Communicating personal amnesty: a model for health promotion in an Australian disability context

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SUMMARY

Currently pathological and illness-centric policy surrounds the evaluation of the health status of a person experiencing disability. In this research partnerships were built between disability service providers, community development organizations and disability arts organizations to build a translational evaluative methodology prior to implementation of an arts-based workshop that was embedded in a strengths-based approach to health and well-being. The model consisted of three foci: participation in a pre-designed drama-based workshop program; individualized assessment and evaluation of changing health status; and longitudinal analysis of participants changing health status in their public lives following the culmination of the workshop series. Participants (n = 15) were recruited through disability service providers and disability arts organizations to complete a 13-week workshop series and public performance. The study developed accumulative qualitative analysis tools and member-checking methods specific to the communication systems used by individual participants. Principle findings included increased confidence for verbal and non-verbal communicators; increased personal drive, ambition and goal-setting; increased arts-based skills including professional engagements as artists; demonstrated skills in communicating perceptions of health status to private and public spheres. Tangential positive observations were evident in the changing recreational, vocational and educational activities participants engaged with pre- and post- the workshop series; participants advocating for autonomous accommodation and health provision and changes in the disability service staff’s culture. The research is an example of translational health methodologies in disability studies.

Key words: disability; health promotion programs; participatory research; social inclusion

INTRODUCTION

Current definitions of health within the disability sector originate from measuring quantities of illness, disease and disability, which in turn situate health as one end of an illness—wellness dichotomy. Alternative models of health measurement have been implemented at various levels and include a growing body of well-being measures including the Positive Affect Negative Affect Schedule (PANAS) for psychological well-being (Watson et al., 1988) and mixed method approaches to health-related quality-of-life indexes used increasingly with patient populations in clinical and community healthcare contexts (Fryback et al., 2007; James and Hockey, 2007). The International Classification of Functioning, Disability and Health (ICF), developed by the World Health Organization, is demonstrative of dominant health ideologies and methodologies adopting social models of disability into classification systems. While progressive in the current climate, the ICF remains reliant on ableist language markers to illustrate a multi-dimensional measurement of the
health of a person with a disability. While many allied health professionals within the disability sector work within a more progressive and less medicalized model, policy surrounding practice remains ableist. Antonovsky (Antonovsky, 1985a,b) rejects the binary of health-sick and instead suggests that an individual's sense of health is situated on a continuum of health ease/dis-ease (Lustig et al., 2000).

In simple terms, instead of measuring ‘quantities’ of illness, disease and disability to determine an individual's health status—‘quantities’ of health should be measured (Davis, 1995, 2002).

The very notion and nature of health well-being as it departs from pathological readings of health/illness dichotomies require that the frameworks and language that individuals, external care providers, medical professionals, social workers and therapists engage with, be evaluated (Macdonald, 2005). Understanding that health is a multifaceted system with countless frameworks for engagement is not an original subject position. Notions of disability, in all their manifestations socially, politically, and individually, are pertinent to the operating discourse of this research. While this research proposes that definitions of health (in general) are imbued within a salutogenic epistemology, the primary focus of this realignment of health is its pertinence to persons experiencing disability.

This study proposes that health well-being can be delineated into two models for interpretation and evaluation: a state of being prescribed by external moderators and clinicians; or a state of being understood experientially and individually. Both models are used interchangeably in health research, however, in maintaining a consistent approach to re-theorizing definitions of health, this study focuses on the potential for individual readings of health well-being to inform a wider scope of health promotion practices.

ARTS-HEALTH INTERSECTIONS

An Arts-Health Intersection can be defined as any program of practical arts activities that develops artistry and health well-being concurrently for a participant (Bishop, 2006). Rather than operating as a creative arts therapy, or arts-interventionist model whereby the diminishment of symptoms are sought through arts-based tools, Arts-Health intersections describe programs which can have direct and/or tangential arts or health outcomes for participants (Eakin, 2003).

Creative therapy programs are usually implemented with participants who experience psychological or psychiatric illness (Landy, 2010). However, Arts-Health intersections propose that engaging in specifically tailored arts activities can provoke positive health well-being responses through encouraging participation, communication and creativity. To frame a definition of Arts-Health intersections, it is first important to articulate the relationship people have with art in their day-to-day lives. While, as Jennings argues, ‘all people are creative and have latent talent with which they can express, communicate, pattern and shape their lives through symbolic interaction’ [in (Schattner and Courtney, 1981), p. 55], having artistic talent and actually using that talent to make art is a noteworthy distinction.

