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Citation: Yoeli, H., Macnaughton, J., McLusky, S. & Robson, M.J. (2020). Arts as Treatment? Innovation and resistance within an emerging movement. *Nordic Journal of Arts, Culture and Health*, 2(2), pp. 91-106. doi: 10.18261/issn.2535-7913-2020-02-02

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Arts as Treatment? Innovation and resistance within an emerging movement

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Abstract

Purpose: For years, the Arts and Health (AaH) movement has been guided by values of art for art's sake, practitioner as Artist and artist as Outsider. These values are instrumental to the effectiveness of AaH as a relational and process-driven tool for individual empowerment, collective health activism and social change. This paper explores how the AaH movement, together with the artists operating as AaH practitioners, has responded to the political and economic and policy transitions of recent years.

Methodology: This paper critically analyses and updates the frequently-cited Diamond model of Smith (2003) and Macnaughton, White and Stacy (2005) exploring how and why, within a UK context of neoliberalism, austerity and evidence-based practice, AaH is being increasingly drawn into the methods and governance of medical and rehabilitative services.

Findings: Whenever AaH in the UK is governed by health services, it becomes reconceptualised as therapy or treatment. It risks relinquishing its artistic and philosophical identity and distinctive effectiveness.

Originality: This paper builds upon the Diamond model to present two new models, the Stalactite and the Helicite. These new models conceptualise the current situation and the potential future fragmentation of the AaH movement, highlighting how AaH might remain faithful to its core values.

Keywords

Arts and health, arts as treatment, participatory arts, artists in health settings, social prescribing

Arts and Health (AaH) and the AaH 'movement'

“Ah, music,” he said, wiping his eyes. “A magic beyond all we do here!” (Rowling, 1997, p. 95)

The arts have always enhanced human wellbeing (All-Party Parliamentary Group on Arts, Health and Wellbeing, 2017). Communities and artists have always collaborated in diverse and ever-changing ways (Daykin, 2019a). The methodological diversity intrinsic to the arts means that the extent to which Arts and Health (AaH) constitutes a cohesive social movement remains a question of nuanced debate (Daykin, 2019b), nevertheless, worldwide AaH activities tend to be guided by broadly similar values (All-Party Parliamentary Group for Arts, Health and Wellbeing (APPGAHW), 2017; All-Party Parliamentary Working Group on Wellbeing Economics (APPWGWE); Clift, 2012; Raw & Mantecón, 2013). The foremost AaH values, we argue, are those of *art for art's sake* (APPGAHW, 2017; Macnaughton et al., 2005), the *practitioner as Artist* (Stickley, Wright & Slade, 2018) and *the artist as Outsider* (Raw & Mantecón, 2013). Foregrounding these values, we seek to update Smith's (2003) frequently-cited Diamond framework (Figure 1), developed within our research centre and published by Macnaughton et al. (2005). Updating this model is necessary, we assert, because the values of AaH are such that the effectiveness of AaH in improving health and wellbeing must be argued in theoretical as well as empirical terms (Daykin, 2019b; Raw, Lewis, Russell & Macnaughton, 2012). We update the Diamond by proposing our Stalactite (Figure 2) and Helictite (Figure 3) models. Our re-engagement with this field after 20 years enables us to bring a refreshed perspective regarding the UK AaH movement. As a mixture of clinical and non-clinical researchers who bring to the medical humanities a range of academic backgrounds and a diversity of artistic interests, we are able to reflect together upon the changing social and political contexts which have precipitated this shift and upon the ongoing theoretical ideas emerging from experts within the AaH field (Daykin, 2019a).

Art for art's sake

Within the philosophy of *art for art's sake*, the arts are inherently beneficial to individuals and to society and cannot in any other way be assigned justification, purpose or economic worth (Macnaughton et al., 2005). *Art for art's sake* is generally attributed to nineteenth and early twentieth century liberalism and bohemianism, reactions against literature and the visual arts being appropriated to propagate religious or political ideology (Poe, 1850). As a philosophical principle, the concept of phenomena holding intrinsic and immeasurable value stretches back to Greek antiquity. Within the rationalist early modern philosophy of Kant (1785), actions are considered ethical and worthwhile only when undertaken according to the categorical imperative, or for their own intrinsic sake. This ethic enters postmodern thinking through strands of positive psychology that emphasise the virtues of self-motivation and serendipitous growth (Csikszentmihalyi, 1998). *Art for art's sake* asserts that AaH is worthwhile and therapeutic simply because it is art (APPGAHW, 2017; Macnaughton et al., 2005).

The concept and value of *art for art's sake* has been criticised for its Eurocentrism, for encouraging elitism and for stifling dissent and protest. Beyond the Western world, the purpose of the arts is often to venerate or to replicate rather than to create or to innovate. Even in the West, globalisation and digital technologies have led to an increasing blurring of the boundaries between art forms, with disciplines such as architecture, fashion and graphics (previously regarded by *art for art's sake* as practical and functional and thereby not proper art) both drawing from and influencing the fine arts, music and literature. In response to allegations of cultural snobbery, AaH initiatives are increasingly looking to these newer and potentially more inclusive art forms such as zines and hip-hop to render its activities more relevant and resonant to people from socioeconomic groups historically excluded from so-called 'high culture' (Olson-McBride & Page, 2012). The *art for art's sake* ethos does not preclude flexibility, responsiveness and learning within AaH.

