A Hole in the Heart : confronting the drive for evidence-based impact research in arts and health

Abstract

The field of arts and health, and associated academic discussion, is beset by a number of interlinked challenges which make it vulnerable to academic dismissal or, at best, poor visibility. One of these is a preoccupation with developing an evidence base of impact. This is compounded by resistance to definitions, disagreement over what constitutes appropriate evidence of success, and inadequate consideration of the mechanisms of arts and health practice, as opposed to outcomes. We argue that increased attention should be paid to the description, analysis and theorising of the practice itself as the basis upon which the findings of impact studies can be understood and accepted. A literature review identifies some important emerging themes in community arts and health practice, and some lacunae in need of further investigation. We conclude that an interdisciplinary theoretical framework for the practice could make a valuable contribution to the academic status of the field.

Keywords: arts and health, participatory arts, practice, interdisciplinarity, theoretical frameworks

Introduction

The field of arts and health, and associated academic discussion, is beset by a number of interlocking challenges that make it vulnerable to academic dismissal or, at best, poor visibility. The field is complex – arts and health denotes a sector so broad that even those involved in it perceive it in very different ways (Clift et al., 2009; Putland, 2008; White, 2009). The term 'arts and health' can include artists working in settings as diverse as hospitals, schools, community centres, prisons, the natural environment or urban streets;

and involves approaches ranging from the professionalised arts therapies, or work alongside clinicians, to informal or intuitive styles of practice, using any artform, working towards a vast range of health, aesthetic and social outcomes. Work can be with an individual or with a group, or may not involve participants at all (Badham, 2010; Putland, 2008; Smith, 2003).

Exploring the academic literature on the field, sitting as it does at an interdisciplinary intersection between health, social sciences and arts research, can be a complex process; terminology differs across disciplines, and there is little consensus on a natural conceptual home for the work. Thus the academic visibility and profile of arts and health research remains indistinct, and despite valiant recent attempts to clean up and clarify the picture (Clift et al., 2009; Cox et al., 2010; Sonke, Rollins, Brandman, & Graham-Pole, 2009; Wreford, 2010), definitions and delineations of the field remain a mire. Yet, while the field may be conceptually ill-defined, it seems it continues to produce good work in the real world (Hacking, Secker, Kent, Shenton, & Spandler, 2006; Staricoff, 2004). Its relative invisibility within academic research does not stem from insignificance as an approach to health and wellbeing but rather derives, we argue here, from the lack of a framework that enables it to be clearly conceptualised, and that can form the basis of an academic discussion.

Academics have made constant calls for evidence based research into the impact of the work (Clift et al., 2009; Dileo & Bradt, 2009; Hamilton, Hinks, & Petticrew, 2003; Macnaughton, White, & Stacy, 2005). However, there is disagreement about what constitutes valid evidence (Putland, 2008). Should a health-related practice always be evaluated using a biomedical model that values scientific, quantitative data and experimental research approaches (Dileo & Bradt, 2009; Hamilton et al., 2003; Stuckey & Nobel, 2010), or is a qualitative, social sciences approach the only way to capture or

measure the outcomes of arts and health approaches (Angus, 2002; White, 2009)? This acute dilemma contributes to the sector's vulnerability.

In this article we argue that the drive of some academics for evidence-based impact research in arts and health may be too narrowly focussed, and that the sector may be overlooking a fundamental weakness in the overall debate. Without some redirection of scholarly effort away from evidence gathering and towards analysing and theorising the practice in question, the basis for understanding and accepting the findings of impact studies will remain insubstantial. As long as the mechanisms remain a mystery, any evidence of impacts will fail to contribute to the field gaining the status which advocates desire it to have (Cohen, 2009).

In developing this argument, we draw out several themes which are beginning to emerge from comparative work across the growing number of community arts and health studies, which we suggest are clustering into pivotal elements of a non-professionalised, participatory arts and health practice. Given the potential of theoretical concepts from anthropology, philosophy, psychology, sociology and other disciplines to support the analysis of these common elements, an interdisciplinary approach to understanding the fundamentals of this non-professionalised practice is necessary. We conclude that a conceptual framework can and should be developed which will place community arts and health practice in a clear, theoretically grounded paradigm, one that draws out its distinctiveness. It could be argued that, by failing to address the nature of the practice and its practitioners - those specialists and the approaches at the heart of the matter, the academic appraisal of arts and health is suffering from a hole in the heart.

Dealing with a complex field

'Arts and health' encompasses a range of ways in which artists may contribute to health

care and health promotion. Reflecting this complexity, the terminologies and definitions for 'arts and health' are currently fragmented and disputed, with a plethora of different terms used and defended by different groups, nationally and internationally.

