreakers and media-based activities taken from *The Expressive Arts Activity Book* (Darley and Heath, 2008). Its Icebreaker activities are usually 15 to 20 minutes long whilst the media-based activities and theme-based activities are typically 30 to 60 minutes. They are an assortment of creative activities ranging from writing to painting, drawing and printmaking. Themed activities in the book with specific agendas and psychological elements will not be used in the group. This is because they contradict with the aim of the research to examine the linkage between exposure to creative activities and mental wellbeing without incorporating psychoeducation and psychotherapeutic elements.

Each session will consist of two to three icebreaker activities and one or two media-based and/or themed activities. Participants are encouraged to participate as much as possible in accordance with their comfort levels. At the start of each session, there

will be a standard greeting message to be recited by the facilitators and at the start of each subsequent creative activity, a set of instructions for the activity will be provided. Facilitators can provide general guidance and support to the participants and manage any problematic behaviours or crises situations as required but should always ensure that the focus of the group is the engagement of participants with the prescribed creative arts activities. Whilst the activities are pre-determined, how participants engage with the activities and associated materials are non-directive.

The facilitators do not necessary have to be a mental health professional, but they should have ready access to one for supervision, referral and debriefing purposes, so that any participant who may require mental health assessment and care will be responded to and referred appropriately. All facilitators will need to undergo a workshop prior to their participation in the research for familiarisation of the group program and to promote uniformity in the approach. There will always be a minimum of two facilitators running the group.

The breakdown of the sessions and activities are as follows:

ART ON OUR MINDS – GROUP PROGRAM

All activities taken from the following resource –

Darley, S., & Heath, W. (2008). *The Expressive Arts Activity Book*, London: Jessica Kingsley Publishers.

Session One – Intro to Creating and Drawings

- Icebreaker: Collection of objects (p61)
- Icebreaker: Collaborative scribble drawing (p60)
- Icebreaker: Mirror Image (p80)

- Medium-based activity: Bookmaking (pp89-91)
- Theme-based activity: Kingdoms (p149)

Session Two – Painting and Colouring

- Icebreaker: Favourite Season (p70)
- Icebreaker: Rorschach Paintings (p84)
- Media-based activity: Mono-printing (p96)
- Media-based activity: Watercolour Techniques (p99)
- Theme-based activity: Desert Island (p126)

Session Three - Creative Writing and Communication

- Icebreaker: Intro Ideas (p77)
- Medium-based activity: Poetry (pp92-94)
  - Cinquain
  - Haiku
  - Triolet
  - Limerick
- Themed Activities: Dialogue balloons (p128)
- Themed Activities: Random acts of kindness – stories and poetry (p171)
- Themed Activities: Seed packets (p179)

Session Four – Music, Movement and Voice

- Icebreaker: Reading aloud (p82)
- Icebreaker: Drawing or painting to music (pp67-68)
- Themed Activities: Design a CD Cover (p127)
- Themed Activities: Voice and Gesture (p189)
- Themed Activities: Movement Mirroring (p159)

Session Five – Making Things

- Icebreaker: Stickers (p85)
- Icebreaker: Bead Bracelets (p81)

- ❖ Themed Activities: Masks (p156)
- ❖ Themed Activities: Person/Plant (p164)
- ❖ Themed Activities: Your favourite meal (p193)

Group conclusion

- Concluding activity – a positive message to be written to each participant, to every other participants
- Certificates to be handed out

After each of the sessions, the facilitators are to ensure that they have completed the custom-designed facilitator's Self-Rating Scale, and that the participants have completed a Session Rating Scale (SRS), Group Session Rating Scale (GSRS) and an Outcome Rating Scale (ORS). The Waitlist Control Group will only need to complete the Outcome Rating Scale to track their progression and not the Group Session Rating Scale or the Session Rating Scale, as they are not participating in any groups at this point. These brief assessments not only provide data on the progress and changes of the participants over the five weeks, it also provides an insight into which creative activities are perceived to be more interesting or useful to the participants as well as alliance within the group process for the Experimental Group participants.

Participants

Participants will be young people from families where a parent, both parents, or at least one sibling or close relative who has a mental illness within the immediate family or household environment. Participants will be of ages eight and up until their 13th birthday, of both genders and can be from any cultural or ethnic backgrounds. Their participation in the research is voluntary and they can withdraw at any time if

they choose to. A consent form, which includes the information about the research, will need to be signed by the parents/guardians. There is also an alternative consent form for the participants to read and sign, which is adopted with more age-appropriate languages. Exclusion applies to those participants who are actively psychotic, acutely suicidal or currently engaging in regular deliberate self harm behaviour, disruptive and violent behaviours or do not have the mental or cognitive capacity to comprehend the group content and materials. Participants who attend the group intoxicated will also be excluded from participating. There is the aim to recruit approximately 100 participants to ensure that results from data collected are statistically significant and can be generalized.

Data Collection

Suitable participants are randomly assigned to either the Experimental (the group which receives the creative arts intervention) or Waitlist Control Group. This is achieved by using the QuickCalcs randomisation calculator available online at http://www.graphpad.com/quickcalcs/randomize1.cfm. This calculator allows a set number of subjects (each of which would first be assigned with a number sequentially), to be randomly assigned to two or more groups with equal numbers in each. In this research, participants will be randomly assigned through a block randomization method (Suresh, 2011).