Marxist, feminist and other emancipatory standpoints argue that artists have a political and moral duty to highlight and to challenge oppression and injustice (Boal, 1979). An insistence upon art being ideologically neutral and apolitical, such a position asserts, risks becoming as censorious and as intellectually dishonest as the artistic movements against which *art for art's sake* dissents (Louis, 2018). This is a critique with which many AaH practitioners themselves concur, especially from within those anti-elitist or emancipatory strands of the AaH movement which aim to improve wellbeing specifically through challenging health inequalities at a political or structural level (Boal, 1979; Daykin, 2019a). Nevertheless, AaH continues to uphold the principle of *art for art's sake* as means of upholding its own creative freedom and in distinguishing itself from mainstream healthcare or therapeutic practice (Macnaughton et al., 2005; Raw & Mantecón, 2013). Generally speaking, AaH tends to regard art as a more important or equally important goal than cure or health improvement or progress.

The practitioner as Artist

In the UK, AaH uses *art for art's sake* to distinguish itself from both the arts psychotherapies and from the ways that art is used therapeutically within occupational therapy and physiotherapy. By regarding *art for art's sake* as a valid and sufficient aim, AaH practitioners identify themselves foremost as artists, distinguishing themselves from healthcare professionals not only by their lack of professional governance, regulation and boundaries but by their lack of explicit clinical goals (Stickley et al. 2018). Beyond the UK, the boundary between arts therapies and AaH is generally more fluid, with the therapeutic and creative aims of AaH less dichotomised from one another (Daykin, 2019a). Across the world, individuals practicing as arts therapists and working within the medically aligned professions do so from a variety of models and standpoints, making use of creativity in a diversity of ways. Both within and beyond the UK, however, one of the centrally defining principles of AaH is that it is facilitated or delivered by artists (Raw & Mantecón, 2013).

This principle of *practitioner as Artist* means that, unlike healthcare aligned therapies, AaH is process rather than outcomes driven (Thiele & Marsden, 2003), with AaH practitioners regarding their participants not as patients but as collaborators and co-producers. The dignity inherent within what we term this *artistic gaze*, arguably juxtaposable to the uni-directional power exerted by Foucault's concept of the *medical gaze* (Foucault, 1963), is central to what renders AaH so empowering. Participants value the gaze of the artist which, unlike that of the therapist, regards them as people with potential – potential to create, to inspire, to develop – rather than a problem to solve (Raw & Mantecón, 2013). The work of artists in healthcare contexts, therefore, aims to produce benefits by virtue of relationships that are creative and mutually instructive, as distinct from the more regulated, bounded and institutionally-led therapeutic relationships that healthcare professionals and patients enter (Jensen, 2019). This, like the philosophical underpinnings of *art for art's sake*, does not readily lend itself to the evaluation methods required by commissioners and funders seeking evidence of AaH effectiveness (Raw & Robson, 2017).

Despite its capacity for mutuality and empowerment, however, the *artistic gaze* nevertheless retains some of the same potential as the medical gaze for power imbalance, control and abuse. AaH practitioners, by virtue of their arts education, hold power over participants that can be misappropriated or misused. This is a risk which AaH seeks to acknowledge and to mitigate through its increasing use of guidelines, ethical frameworks and principles to safeguard vulnerable people as well as to inform AaH practice (Jensen, 2014; Thiele & Marsden, 2003; White, 2009). This paper considers this by addressing all potential facets of the *artistic gaze* that the AaH movement continues to assert its distinctiveness and effectiveness.

The artist as Outsider

Intrinsic to much artistic practice is the concept of creativity, responsiveness, and innovation. Works of art often inherently convey something of the artist's worldview, emotions, and opinions – even when motivated by *art for art's sake* – thereby often conveying social, cultural or political attitudes more than direct forms of communication. In what it communicates, AaH is diverse (Daykin, 2019a, 2019b).

Whether activism-orientated or not, AaH has historically drawn from the *artist as Outsider* tradition (Raw & Mantecón, 2013). AaH practitioners are by definition *Outsiders* to the health services alongside or within which they work because as artists they do not fit within the professional regulations or conventions which impose fixed, pre-defined conventions, expectations or obligations concerning professional behaviour, ethics or culture (Jensen, 2019; Putland, 2008). The *Outsider*-ness of AaH practitioners enables the playfulness and eccentricity of their creativity, and therefore facilitates the distinctive insights and challenge which their work facilitates (Raw & Mantecón, 2013). Daykin (2019a, 2019b) draws from sociological theories around *boundary work* (Matarasso, 2019) to explain how the unregulated *Outsider*-ness of AaH practitioners encourages participants to feel less constrained by the conventions and inhibitions within professional-patient interactions, and to trust and confide in AaH practitioners in ways that they may not with mainstream health practitioners. The *artist as Outsider* heritage and perennial *boundary-spanning* of the AaH movement means that AaH practitioners operate in an ambiguous relationship with mainstream health services, whether or not they engage in explicit activism.

