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Arts and Health: A New Paradigm

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ABSTRACT

This position paper presents a new paradigm about the intrinsic structure and nature of arts and health practice. This paradigm is based on a variety of research experiences over twenty years working as a music therapist, musician, music and health practitioner, researcher and director of an arts and health programme in university teaching hospitals, community contexts, and non-governmental organizations in Ireland and the UK.

The aim of this paper is to propose a new perspective on the term arts and health, to encompass all arts related activity that exists in contexts related to health. This paradigm aims to counter the artificial and defensive barriers constructed between practitioners and professional groups within the field, encourage greater respect and understanding between practitioners and assist in identifying training and development needs for the various arts professionals working in contexts related to health and well-being. It is proposed that the current commonly held assumptions surrounding definitions of arts and health and arts therapies are unhelpful and problematic and should be refined.

Keywords: Arts therapies, arts and health, healthcare, theoretical paradigm

Introduction

This paper presents a new paradigm to redefine the term arts and health^[1]. It is proposed that the current, commonly held assumptions surrounding definitions of arts and health and arts therapies are unhelpful and problematic and should be refined. Arts and health as a term has been adopted largely by the participatory arts community, and it is believed that this definition falls short of the large umbrella of art activities and engagements within health care that should be defined as arts and health.

This paradigm was developed in 2015 following four research activities:

1. Narrative literature review 2010–2014 for a PhD on the role of the arts for older patients in hospital; (Moss et al., 2012)

2. Research to identify training needed for artists working in healthcare settings conducted in 2008–2009 and delivery of a university post graduate pilot course for artists working in healthcare settings from 2010–2013; (Moss & O’Neill, 2009)
3. Twenty years work experience as a music therapist, music and health practitioner, musician and manager of and arts and health programme across UK and Irish health services
4. Workshops and seminars with artists working in healthcare settings, arts therapists and clinical staff from 2011–2015.

Throughout all these activities there was an awareness for this researcher, of unhelpful splits between the various arts practitioners working within the arena of healthcare settings as well as competition for funding amongst some arts practitioners and some funding bodies refusing funds to some types of arts interventions within healthcare settings. Also, rigidity was experienced within some arts practitioners about what constitutes valid arts activity within healthcare settings.

This paradigm aims to address some of these issues and provide some clarity within the field of arts practice that is concerned with health and well-being to benefit both service users and professionals within the health service. The ultimate aim is for arts practitioners working within the health arena, whatever their stance, to be better able to support each other and understand the range of the arts and health professions. Previous papers have addressed each of the various research activities above in more detail (Moss et al., 2012; Moss & O’Neill, 2009). Hence the aim in this paper is to summate the findings of these research activities into a description of a new paradigm to add clarity to the field of arts and health.

This paper is set out with the following sections:

- Background: Current definitions; examples of current practice and the need to re-frame the debate;
- Research that led to development of a new paradigm includes a narrative literature review; research into the training needs of artists working in healthcare settings; work experience as a music therapist, music and health practitioner, musician and manager; workshops and seminars with artists, arts therapists and clinical staff from 2011–2015 and a study of existing paradigms for Arts and health
- A new paradigm for Arts and health
- Conclusion

Background

Current definitions

The definition of arts used for this position paper is the art forms listed by The Arts Council of Ireland. These are architecture, circus, dance, film, literature, music, opera, street arts and spectacle, theatre, traditional arts, and visual arts (The Arts Council, 2006).

The definition for health is taken from the commonly used World Health Organisation definition of health whereby health is a complete state of physical, mental, and social

wellbeing, not merely the absence of disease or infirmity (World Health Organisation, 1946).