When the initial 24 participants are recruited, they will each be assigned with a number from '1' to '24'. They will then be block randomised with QuickCalcs into two groups with equal numbers of 12 each (as 12 is the maximum number of participants for each of the creative arts intervention group). Participants will be

assigned with either the letter 'E', which denotes the Experimental Group, or the letter 'C', in which the participants will be placed into the Waitlist Control Group. The initial set of participants will belong to GROUP ALPHA and hence will be provided with the codes ranging from A1 to A24 against their names. Once the next 24 participants are recruited, the process will be repeated and this second set of participants will belong to GROUP BRAVO (B1 – B24), followed by GROUP CHARLIE (C1 - C24), GROUP DELTA (D1 - D24) and GROUP ECHO (E1 - E24). This means that there will be a total of 120 participants to be randomised to the two conditions of the research.

Previous research and a recent quasi-experimental design by Riemersma, Santvoort, Janssnes, Hosman and van Doesum (2015) on the effectiveness of psychosocial interventions in COPMI populations with mild intellectual disabilities and behavioural problems, demonstrated that between 54 and 80 participants are necessary to show a small to medium effect. This was calculated through a power analysis (two-tailed, alpha 0.05, statistical power 0.80) with two groups. Compensating for an estimated 10% attrition, the sample size of 90 was the minimum. A longitudinal study by Van Loon, Van De Ven, Van Doesum, Hosman and Whitteman (2015), on factors promoting mental health of adolescents who have a parent with mental illness (which used a single regression analyses with one predictor and four control variables, a medium effect size of 0.15, p value of 0.05 and a power of 0.80), yield a minimum of 92 participants. Based on these studies, the targeted sample size of 120 participants appears to be sufficient to detect significant changes. As the research progresses, it is expected that a suitable statistician will be consulted to maximise the appropriateness, accuracy and efficiency of the data analysis.

Quantitative data will be gathered pre- and post-intervention. The assessments will be completed with the participants as a group, with the facilitator in proximity to provide any clarification and explanation of the questions if required. Pre-group measures will be administered to all participants prior to the Experimental group starting the program. After the pre-group measures are completed, either within one day or on the day of the program starting, the Experimental Group will proceed to complete the five-week program (three-hours sessions per week). The first set of post-group measures will be administered to both groups in the final session, or within a week of the final session.

At one months after the intervention, another set of post-group measures will be completed again by both groups to measure longer term outcomes. This also allows a comparison to be made between participants that received the intervention (those in the Experimental group) and those that did not (those in the Waitlist Control group). The assessment measures may either be completed as a group with the facilitator, or if this is practically not possible, they can be completed individually with the facilitator.

Following this initial research phase, the participants from the Waitlist Control Group will then have the option of completing the AOOM program. The pre-group and post-group measures will be completed, in the same manner and timeframe as the Experimental Group before. It is important to note that, if the AOOM program for the Waitlist Control Group starts within a week of the group completing the one-month follow up after the initial AOOM program was completed, there is no need to complete another set of measures.

Quantitative Measures

The quantitative assessments to be completed by participants include the Beck Youth Inventories – Second Edition (BYI-2), the Resiliency Scales for Children and Adolescents (RSCA), and the Child Acceptance and Mindfulness Measure (CAMM). As discussed in the literature review, positive mental health is linked to levels of resilience and mindfulness, hence the use of the RSCA and the CAMM to measure whether the intervention promoted a change in these two factors. The Beck Youth Inventories is able to measure and provide a comprehensive insight into the levels of psychopathological symptoms in the participants.

A description of each of the measures are described below.

BYI-2 - Beck Youth Inventories – Second Edition

Rationale for use: *Measuring a range of psychopathological symptoms and their levels of severity*

The Beck Youth Inventories 2nd Edition (BYI-2) are five self-report scales that may be used separately or in combination to assess a child's experience of depression, anxiety, anger, disruptive behaviour, and self-concept. The inventories are intended for use with children and adolescents between the ages of 7 and 18. The BYI-2 are brief (average takes about five to ten minutes each) assessments of distress and psychopathology in children and adolescents. Each inventory contains 20 statements about thoughts, feelings, or behaviors associated with emotional and social impairments in children and adolescents.

For the purpose of this research, the full combination (all five of the inventories) will be used to assist in the pre and post measure of psychopathological symptoms,

through the use of the BYI-2, for each of the participants. It is anticipated that the creative arts group will help to reduce psychopathologicl symptoms such as depression, anxiety, anger, disruptive behaviour and poor self-concept in the COPMI population.

RSCA – Resiliency Scales for Children and Adolescents

Rationale for use: Measuring resiliency levels in young people

Resilience is often explained as the resistance to risk factors across the lifespan and the ability to 'bounce back' from adversaries, which includes being a child of families/parents with a mental illness. The more resilience a young person is, the less likely that he or she will be affected by difficult experiences and the development of psychopathological symptoms. Despite the complexity of defining and measuring resilience reliably still require further validation work (Luthar, Cicchetti, & Becker, 2000), a number of resiliency measurement tools have been developed over the past two decades with varying degrees of validity and reliability, in an attempt to understand and measure resilience in different population groups. However, psychometrically robust resilience measures for children under 12 years of age are still very scarce (Windle, Bennett & Noyes, 2011). Various resiliency scales were explored for this research, with the aim to select the optimal one that could measure any changes in resilience levels for participants before and after they participated in the creative arts group. The Resiliency Scales for Children and Adolescents (RSCA), is selected to be suitable for the measure of resilience in the participants for the purposes of this research.