AaH practitioners often find navigating the complexity of this boundary-spanning stressful, as it accompanies the emotional labour of their creativity, and especially as it entices their AaH participants and group members to join with their boundary work (Daykin, 2019b). The status and legitimacy of lay involvement and participation in health has always been complex, with the result that the degree of *Outsider*-ness offered by lay workers in health can rarely be straightforwardly defined (Yoeli, Lonbay, Morey & Pizycki, 2016). Foucault (1963) and others have described the immense yet frequently unacknowledged social privilege and power that the medical model and its discourses and narratives hold. AaH practitioners, like all lay health workers (Yoeli et al., 2016) therefore face pressure, often unconscious or unintentional, to relinquish or to temper their *boundary-spanning*, in deference to the epistemology and culture of health professionals. Working in health contexts also confers ethical requirements on practitioners which are part of the legal registration of most health professionals but not of AaH workers, an issue we will return to in the final section of this paper.

Creativity and change within the AaH movement

The earliest and most widely-cited attempt to create a theoretical framework to position AaH activities in relation to UK services is Smith (2003) and Macnaughton et al.'s (2005) Diamond model (Figure 1):

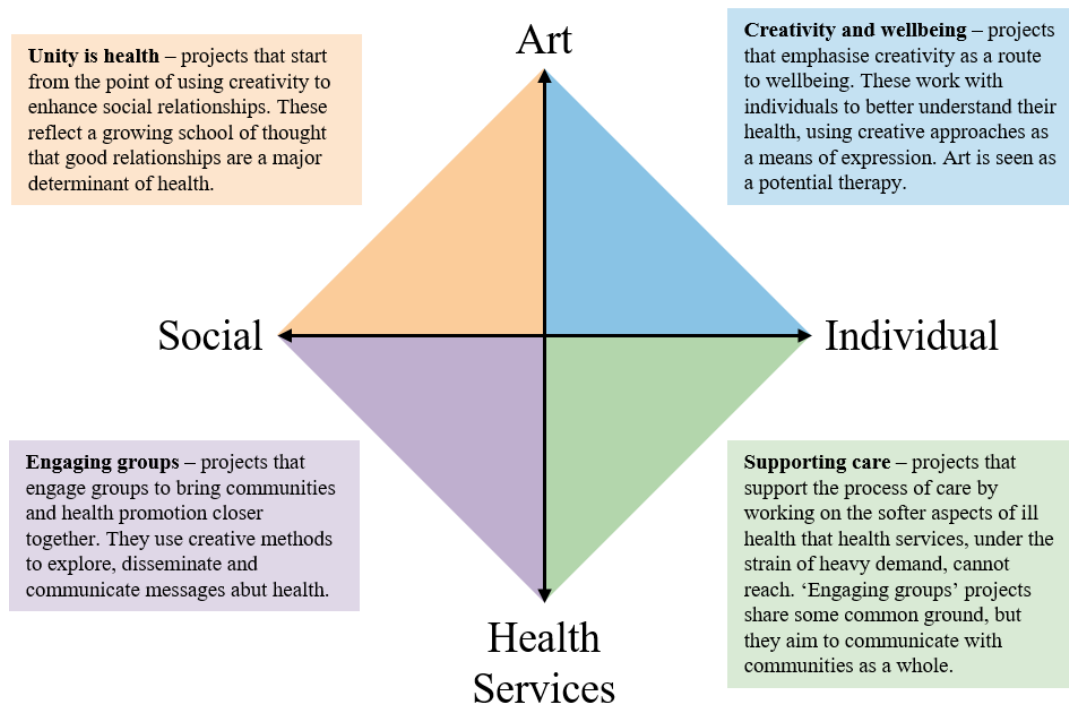


Figure 1 The Arts and Health Diamond Model (Macnaughton et al., 2005; Smith, 2003).

This Diamond model identifies the two main tensions (*art-health* and *social-individual*) shaping the AaH landscape. In recent years, changes to the political, economic and social construction and context of health have meant that AaH has increasingly shifted both away from the *art* world towards greater association with or management by *health services*, and from a community-based or *social* approach towards targeting the *individual*.

From art to health services

In line with its philosophical heritage of *artist as Outsider*, the history of the AaH movement is embedded within socially-engaged creative practices, aiming to improve the artistic representation and multi-faceted wellbeing of communities through their advocacy for social and economic inclusion and justice (Raw & Mantecón, 2013). Until the early 2000s, AaH initiatives operated primarily within the voluntary sector, from community development principles, endeavouring to strengthen and empower vulnerable groups and to address social determinants of health such as poverty, stigma and isolation (Smith, 2003).

In 2007, the Arts Council England and UK Department of Health published their *Prospectus for Arts and Health* in support of AaH principles. In 2014 and 2017, All-party Parliamentary Working Group for Arts, Health and Wellbeing reiterated this policy commitment (APPGAHW, 2017). Nevertheless, this policy support has led to little financial investment, incentivising AaH practitioners to align with or embed within *health services* to safeguard their funding. Over the past 20 years, AaH groups have regarded social prescribing schemes, mechanisms through which primary care practitioners could refer patients to AaH (Bungay & Clift, 2010), as a valuable way of both ensuring their own financial viability and making their artistic practices more widely accessible (South, Higgins, Woodall & White, 2008). Social prescribing has contributed to shifting AaH from the *art* to the *health services* domain (Figure 2).