Numerous authors comment on the difficulties in agreeing a definitive terminology for the field. White (2009), writing on arts practice applied in community health settings, identifies five subtly distinct permutations of terminology: 'arts in health', 'arts for health', 'arts into health', 'arts and health', and 'healing arts' which, he notes, have different emphases, refer to subtly different approaches and denote different beliefs about health, ill-health and the place of arts practice in promoting health. Badham (2010), whose perspective straddles the field in Australia and Canada, finds nine variants on terminology, plus additional, more marginal forms, before choosing for her own purposes the term 'socially engaged arts practice'. Some recent authors have declared that resolving this terminological confusion is an urgent survival imperative for the field (Badham, 2010; Clift et al., 2009; Dileo & Bradt, 2009; Putland, 2008; Sonke et al., 2009; White, 2009).

In order to arrive at some clarity, Clift et al. (2009) underline the value of definitions that delineate the distinct strands of arts and health practice, and put forward structural descriptions that communicate and accommodate its complexity. Each of three definition systems cited in their article outlining the field in the UK – Meyrick's five-strand model (Angus, 2002), Dose's four-strand typography (2006), and Smith's 'diamond' model (2001) – includes a community arts strand, as distinct from art therapies, hospitals based interventions, and the medical humanities. Smith's 'arts and health diamond' (Smith, 2001; 2003, p. 3) draws out as key axes distinctions between a health or an arts emphasis, and between an individual or a group focus in the work. Smith then offers a typography differentiating between healthy 'creative expression';

therapeutic arts; art to support and improve healthcare via input with staff or in healthcare environments; arts as communication – 'as a perspective, messenger and research tool'; community arts; and 'social arts' (Smith, 2003). Sonke et al. (2009) unpack seven strands of arts and health programming and practice, comprising several similar elements, active in the US: 'arts and aesthetics in the built environment'; 'bedside arts'; 'performing arts in healthcare'; 'caring for caregivers'; 'community arts for wellness'; 'arts therapies'; and 'the arts and humanities in medical and other health provider education' (Sonke et al., 2009, p. 112). Angus (2002) offers a structural map comprising five sub-fields – 'built environment', 'art in hospitals', 'medical humanities', 'art therapists' and 'community arts'.

All these models are helpful in accommodating the wide range of components of arts and health activity, but have not yet delineated a unified, bounded framework for the practice that can enable it to be understood and recognised by academics from outside the sector.

The lack of an agreed definition or set of defining characteristics is an obstacle to establishing a visible identity for any discipline, but solving the definitions dilemma is not easy for the arts and health sector, since its very make-up repels consensus. The immense breadth and diversity of practice outlined above and the multidisciplinary nature of delivery partnerships are two regularly cited obstacles to workable definitions. Many arts and health initiatives involve diverse partnerships, with agencies working in a terrain beyond the margins of mainstream institutions and conventions (White, 2009), where the tracks can become muddy and the boundaries unclear. Even the interpretations of what constitutes 'health' and 'arts' can differ within partnerships (Murray & Gray, 2008; Putland, 2008).

Reviewing the field – methodological issues

The widely varying terminology, and the way that key concepts are differently understood and categorised across disciplines, make a literature search of the arts and health field a cumbersome process requiring persistence. For this article, despite using multiple synonyms for the key search terms 'arts', 'health', 'practice', 'community', 'artist', 'theory', 'creative', 'mental', 'emotional', 'participation', 'social', 'impacts', 'development', and associated phrases and strings, searches yielded only limited relevant literature from the main databases (Web of Knowledge, JSTOR, FirstSearch, MEDLINE). The search therefore evolved into a process, in which Google Scholar was particularly valuable, of looking in less likely places such as journals on nursing practice or health psychology where, through a single tangentially related article, it was possible to find references to other relevant pieces in peripherally related source locations. An extensive 'grey' literature of project evaluations and other non-academic resources, of variable quality, came to light when searching in this way, some of the more analytical of which we have been able to draw upon in informing this article. Finally, searching electronic thesis repositories using the terms 'arts', 'health', 'practice' and 'theory', only a handful of theses theorising artists' participatory approaches were found. Such challenging search requirements underline the disparate nature of 'arts and health' as an idea or group of associated ideas, and the need for an interdisciplinary conceptual framework sufficient to support its structure and substance as a field of enquiry.

The review process, in addition to emphasising the current disparity of the field, highlighted the problems inherent in contemporary arts and health work: the obsession with developing an evidence base (which we suggest is partly the result of the confusion of clinical and non-clinically based approaches in the field), the social health paradigm (which is much harder to evaluate in clinical terms) and the lack of theoretical analysis of

non-clinical arts and health practice. We shall go on to discuss these three aspects in turn.

Calls for evidence

A range of reviews over the past twenty years have summarised the body of evaluation literature on arts and health initiatives as rarely academically robust, (Angus, 2002; Daykin, 2008; Hacking et al., 2006; Matarasso, 1997; South, 2004; Staricoff, 2004; Stuckey & Nobel, 2010; White & Angus, 2003) and thus weak in the justification and support they can offer a nascent discipline.