The RSCA consists of three stand-alone scales of 19-24 questions each, with each

scale containing subscales that are theoretically grounded. The three scales and their subscales are as follows:

Sense of Mastery Scale: Optimism, Self-Efficacy, Adaptability

Sense of Relatedness Scale: Trust, Support, Comfort, Tolerance

Emotional Reactivity Scale: Sensitivity, Recovery, Impairment

The RSCA provides a profile of the participants' strengths and vulnerabilities, which examines their capacity to adjust and recover from difficult situations and experiences. The RSCA is also normed with the BYI-2, the other assessment tool used in this research, allowing the opportunity for more targeted data examination and linkages of results.

The RSCA is suitable for young people aged 9-18. As this research is open to participants between the ages of eight to their thirteenth birthday, if there are any participants who are eight years of age at the time of the assessment being administered, the nine years old norms data, as set out in the RSCA, will be used. This will be a limitation of the research, but there are currently limited scales that measure resilience in children and adolescents that caters for a larger age range.

CAMM - Child Acceptance and Mindfulness Measure

Rationale for use: *Measuring mindfulness and personal acceptance of feelings and emotions in young people*

There is preliminary evidence in the current literature that illustrates mindfulness-based interventions in children and youth may be a feasible and effective way to build

resilience in both universal and clinical populations. However, it also suggests that further research is required to consolidate this link (Greenberg & Harris, 2012).

Therefore, this research will aim to explore whether the use of creative activities, where some of which can be classed as mindfulness activities, in a group setting, will enhance the mindfulness of young people. Subsequently, it will also assist to establish the linkage between creative arts activities (particularly activities that are mindfulness-informed) and mental wellness through mental resilience and a reduction of psychopathological symptoms.

The CAMM is a 10-item (originally 25-item) measure of mindfulness and acceptance of feelings and emotions. It assesses the degree to which children and adolescents observe their internal experiences, act with awareness, and accept internal experiences without judgement.

Validation studies of the measure suggest that it is a developmentally appropriate measure with adequate internal consistency. CAMM scores were positively correlated with quality of life, academic competence, and social skills and negatively correlated with somatic complaints, internalising symptoms, and externalising behaviour problems (Greco, Baer and Smith, 2011).

This scale was chosen because validation studies provided evidence that it may be a useful measure of mindfulness skills for school-aged children and adolescents, it is brief and quick to administer with only ten items, as well as freely available with no cost for its use.

During the implementation of the groups, three ultra-brief measures, the Session Rating Scale (SRS), the Group Session Rating Scale (GSRS) and the Outcomes Rating Scale (ORS), will be completed by the Experimental Group participants at the end of each individual session to measure the participant's perceived psychosocial outcomes and perceptions of the associated sessions and group processes. The Youth Outcomes Questionnaire will also be administered to the parents/guardians of the participants, collected at the pre- and post-group periods, providing quantitative data to track participant change from the perspective of the parents/carers.

Ultra-brief Outcome Measures - Session Rating Scale; Outcome Rating Scale/Child Outcome Rating Scale; Group Session Rating Scale (GSRS)

Rationale for use: *measuring session effectiveness, session outcomes for participants and global group alliance in the group process*

Weekly measures will be completed during the delivery of the intervention (which consists of a five-week, three-hour sessions per week, creative activities program). These assessments are ultra-brief and can be completed quickly after each sessions, as well as being cost-effective and results can be easily interpreted. They include the SRS or Session Rating Scale, the GSRS or Group Session Rating Scale and the ORS or Outcome Rating Scale (the Child version, CORS will be used for participants 12 years and under, which simply includes smiley faces in the scale as prompts). The SRS can provide information about the experience, interest and perceived usefulness of the sessions being implemented to the participants. It can also measure the effectiveness of the specific creative art forms used for a particular session. The ORS provides an insight into what participants thought they were able to gain and take

away from the session, and a measure of psychosocial outcomes associated with the particular session. The GSRS provides an insight into the global group alliance within the group processes between the group participants and the group facilitators simultaneously (Quirk, Miller, Duncan & Owen, 2012).

An evaluative research in Australia by Campbell and Hemsley (2009) provided evidence for the validity and reliability of the ORS and the SRS against existing longer measures such as the Quality of Life Scale, Depression Anxiety Stress Scale-21 and the Rosenberg Self-Esteem Scale. Another study where over 3000 young people participated in a four year validation study of the ORS with adolescents between 13 and 17 years of age, as well as the CORS for children between 6 and 12 years demonstrated robust reliability, validity and feasibility, with significant correlation with the larger Youth Outcome Questionnaire (YOQ 30), being demonstrated (Duncan, 2006). Qurik etc (2012) reported that the GSRS, when compared with other commonly used group process measures, proved to be reliable based on Cronbach alphas and test-retest coefficients. The results in the literature ultimately provide supportive rationale for the use of such ultra-brief assessment measures in measuring the sessional outcomes for this research.

