Developing the AMPHORA policy guidelines for heritage projects as mental health interventions: A Delphi Consultation

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Abstract

Purpose: Engaging with heritage to support mental health and wellbeing has become a focus of research and policy, more recently moving towards social prescription of *heritage interventions*. While there are benefits to active participation, there are potential risks to those taking part and to the non-renewable historic remains and landscape that form the core of these projects. The purpose of the current research was to develop best practice guidelines for organisations offering heritage projects as interventions for people who live with mental health issues to protect both participants and heritage.

Design: There were two research phases; a Sandpit with *World Café* discussions to produce a set of research priorities, and a Delphi Consultation, employing three questionnaires distributed over six months, to develop best practice guidelines. The panel in both phases comprised experts through lived experience, policy, practice, and research.

Findings: The AMPHORA guidelines cover three stages: Project Development, Project Delivery, and Project Follow up, with a set of action points for each stage. Of particular importance was authentic participation and expertise to ensure appropriate management of heritage/ historic environment assets and support for participants.

Social implications: The AMPHORA guidelines can assist all organisations in the delivery of safe projects that support the mental health of those involved, as well as enhancing and protecting the historic environment.

Originality: These are the first research-led guidelines that help heritage organisations support those living with mental health issues.

Article Classification: Research Paper

Keywords: Delphi, heritage, mental health, wellbeing, intervention, policy

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Introduction

The impact of heritage on the human experience has been of interest in arts and humanities for some time. Concepts such as ontological security (Grenville, 2007; Sofaer *et al.,* 2021), existential relatedness (Nolan, 2019), and symbolism and containment (see Coles *et al.*, 2019), have been suggested as outcomes of engaging with heritage. In addition, there has been much needed focus on the impact of displacement from ancestral landscapes experienced by Indigenous populations, and the impact this has on wellbeing (Smith *et al.,* 2022).

More recently, these experiences have been explicitly linked with psychological concepts of mental health and wellbeing. In 2018, a scoping review assessed the state of the evidence (Pennington *et al.*, 2018) and the general trend indicated that active participation in heritage-based activities (in cultural settings, object handling, and participation in archaeology and community heritage projects) was linked with an increase in wellbeing for participants*.* A realist review conducted by Gallou (2022), further indicated eight pathways to wellbeing afforded by heritage projects. While these reviews increase broad understanding of the impact of heritage on wellbeing, there are differences in the way that wellbeing is considered. For instance, Gallou takes a wider view of wellbeing to incorporate social benefits. While focused on personal wellbeing, Pennington et al did not differentiate between types of participants. Some were those wishing to experience a general increase in wellbeing from an already normal to high level, while others formed what might be considered *clinical* populations; those who experience diagnosed or undiagnosed mental health issues (e.g. depression, anxiety, posttraumatic stress disorder). It is with the latter that the current study is concerned.

In addition, this paper focuses on *heritage interventions*, defined here as projects that facilitate active participation in, and engagement with, heritage with the explicit intention of supporting mental health and wellbeing (see Burnell and Woodhouse 2022 for a realist-informed review of heritage interventions to support mental health and wellbeing). Some of the most well-known heritage interventions have focused on the role of archaeology to support veteran mental health and wellbeing, with the earliest papers published some eight years ago (Finnegan 2016; Nimenko and Simpson 2014). Other populations have also been supported through heritage interventions, such as homeless populations through archaeology (Kiddey, 2014), those living with mental health challenges through engagement with historic landscapes (Heaslip *et al.,* 2020), and people with dementia through object handling (D'Andrea *et al.,* 2022; Lanceley *et al.,* 2012).

Interest in heritage interventions is increasing and it comes at a critical time, particularly in the UK context, which is why this paper focuses predominately on current provision and evidence in the UK. There has been an increased understanding, and use of, cultural assets to support mental health and wellbeing (Fancourt *et al.,* 2021) against the backdrop of a general decrease in the provision of interventions for mental health issues from within the health sector. As a result, community and voluntary sector organisations (CVSOs) have mobilised to fulfil this need (Baxter and Fancourt, 2020). It is no surprise, then, that heritage interventions to support mental health and wellbeing have become a focus of research and policy (Reilly, *et al.,* 2018), and are increasingly socially prescribed (Historic England, 2019). Social prescribing connects people to activities, information, and advice to support their health and wellbeing (NASP 2021) and in England features in the NHS long term plan (NHS Long Term Plan). Globally, we have lived through a pandemic, and the impact that COVID-19 has had world-wide has increased our awareness of, not only the importance of harnessing assets and the community's role in supporting individuals (Sofaer *et al.,* 2021), but how, in an economically challenged global context, harnessing assets and the provision of projects through CVSOs meets an increasing need for mental health support (Baxter and Fancourt, 2020).

There are positives. The move away from medicalisation of mental health issues (where appropriate) towards an acknowledgment of the social determinants of mental ill-health are empowering; we have the resources we need around us. Research has indicated that for more severe mental ill-health, community-based interventions in combination with medical treatment, seem to improve symptoms, ability to cope, and promote recovery (Wilson, 2018). This supports concepts first noted in the arts and humanities concerning how heritage links us with past, present, and future and the enduring human experience, and strongly echoes the personal experience of McMillan who likened archaeology excavation with mental health recovery (McMillan, 2013). However, while there are benefits to active participation, heritage as intervention, as with other psychosocial interventions, is not risk free.