Goldie argues that ‘...art matters because our being actively engaged with art, either in its production or in its appreciation, is part of what it is to live well’. (Goldie, 2008)

In developing and implementing an Arts-Health intersection project, health well-being benefits are pre-determined as intended outcomes for participants and evaluated accordingly (Rasmussen and Gurgens, 2006; Matarasso, 1997, 2009).

There is not a single glossary of terms in use that effectively convey the joint theoretical and practical disciplines of arts and health. The array of arts practice and disciplines that are used in health settings, or for therapeutic purposes, conflates the need for procedural and controlled instruments that can produce robust data. The performance itself is indicative of many arts-health projects, whereby arts-based products are sought as outcomes of interventions. The sharing (in this case, performance) of the process of participation in art-health activities is essential for a participant to reap the benefits of the intersection/intervention. In much the same way as a treatment outcome is measured as impact, the showcasing of the outcomes of an arts-health intersection has important impacts that require response. The aim of this study was to evaluate the effects of engaging with a drama-based workshop model focussed on learning skills in effective communication, autonomy, resilience and goal-orientation for adults experiencing disabilities with respect to the participants experiences of health well-being (Nye, 1994; Wong, 2006).

The research sought to evaluate if participation...
in the arts-based activity system could influence outcomes in identified areas of health well-being such as—improved confidence, inter-personal communication, autonomous decision-making and re-negotiation/construction of health identities in everyday life.

**METHOD**

The health promotion program model used in this study was developed using participatory action research adapted from Burnaford (Burnaford, 2007), Lloyd (Lloyd, 2002), Pauline (Pauline, 1999) and Schon (Schon, 1983). As such, the researcher, in the role of workshop facilitator, developed the activity system with participants and explored a range of data collection and analysis methods to document and evaluate changing experiences of health well-being using a combination of observational, reflexive and creative analysis instruments. These rich data sets allowed the researchers to identify individual and collective markers in participants’ experience of health well-being and develop activities that aimed to improve key areas of focus as well as effectively document these experiences. The design was intended to provide an extension of superseded anecdotal or subjective observational data, such is the norm in contemporary projects of this nature (Staricoff, 2006; Staricoff, 2004).

**Setting**

The practical workshop program was delivered at a fully accessible theatre and hall in Brisbane, Australia where the Cerebral Palsy League of Queensland operate an adult day service. Appropriate disability access was ensured and both the venue and program were advertised to participants from across Brisbane who had memberships with Access Arts, Inc. (the state disability arts organization) and the Cerebral Palsy League of Queensland.

**Engagement and implementation**

Access Arts, Inc. provided the researchers with a paid support worker as a research assistant to help in the workshops. The lead researcher offered both Access Arts and The Cerebral Palsy League Queensland his services as a drama teacher and workshop facilitator for their service users who had an expressed interest in the program. Additionally, the lead researcher agreed to document and report on the outcomes of the workshop series for the benefit of both organizations in their ongoing efforts to formalize the range of recreational, vocational and educational programs they offer. Arts and crafts activities within disability services are regularly positioned as activities for the purpose of recreational enjoyment for service users. The benefits of participating in arts activities in terms of health and well-being improvements were (and regularly are) missing data sets within service evaluation.

**Participants**

Participants from the disability community were recruited consistent with the research design and aims.

The researchers developed a flyer advertising the workshop and performance opportunity which was distributed through a number of disability service providers to potential participants. Following initial expressions of interest, potential participants were asked to agree to three criteria to participate in the program and research: (i) to commit to participate in 13 weekly workshops and 3 public performance dates in Week 13; (ii) to participate in the research aspects of the project both formally and informally. Specifically, agreeing to three interviews with researchers and ongoing recording of conversations, reflections, discussions and workshops through voice recording, film and photography and (iii) a personal responsibility to ensure that if a personal support worker is needed for personal care/communication support, that staff are provided for the duration of the project.

From this initial meeting, 15 participants signed up to the program to participate in the research. There were six male and nine female participants ranging in age from 22 to 65 years. Within the group, three participants were wheelchair users and three participants were visually impaired or blind. Participants identified as experiencing combinations of intellectual, physical and psychiatric disabilities. Support workers attended regularly and sporadically, depending on the support needs of participants, and between 5 and 10 additional support staff were present at any given workshop. An aim of the program was to develop personal autonomy in the participants; and as such, asked support workers and participants to contractually bind themselves to attend each and every
workshop, promoting personal responsibility for all stakeholders.