Y-OQ - Youth Outcomes Questionnaire

Rationale for use: *measuring intervention progress in relation to psychosocial distress as perceived by the participant's parent (guardian). This will provide the researchers with the unique perspective of the parent/guardian on the outcomes of the group.*

The Youth Outcome Questionnaire (Y-OQ) is a collection of questions designed to

collect data regarding the effectiveness of youth therapies. It is a parent report measure of treatment progress for children and adolescents (ages 4 – 17) receiving mental health interventions. Psychometric properties of the tool were reported to be favourable in relation to internal consistency, test-retest reliability and concurrent validity, making it a valid and reliable self-report measure of psychosical distress in young people of both clinical and non-clinical populations (Ridge, Wareen, Burlingame, Wells & Tumblin, 2009).

The Y-OQ measures six subscales:

1. Interpersonal Distress (ID): e.g anxiety
2. Somatic (S): e.g. dizziness
3. Interpersonal Relationships (IR): e.g. communication styles
4. Critical Items (CI): e.g. suicidality
5. Social Problems (SP): e.g poor conduct behaviours
6. Behavioral Dysfunction (BD): e.g. impulsivity

Quantitative Data Analysis

With the randomised experimental and control group design approach - the pre-group results and the post-group results across the three quantitative measures, the BYI-2, RSCA and CAMM, will be entered and analysed in a statistical package such as SPSS (Statistical Package for the Social Sciences). Changes for each individual over the research period indicated by each of the measures will be tabled.

Deductive direct content analysis will be conducted to explore any common or significant themes gathered from the qualitative measures, particularly in relation to the yielded quantitative data (Creswell, 2006).

Data will be analysed using a repeated measures model with potential covariates being investigated - such as gender, age, types of mental illness within the family and the types of creative activities used (Rutherford, 2011). This analysis technique will assist to ascertain if there are any significant differences between the Experimental Group and the Waitlist Control Group across different variables indicated by the various quantitative data sets collected (Dugard & Todman, 1995). Regression analysis can be used to explore relationships between variables that may be involved with treatment outcome.

Results from the Session Rating Scale (SRS) and Outcomes Rating Scale (ORS) will be used to measure session by session changes. Data will be plotted on appropriate graphs. Once again, the repeated measures model can be applied to examine if there are any significant differences between the Experimental Group and the Waitlist Group across different variables indicated by the SRS and ORS. The data can also further indicate which sessions are reported to be the most effective or useful, as well as any other observable trends of the participants' experiences and changes as they progress through the research period.

Qualitative Measures

For qualitative data, semi-structured interviews will be conducted with the Experimental Group participants at the post-group and post-one-month stages of the research. The semi-structured interviews will use a pre-determined interview schedule consisting of approximately seven to ten broad open-ended questions, which will be relating to engagement of the creative activities, such as their self-perceived

confidence and mastery in the activities, as well as the impact that the AOOM group may have had on their mental state, levels of mindfulness and ability to cope with difficulties (resilience to problems). The actual questions are currently in development and will required ethics approval once completed. The aims of the questions are to elicit information about the perception of the creative arts activities, the group process, experiences of participating, perceived effectiveness of such as group for the participants, as well as future plans for the use of creative activities in their daily lives. The interviews should last no longer than an hour in duration and conducted individually with each participant. Face to face interviews will be ideal but telephone interviews will be conducted if this is not possible. Interviews will be recorded and transcribed. Parental or guardian presence in the interview is not recommended nor encouraged due to the effect this may have on privacy and how readily the participant would be willing to share their thoughts and feelings. However, this should be allowed if this is the wishes of the participants and the family.