The literature shows almost universal calls from authors for higher quality studies investigating impacts from arts and health activity (Argyle & Bolton, 2005; Clift et al., 2009; Daykin, 2008; Dileo & Bradt, 2009; Hamilton et al., 2003; Macnaughton et al., 2005; Sonke et al., 2009; Staricoff, 2004; White, 2009). Over the past five years there has finally been an increase in the amount of academic rigour applied to researching the evidence base (Clift et al., 2009; Cox et al., 2010; Sonke et al., 2009; White, 2009; Wreford, 2010), and the recent literature, galvanised by the emergence of specialist arts and health related journals, shows a sharp increase in academic publishing of case studies, and even quantitative studies of arts and health projects.

However, progress has been hampered by disagreement amongst academics about what constitutes evidence of value. Hamilton, Hinks and Petticrew, Dileo and Bradt, and Stuckey and Nobel see no alternative to providing evidence in as scientific terms as possible, in order to gain attention and regard from the health sector (Dileo & Bradt, 2009; Hamilton et al., 2003; Stuckey & Nobel, 2010). A minority of arts and health practices – for example those involving music, of which there are many studies (Clift et al., 2010b; Cohen, 2009; Harrison et al., 2010; Lowis, 2010; Staricoff, 2004) – have been

investigated using scientific methods. But some academics argue that most arts and health practices – best exemplified by participatory community arts and health – do not fit easily into experimental research models (Broderick, 2011; Clift et al., 2009; Lally, 2009; Macnaughton et al., 2005). Angus (2002) and White (2010) argue that using medical measurement and assessment models is inappropriate, since many initiatives aim at what are more subtle, and certainly different kinds of impacts. Instead they prefer social science, qualitative approaches to studying the field. This methodological argument has the damaging potential to paralyse further progress towards academic understanding and estimation of the sector (Sonke et al., 2009).

There is a danger that, in battling to gain visibility alongside a dominant body of scientific health care research, the unreconciled differences in definitions and delineations within the field have led to the conflation of professionalised, clinically based arts and health practice and non-professionalised, participatory, community based practice. The conceptual foundations of these practices are often very different (Broderick, 2011), and so also are the research methodologies that each require. In the face of these challenges, to offer a stronger platform for the accumulating evidence based impact research, the essential missing step for the field is to focus more attention on understanding the mechanisms of arts and health practice (Cohen, 2009; McCarthy, 2004): there is a need to research and theoretically place the actual processes artists are using, to deliver outcomes and health impacts which researchers are constantly attempting to measure.

Specifying the social

One way of delineating arts and health activity in clinical contexts – where health is understood as medical healing, and activity in non-clinical contexts – for example in community settings, is some authors' specification that the latter form of arts and health

work is underpinned by a social health paradigm. The body of social research on health inequalities (Marmot, 2005; Marmot, 2010; Marmot, Friel, Bell, Houweling, & Taylor, 2008; Marmot, Wilkinson, & Brunner, 2006; Pahl, 1999; Singh-Manoux, Adler, & Marmot, 2003; Wilkinson & Marmot, 2003; Wilson, 1975), though it rarely mentions arts and health strategies to tackle health inequalities itself, is regularly drawn upon in the key arts and health literature (Clift, Camic, & Daykin, 2010a; Matarasso, 1997; Putland, 2008; White, 2009). The social paradigm sees health more broadly, relating to the whole circumstances of people and communities. For example, South defines 'community based arts for health' as practice which:

> involves the active participation of individuals or groups (as opposed to being an audience); is aimed at improving health and well-being in its widest sense….it is not about treatment or therapy; is underpinned by a social model of health, that recognises the wider social, economic and environmental determinants of health (South, 2004).

This definition of community arts and health practice is interesting in its explicit reference to a social rather than biomedical health paradigm. South is making a clear attempt to avoid the blurring of boundaries between the non-professionalised practice which uses a participatory, 'community arts' based approach, and the more visible, familiar, professionalised and apparently tidier arts therapy approaches, which are closer cousins of the biomedical treatment model.

This delineation appears helpful. If non-professionalised, participatory community arts and health practice can be understood as belonging amongst the social sciences and humanities disciplines, rather than amongst the medical health sciences, this may contribute to clarifying the field in three ways: it will advance the process of effectively communicating the nature of this work as ill-charted borderlands, distinct from professionalised, arts therapies approaches; it may help to orientate research

methodologies; and it can contribute towards finding these forms of non-professionalised, participatory practice a meaningful conceptual home.

Participatory, community-based artists are not generally governed by formalised codes, criteria or agreed frameworks (such as those that regulate arts therapists), but rather tend to be guided by their own responsive intuition. This makes their work elusive in terms of conforming to any single definition and leaves it the most unclear to those unfamiliar with it. They reflect what Rapport, Wainwright and Elwyn describe as the methodological 'edgelands' in research:

> These areas appear to be unplanned, uncelebrated, and often incomprehensible to those less familiar with them. This is also, however, a transitional area where most environmental change takes place. (Rapport, Wainwright, & Elwyn, 2005, p. 37).