From social to individual

Historically, AaH has worked with communities, driven by a social model of health and wellbeing as determined by factors beyond the individual (White, 2009). Over the past 20 years, global public health policy has moved towards tackling behaviour change and promoting the self-management of health through the growing personalisation of healthcare (Marmot, Allen, Boyce, Goldblatt & Morrison, 2020). The public health policy shift from *social* to *individual* has been primarily driven by forces of neoliberalism, which regards health improvement as analogous to economic growth (Mooney, 2012), best promoted through privatisation, deregulation, and consumer choice. When appropriated by neoliberalism, AaH would regard the most effective way of improving the wellbeing of communities as to target the specific health needs of each individual citizen. At their inception in the late 1990s and early 2000s, social prescribing schemes sought both to promote cultural capital and community cohesion and to promote the wellbeing of individual patients (Bungay & Clift, 2010). Congruent with wider public health policy developments within the UK's National Health Service (NHS), however, social prescribing is increasingly being reconceptualised as a resource for 'personalised care' for people living with long-term medical conditions (NHS, 2019). To some extent, this development within the ethos of social prescribing has contributed to the *social* to *individual* shift. At the same time, however, the increasingly consumerised ethos of wellbeing and personalised care has led social prescribing to offer a range of group-based and community-focused activities to support the social aspects of wellbeing (South et al., 2008). Personalised care requires the greater collaboration of health and care providers with one another and with AaH and other more complementary, alternative and more informal forms of provision. In so doing, it therefore involves a broadening of models and understandings of health and of traditional understandings of professional hierarchies and boundaries (Daykin, 2019a). The *social* to *individual* transition is therefore multi-faceted, nuanced and complex.

From Diamond to Stalactite

Considering the shifts within the AaH landscape from *art* to *health services* and from the *social* to the *individual*, the Stalactite model (Figure 2) is proposed as an update to the Diamond model:

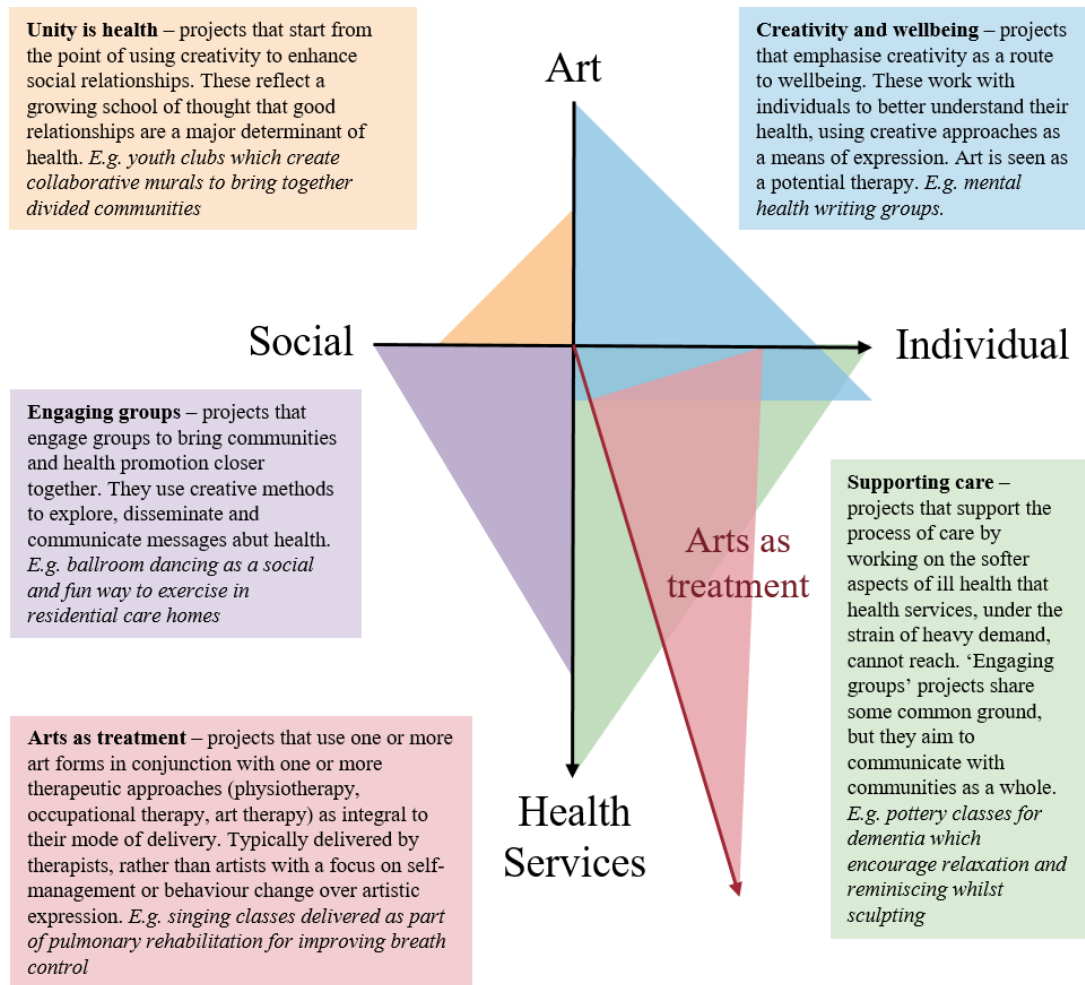


Figure 2 Arts and Health, wellbeing and treatment: the 2020 Stalactite Model.