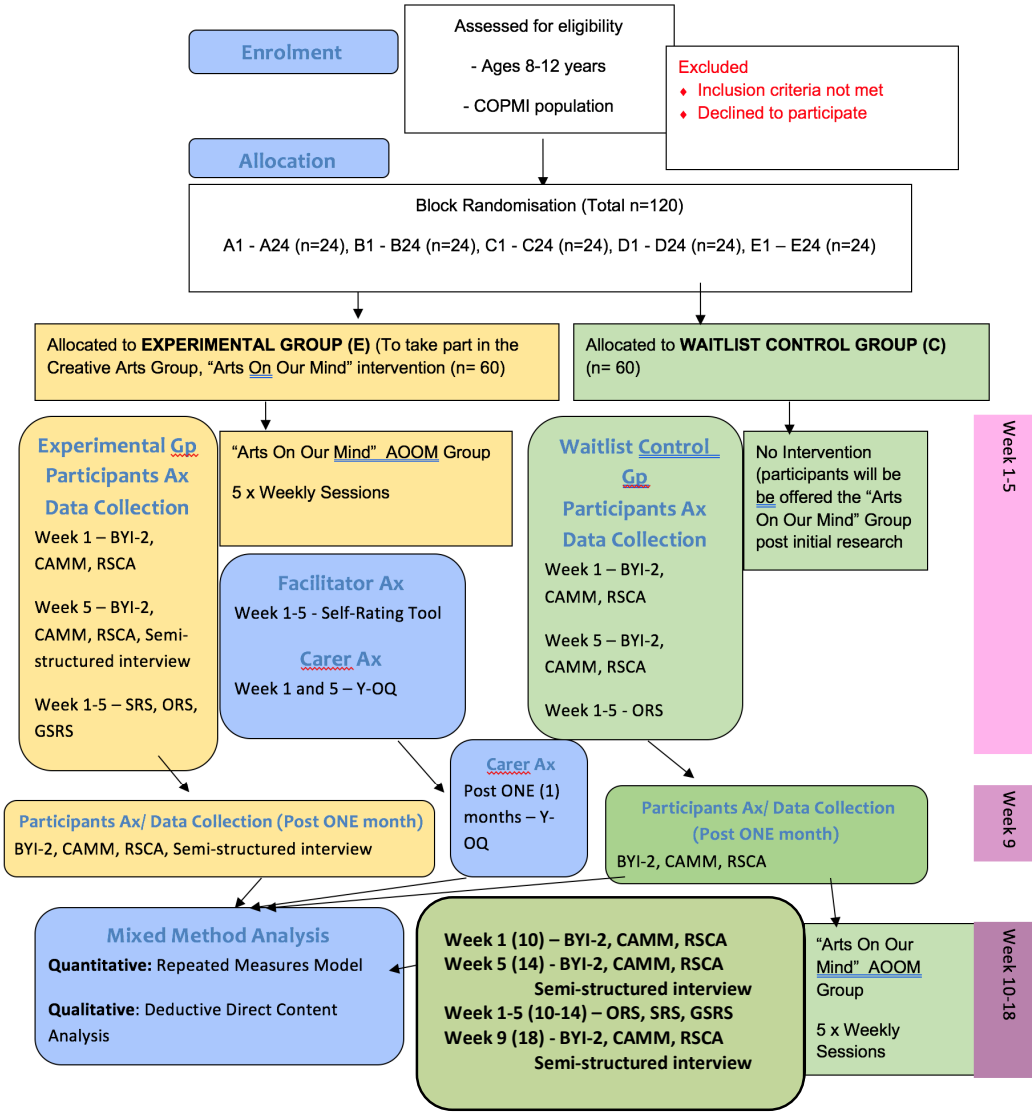
Additional data will also be gathered through a custom-designed facilitator feedback form at each session to rate self-adherence to the program. The purpose of this form is to assess how each facilitator thought about their performance in the session and how much they thought the purposes of the session has been achieved, as well as how closely they adhered to the group instructions and protocols of its delivery.

Qualitative Data Analysis

As there is already some existing research evidence about the potential positive effects of creative activities on mental wellbeing, deductive direct content analysis

will be used to assists with generating the relevant coding schemes (Hsieh & Shannon, 2005). A deductive approach is particularly useful for this research design as groups are being compared at different time periods (pre- and post-intervention) using a number of measures (Elo & Helvi, 2008). Data will be coded and organised under question headings. Any relevant descriptors or keywords will be identified, categorised and given labels. Axial coding will be used to determine relationships between any relevant categories, to assist with the identification of trends and themes. To increase validity and coding consistency, peer checking and review of coded data will be conducted with two other mental health clinicians (independent of the research) in order to ensure agreeability in the recognition of any emerged trends and themes. Regrouping is to be performed if necessary. Please see diagram below for a pictorial representation of the research project:

Arts on Our Mind: The effectiveness of creative activities in promoting mental wellbeing and reducing psychopathological symptoms in children of families with a mental illness



Other Research Information

Location/Logistics of Research

The study will be conducted out of the community health centre located within the Metro South Health Service District of Queensland Health, Australia. Equipment required include simple and common creative art materials. The cost of the materials was funded by the service and the researcher.

Risk Management

The potential difficulties and limitations of the proposed project included:

- Low attendance rates of participants: This can be increased by having a short intervention period such as the timeframe currently being chosen (five weekly sessions only).
- Group dynamics and conflicts: This can be minimized through the use of relevant group facilitation strategies, adequate planning, supervision and debriefing.
- Recruitment and participating issues: This can be supported by the provision of extra resources to promote the group through the use of students and other relevant additional resources.

The group interventions in the research project are designed to be engaging, fun and completely voluntary. All client details will be kept confidential unless significant risks are involved. Data and assessment results obtained will be stored in a confidential manner (e.g. hard copies will be stored in a locked cabinet and secured location, soft copies will be stored on secured computer networks with password protection). The data will only be accessible to the researcher and any suitably qualified personnel appointed by the researcher.

The research requires participants to complete a number of questionnaires and assessments, in which some questions on these tools explore unpleasant experiences that may have happened in the past. It is conceivable but unlikely that participants may become upset when confronted with these questions. However, these assessments are an integral component of the research which helps to provide a better understanding and insight into the participants, their experiences and their needs. The information obtained is also likely to be clinically helpful for the participants. Appropriate support and referral pathways will also be provided to participants if they required it.