Similarly, the study of participatory community arts and health approaches as non-formalised, intuitive practice, and analysis of the data for suggestions of common themes, may present a rich opportunity to characterise as a distinct body of practice – and subsequently to conceptualise – the processes at the very heart of arts and health work.

We will now locate and evaluate the extant literature that seeks to develop a conceptual understanding of the community arts and health field through theorising the practice.

Theorising the practice of community arts and health

Current discussions of community-based arts and health work in the academic literature, rather than stretching to complex theoretical analysis, generally focus on descriptions drawn from diverse data sources – interviews, personal journals, focus group discussions, observation, project reflections, to explore the effectiveness of specific art forms in improving health (Argyle & Bolton, 2005; Brinson, 1992; Clift & Hancox, 2010; Clift et al., 2010b; Davidson & Faulkner, 2010; Everitt & Hamilton, 2003; Gould, 2005; Kagan

& Kilroy, 2007; Kagan et al., 2005; Kilroy, Garner, Parkinson, Kagan, & Senior, 2007; Macnaughton et al., 2005; Matarasso, 1997; Rae, 2010; Rafferty, 2010; Sixsmith & Kagan, 2005; Smith, 2001, 2003; Stickley, 2010; White, 2001; White, 2009).

Amongst the non-academic literature there is a rich body of arts advocacy material including numerous project reports, artist forum discussions, and reflective practitioner accounts in which artists seek a deeper understanding of their own or their peers' developing practice. The material stored in the US Community Arts Network archive, the Australian online resource Disseminate, and *Mailout* online magazine and archive in the UK, amongst many others worldwide, have produced insightful commentary and analysis over many years, seeking to better understand and demystify the work of artists in community and health contexts (Krafchek, 2008; Lewis & Doyle, 2008; Ohm, 2008; Yenawine, 2009). However, the frames of reference used in these practice-based discussions remain embedded within the parameters of the arts and culture fields. Without the imperative to apply academic rigour to research and reporting processes (Daykin, 2008), even the more analytical reflections from the field do not provide new, grounded theoretical insight or a strong theoretical underpinning for the discussion.

Some academic literature focussing directly on characterising and theorising the participatory work of artists does exist, and authors in this pursuit regularly call for deeper analysis (McCarthy, 2004). Hampshire and Matthijsse use Bourdieu's version of 'social capital theory' as a lens through which to evaluate and understand the impacts of a singing initiative on its young participants. However their article focuses not on understanding and theorising the practice of the artists involved, but on unpicking the reasons for the mixed and modest project outcomes they find, and looks largely at the contributing contextual factors rather than the artists' approach (Hampshire & Matthijsse,

2010). Similarly, rather than focusing his analysis on the role or practice of arts practitioners, Stickley's theoretical discussion (2008) uses the identity theories of Erikson and Tajfel to frame the mental health benefits to participants of belonging to an arts project.

Although not quite collating a theoretical framework for the practice, Kuppers and Robertson collect together some fascinating writings in their *Community Performance Reader* (Kuppers & Robertson, 2007). This text, by offering a theoretical backdrop to a diverse range of community performance practices, comes closer to theorising community arts and health practice than most others. Through highlighting a value base that unites all their contributors across disciplines, the authors group the diverse range of artistic disciplines centring on community performance as an interdisciplinary field. By drawing on radical cultural thinkers and artist-activists such as Augusto Boal, Paolo Freire, Jan Cohen-Cruz, Dwight Conquergood and Baz Kershaw, they root their perspective clearly in international theories of radical politics of resistance and community empowerment. However, this book does not attempt to find theoretical paradigms that can accommodate all the artists' approaches, and so place the practices they characterise within a unified framework, which can communicate the essence of the work to an audience beyond the participatory arts world.

Brown (2006) compares the practices of art therapists and non-professionalised visual artists working on participatory projects in mental health settings in the UK, using Csikszentmihalyi's concept of 'flow', and Dissanayake's 'making special' in his analysis of the value of art making processes. Hills (2006) makes a related study of the relationship between visual arts and psychotherapy – focussing in this case on post revolutionary Cuba as a research site – and draws on ideas from Bourdieu, Vigotsky and Freire to analyse the drivers for the work in this context. S. Oliver (2009b) looks at a

community dance initiative for young people through the sociological lens of Bourdieu's theory on 'habitus', finding themes highlighting the importance, for participants' sense of well-being, of negotiating and taking control of their own identity – here achieved through dance.