Arts and Health is a term with myriad definitions within the healthcare sector. Arts Council England define Arts and health as arts based activities that aim to improve individual and community health and healthcare delivery and which enhance the environment by providing artwork or performances (The Arts Council England, 2007). The field of arts in healthcare currently contains a wide range of practices including medical humanities, design aspects of healthcare, arts in hospice/end of life care, arts therapies, community arts, and arts and aging (Brener, 2003). However, in practice there are two strong groups of Arts and health practitioners. The Arts Council of Ireland summarises these distinct positions very clearly:

There is a clear distinction between arts and health practice, where a clear goal is the experience and production of art, and the arts therapies, where the primary goal is clinical. (The Arts Council, 2010)

Two examples of the current issues in the field are given to illustrate the need for a new paradigm.

1. **Is it Music Therapy or Music and Health?** A professional musician visits children in hospital in a large acute teaching hospital. Every week she specialises in singing to sick infants, engaging the children and their parents or guardians in music making. The aim of the session is to soothe children in hospital, make their hospital stay a more positive experience, offer positive distraction from pain, and to encourage the parents/guardians to sing with their babies. Are these clinical or musical aims? Or perhaps educational aims? Is this best provided by a music therapist, a music and health practitioner or a professional performing musician? What training is needed to provide this session effectively?
2. **Should this art project be facilitated by an artist or an art therapist?** A visual artist works with a group of women, identified by staff at a maternity hospital, who have lost infants in the last 5 years. The women create artwork to remember and process their loss. A nurse who is a bereavement counsellor co-facilitates the group to support women who experience strong emotion during the art project. The result of the 12-week programme is an art exhibition where artwork by the visual artist and the clients in the group, is displayed. The exhibition tours the country to wide acclaim. Is this a visual art project or art therapy? The intention of the group is to produce artwork but can we contend that due to the vulnerability of the women and the strong emotional content this group would be more appropriately facilitated by an art therapist?

This researcher has worked, for 20 years, as both arts and health manager and an arts therapist. The current state of play for arts and health practice is, in the UK and Ireland, a separation of arts therapists and arts and health practitioners. Issues this researcher has experienced include the following:

1. Arts therapists are not viewed as artists by some arts and health practitioners, as they are working as therapists
2. Some arts therapists view all work by artists in healthcare settings as suspicious, dangerous and inappropriate, without understanding their expertise and aims

3. Arts and health funding is open only to participatory or collaborative arts in healthcare
4. Arts and health websites and blogs welcome contributions from arts and design, medical humanities and arts performance related activity but not arts therapies activities (for example, www.artsandhealth.ie)
5. The health service employ arts therapists on salary scales, but artists often apply for one off funding or bursaries.

In the USA, Canada, and Australia there is more evidence of shared associations and closer working between arts therapists and artists (for example, the recently ceased organization Society for the Arts in Healthcare in USA regularly featured work on its website and at conferences by arts therapists as well as arts practitioners). However, the distinction between arts and health practice and arts therapies is not the only separation within the field. Medical or health humanities is also a separate field of academic enquiry. For example, the Trinity College Dublin group defines their work as being:

To cultivate a richer understanding of the interactions and synergies between practices and discourses of wellness, health or medicine and the arts, humanities or culture through interdisciplinary research and education.
(Trinity College Dublin, 2016)

Here, the arts are named in a broad, undefined sense. It is interesting to note that this health humanities group do not involve themselves in notions of arts therapies or arts and health; rather the group is concerned with arts as a broad topic and its relation to discourses of health, medicine, and wellness.

In another arena of artistic life, many cultural institutions such as orchestras, art galleries, and cinemas, offer a range of health related outreach programmes, or example orchestras in residence in hospitals and dementia friendly film viewings. These are less focused on participatory arts and may have a more receptive element. Finally, everyday aesthetic experiences (such as listening to music on the radio or watching films) have an important place in healthcare settings and are often overlooked by arts and health enthusiasts who place predominant focus on participative arts in both literature and in the field.