Benefits of the Research

Benefits to the Individual: Participants of the research are expected to develop mental resilience, mindfulness, self-empathy and insight that assist to promote mental wellbeing and resilience, and may demonstrate a reduction in psychopathological symptoms. Participants are also provided with opportunities to express their creativity and may assist them to develop a new hobby in the creative arts. A sense of satisfaction and achievement is also likely to be encountered after the completion of each creative process or the group program. Both participants from the Experimental Group and the Waitlist Control Group will have access to the same creative activities group. The Waitlist Control Group will be offered the opportunity to take part in the group after the initial research and data gathering period. Further data will be recorded when the Waitlist Control Group takes part in the intervention, the AOOM program.

Benefits to the Community: The research group interventions provides an additional option of intervention for those who are clients of the local mental health service. For those participants who are not clients of the local mental health service, they will be provided with the relevant support if further mental health needs are identified during the course of the group intervention. Outcomes of this research will provide evidence and information on the effectiveness of exposure to creative activities in promoting good mental health and reduction of psychopathological symptoms for a particularly at-risk population group - Children of families with a mental illness. It may assist to rationalise and increase the use of creative activities in mental health promotion and early intervention, as well as the prevention of mental illnesses, across various healthcare settings. If the research can demonstrate that the prescription of simple and inexpensive creative activities a group format can produce positive results for mental resilience and a reduction of psychopathological symptoms in the COPMI population, there is the potential for youth-related organisations across Australia to implement such strategies in their service delivery.

Discussion

This research aims to explore the relationship between the use of creative activities in a group setting and the level of resilience, mindfulness and mental wellbeing in young people from the COPMI population. As a randomised control trial, it aims to yield more robust evidence to support whether the prescription of simple and accessible creative activities are effective in promoting positive mental health. However, being a more vulnerable and at-risk population, a possible obstacle for the research would be acquiring adequate participants within a prescribed timeframe. This is because participants from families with a mental illness, which is more likely to be unstable and conflictual, may have a higher rate of non-completion or lost to follow up. The children would often become unavailable or are being moved around geographically between extended family members, such as when the main carer/parent is being admitted into hospital. Attempts are being made to negate these risk factors with the proposed research design, where the time-limited group program is scheduled to occur over five weeks. This relatively short timeframe would assist to enhance the completion rate by the participants. The post group follow up period is also set at just one month to reduce lost-to-follow-up rates whilst still providing some data showing longer term effects.

This research is also restricted with participants from one specific metropolitan area (Brisbane South, Logan-Beaudesert and Bayside area), which may limit the generalisability of the research. However, If the research results positively demonstrate a correlation between creative activities and mental wellbeing as well as a reduction in psychopathological symptoms, it may provide the rationale for other locations to replicate the study within their own area.

Timeline

The approximate timing of studies and expected date of submission are as follows:

- Attain/renew Ethics Approval January 2017
- Renew/Complete Literature Review December 2017
- Confirmation of Candidature February 2018
- Re-approval of Amendments April 2018
- Attain Site Approval April 2018
- Conduct groups/data collection June 2018 – January 2019
- Analysis of results February 2019 - April 2019
- Mid-Candidature Review April 2019
- Further groups/data collection April 2019 - September 2019
- Thesis write up/Analysis of results September 2019 – December 2019
- Thesis review/Final analysis February 2020 – April 2020
- Thesis submission May 2020
- Completion of PhD December 2020

References

1. Aldridge, J. (2006). The experiences of children living with and caring for parents with mental illness, *Child Abuse Review*, 15, 79-88.
2. All Party Parliamentary Group on Arts, Health and Wellbeing. (2017). *The Inquiry Report, Creative Health: The Arts for Health and Wellbeing – second edition*, All Party Parliamentary Group on Arts, Health and Wellbeing, London, Arts Council England.
3. Australian Infant Child Adolescent and Family Mental Health Association, ' *Principles and Actions for Services and People Working With Children of Parents With a Mental Illness'* Stepney: Australian Infant Child Adolescent and Family Mental Health Association, 2004.
4. Beardslee, W.R., Versae, E.M. & Gladstone, T.R.G. (1998). Children of affectively ill parents: A review of the past 10 years, *Journal of the American Academy of Child and Adolescent* Psychiatry, 37. 11, 1134-1140.
5. Brockington, I., Chandra, P., Dubowitz, H., Jones, D., Moussa, S., Nakku, J., & QuadrosFerre, I. (2011). WPA guidance on the protection and promotion of mental health in children of persons with severe mental disorders. *World Psychiatry*, *10*, 93–102.
6. Bungay, H., & Vella-Burrows, T. (2013). The effects of participating in creative activities on the health and well-being of children and young people: A rapid review of the literature. *Perspectives in Public Health*, *133*(1), 44-52.
7. Butler, M., & Devenney, S. (2015). Draw on your emotions: creative arts groupwork with adolescents attending a mental health service, *Irish Journal of Social Work*, Autumn 2015.