Overview of the Stalactite model

The shifts from *art* to *health services* and from the *social* to the *individual* underpinning the Stalactite model have most markedly decreased the size of the Diamond’s *Unity is health* (UIH) domain, an area of AaH activity which has always maintained the strongest philosophical commitment to the principles of *art* and to the *social*. The *Engaging groups* (EG) domain remains of equal size, though is different in character (hence its altered shape in the Stalactite), shielded from the detrimental effect of the *social-individual* shift by the growing strength of its alignment to *health services* and by the funding this provides. The *Creativity and wellbeing* (CAW) has grown slightly; subjected to the cross-currents, the shift away from *arts* activities yet towards *individual* forms of AaH practice, it has nevertheless held its position and has sometimes been boosted by those models of social prescribing which support community-level interventions. The *Supporting care* (SC) domain, which had always focused upon *health services* partnership and upon addressing the health needs of the *individual*, has most markedly expanded. This expansion has occurred particularly in the direction of the funding which *health services* provide, hence the shape and orientation of the domain in the Stalactite. The shift from *art* to *health services* has led to increasing col-

laboration between artists and clinicians and thereby to some ambiguous boundaries in the resulting understandings of wellbeing and care or art and therapy. Thus, the Stalactite shows some overlap between the CAW and SC domains. From this intersection, collaboration and ambiguity, the *arts as treatment* (AAT) domain emerges as AaH becomes assimilated within professional practice.

Unity is health

Within the Stalactite model (Figure 2), the *Unity is health* (UIH) domain has receded significantly from the Diamond's (Figure 1). The shrinking of this area has been driven by the recession and austerity of recent years, which has led to decreased government investment in most areas of the arts (APPGAHW, 2017). UIH activities which remain, then, tend to be those more radical groups which hold an ideological or political objection to assimilation or partnership with *health services*. Examples of this include the elements of the anti-psychiatry and Mad Pride movements (Castrodale, 2019) which use music, literature and pop-up theatre as tools of participatory activism to challenge the epistemological and power structures of the medical model in mental health treatment. Although smaller, the UIH domain remains politically active, and arguably more radical than ever.

Engaging groups

Within the Stalactite model (Figure 2), the *Engaging groups* (EG) domain remains constant in size though has changed in nature. A growing alignment and alliance between artists and healthcare practitioners across the world has led, as we subsequently explain, to greater innovation in both clinical practice and research. One of the strongest examples of this is in the area of singing, within which vocal practitioners and clinicians are collaborating to develop choirs to address the specific needs of groups with a range of conditions (Daykin et al., 2018) However, the need to engage with or to defer to the traditionally apolitical and value-neutral governance or culture of *health services* has led some AaH activities to dilute or to temper their political activism or social message (South et al., 2008). A move towards *health services*, then, frequently involves a move away from radical activism, or from the freedom of creative self-expression which *art* traditionally provides.

Creativity and wellbeing and Supporting care

The *Creativity and wellbeing* (CAW) domain has grown slightly, primarily due to the continued growth of social prescribing. Meanwhile, the *Supporting care* (SC) domain has expanded very markedly, due to the previously outlined trends towards *health services* and the *individual*. This expansion has often been effective in making AaH activities more affordable to members of vulnerable communities. As personalised forms of social prescribing have grown, however, they have also become more professionalised. Affiliation of *health services* funded membership organisations, may require individuals to provide risk assessments from a GP or social worker, stipulations which may prove problematic for potential members who are not engaged with mainstream *health services* or whose approaches may challenge traditional risk algorithms. A move towards *health services* may threaten the traditional inclusivity of the AaH movement.

New to the Stalactite model (Figure 2) and emerging from the intersect of its expanded and overlapping CAW and SC domains, is the *arts as treatment* (AAT) domain. The shifts within the AaH landscape from *art* to *health services* and from *social* to *individual* (Figure 1) has increasingly led to AaH activities being operated alongside, within or run by mainstream

medical and rehabilitative services, modelled here as AAT. Condition-specific AAT activities tend particularly to focus upon those LTCs traditionally regarded as progressive and degenerative (Daykin et al., 2018). Within an AAT model of AaH, the aims, ethos and values of AaH become either assimilated within or subordinated to the core values of individual *health services* provision.

Arts as Treatment (AAT)

There are some benefits of AaH transition towards *health services* and towards the *individual*. Whenever AaH is supported by organisations such as the UK National Health Service (NHS) which can provide ongoing support, it becomes affordable to many who could not afford to finance their own participation (White, 2009). Links to social prescribing schemes mean that AaH can be offered by clinicians to individuals who might not otherwise be aware of the existence of AaH or who might not regard the arts as relevant to their lives (Bungay & Clift, 2010). Therefore, AAT has the potential to engage a greater socio-economic and cultural diversity of communities than other forms of AaH. All forms of boundary shift can provide significant learning opportunities both for individuals and organisations (Akkerman & Bakker, 2011), and AAT promotes dialogue and collaboration between artistic practitioners, clinicians and researchers and this often leads to innovative forms of AaH practice, evaluation and service development (White, 2009). By bringing the fields of the arts and healthcare more closely together than other forms of AaH, AAT might potentially be more able than any other form of AaH to engage with the boundary work of reconciling traditional divides between artistic practices and health (Daykin, 2019a; Matarasso, 2019).