Kira Tozer (2016) of the Arts Health Network Canada gave a compelling definition of arts and health:

Arts & Health is an umbrella term that includes [these] pursuits: bringing visual arts, music, performances and art-making opportunities into health care environments; the creative arts therapies like music therapy, dance therapy, art therapy; community arts projects that address health or social problems faced by a group of people; arts-based health research; arts-based health communication; using the arts in the education of health care professionals, etc.

The arts and health can intersect in many different ways, with different aims and outcomes. The arts can help us to understand, communicate and cope with various experiences of human illness – be it our own or a loved one's, a patient's or a provider's. The arts help to reconnect us with the human element of health and health care.

While this definition encapsulates arts and health beautifully, in practice this is not always the reality. Professional groupings understand the relationship between arts and health in different ways and the field is currently diverse, with no comprehensive view of arts and health on which all parties agree. It is arguable, therefore, that there is a need to consider an alternative paradigm to address this diversity.

Research That Led to Development of this Paradigm

In response to these apparent issues within the field, this researcher undertook five activities to develop a new paradigm. These are presented very briefly here.

Narrative Literature Review 2010–2014

An extensive review of literature was undertaken from 2010–2014 to explore the specific role of aesthetics in the healthcare environment and in particular in hospitals. Major medical, health sciences, and arts based databases were searched as well as grey literature, specifically relevant journals and websites of relevant international research and policy groups on arts and health (Moss et al., 2012).

While arts have been integral to all cultures, it is a relatively recent research phenomenon to explore and examine the association between arts, health, and well-being (Johnson & Stanley, 2007). Activities within the arts and health term range from receptive involvement (such as reading, listening to music) to active participation (such as performance, painting, and dancing). The purpose of aesthetic activities in healthcare varies widely, from environmental enhancement to contributing to clinical interventions to health promotion and staff education. There is increasing acceptance in current times that health, wellbeing, and quality of life are reliant upon interconnections between physical, psychological, and social functioning (Thomson, Ander, Menon, Lanceley, & Chatterjee, 2012).

The field of arts in healthcare embraces a wide range of practices including medical humanities, design aspects of healthcare, arts in hospice/end of life care, arts therapies, community arts and arts and aging (Brenner, 2003). The field of arts in healthcare intersects with a number of disciplines including medicine, architecture, arts therapies, and medical education (Dileo & Bradt, 2009). For example, the growth of medical and health humanities academic groupings are exploring the role of the arts and humanities in medical education and narrative medicine. Healthcare design increasingly engages with the arts in terms of interior design, way-finding, and quality of patient care. Dementia-friendly and hospice-friendly hospitals design initiatives, for example, integrate the arts as part of making hospitals less intimidating, more welcoming, and a more positive experience for patients and families.

The *arts* of arts practices also cover a very wide range of forms including visual arts, performing arts, technology, creative writing, horticulture, video arts, and film. Arts in healthcare can also be defined by the healthcare contexts in which it takes place, again very diverse, from community health to educational settings to hospitals to drug rehabilitation centres to care homes. Participants of arts and health programmes are also varied, from patients to carers to medical students and healthcare staff and there

is no one designation or recognised qualification for arts practitioners in healthcare (Dileo & Bradt, 2009; Moss & O'Neill, 2009).

As far as arts and health practice is concerned, the predominant art forms in the literature are music (by far the most researched art form), visual art, drama, and dance with some research relating to digital art, literature and other art forms. The predominant areas where the arts are reported, qualitatively, to have benefits for clients' wellbeing, are mental health, older adults, and paediatrics. The role of community arts and cultural consumption (for example, attending galleries and concerts as part of health and well-being) has also received some attention in the literature. It is notable that arts and health literature is predominantly focussed on the participative arts (for example, engaging in arts activities such as painting or singing in a choir while in hospital or attending a health centre) as opposed to receptive arts (for example, listening to music, reading a book, watching a film).