8. Camilleri, V. A. (Ed). (2007). *Collaboration and creativity: Art therapy groups in a school suspension program*, London, Jessica Kingsley Publishers.
9. Campbell, A., & Hemsley, S. (2009). Outcome rating scale and session rating scale in psychological practice: clinical utility of ultra-brief measures, *Clinical Psychologist*, 13(1), 1-9.
10. Case, C., & Dalley, T. (2014). *The Handbook of Art Therapy*, 3rd Eds, London: Taylor & Francis Ltd.
11. Cogan, N., Riddell, S. and Mayes, G. (2005) 'Children living with an affectively ill parent: How do they cope?' *Educational and Child Psychology,* 22(4), 16-28.
12. Coholic, D., Eys, M. & Lougheed, S. (2012), Investigating the effectiveness of an arts-based and mindfulness-based group program for the improvement of resilience in children in need, *Journal of Child and Family Studies,* 21(5), 833-844.
13. Coholic, D., Lougheed, S., & Cadell, S. (2009). Exploring the helpfulness of arts-based methods with children living in foster care. *Traumatology,* 15(64).
14. Coholic, D., Lougheed, S., & Lebreton, J. (2009). The helpfulness of holistic arts-based group work with children living in foster care. *Social Work with Groups,* 32(1-2), 29-46.
15. Cortina, M. A., & Fazel, M. (2015). The Art Room: An evaluation of a targeted school-based group intervention for students with emotional and behavioural difficulties, *The Arts in Psychotherapy*, 42, 35-40.
16. Cowling, Vicki (1999). Children of Parents with Mental Illness. Melbourne. The Australian Council for Educational Research

17. Creswell, J. (2006). *Qualitative inquiry and research design: Choosing among five approaches*. London: Sage.
18. Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and conducting mixed methods research* (2nd ed.). Thousand Oaks, CA: SAGE Publications.
19. Cynkin, S., & Robinson, A. M. (1990). *Occupational therapy and activities health: Toward health through activities*. Boston, MA: Little Brown & Co.
20. Darley, S., & Heath, W. (2008). *The Expressive Arts Activity Book*, London: Jessica Kingsley Publishers.
21. Davis, B.J. (2015). *Mindful Art Therapy: A Foundation for Practice*, London, Jessica Kingsley Publishers.
22. Daykin, N., Orme, J., Evans, D., Salmon, D. (2008). The impact of participation in performing arts on adolescent health and behaviour, a systemic review of the literature, *Journal of Health Psychology*, 13(2), 251-264.
23. Dugard, P. & Todman, J. (1995). Analysis of pre-test-post-test control group designs in educational research, *Educational Psychology*, 15(2), 181-198.
24. Duncan, B. L., Sparks, J., Miller, S. D., Bohanske, R., & Claud, D. (2006). Giving youth a voice: A preliminary study of the reliability and validity of a brief outcome measure for children, adolescents, and caretakers. *Journal of Brief Therapy,* 5, 66- 82.
25. Elo, S. & Helvi, K. (2008). The qualitative content analysis process. Journal of Advanced Nursing 62(1), 107-115.
26. Fenner, P., Rumbold, B, Rumbold, J, Robinson, P, Harpur, S. (2012). Is there compelling evidence for using the arts in health care?, Deeble Institute Evidence Brief, 4.

27. Fogo, L. G. (2017). *Engagement with the visual arts increases mindfulness*. Honours Theses. University of Tennessee at Chattanooga.
28. Fraser, E. & Pakenham, K. I. (2009). Resilience in children of parents with mental illness: Relations between mental health literacy, social connectedness and coping, and both adjustment and caregiving, *Psychology, Health and Medicine*, 14(5), 573-584.
29. Fraser, E. & Pakenham, K. I. (2008). Evaluation of a resilience-based intervention for children of parents with mental illness, *Australian and New Zealand Journal of Psychiatry*, 42: 1041-1050.
30. Fudge, F. (2002). *Reports of various consultations with consumers of mental health services, their carers, familes and service providers,* Adelaide.
31. Greco, L.A., Baer, R.A. & Smith, G.T. (2011). Assessing mindfulness in children and adolescents: development and validation of the Child and Adolescent Mindfulness Measure (CAMM), *Psychological Assessments*, 23(3), 606-14.
32. Greenberg, M.T. & Harris, A.R. (2012). Nurturing mindfulness in children and youth: current state of research, *Child Development Perspectives*, 6(2), 161-166.
33. Hosman, C., van Doesum, K. and van Santvoort, F. (2009). Prevention of emotional problems and psychiatric risks in children of parents with a mental illness in the Netherlands: I. The scientific basis to a comprehensive approach' *Australian e-J for the Advancement of Mental Health*, 8(3).
34. Hsieh, H. & Shannon, S.E. (2005). Three approaches to qualitative content analysis, *Qualitative Health Research*, 15(9), 1277-1288.

35. Khadar, M. G., Babapour, J., & Sabourimoghaddam, H. (2013). The effect of art therapy based on painting therapy in reducing symptoms of oppositional defiant disorder (ODD) in elementary School Boys, *Procedia – Social and Behavioural Sciences* 84, 1872-1878.
36. Kim, J., Kirchhoff, M., & Whitsett, S. (2011). Expressive arts group therapy with middle-school aged children from military families. *The Arts in Psychotherapy*, 38.
37. Kozlowska, K. & Hanney, L. (2001). An art therapy group for children traumatized by parental violence and separation. *Clinical Child Psychology and Psychiatry*, 6(1).
38. Leckey, J. (2011). The therapeutic effectiveness of creative activities on mental well-being: a systematic review of the literature, *Journal of Psychiatric and Mental Health Nursing*, 18, 501-509.
39. Lougher, L. (2001). *Occupational Therapy for Child and Youth Adolescent Mental Health*, Harcourt Publishers, London.
40. Lougher, L. (2000). *Occupational Therapy for Child and Adolescent Mental Health*, London, Churchill Livingstone.
41. Luthar, S., Cicchetti, D. & Becker, B. (2000). The Construct of Resilience: A Critical Evaluation and Guidlines for Future Work. *Child Dev*, **71**(3):543–562
42. Macpherson, H., Hart, A. & Heaver, B. (2013). *Connected Communities – Building resilience through collaborative community arts practice: a scoping study with disabled young people and those facing mental health complexity*, The Connected Communities (UK).

