

# Social movements and boundary work in arts, health and wellbeing: A research agenda

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## Abstract

**Purpose:** Despite a growing evidence base and increasing recognition of the connections between arts, health and wellbeing, arts and creativity are some distance from being fully integrated into health and care services. Further, there is a lack of consensus about the best way to develop the evidence base and progress the field. This paper draws on social movement theory and the related field of boundary studies to explore these critical challenges.

**Design:** The paper critically examines the developing international field of arts, health and wellbeing, drawing on a literature from several disciplines including arts and health, social and political sciences, and organisational studies.

**Findings:** While it is important to continue to develop evidence, theories and frameworks are also needed to address strategic questions, such as the relationship between evidence, policy and practice, as well as practical issues of propagation and scale in arts, health and wellbeing.

**Research limitations:** This is a discursive paper. It does not suggest definitive answers; rather, it signals new directions for further empirical research, including studies of social movement theory and boundary work in arts health and wellbeing.

**Originality/value:** A focus on methodology within an evidence-based medicine paradigm has meant that key questions concerning the development and impact of arts projects and programmes in health and wellbeing have been neglected. Social movement theory and boundary studies offer insights into the potential role of arts in reducing divisions, fostering collaboration and contributing to the transformation of health and care policy and practice.

## Keywords

arts, health and wellbeing, social movements, boundary work, boundary objects, evidence, evaluation, research

## Introduction

A growing evidence base has documented many benefits of arts, including music and visual arts activities across the life course and in a wide range of settings (Clift & Camic, 2016; Fancourt, 2017; All Party Parliamentary Group on Arts, Health and Wellbeing, 2017; Staricoff, 2004; Staricoff & Clift, 2011; Daykin et al., 2018a; Arts Council England, 2018). This expanding field encompasses many domains, from arts therapies through to participatory arts, healthcare design and general participation in arts and culture. The field is a global one,

although its development has been uneven, with most attention focused on affluent English-speaking countries (Clift & Camic, 2016).

Policy makers in many countries increasingly recognise that arts and creativity can help to address common problems, such as the consequences of increased life expectancy, the growing numbers of people living with chronic mental and physical health conditions, and public health challenges arising from widening inequalities. Policy makers and practitioners in the Nordic and Scandinavian countries have embraced the use of arts and culture for health, with a range of models and approaches (Cuyppers et al., 2011; Jensen, Stickley, Torrisen & Stigmar, 2017; Theorell, Horwitz & Wikström, 2015). Examples include the Finnish per cent for art operating model, which provides funding from construction projects for the acquisition of art-based and culture-based wellbeing services. A recent report on arts, health and wellbeing in the WHO European Region puts forward policy recommendations ranging from ensuring arts provision in communities and removing barriers to arts, to implementing well-evidenced interventions, facilitating partnerships and investing in research (Fancourt & Finn, 2019).

Despite these developments, several challenges remain. There are different views about how to evaluate arts in ways that capture nuanced experiences of participation, as well as ongoing questions about what type and how much evidence is needed to justify investments in arts (Daykin et al., 2017). Further, the field is relatively fragmented, often surviving on the energies of small organisations and individuals, with no shared vision of how to scale up activities to benefit a wider range of participants in different contexts (Daykin, Willis, McCree & Gray, 2016).

These challenges are unlikely to be resolved by research and evidence alone as they are not simply scientific or technical problems; rather, they require an understanding of the forces that shape political and moral decisions and choices about how to prioritise and what to value in society, health and care. To date, research discussions in arts, health and wellbeing have focused on the nature of evaluation rather than developing frameworks for understanding strategic and political questions. This has sometimes led to circular debates about research and evaluation. In health care, the dominant paradigm regarding the nature of evidence has been that of evidence-based medicine (EBM), which seeks to harness the best available evidence for cost-effective clinical decision making (Masic, Miokovic & Muhamedagic, 2008). EBM employs formal methods for judging evidence quality, guided by hierarchies of evidence that rank experimental methods such as randomised control trials more highly than non-experimental methods. The growth of EBM has led to a proliferation of systematic reviews and meta-analyses in an increasingly broad range of topics. These extend beyond the clinical arena to encompass community health, arts and wellbeing. For example, the UK What Works Centre for Wellbeing commissions evidence reviews in culture and sport including music, dance, visual arts and outdoor leisure ([www.whatworkswellbeing.org](http://www.whatworkswellbeing.org)).