The lead researcher assumed the role of translator to support participants with navigating some of the data collection methods used. This was important to ensure maximum involvement from all participants and to clarify some of the methodological design principles for further research involving people experiencing disabilities (Campbell, 2008, 2009). For example, written documents needed to be explained verbally to some participants, converted into Braille for others. In some cases, surveys were conducted verbally to alleviate any literacy competency requirements that could have been inadvertently imposed. Some activities were physically adapted to ensure optimum engagement and maximum opportunities for individual reflection. For example, film and photography were used in place of written documentation for some participants to reflect on their experiences. Participants were made aware that they had the option of having an advocate (either appointed by the participant, the researcher or their respective disability service provider) present at any point in the process.

All participants involved in the research were supported over an extended period of 2 years, first within the workshop series and then through professional development mentoring during and after the workshop series; ongoing support and advocacy to access vocational, educational and recreational goals determined during the program. The further engagement following the workshop series was developed in consultation with participants about what kinds of services would be most effective in meeting their individual and collective interests.

**Intersection and procedure**

The initial phase of research was to determine participants’ goals in developing arts-skills and improving experiences of health and well-being. There were three sections/phases to the program.

(i) The development of activities and curriculum involved both the researchers and participants. The focus of the activity system was the relationship between performative narratives and the changing status of disability. Example activities included exploring personal experiences of ill-health, disease and disability and then engaging with the dramatic form of reconstructing personal narratives. In this way, participants were invited to critically reflect on their creative skills as well as their perceptions of their own health identities. This process is called reflexivity (Ellis and Bochner, 2000). Content was developed by the participants’ specific to their individual experiences of health.

(ii) Activities were evaluated at regular junctures in terms of their success in meeting participants’ identified health well-being goals. Once identified as a positive experience within the workshop setting, participants were encouraged to action the skills and devices in their everyday lives.

(iii) The facilitator worked with 15 support staff in various professional capacities to promote the ongoing application of the key aims of the workshop outside of the actual program in their daily support worker roles. The aims were informed by participants identifying that independence and autonomy were key areas that support staff could assist in aiding their realization of positive health well-being outcomes.

In the workshops, the lead researcher focused primarily on teaching drama skills of improvisation, vocal and physical technique and performance. It was intended that developing skills in these areas would have direct impact on improving participant’s experience of physical and creative awareness. Through commitment to individualizing the activity program, the researcher provided some training in visual arts, dance, film and singing to interested participants and when the researcher’s skill base lacked, the researcher linked interested participants with other training opportunities in the community.

Participants rehearsed and performed a devised performance at the culmination of the workshop series where family, friends, support staff and the wider community were invited and where the experience could provide a performative opportunity to implement participants’ learned skills and perform re-narrated personal stories. This platform was identified by participants as crucial to enabling an act of amnesty where presumptions about disability, disease and health could be publicly challenged.

**Data collection and measures**

Participants identified their own parameters for measurement of their own well-being through
interviews and ongoing reflexive feedback with the lead researcher. The factors identified by participants as constitutive of positive health well-being included: stable employment, physical wellness, psychological wellness, happiness and meaningful relationships. Each week, participants were asked to scale their changing experiences of health and well-being as the workshop program unfurled. Participants used a communicative creative scale, involving the performance of emotions. The measure was an extension of a typical visual analog scale (Wewers and Lowe, 1990), and was intended to be an inclusive communicative mode. As well as the individualized scaling of personal well-being, the researchers implemented a longitudinal observation scale, an extension of (Thiele and Marsden, 2003) Dynamic Observation scale. The observation scale consisted of 19 pre-designed factors of assessment for observing the experience of health and well-being in an arts-health intersection. A common activity in a drama group is a ‘check-in’ process, where all parties present make themselves known by verbal introduction. A creative member-checking process using conversational and performative narrative-building processes was devised as an additional method for participants to describe and articulate their own health status. The check-in process was performative and involved performing emotions, feelings and personal identity markers. To complement the measures and consolidate the data set, participation through engagement with activities from support workers, additional staff, family, friends and the general public were factored as data collection areas too. This was an important component of the researchers’ commitment to building effective and inclusive translational approaches to health evaluation within and outside of disability-specific environments. Generally, such measures are made by the external stakeholders in people’s lives. To promote the efficacy of new and individualized modes, it was important to collect data arising from the individual and from the various caregivers in their lives.