Intervention itself necessitates conditions in which a person can experience change, and not all change is positive, and not all staff have sufficient training and skills to minimise risk and maximise support for people who experience mental health challenges (Baxter and Fancourt, 2020). In particular, there have been concerns about the nature of activities being labelled as *therapeutic* but offered without the presence of experienced therapists. Sadly, there is also a perception that CVSOs are motivated to offer heritage for wellbeing projects because they are good candidates for funding. These factors present risks to participants but, uniquely in the case of heritage, there are risks to the non-renewable historic environment (Ander *et al.,* 2012), such as damage caused by unskilled excavation to artefacts and incorrect and appropriate treatment of human remains. Heritage

professionals, such as archaeologists, have an ethical responsibility to act as stewards of the historic environment and are often bound by the codes of conduct of their relevant professional bodies (for example, the Chartered Institute of Archaeologists (CIfA) in the UK). The standards and guidance of these bodies recognise the destructive nature of tasks such as archaeological excavation and the importance of good professional practice in relation to the "historic environment – a vulnerable and diminishing resource" (CIfA, 2022: 3). Consequently, it is essential that best practice is observed to protect participants *and* heritage, and to recognise the increased responsibilities for organisations.

Despite these identified risks, there is no guidance for organisations who provide heritage interventions. The purpose of the current study was to develop best practice guidelines for the delivery of heritage interventions. The guidelines can also support social prescribers in identifying best practice projects, and empower potential participants to ask questions about projects they are invited to join to ensure they are able to participate in a safe and boundaried intervention (see Tierney *et al.,* 2022 for a complementary discussion concerning heritage activities for older adults).

Methods

The guidelines, known as AMPHORA (Authentic and Meaningful Participation in Heritage or Related Activities), were developed over two phases: An initial Sandpit to discuss current understanding of archaeology for wellbeing, and an online Delphi Consultation to develop and agree a set of collaborative, comprehensive best practice guidelines. Both phases were funded by UKRI MARCH Mental Health Network and took place between February 2020 and November 2021.

Phase 1: Sandpit

The Sandpit brought together key stakeholders in archaeology and veteran mental health and wellbeing. Attendees were those with lived experience, and with expertise from the fields of policy, practice, and research. World Cafés were conducted over the course of the day, which focused on benefits and risks, active ingredients, how to measure change, and the *ideal* service (see Löhr *et al.,* 2020 for further discussions on World Cafés).

Phase 2: Delphi Consultation

A Delphi Consultation further explored the themes from the Sandpit; this time for a wider range of heritage activities and target participants. Delphi Consultations (Hasson *et al.,* 2008) involve the collation of expert opinion through a series of questionnaires, and are particularly helpful in establishing guidelines or processes where the evidence base is still developing, as is the case for heritage interventions. For the current study, an online method was adopted to ensure anonymity for our panel, but was also particularly advantageous during the COVID-19 pandemic.

Ethical considerations

Ethical approval was provided by Solent University Psychology Ethics Committee.

Panel Members

Potential members of the expert panel were identified by the research team and compiled by the Research Associate. The full panel was known only to the Principal Investigator and Research Associate. In total, 49 individuals registered to participate and were; experts through lived experience, carers, professionals with heritage and/or mental health knowledge, policy makers, and volunteers within mental health and heritage organisations. 'Other' expertise concerned broad involvement in participatory organisations as well as student status. All expertise was valued equally, and many participants represented more than one of these categories. Table 1 provides a summary of expertise on the panel. While there was a drop in participation between Delphi 2 and Delphi 3, lived experience remained well represented, and representation of heritage professionals and mental health professionals remained balanced. In addition, it is not uncommon that panel members do not respond to the final round of a Delphi process, and this can be taken as an indication of consensus (Keeney *et al.,* 2001).

Table 1. Representation of type of expertise for each Delphi round.

		Number of participants with particular expertise						
		Lived Experience	Carer	Heritage Professional	Mental Health Professional	Policy Maker	Volunteer (Mental Health)	Volunteer (Heritage)	Other
Delphi Round	Delphi 1	23	8	30	23	8	6	9	4
	Delphi 2	19	7	23	20	7	3	8	3
	Delphi 3	16	6	17	15	6	1	6	3
	Drop out between Delphi 2 and 3	15%	15%	26%	25%	14%	67%	25%	0%

*Note. Categories were not mutually exclusive and so N>49.

Materials, Procedure, and Analysis

The Delphi process is iterative and so material design, procedure, and analysis are presented together for each round. The Delphi Consultation comprised three rounds, each using a questionnaire created using Jisc Online Surveys.

For each round, an email with a link to the Delphi questionnaire was sent to panel members. Non-response to a round triggered reminder emails from the Research Associate to ensure that as many

participants as possible continued to the next round. Panel members who did not take part in a round were excluded from further involvement.

Delphi Round 1. The first questionnaire comprised 55 mandatory questions, of which 36 were open ended. These initial questions were based on current evidence and the findings of the Sandpit. The first Delphi questionnaire received 44 responses. Thematic analysis (Braun and Clarke 2006) was carried out on the answers to open questions to identify main themes, which were developed into statements for subsequent rounds. The statements maintained the original wording of the panel members, and anonymised quotes were used to illustrate points made.