Training Needs of Artists Working in Healthcare Settings

A consortium involving a university teaching hospital, a school of art and design, and a national development agency for collaborative arts was commissioned by the Arts Council of Ireland to research, develop and implement a course that would be mutually beneficial for both artists and healthcare organisations. The course arose from a demand from artists working in the field for relevant training, other than arts therapies training, which was all that was available in Ireland for artists interested in the health arena. Prior to this commission, a series of workshops and networking events were held where arts and health practice was discussed and debated. This author conducted a separate literature review specifically reviewing training courses for artists and potential content, as well as conducting an extensive consultation process with stakeholders. While professional training in the arts therapies (art, music, drama, and dance therapy) is well established in a number of countries, a large number of artists (of all art forms) find themselves working in healthcare settings outside of the model of arts therapies (for example, artists in residence, performers, writers in residence, and designers). Although a need for appropriate training has been identified by artists in the field in the UK and Ireland (Arts Council, 2006; Arts Council 2010), the healthcare literature offers little guidance on the content or delivery of such training[2]. The result of the literature review and consultation was a clear wish for training to equip artists for the specialised arena of healthcare settings, without this necessarily being an arts therapies course. A pilot course was designed and delivered by the consortium. It is interesting to note that some modules of the course overlapped with training of arts therapists, for example reflective practice, group work, facilitation skills, and professional behaviour[3].

This research confirmed the gap in the arts sector with regard to training artists to work in healthcare settings. For this researcher, the importance of understanding and catering for a wide range of arts practitioners within healthcare was highlighted. The process of delivering the course illuminated the lack of recognition of artists working in healthcare and the lack of training available to them as compared to the rigorous demands of the arts therapies training. This experience built towards this new paradigm of arts and health, in that it highlighted the many ways in which arts are utilised in healthcare and the lack of training and standards for the diverse practitioners in the sector. This leaves a vulnerability within the sector regarding the issue of training and standards of practice. There is a need for the health sector to formalise a currently ad hoc approach to employing artists in healthcare settings and

to ensure that all arts practitioners are trained and sensitive to the vulnerability of patients and clients of health services.

Work Experience as a Music Therapist, Music and Health Practitioner, Musician and Director of Arts and Health Programmes Across UK and Irish Health Services

In addition to the literature reviews, research processes and course design described above, the work experience of this researcher concurs with the above findings and this adds weight to the argument for this new paradigm. The researcher reflected on her work experience over 20 years working in health settings in the following clinical services: paediatric hospital (general); adult and adolescent mental health; forensic mental health; adult acute hospital (specifically oncology, cardiac rehabilitation, nephrology, and neurology services); older age (including stroke, dementia, and Parkinson's disease); children with intellectual disabilities, and palliative care services. Throughout her career the researcher has received professional and clinical support, mentoring, and supervision. In particular, the experience of service users has been taken into account in this part of the reflection. The researcher has conducted many service user evaluations, workshops, therapy sessions and other activities across the arts, health and well-being spectrum, and in all cases has gathered feedback and evaluation as to the effectiveness of the arts programmes offered. This position paper is a result of reflecting over many years on arts and health practice, arts therapies, artists residencies, community arts and health humanities and the need to reframe the debate arises directly from work experience in the field.[\[4\]](#)

The overarching issues this writer encountered were professional insecurities, a lack of clear definition of roles and boundaries and a competition for funding between different arts practitioners in the field. Overall, the impression of this author, after years in the field, was that the service user's arts preferences and needs were being neglected, due to arts practitioners focus on their own practice needs and recognition of their identity within the diverse field. As a clinical supervisor this researcher spent many hours with music therapists defining and re-defining how they see their role and remit in their particular clinical settings, whilst simultaneously engaging with funding bodies in her work as an arts and health manager where only participatory or collaborative arts projects were eligible for arts and health funding. Similarly, this researcher engaged in professional activities in medical humanities, arts and health and arts therapies groupings and found overlaps throughout, for example in the areas of singing and health or museum education programmes and curatorship.