The data were collected through interviews, observation and creative/performative measures. Interviews were conducted with participants at three official junctures in the research cycles to generate a basic longitudinal data set. Questionnaires and surveys were conducted with support workers and audience members. The project had approval from the Queensland University of Technology Human Research Ethics Committee and informed consent was obtained from all participants prior to the data collection process. Ethnographic and reflexive data were collected by the researchers and participants prior to the implementation of the program and on a weekly basis within the workshop program as consistent with a participatory action research design. The emergent data informed the design of subsequent activities in workshops and aided in consolidating data collection instruments.

Baseline health well-being data were collected through interviews before the beginning of the workshop series and at two other junctures (mid-way and at the end of the workshop program). Journal entries, pictures, drawings, paintings, photographs, voice recordings, letters and personal correspondence were all collected in addition to surveys, questionnaires, interviews and observational data collected through participatory ethnography.

Through critical evaluation of participant responses and observational data, the researchers developed a framework for evaluating changes in participant’s confidence levels according to three areas: improved skills in public inter-personal communication; increase in drive, ambition and goal-realization; increased physical and creative awareness. Interview questions addressed participants’ understanding and experiences of creativity and health. Ongoing journaling, critical feedback, discussion forums and interviews documented changes in participants’ relationship to their individual health status and to their changing perceptions of the status of disability in their own lives.

The impact of the program can be determined through engaging with a triangulation of participants’ observations, researcher’s observations and key stakeholder’s observations (collected through surveys and vox pop during public performance and post-program interviews). Individual health goals were determined through communicative and practical arts-based exercises as well as performative discussions on a weekly basis during the workshop program.

The range of data collection methods used in this study is indicative of the multi-modal and responsive approach researchers can adopt when working with participants experiencing disabilities. The wide range of tools used was necessary due to the different and complex communication needs of participants. Ultimately, flexibility in data collection processes was helpful in generating rigorous qualitative data from each individual participant involved in the research.
RESULTS

Analysis suggests common outcomes for the majority of the 15 participants involved in the research. Analysis of interviews conducted with participants; surveys with audience members and key stakeholders in participants’ lives and the reflections of participants who implemented their learned skills in other areas of their lives is reported in this article. Findings suggest that the social and health-based outcomes for participants are constitutive of a successful health promotion program. In preliminary and ongoing conversations with participants, dissatisfaction with quality of life—according to key areas of access, inclusion, inter-personal relationships, physical and psychological well-being and autonomy—was identified by all participants. Data collected were analyzed according to three areas of inquiry:

(i) The impact of engaging with the workshop program on participants’ experiences of improved health and well-being.
(ii) The effectiveness of the evaluative framework of the case study design for use in other Arts-Health intersections.
(iii) The outcomes of engaging with the activity system for external stakeholders (i.e. support staff, family, friends and general public) in terms of changing perceptions and describing a clearer understanding of the health status of participants.

Positive experiences of participating in the workshop program were identified by all 15 participants in interviews and feedback. Participant N commented,

‘I really have learnt many different techniques and ways to express. I like the way it changed over time from the stage where we were writing stories and how that evolved and then coming up with the presentation itself evolved. I liked that process because I had no idea at the beginning and I was completely stumped after about week three racking my brains. It was very interesting to see’.

Health and well-being indicators suggested that each participant experienced varied levels of health well-being improvement throughout the workshop series. Many of the benefits of participating in the program were related to skills developed through the workshop program, and the personal implementation of these skills in day-to-day life. For example, an increase in skills of inter-personal communication had benefits in pursuit of reciprocal relationships with friends, family, staff and public.

Throughout the workshop series, the lead researcher collected observational data relating to the three areas outlined and noted changes expressed by participants in all areas. Individual case studies of five participants (two female and three male) have been chosen to illustrate some of the diverse outcomes for participants and to serve as exemplar of general participant outcomes.

Outcome one: confidence

At the inception of the research project, it was clear that many participants had low self-confidence evident in the lack of inter-personal communication between participants, with support staff and with the researcher. This was later articulated by some members of the group. Confidence was an area that all participants identified as wanting to improve. A lack of self-confidence was identified by participants as being an important barrier to positive health well-being in initial interviews. One participant (M) noted,

‘I found the workshop very intriguing to begin with but the time showed that my confidence improved and I really started to enjoy the sessions and do the things by myself that I normally not able to do ... My body seemed to be much more relaxed than it was some time ago’.