In his exploration of creativity and the use of improvisation in a healthcare setting J. Oliver (2009a) questions interpretations of creativity framed by the narrowing concept of 'innovation' – which he relates to products – seeing instead that in his case study clowns were using the interruption of structure, and opening up moments of improvisation, without events or outcomes governed by the intentions of artists or of policy makers. Through a 'situational' lens he argues that the power of such moments is in 'reading creativity forwards', participants and artists collectively improvising what happens next, which creates a form of 'communitas'. Phelan's (2008) exploratory article searches for recurrent strategies and contextual conditions in projects, rather than recurring themes in processes, to help characterise community music practice, using ritual scholar Bell's (1992) analysis of 'practice theory' as a reference point. Bell argues that when considering a diverse form of practice based on individual practitioner intuition, such broader, contextual perspectives are essential for building a cohesive discipline concept.

Two further, as yet unpublished, pieces show the potential for using concepts from geography, anthropology and psychology to build a theoretical frame. In a discussion paper relating to the nature of the project space created by artists, how it is experienced by participants and functions for the work, Atkinson and Robson have suggested that using strategies to build liminality may be key to the spatial practice of participatory artists (Atkinson & Robson, 2011). Elliott uses Turner's exploration of liminality, focussing on structure and 'anti-structure', marginality and van Gennep's

study of ritual and rites of passage, developing Combs and Krippners' concept of 'platforming', to consider the function of art making and arts based reflection, as facilitating agents of deep change and transformation (Elliott, 2011).

Reflection on the value of interdisciplinarity to understanding non-professionalised arts and health practices

The texts discussed above are threaded with rich veins for further exploration, and we cite them to highlight the potential for a high level, interdisciplinary conceptual discourse on this practice.

However, there a numerous lacunae brought to the fore through a perusal of more descriptive accounts and literature, which assess the effectiveness of the practice rather than theorising it. These begin to cluster thematically, suggesting some hitherto under-theorised elements that may be pivotal to non-professionalised arts and health practice. We outline these here, together with some suggestions for how concepts from various social science and humanities disciplines could form the basis for their theoretical exploration. Key recurring themes and associated theoretical angles include:

- Creating a sanctuary or suspended, protected space, where new things are possible (Gould, 2005; Kilroy et al., 2007; Putland, 2008; Sixsmith & Kagan, 2005; White, 2004). This is a rich vein for further exploration, drawing on spatial concepts from an education theory perspective (Boyce-Tillman, 2009), and anthropological concepts relating to ritual (Turner, 1979).

- The value of modelling and legitimising fun, playfulness, and improvisation (Badham, 2010; Davidson & Faulkner, 2010; Dooris, 2005; Landy, 2010; Low, 2010; Mwalwanda, 2010; Oliver, 2009a; Rae, 2010; Sixsmith & Kagan, 2005). This could be further explored using ideas on the importance of play from the

fields of cultural theory (Huizinga, 1970), psychology (Winnicott, 1971) and theatre (Schechner & Schuman, 1976).

- The common practice of building a specific culture within a project space, based on strong principles (Kilroy et al., 2007). This aspect of the work suggests potential for exploring concepts in the fields of geography and anthropology (Hallam & Ingold, 2007; Ingold, 1996) to theorise how and why the artists develop a distinctive culture through which to carry out their work.

There are additional elements that our own current research into the practice of participatory artists working in health and community settings is revealing, and which have not been emphasised by other scholars. These include:

- Artist facilitators brokering equal status in their interactions with participants - this theme indicates potential for viewing the practice through the lens of sociological concepts exploring conscious and subconscious constructions of social dynamics, power and community, charisma, and for example Durkheim's 'effervescence' (Carlton-Ford, 1992; Durkheim, 1976; Goffman, 1956, 1970).
- The central role of conversation in the work - which may indicate potential for interpretations of the artists' practice using concepts from the anthropology of communication (Douglas, 1999).
- How participants perceive the artists, how artists see themselves, and the impacts of these interpretations on their interactions, and the importance for participants of the 'difference' of the creative practitioners, compared to most other people they interact with in daily life. These themes could be explored by engaging with theories on the anthropology of culture and the role of the outsider (Turner, 1969) and on the philosophy of symbols (Langer, 1957).

These emerging findings demonstrate the potential for a deeper insight into what artists working in community-based projects are up to, and highlight further potential avenues of theoretical exploration. In this way scholars in the field can use a broader, conceptual view from a range of disciplines, to begin theorising what is a complex, interdisciplinary practice.

Conclusion

We have argued that academics have paid little attention to analysing the actual mechanisms by which artists, working in community-based arts and health, facilitate change, and how these can be theorised. We suggest that an interdisciplinary theoretical framework may best serve to accommodate what is a complex practice methodology. We believe that, in efforts to further the development of an academic discussion of the arts and health field, scholars have become distracted, obsessively dressing what amounts to a secondary wound in the debate – the exposed and unsupported evidence base for the practice. Some recently published material highlighted here, and some non-academic reflective accounts of artists' practice, together with some new themes from current research that are beginning to emerge as common to artists' practice in the field, indicate a number of potentially fruitful concepts that might assist in developing a theoretical base for community arts and health practice. These concepts come from leading scholars in a range of social sciences and humanities disciplines. Further work is required to bring these concepts together to develop an interdisciplinary theoretical base, from which a healthy and robust arts and health debate can be established.