43. Maybery, D. J., Reupert, A. E., Patrick, K., Goodyear, M. & Crase, L. (2009). Prevalence of parental mental illness in Australian families, *Psychiatric Bull*, 33, 22-26.

44. Maybery, D., Reupert, A., Partick, K., Goodyear, M. & Crase, L. (2005). *VicHealth Research Report on Children at risk in families affected by parental mental illness,* Victorian Health Promotion Foundation mental Health and Wellbeing Unit.

45. Mental Health Council of Australia. (2012) *Statistic of mental health (Fact sheet).* Mental Health Council of Australia. Retrieved from www.mhca.org.au

46. Mental Health Foundation and Baring Foundation (2011). An evidence review of the impact of participatory arts on older people. MHF, Edinburgh, pp. 12-15.

47. Perruza, N. & Kinsella, E. A. (2010). Creative arts occupations in therapeutic practice: a review of the literature. British Journal of Occupational Therapy, 73(6), 261-268.

48. Pifalo,T. (2002). Pulling out the thorns: art therapy with sexually abused children and adolescents. Art Therapy: *Journal of the American Art Therapy Association,* 19 (1).

49. Pretis, M. & Dimova, A. (2008). Vulnerable children of mentally ill parents: towards evidence-based support for improving resilience, *Support for Learning*, 23(3), 152-159.

50. Quinlan, R., Schweitzer, R. D., Khawaja, N., & Griffin, J. (2016). Evaluation of a school-based creative arts therapy programme for adolescents from refugee backgrounds. *The Arts in Psychotherapy*, *47*, pp. 72-78.

51. Quirk, K., Miller, S., Duncan, B. & Owen, J. (2012). Group Session Rating Scale: Preliminary psychometrics in substance abuse group interventions, *Counselling and Psychotherapy Research*, 1-7.

52. Reupert, A. E., Maybery, D. J. & Kowalenko, N. M. (2012). Children whose parents have a mental illness: Prevalence, need and treatment, *Medical Journal of Australia Open*, 1(1), 7–9.

53. Ridge, N. W., Wareen, J. S., Burlingame, G. M., Wells, M. G. & Tumblin, K. M. (2009). *Reliability and validity of the youth outcome questionnaire self-report*, Journal of Clinical Psychology, 65, 1115-26.

54. Riemersma, I., von Santvoort, F., Janssens, J. M. A. M., Hosman, C. M. H. & van Doesum K. T. M. (2015). *'You are Okay': a support and educational program for children with mild intellectual disability and their parents with a mental illness: study protocol of a quasi-experimental design*, BMC Psychiatry, 15: 318,

55. Rogers, J. Earl (Ed). (2007). *The art of grief: The use of expressive arts in a grief support group*, New York, Routledge/Taylor & Francis Group.

56. Rosal, M. (1993). Comparative group art therapy research to evaluate changes in locus of control in behaviour disordered children. *The Arts in Psychotherapy*, 20.

57. Rutherford, A. (2011). *Front Matter, in Anova and Ancova*, Second Edition, John Wiley & Sons, Inc., Hoboken, New Jersey.

58. See, B. H. and Kokotsaki, D. (2015). *Impact of arts education on the cognitive and non-cognitive outcomes of school-aged children – a review of evidence*, Project Report, Durham: Education endowment Foundation.

59. Stevenson, A. (2010). Creativity. *Oxford English Dictionary*. Oxford: Oxford University Press.

60. Suresh, K.P. (2011). An overview of randomization techniques: an unbiased assessment of outcome in clinical research. *Journal of Human Reproductive Sciences*, 4(1): 8-11.

61. Tischler, V. (2010). *Mental health, psychiatry and the arts: a teaching handbook*. Oxford, Radcliffe Publishing.

62. Van Loon, L. M. A., Van De Ven, M. O. M., Van Doesum, K. T. M., Hosman C. M. H. and Witteman, C. L. M. (2015). Factors promoting mental health of adolescents who have a parent with mental illness: a longitudinal study, *Child Youth Care Forum*, 44(6), 777-799.

63. Windle, G., Bennett, K.M. & Noyes, J. (2011). A methodological review of resilience measurement scales. *Health and Quality of Life Outcomes*, 9:8.

64. Wurzel, J. (2011). Learning to cope with stress through art: an evaluation of a school-based creative arts primary prevention program for children in elementary school. *Fordham University: Graduate School of Social Service*

65. Zarobe, L. and Bungay, H. (2017). The role of arts activities in developing resilience and mental well-being in children and young people a rapid review of the literature. *Anglia Ruskin University (UK).*