Common interest in the marginalization and social exclusion of disability was noteworthy among all participants too. Another participant (P) commented, ‘I have found a manner and a vehicle by which I can participate and get involved with other people’.

The following case study demonstrates the impact of improving confidence through gaining new skills in communication for people with acquired disabilities.

Participant G is a middle-aged man whose life had changed significantly a few months before beginning the workshop series. Participant G had acquired a traumatic brain injury which had created a number of medical issues, including becoming permanently blind. Participant G’s changed communication strategies had proved to be an important learning curve and his decrease in physical and psychological health well-being had proved understandably difficult for Participant G to resolve in his day-to-day life. In Week 9 of the 13-week research project, Participant G asked if he could bring a guest to the workshop series.
The lead researcher agreed but stipulated that Participant G would have to gain the permission of the other participants. This was granted. Participant G arrived the following week with a guide dog and explained that he had worked up the courage to seek support in the form of a guide dog and expressed his gratitude to the rest of the participants and the workshop experience for helping him develop his confidence. In an interview with Participant G at the end of the workshop series, he noted improvements in his skills of inter-personal communication.

‘I reckon I could actually speak publically now and not be perturbed. It’s going to help me a lot too because I’m doing a diploma in counselling and this is going to be really important for that’.

Participant G had been notably shy at the beginning of the workshop series both in conversation and a demonstrated willingness to participate in activities. The researcher noted two important outcomes for Participant G: he had developed confidence in himself in terms of accepting responsibility for implementing positive changes in his life; and had developed confidence in terms of communicating with other participants about important changes in his life. These articulation skills were helpful in other areas of his life too. At the beginning of the workshop series, Participant G was notably fixated on what he saw as his ‘fate’. He talked negatively about his experience of blindness and about the drastic changes in his life since his accident impacting negatively on relationships with family and friends. By the end of the workshop, Participant G had improved skills in inter-personal communication and narrative reconstruction, specifically assisting him to communicate a newly constructed identity of positive health well-being inside and outside of the workshop program. Participant G’s increase in confidence can be identified as directly correlating with the aforementioned components of health well-being. In terms of autonomy, Participant G developed personal responsibility for his life situation and had begun to take important steps toward his intended goals for expanding his access to the wider community. Secondly, Participant G notably developed resilience through a deeper understanding of his experience of disability is illustrated through his continued involvement in community drama groups following the active component of this research, and his ongoing relationships with other participants experiencing disability. His active seeking of support was directly related to a building of resilient processes that continue to improve his health well-being. One year on, Participant G’s goals for vocational re-training and re-entering the workforce have been realized and consolidated alongside his independent living status and autonomous support service design.

Outcome two: drive, ambition and goal-setting

As mentioned, the researchers noted that a key observable area of increased confidence for participants could be identified in participants’ changing perceptions and mapping of their future goals and the strategies used for attaining these goals. Participant I claimed that the workshops had been ‘very uplifting in terms of confidence building and becoming more faithful about the future’. Participant I is an accomplished musician and talented artist and had discussed with the lead researcher prior to the beginning of the workshop series that he had wanted to pursue formal tertiary education to consolidate his arts practice for some time. He often strategized openly with the researchers and participants about possible avenues he might pursue to meet his goal of tertiary qualifications in the creative industries. One week, (between workshop five and six) Participant I phoned the researcher to discuss his plan. He explained that it was his intention to apply for admission into a university course the following academic year and wanted some assistance completing his application. The researcher agreed to meet Participant I to discuss some options the following afternoon. Participant I did not show up for the meeting and when the researcher tried to phone him, Participant I had switched his phone off. Two weeks later, the researcher received another phone call from Participant I, this time he seemed panicked and anxious about the upcoming deadline for applications for the university course. The researcher agreed to meet Participant I that afternoon to discuss possibilities. Together with the researcher, Participant I filled out the application forms. The following week, Participant I explained to the researcher that he had not submitted the application. Although the researcher was disappointed, the experience highlighted an important outcome for Participant I and for the research. One of the major intentions of the research was to assist participants in developing skills in autonomy and communication. In the example given, it can be argued that Participant I was
displaying clear decision-making and autonomous processes. The accumulation of skills and the implementation of these skills are not necessarily cause and effect and certainly not confined to immediate effect. However, approximately 3 months after the culmination of the workshop series, the researcher received another phone call from Participant I. This time he was calling to tell the researcher that he had enrolled in a short course at a higher education institution in music production and that he was due to begin the following week. Consolidating and reflecting on goal setting and achievement is arguably a positive health well-being outcome for Participant I and is demonstrative of the importance of drive, ambition and goal setting within health promotion program design.