References:

Angus, J. (2002). *A review of evaluation in community-based art for health activity in the UK* (No. 1842791184). Durham: Health Development Agency.

Argyle, E., & Bolton, G. (2005). Art in the community for potentially vulnerable mental health groups. *Health Education, 105*(5), 340-354.

Atkinson, S., & Robson, M. (2011). Liminality and transformation in social and emotional wellbeing: arts-based intervention for primary school children. Durham University Centre for Medical Humanities.

Badham, M. (2010). Legitimation: The Case for'Socially Engaged Arts'-Navigating Art History, Cultural Development and Arts Funding Narratives. *Local-Global: Identity, Security, Community, 7*, 84-99.

Bell, C. M. (1992). *Ritual theory, ritual practice*: Oxford University Press, USA.

Boyce-Tillman, J. (2009). The Transformative Qualities of a Liminal Space Created by Musicking. *Philosophy of Music Education Review, 17*(2), 184-202.

Brinson, P., H Champion, M Duffy, F Ellis, L Haye, C Higney, L Dawe Lane, L Moran, S Reid, J Scully, W Van Rees, G Chanan, L Clinton. (1992). *Arts and Communities: The Report of the National Inquiry Into Arts and the Community* (No. 0902406698). London: Community Development Foundation.

Broderick, S. (2011). Arts practices in unreasonable doubt? Reflections on understandings of arts practices in healthcare contexts. *Arts & Health, 3*(2), 95-109.

Brown, L. (2006). *Is art therapy?: art for mental health at the millennium.* Manchester Metropolitan University, Manchester.

Carlton-Ford, S. L. (1992). Charisma, Ritual, Collective Effervescence, and Self-Esteem. *The Sociological Quarterly, 33*(3), 365-387.

Clift, S., Camic, P., & Daykin, N. (2010a). The arts and global health inequities. *Arts & Health, 2*(1), 3-7.

Clift, S., & Hancox, G. (2010). The significance of choral singing for sustaining psychological wellbeing: findings from a survey of choristers in England, Australia and Germany. *Music Performance Research, 3*(1), 79–96.

Clift, S., Hancox, G., Morrison, I., Hess, B., Kreutz, G., & Stewart, D. (2010b). Choral singing and psychological wellbeing: Quantitative and qualitative findings from English choirs in a cross-national survey. *Journal of Applied Arts and Health, 1*(1), 19-34.

Clift, S., M. Camic, P., Chapman, B., Clayton, G., Daykin, N., Eades, G., et al. (2009). The state of arts and health in England. *Arts & Health, 1*(1), 6-35.

Cohen, G. (2009). New theories and research findings on the positive influence of music and art on health with ageing. *Arts & Health, 1*(1), 48-62.

Cox, S. M., Lafrenière, D., Brett-MacLean, P., Collie, K., Cooley, N., Dunbrack, J., et al. (2010). Tipping the iceberg? The state of arts and health in Canada. *Arts & Health, 2*(2), 109-124.

Davidson, J. W., & Faulkner, R. (2010). Meeting in music: The role of singing to harmonise carer and cared for. *Arts & Health, 2*(2), 164-170.

Daykin, N., Orme, J, Evans, D, Salmon, D (2008). The Impact of Participation in Performing Arts on Adolescent Health and Behaviour : A Systematic Review of the Literature. *Journal of health psychology, 13*(2), 251-264.

Dileo, C., & Bradt, J. (2009). On creating the discipline, profession, and evidence in the field of arts and healthcare. *Arts & Health, 1*(2), 168-182.

Dooris, M. (2005). A qualitative review of Walsall Arts into Health Partnership. *Health Education, 105*(5), 355-373.

Dose, L. (2006). National Network for the Arts in Health: lessons learned from six years of work. *The Journal of the Royal Society for the Promotion of Health, 126*(3), 110-112.

Douglas, M. (1999). *Implicit meanings: selected essays in anthropology*. New York: Psychology Press.

Durkheim, E. (1976). *The elementary forms of the religious life*. London: Routledge.

Elliott, B. (2011). Art-Based and Narrative Inquiry in Liminal Experience Reveal Platforming as Basic Social Psychological Process. *The Arts in Psychotherapy, 38*(2), 96-103.

Everitt, A., & Hamilton, R. (2003). *Arts, health and community: A study of five arts in community health projects.* Durham: Centre for Arts and Humanities in Health and Medicine, Durham University.

Goffman, E. (1956). *The presentation of self in everyday life*. Edinburgh: University of Edinburgh.