Delphi Round 2. The second questionnaire comprised 91 statements, which the panel were required to rate on a 5-point scale (where 1 = strongly disagree and 5 = strongly agree), and answers were mandatory. A long report, a summary report, and an infographic of the findings from Delphi 1 were created for the panel to explain how Delphi Round 2 was developed, which allowed the panel to rate statements from an informed position. In addition, a short summary of findings from Delphi 1 was provided before each section to ensure that all respondents were aware of the main findings even if they did not read the other reports*.* Forty of the 44 questionnaires were returned. Quantitative analysis was carried out for these questions using Statistical Package for the Social Sciences (SPSS) 27 software. Prior to Round 1, the research team defined consensus as achieving more than 75% for agree or strongly agree (Diamond *et al.,* 2014), and Inter-Quartile Range (IQR) of less or equal to 1 (von der Gracht, 2012). Of the 91 statements, 72 reached consensus.

Delphi Round 3. The 19 statements that did not receive consensus in Delphi 2 were modified into 21 amended statements. Delphi 3 included an introductory text with information about what was being included in the survey and why. A transcript of the original statements was also included so that respondents could see how the statements had been modified. Responses were mandatory and, if respondents did not agree with a statement, they were asked to provide reasons to aid understanding and interpretation.

A personalised Excel spreadsheet was included with Delphi 3 containing the overall ratings for each of the 91 statements of Delphi 2 together with each participants' personal ratings. Panel members were given the opportunity to change their ratings in accordance with the Delphi method (Keeney *et al.,* 2001). No responses were changed.

Of the 40 questionnaires sent out, 29 were returned. Of the 21 statements contained within Delphi 3, 19 achieved consensus. Two did not and were discarded. These two statements were discarded. Figure 1 presents a summary of the Delphi Consultation process.
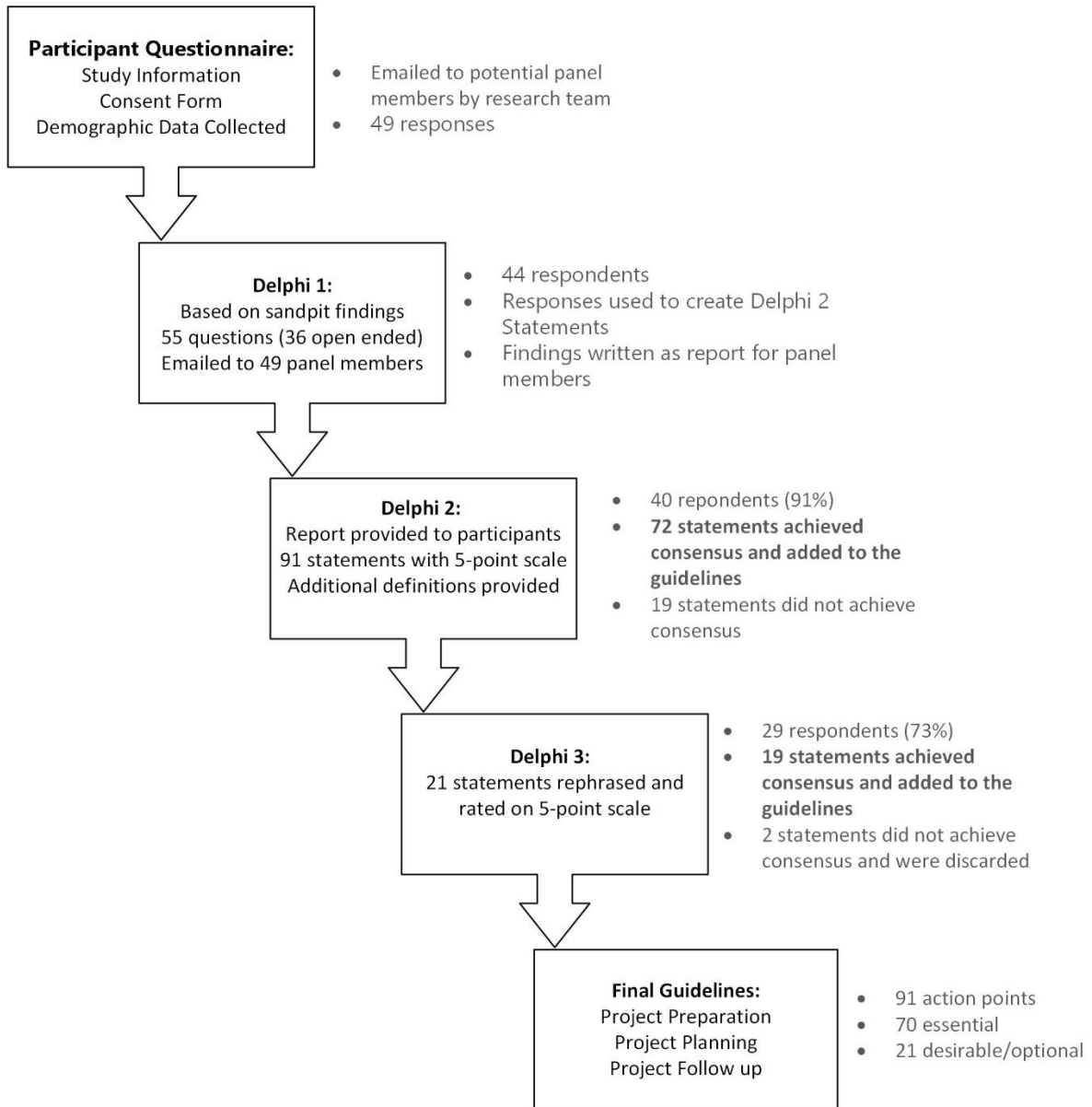
Participant Questionnaire:
Study Information
Consent Form
Demographic Data Collected