Outcome three: physical and creative awareness
The following case study exemplifies how the development of skills in physical and creative awareness gained through drama and movement training can have significant impact in terms of health and well-being. One participant, Participant P had a vested interest in developing skills in dance. At the beginning of the workshop series Participant P showed little interest in the activities being facilitated with the group. The researcher noted that Participant P was easily distracted and generally unfocussed in many of the drama activities. However, when activities focused on physical performance or dance Participant P became increasingly involved in the activity. Additionally, when the researcher introduced music or sound to an activity, Participant P responded by enthusiastically involving herself physically in the task. Participant P was encouraged to use the art form of dance to devise and perform her solo performance. Participant P does not use verbal communication as her primary communication mode; however, does have some verbal communication skills. This presented an obstacle in the research. The obstacle was that Participant P used to communicate with the public through verbal communication and as such responded to interviews, conversations and reflexive exercises verbally. However, Participant P's verbal responses were observably different from the experience Participant P seemed to be having in the workshop series. The researcher asked Participant P to communicate through dance instead of words. At this point, Participant P became actively engaged in group communication, improvising and devising activities. As an example, when participants were asked to reflect and critique their performance in activities, Participant P would perform an interpretive dance for the group in her response. This was a welcome and interesting form for the rest of the group to engage with. It also opened up communication channels with other participants for Participant P and the researcher observed an increase in inter-personal communication between Participant P and the other participants within and outside of the workshop setting. When asked what component of the workshop series she most enjoyed, Participant P responded (through verbal communication), ‘I had fun with my dance’. At the end of the workshop series, the researcher encouraged Participant P to pursue her interest in dance. She has joined two community dance groups and attends zumba classes three times a week as well. This is a major change in Participant P’s life as identified by her support worker and family. A year after the workshop series, Participant P contacted the researcher to ask about other performance opportunities. In conversation, Participant P told the researcher that she has begun formal supported employment working as a cleaner in a local retail outlet. Prior to the workshop, Participant P had had no success in gaining employment. Participant P explained that she wears earphones when at work and ‘dances’ through the cleaning tasks.

Outcome four: collaboration
The researchers intended for participants to develop skills in narrative re-construction, a form or genre of performance making developed within the workshop setting. Many participants in the workshop series relied on various support staff and apparatus to engage in public community settings. The researcher insisted that support staff be passive participants within the process and that decision-making and performance would be the responsibility of each individual participant. When the researcher was successful in articulating this intention to support staff, the participants who had previously relied on support had to build alternative strategies for support. For the most part, participants engaged one another for this physical and emotional support. One example of this was the collaborative working relationship between Participant M and Participant G. Prior to the workshop series Participant M and Participant G had not met each other.
Participant M had great difficulty at the beginning of the workshop series controlling his physical impulses and movements particularly when asked to publically perform. Participant G who had recently become blind, was still adjusting to building new strategies for accessing support in his life. In workshops the two men built a strong bond together having been paired in a number of creative activities. At first glance, it seemed as if Participant G was assisting Participant M by supporting him physically to move around the performance space. However, on closer inspection, the collaborative relationship was actually mutually beneficial. Participant M found a device to focus his energy toward his performance by providing Participant G with assistance to navigate the space. In turn, Participant G supported Participant M by engaging in conversation and action with Participant M to encourage him during performance. Participant M described Participant G’s support as windowing, ‘I really did well and thanks to Participant G for taking my charge of my body when I needed to be windowed around’. This was an important and interesting outcome of collaborative practice and it could be argued that the support network created between participants was indicative of improving resilience. Resilience in this example can be identified as Participant M and Participant G’s willingness to devise and strategize multiple approaches to improving their situation. They were probably an unlikely pair to develop such a strong collaborative relationship, however both participants had resolved to engage with the stipulations of the researcher to find alternative solutions for support, and the outcomes for both participants were demonstrative of this.