EBM approaches have drawn critical scrutiny for decades, not least by artists who are critical of hierarchies of evidence, and of methodologies that rely solely on validated, individually based outcome measures. While these may produce the kinds of information that policy makers seek, they may limit evaluation and fail to match the outcomes and priorities valued by project participants and stakeholders (Crossick & Kaszynska, 2016). It is increasingly recognised that qualitative research based on interactionist, phenomenological and constructivist interpretive frameworks can contribute useful evidence for policy and practice (Snape et al., 2019). Hence recent evidence reviews on culture and wellbeing include both quantitative and qualitative research (Daykin et al., 2018a; Tomlinson et al., 2018; Mansfield et al., 2018). Methods such as action research, participatory and arts-based methods have

many advantages, such as generating rich data and engaging participants throughout the research cycle (Abma & Schrijver, 2019; Pain et al., 2015). The use of visual methods such as photovoice can be meaningful to people who may be unlikely or unable to respond to traditional data collection techniques (Wang, Morrel-Samuels, Hutchison, Bell, & Pestronk, 2004; Wang, 1999; Byrne, Daykin & Coad, 2016; Liebenberg, 2018). Nevertheless, implementing and evaluating participatory methods is not without difficulties (Mey & van Hoven, 2019). Challenges include building relationships, developing researcher skills, managing research quality and translating findings for different stakeholders. Participatory approaches challenge researcher dominance, emphasising coproduction and mutual learning among multiple partners, and this can lead to different kinds of impacts than those valued in traditional policy making (Banks, Herrington & Carter, 2017). Successful participatory research therefore requires realistic discussions between stakeholders and clear expectations from an early stage of the research process.

When it comes to reviewing evidence, it can be difficult to judge qualitative research, which is often heterogeneous. Further, the use of these methods in evaluation is somewhat undermined by the tendency to impose language and concepts better suited to quantitative outcomes studies. Within the arts, health and wellbeing field, there are many examples of qualitative and participatory studies, but when it comes to generating evidence for policy and commissioning of local services, qualitative and arts-based approaches are reported by practitioners as holding little traction (Daykin et al., 2016).

While discussions about methodologies are important, in this paper I seek to start a different type of conversation about arts, health and wellbeing. In the following sections I explore the development of the field in terms of social movement theory, which has been developed in social and political science, and in terms of boundary work, developed in organisational studies. In my view, these frameworks offer a useful starting point for further research for three reasons. First, social movement theory may help to unpack challenging questions about the nature of evidence by highlighting their political and moral basis. Second, these theories may illuminate strategic issues, such as how to scale up projects and programmes in order to extend the benefits of arts more widely. Third, a focus on boundary work and boundary objects may reveal important mechanisms that shape the potential for arts to successfully connect fields, groups and specialties, overcome divisions, amplify marginalised voices and foster new thinking about shared problems in health and care.

## **Arts, health and wellbeing as a social movement**

Arts, health and wellbeing has been described as a social movement (Parkinson, 2015; Royal Society for Public Health Working Group on Arts, Health and Wellbeing, 2013). While social movements are not necessarily coherent groups with clear aims, they are distinguishable from other groupings and forms of social action (Tilly, 1999). They usually involve power holders, a range of participants and a subject population on whose behalf claims are made. They are not defined by specific activities; rather, they are networks of interactions between individuals and groups engaged in political or cultural conflicts based on their shared collective identities and purpose (Kapilashrami et al., 2015).

Social movements in health (HSMs) have played an important role in health improvements since the industrial revolution. Early movements focused on issues such as occupational health and social regulation, which helped to reduce the impact of infectious diseases on life expectancy and health (McGovern, 2014; McKeown, 1976). More recent examples

of HSMs include the women's health movement, and campaigns to reframe issues such as HIV/AIDS, mental health and disability (Brown & Zavestoski, 2004; del Castillo, Nicholas, Nye & Khan 2017). As well as challenging stigma and discrimination, HSMs often focus on policy issues including research priorities and methods of evidence production (Brown et al., 2004; del Castillo, Khan, Nicholas & Finnis, 2016; Epstein, 1995).