- Emailed to potential panel members by research team
- 49 responses

Delphi 1:
Based on sandpit findings
55 questions (36 open ended)
Emailed to 49 panel members

- 44 respondents
- Responses used to create Delphi 2 Statements
- Findings written as report for panel members

Delphi 2:
Report provided to participants
91 statements with 5-point scale
Additional definitions provided

- 40 repondents (91%)
- **72 statements achieved consensus and added to the guidelines**
- 19 statements did not achieve consensus

Delphi 3:
21 statements rephrased and rated on 5-point scale

- 29 respondents (73%)
- **19 statements achieved consensus and added to the guidelines**
- 2 statements did not achieve consensus and were discarded

Final Guidelines:
Project Preparation
Project Planning
Project Follow up

- 91 action points
- 70 essential
- 21 desirable/optional

Figure 1. Summary of the Delphi Consultation process

Findings

The guidelines are structured into three project stages identified through the Delphi Consultation; Project Preparation, Project Delivery, and Project Follow-up. Each stage has areas of consideration, and within these areas are a list of action points, which are the statements which achieved consensus.

Table 2 provides a summary of the guidelines. The full guidelines can be found here:

Table 2. Summary of the guidelines

Project Stage	Areas for Consideration
Project Preparation	- Project aims and anticipated benefits
	- Group composition
	- Initial contact and joining a project
Project Delivery	- Working in partnership
	- Safeguarding responsibilities
	- Project delivery to enable participation
	- Staff expertise and training
	- Model of delivery
Project Follow up	- Expectations for evaluation
	- Post project support

It is beyond the scope of the paper to provide a detailed account of how each action point was developed. These details can be found in the project report (). What follows is a more discursive account of the guidelines, using the words of our panel to provide context and explanation as to *why* these areas of consideration were developed and incorporated into the guidelines.

Project Preparation

Project Preparation concerned aspects of what projects should explicitly aim to achieve (aims and benefits), considerations as to who target participants should be (group composition), how initial contact should be made, and considerations of ways to support initial engagement (initial contact and joining a project).

Project aims and anticipated benefits. In Delphi 1, the panel felt the most important aim should be to improve the mental health and wellbeing of those taking part (100%), with 75% also believing that projects should enhance heritage with a synergistic relationship between the two. As one panellist explained, there should be *"The dual benefit of enriching the participants' wellbeing whilst improving a heritage site"* (mental health professional with lived experience).

There was a general agreement that heritage contexts provide a unique opportunity to support wellbeing:

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> *I believe that by engaging in something bigger (i.e. heritage) can promote an embrace. Specifically, that the world is not small, people have come before and will come after and evolution is always constant.* (Heritage professional).

How heritage interventions may improve wellbeing was also considered. The panel raised ideas about improving wellbeing through educating, promoting diversity and inclusion, empowering through involvement, offering a safe environment, encouraging social skills, and generating further support. The panel also considered how projects could provide opportunity for change and that projects should present opportunities to create purpose and meaning. Finally, engagement could support wellbeing by addressing a perceived disconnect between individuals and their environment:

> *Everybody has a connection to heritage through their own cultural and aesthetic predispositions and experience, a lot of mental health issues often appear to be because of a serious disconnect between the individual and their understanding of how the world has shaped them and those around them* (Heritage professional with lived experience).

Panel members felt strongly that engaging with historic landscapes and objects promotes reframing of experiences and provides opportunities to contribute authentically and meaningfully. The idea of authentic contribution also linked to ways in which heritage could be enhanced through involvement of non-professionals who could offer different viewpoints. These viewpoints could either add additional context, particularly in the case of veterans working in conflict archaeology, or decolonise current narratives:

> *To provide and support more critical, democratised and decentralised narratives to prevail. To improve research, prevention, interpretation and conservation. To enable inclusively in practice and audiences, to support heritage to be relevant.* (Heritage professional).

Another panel member suggested that:

> *Participants may be able to help draw out meaning or context, relate to it in unique ways, and 'transform' it through building their own stories into and onto it* (Mental health professional).

These ideas were turned into statements for Delphi 2, and all achieved consensus.

Group composition. Heritage projects often target groups with specific experiences in common or characteristics, for instance projects for veterans. Delphi 1 asked panellists whether projects should

be designed to include everyone (not exclusively those with mental health issues), those with mental health issues only, or those with a particular experience or from a particular cohort. Responses suggested that group composition would depend on the aims of the project and the needs and preferences of participants. In particular, available resources, such as expertise, would dictate involvement to ensure safe practice, which was a recurring theme through the consultation:

> *We work with small groups in sustained engagement projects, and members usually have serious mental health issues. The groups do include people who do not have mental health issues as carers, staff etc. You need a level of expertise inside the project and in partnerships to ensure that such a project is safe and properly run.* (Heritage and mental health professional).

Whether projects should be offered to specific or mixed groups elicited a range of opinions. For those who felt that people with a broad range of experience should be invited, this was because to divide was potentially harmful:

> *A project should not be divisive, exclusive. Neither should it be attempt to separate or exclude or make people feel they are 'different' or not part of normative processes in heritage. This would serve to be divisive and honestly potentially do harm.* (Heritage professional).