However, there are also drawbacks to this shift. AaH organisations may become subsumed into the ethos, culture and governance of the health sector, and in so doing may abandon their defining philosophies of *art for art's sake* and *artist as Outsider*, surrendering their artistic freedom, activism and boundary-spanning – and ultimately risking the loss of their creative integrity, effectiveness and identity. By reducing their commitment to the inherent value of *art for art's sake*, AAT initiatives become drawn into the requirements and mechanisms of evidence-based practice (Reason, 2017). By re-aligning their aims and ethos to assimilate with those of their collaborating or partner organisations in health, AAT initiatives may lose the *Outsider*-ness which informs and facilitates radicalism, activism and the capacity of AaH to challenge the way that *health services* operate (Raw et al., 2012).

Art for evidence's sake... evidence for art's sake

The *art for art's sake* ethos underpinning all AaH activities is difficult to reconcile philosophically with the empiricism that AAT initiatives tend to adopt (Reason, 2017). From an *art for art's sake* perspective, AaH activities reflect the inherent value of engagement in the arts for human wellbeing and flourishing, but *health services* require more objective proof and evidence-based practice (Raw et al., 2012). Within contexts of neoliberalism, austerity and thereby competition for resources, health service commissioners and funders rely primarily upon their evaluations of the empirically formulated evidence bases which each individual AaH project provides. Irrespective of their own personal values, AAT practitioners tend therefore to regard the adoption of empirical methods as a financial necessity (Raw & Robson, 2017; White, 2009).

The AAT surrendering of an *art for art's sake* ethos in favour of evidence-based prac-

tice is problematic for two reasons. Firstly, the philosophical incongruity between *art for art's sake* and empiricism means that evidence bases which AAT initiatives generate tend to appear weak; the empirical methods of evidence-based practice are epistemologically insufficient to capture the health benefits AaH provides (Raw & Robson, 2017; Reason, 2017). Secondly, evidence-based practice advocates that health initiatives build their activities upon those specific aspects or components of their practice that have been evidenced as improving clinically defined aspects of health; AAT risks surrendering the artistic intuition and responsiveness that distinguishes AaH from the arts psychotherapies (White, 2009).

Some models of AAT practice – for example, the Singing for Breathing research group at Imperial College – have succeeded in establishing an evidence base for their work (Lewis et al, 2016). Most, however, have not, and this can be a source of frustration to artists, clinicians and patient advocates for the value of their AAT practice who are anecdotally and intuitively confident of the effectiveness of their work (Raw et al., 2012; White, 2009). Evidence-based research tends to under-represent the benefits of AaH activities. On the one hand, some of the benefits of the arts can be empirically identified; it is possible, for example, to use validated measures of lung function to quantify how techniques taught in singing lessons might improve the outcomes of pulmonary rehabilitation (Lewis et al., 2016). On the other hand, however, empiricism relies upon the observation of outcome measures, and much of the value of the arts rests upon its process: the capacity to influence individuals aesthetically and emotionally, often in ways that fundamentally change lives beyond the arts ‘intervention’ and challenge the capacity of human language to explain. The empirical methodologies of evidence-based practice, then, often struggle to afford credence to the complexity or nuances of the holistic AAT experience. If AAT initiatives are to fully demonstrate their inherent worth and benefit they must find ways to articulate to potential commissioners, funders and the public their intrinsic value as *art for art's sake*. Within the AaH movement, researchers from a range of academic disciplines have long sought to conceptualise and to articulate alternatives to the conventional outcome studies favoured by evidence-based practice (Putland, 2008). Qualitative research using descriptive, narrative or case-study methods is generally considered to offer more rigorous or valid appraisals of the benefits of AaH (Macnaughton et al., 2005; Raw et al., 2012). The effect of a positive artistic gaze is not measurable empirically but can be assessed through methods that can capture the nuance of relational engagement and aesthetic experience, such as ethnographic observation and phenomenological analyses (Raw & Robson, 2017; Reason, 2017). Exploring the benefits of AaH through constructs of social cohesion, social capital or cultural capital is also regarded as providing a rigorous rationale for the role of AaH (Putland, 2008).

The philosophical incongruence of *art for art's sake* with both evidence-based health practice and the health therapies demonstrates the drawbacks of allowing AaH and AAT to be subsumed into the stipulations, expectations and assumptions of the health sector. If AAT is to flourish as a distinctively effective discipline, this paper therefore argues, AAT practitioners – and indeed all AaH activities – must keep their focus foremost upon creating art.