This leads to this researcher's conclusion that no particular approach is more effective than another, but that all offer specific benefits to service users at particular times in their journey towards improved health and well-being. For example, in this researcher's professional role as arts and health manager at a major hospital she programmed performing musicians to play in the hospital atrium, provided community musicians to carry out music making workshops for children in emergency departments while they wait for stressful treatment, and employed a music therapist to provide a choir for people with dementia. She also delivered individual music therapy for patients recovering from stroke and provided a volunteer-led music listening service (CDs and listening devices) to patients in an older adults ward. It is not possible to grade these arts activities in order of importance. All are based on

sensitive consideration of the appropriate and necessary service for different clients groups based on their needs at different times.

Workshops and Seminars with Artists Working in Healthcare Settings, Arts Therapists, and Clinical Staff From 2011– 2015 to Develop the Paradigm

From 2011–2015 the researcher was involved in and responsible for delivering 3–5 professional development seminars, master classes, and courses each year. Professionals in the field, who needed continuing professional development and support in their arts and health practices, demanded these workshops. These ranged from a 1-day seminar on arts and health: *Sharing international best practice* to a *Music and Health* seminar bringing together musicians, music therapists, and music and health practitioners for debate, discussion, and sharing research and work experience. The master classes included modules entitled *Reflective practice for artists working in healthcare settings* and *An overview of Arts and Health*. In many of these activities and discussions, the idea of a broader view of arts and health was welcomed, as well as a desire to reduce the perceived split between arts therapies, medical humanities and arts and health practice. Many discussions centred on misunderstandings within the arts and health field, with a need for professional distinctions centred on mutual respect for the specialized training of the various arts practitioners. Throughout these professional development activities, the researcher was actively discussing arts and health issues with practitioners, researchers, and clinical professionals and formulating ideas and this paradigm^[5].

These four research activities led to the development of a new paradigm. After examining current paradigms and finding shortfalls, these four activities are presented to show diverse aspects of arts and health and to outline the broadness of this field and to challenge narrow limitations imposed by some arts and health professionals. Service users and clinical staff do not always clearly differentiate between practices – for example a performing musician and a music therapist - however, when the roles and aims are clearly defined by the practitioner there is seldom role confusion. A person-centred approach ensures that the needs of the service user are paramount over professional insecurities.

Existing Paradigms for Arts and Health

Very few paradigms exist for thinking about arts and health, although many countries have tried to define what they mean by arts and health. Three useful paradigms were found during the literature review.

1. McDonald et al. (McDonald et al, 2013) proposed a very useful model of music and health which began to explore the intersection and overlap that is experienced in practical work experience (Figure 1). Here, educational, therapeutic and everyday uses of music are explored as inter-related rather than separate activities. This model does not use the term *Music and Health* specifically. The model is clear and comprehensive, but it seems that an overarching music and health umbrella term would be useful as well as an equal weighting to all the activities (rather than a smaller music medicine subset of music therapy as in this model). However, many aspects of music making are covered in this model, not all of which necessarily fit

under the arts and health umbrella. This paradigm initiates thought about how arts practitioners might collaborate in any context and leads naturally to development of the new paradigm discussed in this paper which explores a range of music making activities in the health context.