In contrast, others felt a strong need for participants to be similar in terms of their lived experience, not least for the peer support benefits, but to ensure a focused project too:

> *My sense is it is easier to deal with a specific group with similar issues. Opening up to anyone could make the group too diverse and cause issues on where best to focus.* (Heritage professional with lived experience).

A solution was to base group composition around the needs and preferences of the participants themselves, but this too was seen as difficult because needs and preferences may not align and may not promote wellbeing. An example was given about the veteran community, who may prefer to be in a dedicated project, but who might benefit from more integration:

> *There is merit in narrowing the focus to a particular cohort given the complexity of the interacting causal mechanisms that underpin a successful project and its evaluation. However, there is a risk of creating an exclusionary/special mindset for the participant group when there would be greater community integrative benefits by having a wider participant group. This is pertinent for the veteran cohort who often define themselves as*

separate from 'civvies' yet need to function and live alongside them. (Heritage professional and carer).

In Delphi 2, these themes were amalgamated into statements, but consensus was not reached. While it was agreed that the group composition should be based on resources and the aims of the project, there was no agreement as to whether it should be based on the goals or preferences of participants. In Delphi 3, disagreement remained when we asked whether participants should be asked who they would prefer to be in a group with. Some of this disagreement seemed to be based on projects being too specific and not financially viable, but the stronger theme was that participants should be encouraged to challenge themselves to grow:

> *In short, we all need opportunities, space and support to learn and grow, but we are unlikely to know and define this for ourselves. Apprehension about moving out of our comfort zone is common to us all, but necessary if we want to learn and grow. Being intentional about this enables support to be available and any reasonable adjustments to be made in the spirit of this.* (Mental health professional with lived experience and caring responsibilities).

Only two action points were added to the guidelines concerning group composition, with the consensus that group composition should be determined by a) the aims of the project, and b) the available resources. Who will form the group should be communicated to all potential participants to allow them to decide if they wish to take part.

Initial contact and joining a project. How people find out about, and are invited onto, projects was another important consideration. In Delphi 1 we did not explicitly ask about initial contact. This emerged from the open-ended questions concerning barriers to participation. When we asked about facilitators, such as provision of information, we learned about the importance of pre-project contact to determine whether projects can meet the needs and aspirations of the potential participants; how contact is made; and the nature of initial contact.

In Delphi 1 the panel suggested emotional and psychological barriers that would prevent people from joining projects. These could be social anxiety, avoidance, lack of confidence, as well as challenges associated with mental health itself:

> *Mental health conditions vary so widely; it would be impossible to summarise. However, it's quite possible that simply getting somewhere on time and entering a new building will be a huge thing. No matter what is waiting on the other side of the door, it's a long journey to the door. It can be like climbing a mountain.* (Person with lived experience).

Consideration of barriers naturally led panel members to consider ways of reducing these barriers, including how projects can best make initial contact and encourage participation. Information sharing was considered key and orientation packs, informal conversations, or pre-project meetings were suggested methods and served to start building trust and rapport, with the participant's voice at the heart of planning:

> *In my experience, a chat with an individual is very productive and allows the foundations of a rapport to be built. Informal conversations can help uncover the anxieties and negative aspects of an illness that the individual might feel would prevent them from participating. By having these conversations we are able to develop mitigation strategies with participants, take their knowledge of their own situation and use this to inform our own 'actions on' should they need our support on site.* (Mental health and heritage professional and volunteer with lived experienced and caring responsibilities).

In Delphi 2, we created statements to capture these ideas. All statements achieved consensus and included: projects providing information upfront; projects sharing information about their work with other professionals and organisations to reassure participants that support is present from the start; ensuring wellbeing plans, including support that might be needed, are co-created with participants; projects encouraging participants to attend with someone they trust should they wish to.

Additionally in Delphi 2, some panel members suggested an initial easing-in period, such as a taster sessions, to allow a gradual involvement in a project particularly on longer-term projects. Others suggested working with partners to raise awareness of projects. These suggestions were turned into statements for Delphi 2; however, they did not reach consensus. Open ended responses indicated that phrasing these ideas as things projects *should* do was problematic. In Delphi 3, *should* was changed to *could* to recognise that they are recommended, but not essential action points.

Project Delivery

How to deliver a project to maximise benefits was the next project stage developed through the consultation. Project Delivery concerned the importance of working in partnership (heritage organisations seeking support from mental health professional and vice versa), link working, safeguarding responsibilities, enabling continuing participation, expectations for staff expertise and training, and the model (but not content) of delivery.

Working in partnership. Working with partners considered vital at the project delivery stage to overcome barriers and enable participation, and concerned working in partnership with other

organisations as well as seeking involvement from other individuals (including mental health professionals as well as volunteers and peers) in the project itself. Panellists indicated that working in partnership would ensure that all expertise necessary was present to run a project safely and effectively:

> *Not trying to be something you and your project are not – archaeologists and heritage professionals are not health care professionals, psychologists, mental health specialists, this is important to consider (critically), it is one thing supporting positive mental health it is another thing trying to run a project specifically for people with mental health issues (especially those medically diagnosed).* (Heritage professional).