The practitioner as no-longer-Artist

Whenever AAT relinquishes or subordinates the *art for art's sake* ethos in favour of more explicit goals for health improvement, it struggles to argue the necessity of the AaH group leader or facilitator being an artist practitioner rather than a healthcare professional. In the

UK, a number of rehabilitative services which assimilate AAT activities into their therapeutic programme are increasingly encouraging their own staff members to deliver AaH groups in order to avoid sourcing or funding AaH practitioners from elsewhere (Personal correspondence). Through delivering AAT in a setting and context within which their primary identity and role is that of a healthcare professional, however, these staff members (typically nurses, physiotherapists or occupational therapists) will remain bound by the codes and conventions of their practice and practice setting (Jensen, 2019), and so will likely have both ethical and social difficulties in shifting their approach from the clinical to the artistic gaze. As we have suggested, the mutuality, equality and informality with which artistic practitioners and participants relate to and collaborate with one another is axiomatic to the effectiveness of AaH. In order to retain its effectiveness, we therefore argue, AAT and AaH interventions are best led by artistic practitioners rather than by healthcare professionals involved in the treatment or care of participants.

The artist as no-longer-Outsider

Outsider-ness conveys upon artists a level of insight and perspective that is difficult to maintain whilst working within professional systems (Raw & Mantecón, 2013). Once working in close collaboration or partnership with clinicians or *health services*, AAT practitioners and AAT activities may lose their *artist as Outsider* status. The resultant lack of an *Outsider* challenge generally asserted by AAT practitioners can be seen in the previous analysis of how AaH activities so frequently accept the health services demand for them to use evidence-based practice, despite the very concept being anathema to their artistic practice. This reduction in boundary-spanning can also be identified in the prior description of how AAT initiatives and AaH activities have accepted uncritically the *social-individual* shift, even though the foundations of AaH practice are so firmly grounded within social models of health and in addressing the social determinants of health (Putland, 2008). Like its fundamental philosophical challenge to evidence-based practice, the ideological resistance to individualised biomedical models of health is central to the heritage and value-base of the AaH movement (Daykin, 2019a) and also, we suggest, to its effectiveness. Within the current climate of job insecurity caused by neoliberal disinvestment, the recent recession and austerity and Covid-19, *no-longer-Outsider* AAT practitioners can be reluctant to ‘rock the boat’, ‘step out of line’ or to be seen as critical of their employers or funders. As Putland (2008) cautions, AaH that has surrendered the ability to offer an unsettling or subversive social commentary risks losing its creative effectiveness in all aspects of its collective activities. Whereas an AAT approach to AaH may make radical activism difficult, then, AAT nevertheless can – and, we argue, should – challenge *health services* to engage with social models of health.

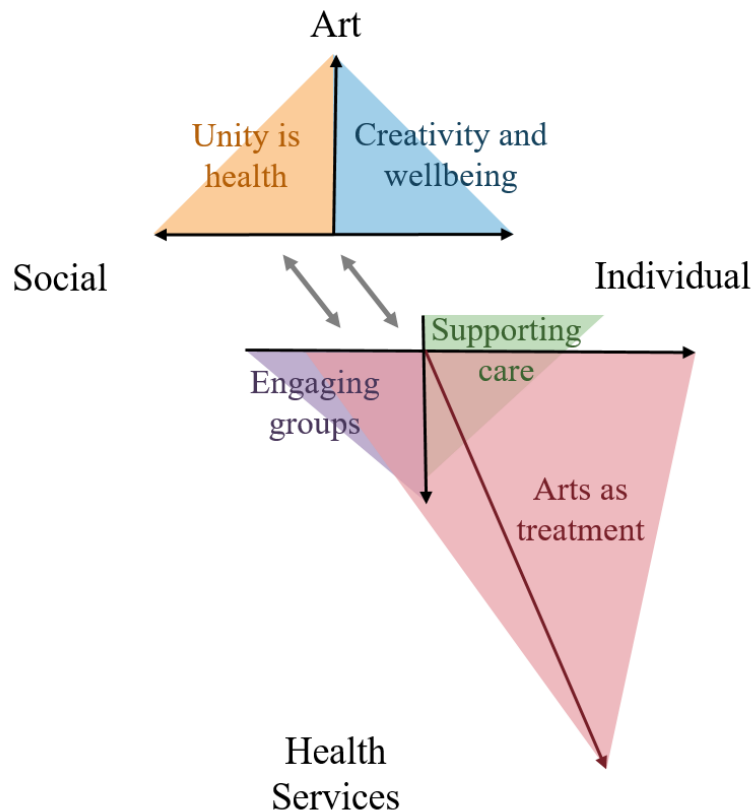


Figure 3 Arts as Treatment and beyond: A possible Helictite model.

If, as is likely in a post Covid-19 world, the context of austerity for artists remains, it is likely that this expanding AAT sector will continue to align itself with a health service-driven model and to relinquish the core values of AaH: those of *art for art's sake*, the *practitioner as Artist* and the *artist as Outsider*. The tentative and speculative model of Figure 3 shows how the broadly unified Stalactite depicted by Figure 2 may then become a Helictite, a Stalactite which disintegrates. In this Helictite model we propose, the AAT domain subsumes the *Engaging Groups* (EG) and *Supporting Care* (SG) domains to become fully embedded within health services, with *art for art's sake* replaced by a set of therapeutic goals and with the artistic gaze of the Outsider artistic practitioner replaced by the medical gaze of the healthcare professional. The *Unity is health* (UIH) and *Creativity and wellbeing* (CAW) domains should remain. Their fragmentation may nevertheless reinvigorate or revitalise these currently struggling domains, challenging them to reassert and perhaps to rediscover the philosophical distinctiveness and social and artistic freedom which impel them to remain independent of the growing AAT movement.