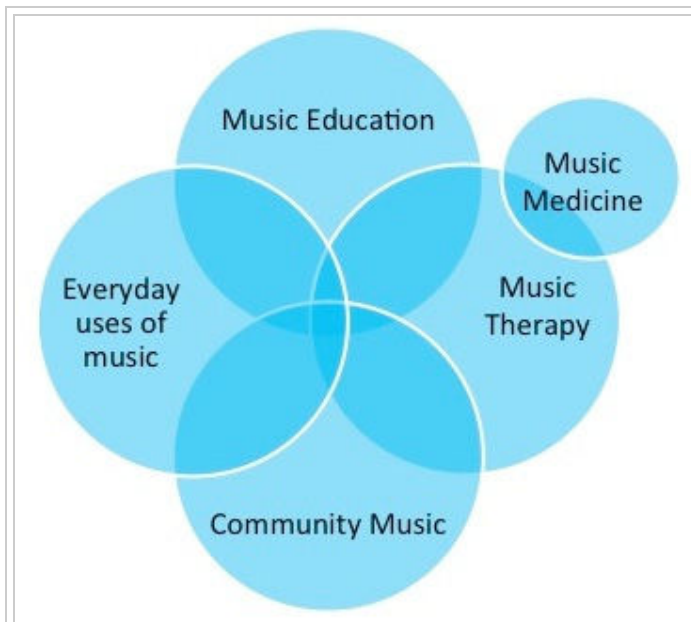


Figure 1: McDonald et al. (2013) model of music and health. (CC BY 3.0) by @ R. MacDonald

2. One of the few models emerging specifically from the arts and health field is that of Community arts and health, by White (2009). White identified four key dimensions of arts in community health contexts, named as art, social, individual, and health services. He argued that these four key dimensions of arts and health practice focus on six elements and can be placed on an axis (White, 2009, p. 90):

1. The role of the arts in group engagement
2. Building good social relationships that improve health
3. Engaging groups to bring communities together
4. Using creative methods to communicate health messages
5. Providing creative groups for self-expression and
6. Arts projects that support the process of care.

Whilst this model is helpful it was felt that a clearer explanation of each arts practice currently employed within healthcare settings needed to be named, and placed with equal value, within the arts and health model. Nonetheless, this model provides useful thinking about why we use arts in health settings and helps arts practitioners to clarify the reason for their work.

3. A seminal model of *health musicing* is described by Lars Ole Bonde (2011), whereby the field of music and health is asserted to cover lay-therapeutic musicing in everyday life as well as community musicing and the more specific professional practices of music and medicine and music therapy⁶. Bonde created a quadrant

model showing how health musicing relates to four major purposes or goals (Bonde, 2011 p. 122):

1. The development of communities and values through musicing
2. The shaping and sharing of musical environments
3. The professional use of music(ing) and sound(ing) to help individuals and
4. The formation and development of identity through musicing.

This model is closely related to the model proposed in this paper, as it encompasses both music therapy and any other music related activity taking place in healthcare settings under one umbrella term *health musicing* (Bonde, 2011). This model looks purely at music, rather than arts, and focuses on some, but not all, of the practices in the new paradigm (presented below). This is a very useful model as it focuses on the role of music in forming identity, creating communities, in sharing moments and as a professional activity within healthcare. It also focuses on different kinds of musicing, from individual to communal activity. This model has informed the development of the new paradigm, but it is believed that the arts and health field needs further clarification. The new paradigm focuses on identifying and naming the many practices and approaches that fit together under one umbrella term arts and health. The focus of the new paradigm is on the actual role, players, practitioners, and skills involved in the different areas of arts practice in healthcare.

A New Paradigm for Arts and Health

The need for this new paradigm arises from this researcher's work experience and a belief that a new way of working together and a more comprehensive model is required in the field. Bonde (2011) raised concerns in his paper regarding adding more definitions and models in the field. However, this new paradigm is an attempt to provide some orientation tools, add understanding and depth to the field, and to stimulate debate and discussion, while keeping the needs of service users as paramount. "We need some orientation tools, as the field of music, culture and health is rapidly growing and becoming potentially confusing" (Bonde, 2011, p.133).

In this paradigm there is equality amongst all approaches to arts in healthcare settings. Arts and health is now the umbrella term for *all* activities engaged in combining arts and healthcare or health related activities. Arts and health is no longer a term understood as *not arts therapies* or *participative arts* or *collaborative arts*. For example, receptive arts experiences and both active and receptive everyday arts experiences are included as equally important as participatory and therapeutic activities. For some health service users, normalised access to arts activities that they enjoy are more important than engaging in therapy or workshops.