Enhanced link working was also an important theme in Delphi 1. This related to both link working to create more direct links to projects, such as through direct advertising of projects, but also in the social prescribing context:

> *I would like to see Heritage Link Workers in place who actively seek opportunities for people with mental health issues to take part in heritage opportunities where they live, with the supporting structures that need to be in place to make this possible for people.* Heritage and mental health professional).

Finally, panellists suggested that people with lived experience are important partners and could co-design the project and offer peer support or buddying during the delivery. Volunteers and carers could also be included in the project delivery, especially if projects or certain participants require the presence of extra support.

These ideas were turned into 19 statements for Delphi 2. Consensus was achieved for the majority of statements about working in partnership with professional organisations, but statements about the involvement of peer supporters, volunteers, and carers did not. In Delphi 3 it became apparent that the panel felt peer supporters, volunteers, and careers could be involved dependent on role:

> *So volunteers can contribute a great deal, but they should not take the place of staff and are not essential to delivering a project.* (Heritage and mental health professional).

In addition, the panel felt strongly that organisations not working in partnership should be cautious. At the heart of the comments, even in Delphi 3, was the need for projects to operate within capabilities.

> *We would not praise someone who attempted to excavate a site without resources or training for their enthusiasm, we would condemn them for being irresponsible. We would*

tell them to spend the years (decades) getting the necessary degrees and expertise [otherwise] they should not lay a finger on that site because their enthusiasm alone does not equate to being able to do the job responsibly. At present this professional culture does not exist at the intersection of archaeology and mental health. (Heritage professional with lived experience).

In summary, the panel felt it was essential that projects work in partnership with expertise in both heritage and mental health clearly represented, and that projects should also be co-created to recognise the value of lived experience. Though not essential, projects could benefit from involving peers and volunteers. Finally, projects could then use their partner networks to increase the reach and awareness of projects as a form of link working.

Safeguarding responsibilities. Safeguarding was at the forefront of panel discussions, which concerned recognising and mitigating risk, making reasonable adjustments, and training and debriefing for staff.

Safeguarding was also considered for the heritage assets themselves, particularly in the context of quality of work when the project was *real* i.e. an archaeological excavation carried out for a specific purpose:

The quality of work produced cannot be compromised to accommodate the wellbeing component. Individuals working on sites or in labs require training to conduct this work and there must be quality control standard in place to reassure the archaeological community that material is not being damaged and to reassure the participants that the work they are doing is consequential. (Heritage professional with lived experience).

Managing expectations before and during projects and making reasonable adjustments were also seen as a way to minimise risk:

Being honest about limitations and boundaries e.g. if specific times/charges apply at the outset, reminding people/partners involved of dates and project aims/outcomes, reviewing these aims /outcomes regularly together and making adjustments where necessary. (Heritage professional and policy maker).

Finally, involvement of suitably trained staff was seen as vital:

The skills and abilities of those delivering the programme need to be high and there does need to be some professional therapeutic support, again based on the severity of the presenting issues. (Heritage professional and volunteer with lived experience).

All statements in Delphi 2 achieved consensus, apart from a statement about ensuring quality of work to reduce risk of damage. For some, the notion of why damage could be done and issues of quality were found to be deeply stigmatising. Others felt the statement placed too much responsibility on participants and that they should not be put in a position to be worried about this:

> *No public participant in any heritage project should be in the position of worrying about the outputs of their work, and especially not someone with mental health issues. The important factor is the outcome – not the outputs. For heritage engagement in something with quality controls e.g. excavation – people should be given tasks commensurate with their experience. (Person with lived experience).*

This conversation was taken forward into Delphi 3. The research team provided more context of the types of situations in which irreparable damage could be done and why risk might need to be mitigated. The panel reached consensus that projects should mitigate risk to both participants and heritage, while also encouraging and maintaining authentic *(consequential)* participation and meaningful contribution.

Project delivery to enable participation. This section concerns aspects of project delivery that enable continued participation in projects. In Delphi 1 the panel raised a number of ways in which participation could be maintained. The panel indicated that projects recognising their duty of care and the importance of signed codes of conduct. Flexible participation was important, as well as offers of transport and food. Adaptations to participation should be provided to support participation, along with provision of safe space provided, and attendance of carers if desired. The panel also felt that wellbeing should be monitored throughout. These factors are summarised in the quote below:

> *Space and time, that allows participants with mental health issues, individually or in small groups, to experience heritage sites or collections without too much structure or formal explanation and facilities that allow time for participants time to explain their feelings and experience of what they have observed.* (Heritage professional with lived experience).

These ideas formed statements for Delphi 2, and all achieved consensus.

Staff expertise and training. Linked with working in partnership and safeguarding responsibilities the panel considered the types of expertise that should be present during a project, and training that existing staff and volunteers should be offered. Delphi 1 revealed that training was important to:

> *Eradicate misconceptions, prejudice and unconscious bias towards people who experience mental health issues.* (Mental health professional with lived experience and a carer).

Other free text responses in Delphi 1 concerned ensuring that staff were adequately trained to support mental health needs, and that this training should be provided by "*qualified and competent service providers*".

For Delphi 2, responses were grouped into statements focusing on mental health awareness, mental health first aid, equality and diversity, and safeguarding of adults at risk and of personal data. All achieved consensus aside from Coaching Skills and Transformative Skills training, which were explored further in Delphi 3 as optional elements of a project.