The resurgence of the artist-Outsider AaH practitioner

Despite the challenges we outline, artists are increasingly responding to and engaging with the challenge of retaining their artistic gaze, Outsider-ness and boundary-spanning whilst adapting to the systems and procedures required to work within an AAT framework. This resurgence is taking two main forms. Firstly, AaH practitioners are increasingly drawing upon more formalised consensus-based methodological and ethical frameworks that previous AaH groups have created to inform their work. Secondly, and relatedly, AaH prac-

titioners, together with their partner organisations and academic researchers, have begun to consider mechanisms for understanding, reflecting upon and addressing the challenge through dialogue and relationship-building.

Developing cohesive AaH principles

An earlier endeavour to describe the ethical principles that should inform AaH practice derives from the Australian *Artful Dodgers Studio* (Thiele & Marsden, 2003), a visual arts initiative to engage young people with mental health and substance abuse challenges, arguably part of the Diamond model’s *Engaging Groups* domain (Macnaughton et al., 2005; Smith, 2003). Thiele & Marsden (2003) describe a Pentagon model of core principles (Table 1).

As a means for upholding the distinctiveness of the artistic gaze and Outsider-ness, Robson and White (White, 2009) propose the introduction of more formalised structures of peer support and supervision for AaH practitioners. Such structures, they assert, might be analogous to those required of arts psychotherapists but should be specifically tailored to the challenges raised by the AaH practitioner role, providing a reflective space which empowers AaH practitioners to uphold their distinctiveness.

These concepts of practitioner reflexivity and the importance of reflective practice (Schön, 1987), together with an emphasis upon placing participants at the centre of all creativity are central to their subsequent *Guidelines for Good Practice* produced in conjunction with the Waterford Healing Arts Trust, Irish Health Service Executive and Arts Council Ireland/ An Chomhairle Ealaion (Robson & White, 2010). These guidelines have since been disseminated throughout the AaH sector, with most AaH practitioners in consensus that they should not be afforded the status of regulatory standards (White, 2010). Table 1 compares these guidelines with the ethical principles created by the *Artful Dodgers* studio.

Since 2010, there has been an increased public awareness and consciousness of the potential harm that healthcare interventions and healthcare practitioners can cause, both at individual, organisational and structural level (Jensen, 2019; Marmot et al., 2020). This has led to significant developments in healthcare governance and wider public policy which have increasingly required AaH to articulate more formalised standards of practice (Jensen, 2019). Although the formalisation of AaH practice into a professionally-regulated entity would compromise the very Outsider-ness of its artists, some degree of professionalism may ultimately be required (Jensen, 2014, 2019)

Table 1 A summary comparison of Guidelines for Good Practice with the ethical principles created by the Artful Dodgers studio

The Artful Dodgers Studio Pentagon model of ethical principles for community cultural development practice (from Thiele & Marsden, 2003, pp. 82-93)	The Waterford Healing Arts Trust Guidelines for Good Practice for Participatory Arts practice in Healthcare Contexts (from Robson & White, 2010, pp. 6-11)
Artistic function and outcome	Participants come first
Building connectedness	A responsive approach
Exchange of knowledge	Upholding values
Respect	Feedback and evaluation
Possibility	Good management and governance

Exploring the challenge

In the same way that proponents of AaH guidelines and principles emphasise reflexivity and reflective practice as crucial to maintaining or reasserting a distinctive AaH practitioner identity in AAT, so also do proponents of more discursive and relational approaches. In her research into the difficulties of boundary-spanning in AaH settings akin to AAT, Daykin (2019a) draws upon the four-stage process devised by Akkerman and Bakker (2011) to enable organisations to understand and discuss their boundary work. This process – identification, coordination, reflection and transformation – may be helpful in informing future research.

Conclusion

This paper has advanced a novel Stalactite model (Figure 2) of the AaH landscape, according particular focus to the emerging area of the AAT in the UK. We have outlined the reasons for this shift: the background of austerity driving hard-pressed artists, who are committed to AaH, work to align themselves more effectively with a ‘treatment’ model in order to access increasingly scarce funding resources; and we have suggested the potential negative outcomes: AaH practitioners losing the very value that their unique position as artists within the health care context confers. As our more speculative Helictite model (Figure 3) suggests, this may lead to so-called AAT activities moving fully from a practice of AaH to a discipline within physiotherapy or occupational therapy, to the detriment of their own effectiveness. The requirements of an effective evidence base for these activities are clear, but it is important for researchers in this field to assert the importance of methods that actually investigate the potential value of Arts and Health activities, methods that focus on relationships, the positive gaze of the artist and the inherent value of art itself. We have explored some of the ways in which AaH practitioners might assert this distinctiveness.

Ethical considerations

This research was undertaken as part of the Life of Breath project, funded by the Wellcome Trust [grant number 103339], Institute for Medical Humanities, Durham University and Department of Philosophy, University of Bristol, UK. This study complies with all ethical and governance frameworks of the Department of Anthropology, Durham University.

Statement of interest

The authors declare no conflicts of interest.

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