Goffman, E. (1970). *Strategic interaction*. Oxford: Blackwell.

Gould, H. G. (2005). *A Sense of Belonging: Arts and Culture in the Integration of Refugees and Asylum Seekers*: Creative Exchange.

Hacking, S., Secker, J., Kent, L., Shenton, J., & Spandler, H. (2006). Mental health and arts participation: the state of the art in England. *The Journal of the Royal Society for the Promotion of Health, 126*(3), 121-127.

Hallam, E., & Ingold, T. (2007). *Creativity and cultural improvisation*. Oxford: Berg.

Hamilton, C., Hinks, S., & Petticrew, M. (2003). Arts for health: still searching for the Holy Grail. *Journal of epidemiology and community health, 57*(6), 401-402.

Hampshire, K. R., & Matthijsse, M. (2010). Can arts projects improve young people's wellbeing? A social capital approach. *Social science & medicine, 71*, 708-716.

Harrison, S., Cooke, M., Moyle, W., Shum, D., Murfield, J., Camic, P., et al. (2010). Development of a music intervention protocol and its effect on participant engagement: Experiences from a randomised controlled trial with older people with dementia. *Arts & Health, 2*(2), 125-139.

Hills, M. (2006). *An inquiry into the relationship between the visual arts and psychotherapy in post revolutionary Cuba.* Queen Mary University College, London.

Huizinga, J. (1970). *Homo Ludens: A study of the play element in culture*: J. & J. Harper Editions.

Ingold, T. (1996). *Key debates in anthropology*. London: Routledge.

Kagan, C., & Kilroy, A. (2007). Psychology in the community. In J. T. Haworth & G. Hart (Eds.), *Well-being : Individual, Community and Social Perspectives* London: Palgrave Macmillan.

Kagan, C., Sixsmith, J., Siddiquee, A., Bol, S., Lawthom, R., & Kilroy, A. (2005). *Community psychology and participatory arts: well-being and creativity*. Paper presented at the HOMINIS International Conference, Havana Cuba.

Kilroy, A., Garner, C., Parkinson, C., Kagan, C., & Senior, P. (2007). Towards transformation: exploring the impact of culture, creativity and the arts of health and wellbeing. *Arts for Health, Manchester Metropolitan University*.

Krafchek, K. (2008). A New Day in the Academy [Electronic Version]. *Community Arts Network Reading Room*. Retrieved 11/07/2011 from http://www.communityarts.net/readingroom/archivefiles/2008/06/a_new_day_in_th.php.

Kuppers, P., & Robertson, G. (2007). *The community performance reader*. London: Routledge.

Lally, E. (2009). 'The power to heal us with a smile and a song': Senior Well-being, Music-based Participatory Arts and the Value of Qualitative Evidence. *Journal of Arts & Communities, 1*(1), 25-44.

Landy, R. J. (2010). Drama as a means of preventing post-traumatic stress following trauma within a community. *Journal of Applied Arts and Health, 1*(1), 7-18.

Langer, S. K. K. (1957). *Philosophy in a new key: A study in the symbolism of reason, rite, and art*: Harvard Univ Pr.

Lewis, A., & Doyle, D. (2008). *Proving the Practice: evidencing the effects of community arts programs on mental health*. Freemantle, WA: DADAA Inc

Low, K. (2010). Creating a space for the individual: Different theatre and performance-based approaches to sexual health communication in South Africa. *Journal of Applied Arts and Health, 1*(1), 111-126.

Lowis, M. J. (2010). Emotional responses to music listening: A review of some previous research and an original, five-phase study. *Journal of Applied Arts and Health, 1*(1), 81-92.

Macnaughton, J., White, M., & Stacy, R. (2005). Researching the benefits of arts in health. *Health Education, 105*(5), 332-339.

Marmot, M. (2005). Social determinants of health inequalities. *The Lancet, 365*(9464), 1099-1104.

Marmot, M. (2010). *Fair society, healthy lives: the Marmot review; strategic review of health inequalities in England post-2010*. London: The Marmot Review.

Marmot, M., Friel, S., Bell, R., Houweling, T. A. J., & Taylor, S. (2008). Closing the gap in a generation: health equity through action on the social determinants of health. *The Lancet, 372*(9650), 1661-1669.

Marmot, M., Wilkinson, R. G., & Brunner, E. (2006). *Social determinants of health*: Oxford University Press Oxford.

Matarasso, F. (1997). *Use or ornament? : the social impact of participation in the arts*. Stroud: Comedia.

McCarthy, K. F. (2004). *Gifts of the muse: Reframing the debate about the benefits of the arts*: Rand Corporation.

Murray, M., & Gray, R. (2008). Health psychology and the arts: A conversation. *Journal of health psychology, 13*(2), 147-153.

Mwalwanda, B. N. (2010). Towards the use of drama as a therapeutic tool to enhance emotional rehabilitation for people living with HIV/Aids: a case study of Paradiso HIV/Aids support organisation.