Model of delivery. Panel members with expertise in heritage were drawn from a wide range of disciplines. This diversity meant that we did not ask about *what* heritage activity should be offered as intervention. Instead, we asked what the model of delivery should be. Delphi 1 responses focused on the structure of activities and projects:

> *I'd say semi-structured is best, and possibly with both progression and soft exit points. Being able to evolve to meet group needs is vital. However, be aware of framing this clearly and of having some fixed points. If you said coffee break is at 10:30am, there are some people who will really need that to happen!* (Person with lived experience).

These ideas were turned into statements for Delphi 2 and the panel agreed that project models should be appropriate to the objectives set, to the skill set of those facilitating the project, and should provide some predictability/structure in terms of activity during a typical day or session. However, some flexibility in the delivery of a project would be necessary so that it could be adapted for participants.

Project Follow up

Project follow up concerns (if and) how projects should be evaluated as well as the types of support that should be provided after a project has finished.

Expectations for evaluation. Project evaluation gave rise to very mixed responses. In Delphi 1, 98% of the panel agreed that there should be some post project evaluation. However, what and how to evaluate did not achieve a clear consensus. In terms of *what*, the most mentioned aspects were participant wellbeing and safety and sustainability of a project. In terms of *how* to measure, some panel members argued for formal methods, including validated scales, while others preferred

informal methods. Delphi 2 statements focused on the use of validated psychological measures (to capture wellbeing outcomes) and the use of financial information to evaluate projects' sustainability. Neither achieved consensus and were re-framed in Delphi 3 as optional and achieved consensus. Responses in this round shone light on why consensus may have been difficult. The panel felt that whatever method is used, it should be agreed with project participants and was conserved an essential aspect of evaluation:

> *An organisation could use a validated tool, but whatever evaluation method or tool is used needs to be meaningful for the participant also. This is especially important for people with mental health issues so that they have the opportunity to reflect and see for themselves what they have learned and gained from participating in the project.* (Mental health professional with lived experience and caring responsibilities).

Post project support. In Delphi 1 we asked the panel about support for participants after a project finishes and three areas emerged: support offered by the project, support provided by other organisations through signposting, and supporting participants to develop new roles within projects to maintain involvement and provide (career) progression in the project. Those who felt support should be offered by projects suggested that participants should be seen as members of organisations, rather than a participating in discrete projects. Project support would then happen naturally:

> *Participants join and are then considered to be part of the program indefinitely, on and off-site.* (Health professional with lived experience).

While other panel members felt that support should be provided by external, specialist organisations:

> *I believe the support should be offered externally. This should be for the mental health provider to facilitate. I believe some degree of duty of care responsibility is created by starting or even participating in the conversation.* (Heritage professional).

Among the panellists, there was concern that if projects provided support, then participants may become dependent, which would impact wellbeing and recovery:

> *Only in so far as assisting someone to find a heritage related opportunity should they wish to continue their interest (I have a perpetual worry bead about dependency with these types of programme.* (Heritage and mental health professional who volunteers and has caring responsibilities).

These ideas formed statements in Delphi 2 and all but two achieved consensus. The panel agreed that projects should signpost to further support, keep participants informed of future opportunities for involvement, encourage peer support post-project, check in with participants after a project finishes, and encourage participants to progress in new roles. The statements that did not achieve consensus concerned ensuring opportunities for career development and limiting dependency (although the majority of panellists felt it was important to avoid dependency). Guidance about career progression was reframed in Delphi 3 as optional, and this reached consensus. In terms of dependency, the team took on board feedback from the panel cautioning us to distinguish between potentially problematic dependency, and a healthy enthusiasm for active participation in heritage:

> *I find dependency a problematic concept as we don't encourage people with hobbies or who join clubs to stop doing them in case they become dependent. but equally people should have an empowering experience through this that isn't disabling.*

Discussion

The aim of the Delphi Consultation was to address gaps in current understanding and practice concerning the provision of heritage as intervention. The guidelines were developed through three Delphi rounds, and the expert panel achieved consensus on a comprehensive list of statements concerning project set up, delivery, and post project support. Particular emphasis was placed on the importance of working in partnership to ensure that expertise in heritage and mental health were represented in all projects, which echoes the concerns of link workers in the Tierney *et al.,* (2022) study, and the concerns raised by Baxter and Fancourt (2020). Another important area was that the aims of the project and the target group of participants should be clearly communicated with potential participants and that plans for involvement are co-created. Also of interest was that perceived barriers mirror many recognised barriers in accessing psychological support.

Involvement with heritage can offer a deeper connection with the past. This connection can help an individual identify the natural, social or cultural factors that shaped them and those around them, and to see their place in a world that extends into the past, as well as forwards to the future, and is constantly evolving and adapting. In the panel responses, there was a sense that active participation in heritage should be authentic and meaningful in order for change to take place, which particularly echoes the work of McMillan (2013), and links to the developing model of heritage for wellbeing (see Burnell and Woodhouse, 2022). It may not be enough to offer participation in heritage *per se*, but to offer participation in projects that are *real* i.e. excavation that would happen with or without community engagement. In these scenarios, those with mental health issues take part as volunteers and contribute in the same way as other volunteers on projects. This allows

participation on an equal basis and could remove feelings of otherness or stigma that may otherwise be experienced. It is for this reason that commentary from one panel member about stigmatisation of mental health issues in the questionnaires and guidelines needs to be acknowledged and discussed:

> *I worry about the framing of people with mental health challenges in this study - and some of the questions perpetuate an understanding of people being risky and dependent rather than as individuals with talents and strengths that given the right environment and support will flourish.* (Mental health professional).