Arts and health practitioners encompass those artists who engage in participatory or collaborative work in healthcare settings or in areas related to health. Other forms of activity, such as creating original new work (for example, a composer in residence creating new work in response to a residency in a dementia facility) are named as such, in this paradigm as *Artist Residency* rather than having to fight for existence within a participatory or collaborative arts milieu. Arts education is included in this model – often in arts and health practice and arts therapies any overt educational goals are viewed with suspicion or avoided in order to clarify roles and training requirements to teach. However, flexibility in healthcare contexts may require a

therapist to be open to referring a client to arts education or engaging in relevant professional development where this will support clients' needs. It acknowledges that some art programmes (for example, a community based art therapy group for people with chronic pain) may contain both psychotherapy and educational aims, such as learning new skills, managing pain and psychotherapeutic reflection all within one group programme.

It is hoped that this model (Figure 2) may assist policy makers and funders. For example, a writer who wanted to carry out a residency in a hospital to create new work had to squeeze his project into a funding application for the Arts Council of Ireland to fit into a *participatory arts* box, under which section all arts and health activities are considered. To do this, patients' writing workshops were given precedence in the application over creation of his original poetry created in response to the hospital residency. This new model allows for recognition of many ways of working in a climate where participatory and collaborative arts may currently have wider access to funding.



Figure 2: A new paradigm for arts and health.

This model can be adapted to any art form specifically. Of interest to this readership, and this author, is the music and health model (Figure 3) which has been created from this basic paradigm. It can be seen that each approach is presented as quite

separate, however there may be fluidity in that certain practitioners might move between roles. For example, a music therapist might also be a performer or a music educator or a community musician.



Figure 3: Music and health paradigm.

Arts and Health: A Continuum of Practice

The second part of this new paradigm is a continuum of practice (Figure 4). This is aimed at practitioners in the field, to assist them to place their work within a broad field and to identify both their role and their learning needs. This continuum was developed in discussion with Dr David McCormack, a specialist in Continuing and Adult Education and Reflective Practice. In this continuum, all types of practice are recognised as equal in value. One can move along the continuum in either direction, depending on the work, the skills required and the client needs. Whilst there is fluidity and movement between roles, the continuum indicates that extra training or specialised skills may be required at either end of the continuum. A few examples follow:

- A musician performs in a hospital (Artist). She plays her instrument in a concert setting within a ward. A patient in the audience breaks down and cries. The musician is not expected to support this person or respond musically to this and would be required to alert a clinical staff member that the patient is upset. However, a music therapist, playing the same piece of music in the same ward would have a focus on responding to the client's reaction, supporting them, and using their therapy skills to respond verbally and musically to help them deal with the reactions that arise.
- A community artist provides art sessions for adults with chronic pain on a weekly basis. After a number of weeks of creative activity, the clients request education, wanting to improve their drawing and technical skills. The arts practitioner working in healthcare settings decides to attend some professional development in continuing and adult education to better meet the needs of this group at this time.
- A community artist carrying out an art group for people with chronic pain will understand, from this continuum, that there is a level of emotional support they can provide, but in certain cases they may recommend the person attends a therapist. Similarly, a music therapist working with a man with a brain injury who was a great drummer before the injury, may at a certain point in the work, recognise that engagement with a community musician would be of benefit to enable the client to re-engage with his normal musical life and cease therapy.



Figure 4: Arts and health: a continuum of practice.

Validity

Once developed, this paradigm was shared at three professional development seminars in 2015 and shared with ten experienced practitioners in the field. These practitioners were: (a) an American arts and health director; (b) two Irish music therapists (c) two Irish art therapists (d) an American dancer and dance therapist (e) a curator in a hospital in Ireland and (f) two arts and health practitioners in Ireland (g) a County Arts Officer with special responsibility for arts and health.

Feedback was qualitative and involved conversations focused on two questions: (a) Does this model resonate with you? Is it useful for your practice and thinking about your work? (b) Do you feel that this model adds to the understanding of arts practice in healthcare?