Ohm, M. (2008). Best Practices or Principles of Practice? Reflecting upon Language and Roles [Electronic Version]. *Community Arts Network Reading Room.* Retrieved 12/07/2011 from http://www.communityarts.net/readingroom/archivefiles/2008/07/best_practices.php.

Oliver, J. (2009a). Creativity as Openness: Improvising Health and Care 'Situations'. *Health Care Analysis, 17*(4), 318-330.

Oliver, S. (2009b). *Community-based creative dance for adolescents and their feelings of social wellbeing.* Queen Margaret University, Edinburgh.

Pahl, R. (1999). *Social trends: The social context of healthy living*. London: Nuffield Trust, & Judge Institute of Management Studies, Cambridge University.

Phelan, H. (2008). Practice, ritual and community music: doing as identity. *International Journal of Community Music, 1*(2), 143-158.

Putland, C. (2008). Lost in Translation. *Journal of health psychology, 13*(2), 265-276.

Rae, K. (2010). Wearing someone else's shoes. *Medical Humanities, 36*(1), 40-42.

Rafferty, Z. (2010). *"Everybody Can Dance the Colour Pink": A Phenomenological Exploration of the Meanings and Experiences of Inclusive Arts Programs for Practitioners.* Unpublished MA, University of Waterloo, Ontario, Canada.

Rapport, F., Wainwright, P., & Elwyn, G. (2005). "Of the edgelands": broadening the scope of qualitative methodology. *Medical Humanities, 31*(1), 37-42.

Schechner, R., & Schuman, M. (1976). *Ritual, play, and performance: readings in the social sciences/theatre*: Seabury Press.

Singh-Manoux, A., Adler, N. E., & Marmot, M. (2003). Subjective social status: its determinants and its association with measures of ill-health in the Whitehall II study. *Social science & medicine, 56*(6), 1321-1333.

Sixsmith, J., & Kagan, C. (2005). *Pathways project evaluation: final report* (No. 1900139375). Manchester: RIHSC, Manchester Metropolitan University.

Smith, T. (2001). *Common knowledge: the Tyne and Wear Health Action Zone's arts and health project, interim evaluation report.* Durham: Centre for Arts and Humanities in Health and Medicine, Durham University

Smith, T. (2003). *An Evaluation of Sorts: Learning from Common Knowledge*. Durham: Centre for Arts and Humanities in Health and Medicine, Durham University, & Nuffield Trust. .

Sonke, J., Rollins, J., Brandman, R., & Graham-Pole, J. (2009). The state of the arts in healthcare in the United States. *Arts & Health, 1*(2), 107-135.

South, J. (2004). Community-based arts for health: A literature review. Leeds: Centre for Health Promotion Research, Leeds Metropolitan University.

Staricoff, R. L. (2004). *Arts in health: a review of the medical literature. Research Report 36*. London: Arts Council England.

Stickley, T. (2008). *Promoting mental health through an inner city community arts programme: a narrative inquiry.* Nottingham University, Nottingham.

Stickley, T. (2010). The arts, identity and belonging: A longitudinal study. *Arts & Health, 2*(1), 23-32.

Stuckey, H. L., & Nobel, J. (2010). The connection between art, healing, and public health: a review of current literature. *American journal of public health, 100*(2), 254-263.

Turner, V. (1969). *The ritual process : structure and anti-structure*. London: Routledge & Paul.

Turner, V. (1979). Frame, flow and reflection: Ritual and drama as public liminality. *Japanese Journal of Religious Studies, 6*(4), 465-499.

White, M. (2001). *Determined to Dialogue: A Survey of Arts in Health in the Northern and Yorkshire Region*. Durham: : Centre for Arts and Humanities in Health and Medicine, Durham University.

White, M. (2004). Arts in mental health for social inclusion: towards a framework for programme evaluation. In *For Art's Sake* (pp. 75-99). London: Athena Press

White, M. (2009). *Arts Development in Community Health: A Social Tonic*. Abingdon, Oxon: Radcliffe

White, M. (2010). Developing Guidelines for Good Practice in Participatory Arts-in-healthcare Contexts. *Journal of Applied Arts and Health, 1*(2), 139-155.

White, M., & Angus, J. (2003). *Arts and adult mental health literature review*. Durham: Centre for Arts and Humanities in Health and Medicine, Durham University.

Wilkinson, R. G., & Marmot, M. (2003). *Social determinants of health: the solid facts*: World Health Organization.

Wilson, M. (1975). Health Is For People. London: Darton: Longman & Todd Ltd.

Winnicott, D. W. (1971). *Playing and reality*. London: Tavistock Publications.

Wreford, G. (2010). The state of arts and health in Australia. *Arts & Health, 2*(1), 8-22.

Yenawine, R. (2009). The art of discussion : defining community art methodology, *Community Arts Network Reading Room.*