It is important to note that the guidelines were created inductively, with open-ended responses at the heart of Delphi 1. The concerns of the panel also map onto existing literature, and the guidelines address *on the ground* concerns. That said, the above quote raises genuine and relevant concerns, providing vital lessons in how these guidelines are framed and communicated. There is no suggestion that individuals with lived experience are *risky and dependent*; this is counter to the broad narrative of the guidelines in which understanding of heritage can be enriched through widening participation, the ethos and values of the work and project team, and the values of organisations represented by the panel. What the guidelines highlight is that *participation in* heritage activities can be risky and confronting. The risks associated with working with human remains or in environments that may be reminiscent of previous experiences (battlefields for instance) must be fully acknowledged and understood, particularly when these activities are being offered with the explicit intention of supporting mental health and wellbeing. To flourish, individuals need to feel safe. The guidelines provide reassurance that these risks have been considered and understood.

Concerns about stigmatisation are crucial to understand. The guidelines are intended for projects in which the target participants are individuals with complex and enduring mental health issues. If other target groups are in mind, for instance those who live with less severe and challenging mental health issues, then the guidelines may appear too rigid with unnecessary infrastructure. This may lead to perceptions of stigma and may also prohibit projects from offering activities due to worry about costs and expertise. This is not the intention. The guidelines are intended to support projects to think through support that should be in place and the expertise that should be involved, and future research and evaluation should focus on the appropriateness of the guidelines and the messaging surrounding the guidelines for different populations

The composition of the panel is a consideration. A number of panel members (who waived anonymity) were drawn from veteran services and organisations. While this is representative of the

majority of heritage interventions currently offered in the UK, it is important to consider how this impacts the context of the guidelines, and may not be relevant to all groups. Veterans come to projects via a number of pathways, including self-referral. Veteran-focused projects will also bring people with a similar background (though not necessarily experience) together, and participants will have a range of mental health issues and/or physical issues. In these contexts, it has been essential to recognise the nature of engagement and potential risks. Despite this, it is logical to assume that the guidelines will be relevant in other contexts given that other sectors were represented by panel members, but it may explain why there was variance in opinion, perhaps between the veteran and non-veteran members of the panel, despite consensus overall. Again, this is an important area of future research.

Another area of work that is required is that of evaluation in the context of heritage interventions. Views in the consultation ranged from collecting bespoke participant feedback to advocating for validated psychological scales. This is a complex issue. Clearly, it is not appropriate for evaluation to be carried out if it is not within the expertise of the project providers. Indeed, the collection of any data, quantitative or qualitative, carries a risk of distress and ethical considerations need to be at the fore, even if the work is considered only service evaluation or audit. However, evaluation remains important in understanding if and how heritage interventions support mental health and wellbeing. Not only does this provide reassurance to potential participants, but evaluation contributes to the growing evidence base. In addition, many projects rely on funding (another theme raised in the introduction), and to demonstrate benefit remains critical. Future research must consider the most appropriate ways heritage interventions could be evaluated In recent years, heritage professionals have increasingly been tackling issues around diversity and inclusion, and barriers to participation. This is largely driven by a desire to widen access to, and engagement with, the historic environment among marginalised groups, particularly recognising the important role of 'place' in identity and community building. However, more research is needed to identify the mechanisms through which heritage can provide an effective vehicle for positive change. Evaluation can help us understand these mechanisms.

Despite limitations and further considerations, supporting and better equipping organisations to provide heritage projects for mental health must be seen as a positive step forward. While developed specifically for heritage for mental health and wellbeing, and specifically for people who experience enduring mental health challenges, these guidelines could be adapted to a wide range of activities that offer active participation as intervention, and for a broader range of target beneficiaries. This is not to say that engagement with heritage is akin to other pursuits, perhaps horse riding, walking, or gardening. While there may be parallels in the literature, many of which

were highlighted by the panellists such as barriers to participation and the importance of group composition allowing for peer support, other concepts must be considered. Engagement with the past to bring understanding to the present is not a new concept psychologically, narrative psychology has a particular focus here, but concepts such as ontological security and existential relatedness have powerful explanatory power for psychological enquiry and have not yet been explored through this lens. Truly interdisciplinary work, in which theory is developed and shared between disciplines is needed to understand how and why engagement in heritage impacts mental health and wellbeing. In doing so, we can better understand what heritage interventions should offer as well as the infrastructure they should have. Clearly, future avenues of research continue to be understanding how and why engagement with heritage interventions impacts mental health and wellbeing. In terms of the guidelines specifically, it is essential that these are reviewed and developed to reflect different populations with different needs and lived experience both in the UK and internationally.

Conclusion

The guidelines were produced through a Delphi consultation and aim to ensure that heritage intervention are offered in the safest way for both potential participants and heritage assets, through authentic and purposeful participation. As such, these guidelines could help organisations make a heritage project more intentional and specific in its wellbeing outcomes; not by replacing any therapeutic interventions provided by qualified professionals, but by creating an environment that facilitates engagement in a learning opportunity and growth experience. These guidelines bring the discussion of heritage interventions into the realm of mental health and wellbeing and raise the profile of heritage as an essential part of our human experience.

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