Every participant consulted indicated that the model should be published and made available as a useful addition to the theory and discourse in both arts therapies and

arts and health fields. In particular, the continuum of practice was seen as a useful way of thinking about what training and development a practitioner might need.

In a few cases practitioners felt that this paradigm would confuse people and weaken their particular professional position. One practitioner expressed concern that they were extremely well qualified and felt that other practitioners were not and that some of the listed arts practices in healthcare settings were not as important as their approach. Bonde (2011) raised concern that new paradigms may sacrifice the evidence-based competencies of music therapists and leave the field open to less qualified professionals. It is important to note the value of different arts activities and events in everyday life, and the equivalent value in situations where health is compromised. Professional insecurity and competition for funding has led in some jurisdictions to difficult relationships between arts therapists and other arts practitioners in healthcare settings and it is hoped that the positive feedback received for this new paradigm indicates a growing confidence in the importance of the arts on health and well-being as well as less need for professional struggles to dominate the field. The intensive training of music therapists is important to recognise. Music therapists are trained to engage meaningfully, through the arts, with a broad range of clients who cannot access mainstream activities due to illness or disability. However, it is also important to recognise that intensive training is involved to work as an arts educator, performer or collaborative artist in healthcare settings. Whilst it is important to recognise the uniqueness of arts therapists and their intensive training to engage with clients who cannot participate in performance or participative arts activity, it does not follow that arts therapies are the right intervention for ALL clients ALL the time.

The majority of those consulted added strength to the model by sharing work experiences where their arts work in healthcare was confused for something else by clinical staff or where they felt aspects of arts practice were neglected (for example noise pollution or interior design considerations in hospitals). Others shared their own experiences of being a patient and not having access to receptive arts that they enjoyed. These participants welcomed the inclusion of so many aspects in the one umbrella term.

Conclusion

The aim of this paradigm is to challenge the status quo that sees arts and health emerging as a predominantly participative arts field, to the exclusion of other approaches, and to return to the idea of arts as a broad field that interacts with health, well-being and healthcare settings in myriad ways.

Further research on the validity of this paradigm is needed. Consultation with practitioners and experts in the field on a more formalized level is required. Although service users were informants throughout the researcher's work experience, a limitation is the lack of formal evaluation of the model and input by service users. This is recommended in the future to strengthen the validity of the paradigm. Likewise, involvement with other stakeholders in health and well-being contexts (for example clinicians of various disciplines) would be useful to further develop the paradigm. Future inter-disciplinary working and research is recommended. However, it is hoped that this paradigm will serve as a catalyst to spark debate and reflection.

A new paradigm of arts and health not only offer service users an opportunity to access the most relevant activity to meet their needs but also requires that different

professionals clearly differentiate their roles and acknowledge that different training and professional approaches within their field are valuable and a positive addition to their own training and professional stance.

It is hoped that this new paradigm will be useful to practitioners, service providers, policy makers and service users in engaging with the wide variety of ways that arts can assist in improving health and well-being. Above all, it is hoped that this paradigm will ignite discussion and debate to the benefit of mutual understanding and respect among practitioners and higher quality practice for health service users.

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Notes

[1]The term arts and health is used to refer to any artist refers to working in a healthcare setting (for example, participative artists, arts therapists, performers and artists in residence) as well as to an arts and health specific group who currently use the term to identify their work as practising artists, usually working in collaborative or participatory practice. In other instances the term 'arts' is used to refer to all art forms as defined by the Arts Council of Ireland (2006).

[1]For full description and results of this research please see (Moss & O'Neill, 2009).

[2]For details please see (Moss & O'Neill, 2009)

[3]For more information on this work, please see Moss (2007).

[4]See www.artshealthwellbeing.ie for more details of the seminars, speakers and podcasts.

[5]For more information on this model please refer to Bonde (2011).

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