**Outcome five: performance**

The opportunity to perform to a wider public audience was a focus of many participants and a motivation to engage in the workshop and rehearsal process. For many participants of the workshop series, the experience of performing publically was foreign. In fact, for many participants, inter-personal communication had typically been regulated by the support staff and services that the participants engage with each day. Reflections on the public performance from all participants were positive as were audience responses. The public performance was intended to provide participants with a vehicle to actively and publicly re-narrate their personal stories within a creative, and safe environment. While research interests were primarily focussed on participant health and well-being benefits generated within the workshop setting (the process), for many participants the performance was instrumental in consolidating their experiences and positive well-being benefits. The performance itself was an act of autonomous collaboration and required much organization and responsibility from all participants, and in many ways served as another training space.

The further performance and enacting of skills learned in workshops was an important and positive outcome of the program too. An example of this is evident in the experience of Participant O. Participant O and her support worker arrived early every week. The relationship between them, although notably a compassionate, empathetic and respectful one had been built on the premise that the support worker worked in an advocacy role for Participant O. Participant O lived in a share-house, full-time care environment — a long-standing assisted-living model reminiscent of institutional living. The support worker explained that Participant O had been struggling with a number of issues involving support staff and her roommate at her house. Since beginning attending the workshops, Participant O had initiated some major changes including applying for independent living status and lodging complaints about the performance of two staff members. Her actions had snowballed some important changes in her residence, including her beginning a group session (to be implemented once a week) whereby residents of the accommodation service meet and discuss any issues regarding their living situation. In the group setting it was Participant O’s intention to generate teamwork among residents. The support worker explained to the researcher that prior to beginning the workshop program Participant O had been extremely shy, anxious and self-conscious. Since beginning the program Participant O had initiated major changes within her life and positive installments evidenced through active decision-making are being demonstrated. The direct impact of the workshop program on Participant O’s life is difficult to quantify; however, it is important to note that personal autonomy and resilience were skills that were being accumulated and implemented positively. Increases in confidence and creative communication skills both in workshops and in a public performance arguably provided Participant O with the stimulus and skills to renegotiate her living situation and her working and personal relationships to improve her quality of life.
Considerations
The workshop series was 13 weeks long. For participants, the weekly workshops were an important socializing activity, community access point and enjoyable experience within their everyday life. Currently, there are limited opportunities for people with disabilities to engage in recreational, vocational or educational arts activities. The two primary barriers for people with disabilities to engage with arts-training and/or activity programs can be attributed to access and cost. As the workshop series was free for all participants, they were willing to attend, and continue to attend, the workshops. However, as many participants relied on the support of staff and services to coordinate scheduling and transport, on multiple occasions support staff and services did not meet their responsibilities causing tardiness and/or absenteeism. For participants, connecting with other community groups and people in different communities were identified goals of the program. Building skills in these areas was difficult for many participants as responsibility for meeting time constraints, punctuality and task completion is often shared with support staff and services. This is an ongoing obstacle in disability services and for people experiencing disability. Participants commented that they were disappointed as the workshop series was only 13 weeks in length. The length of the program was pre-determined; however, it is worth noting that many participants noted in interviews that a shorter time frame would not be effective or sufficient for generating similar outcomes.

CONCLUSION
For many participants, the workshop series was an introduction to re-entering group contexts. Many participants were socially isolated, did not involve themselves in their private or public communities, and had difficulty gaining employment or financial/social independence. The model of implementation and action presents a set of guiding principles to orientate social care workers in their design and provision of health and well-being aligned activities and programs. Health and well-being was notably improved for participants according to the aforementioned markers of increased levels of confidence, autonomy and collaborative skills. All participants developed personal goals pertaining to improving independence, health well-being and artistic skills. The researchers were able to provide each individual participant with multiple suggestions and access points for creating further opportunities for themselves. The project demonstrated that the evaluation of participation in activities with effective evaluative processes in-built is indicative of a changing person-centred, and non-pathological approach to the measure of the health status of persons with disabilities, particularly within the context of health promotion programs in disability services. While the researchers intended to promote multiple modes of communication between persons with disabilities and the wider community in an effort to improve data collection and analysis methods in disability-related research, it should be noted that time management, punctuality and personal responsibility for task completion are all important components of engaging with any participatory action research project. This research adds a range of methodological ways of engaging diverse and marginalized populations in qualitative health-based research. Using person-centred and individualized modes of data collection and analysis, the research adds a new approach to health evaluation in community healthcare settings.

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