Social movements can be progressive, reformist or conservative, powered by elites and vested interests (Kapisashrami et al., 2015). While many progressive social movements have been borne out of shared experiences, movements also include supporters and allies such as sympathetic leaders, officials, researchers and other stakeholders (Christiansen, 2009; Guigni, 1999). From this vantage point, the field of arts, health and wellbeing exhibits characteristics of a social movement. It is diverse, drawing in artists, grassroots participants and activists, as well as research and policy leaders. Some are motivated by personal experience, while others seek to resolve specific professional or clinical problems, and others are focused on strategic policy issues and resources. A few operate from commercial interests, while many emphasise a rights-based approach to arts, culture and wellbeing, advocating socially engaged arts practice as a way of challenging elitist notions of 'high art' in favour of community involvement and social inclusion (White, 2009). Leadership and advocacy have been provided by prominent organisations. For example, in the UK the Royal Society of Public Health, an independent charity that seeks to improve and protect public health and wellbeing, has connected people through networking events and conferences as well as through its Arts, Health and Wellbeing Special Interest Group (SIG). Similarly, the UK All Party Parliamentary Group has brought together experts and lay people to provide international evidence to a two-year inquiry, resulting in the report 'Creative Health' (APPGAHW, 2017). Similar developments have taken place in Finland, where Taikysydän, a national coordination and leadership organisation, has been established to disseminate evidence and knowledge about good practice in arts, health and wellbeing (<https://taikusydän.turkuamk.fi/>).

Some social movement theorists have emphasised the fact that a sense of grievance is a defining characteristic (Brown et al., 2004). However, recent thinking has shifted away from a focus on contentious politics to emphasise the potential for the energies of social movements to be harnessed to address challenges in health and care, for which medicine alone cannot provide solutions (Arnold, Coote, Harrison, Scurrah & Stephens, 2018). Hence collaboration between decision makers, practitioners, researchers and community members can foster more equal relationships and help to create new knowledge for policy and practice (Kapilashrami et al., 2015). However, social movements cannot be simply led from above: artificial connections that serve policy agendas can be exploitative of the energies of local people and can reinforce boundaries and hierarchies. Nevertheless, policy leaders can encourage social movements such as arts, health and wellbeing to flourish in order to help to change the culture of local services and draw on valuable community assets to address common needs (Burbidge, 2017; del Castillo et al., 2016).

This suggests that for arts, health and wellbeing to flourish, attention needs to be paid to capacity building at the grassroots level. The sector remains relatively weak and fragmented, characterised by small organisations and even individuals competing for ever-diminishing funds. Many artists and project participants struggle to engage with health care systems, often feeling overwhelmed and disempowered by scientific and medical culture and language (Daykin et al., 2016). Further, arts projects and programmes have been disproportionately affected by financial crises and funding constraints. For example, Clive Parkinson reports how the crash in 2008 disrupted a steady growth of grassroots arts activity, relation-

ships and connections between artists, public health professionals, academics, activists and community participants in the North West of England (Parkinson, 2015).

### Social movements, research and evidence

Social movement theory may shed light on the paradoxical relationship with research and evidence that is often apparent in discussions about arts, health and wellbeing. While social movements often challenge mainstream research priorities and framings, they also seek to harness scientific knowledge and resources for their purposes (Brown et al., 2004; Kapilashrami et al., 2015). As we have discussed, in arts, health and wellbeing, hierarchies of evidence are viewed with suspicion, even as the evidence they produce is mobilised in discussions about policy and resource allocation. Such ambiguous positioning can lead to trade-offs that can in turn create problems for social movements. For example, the strategy of gaining cultural competence by aligning with internal scientific debates and acquiring technical language can open doors but can also replicate the expert/lay division within the ranks of social movement activists, alienating the grass roots and ultimately reinforcing power divisions (Epstein, 1995). Social movement theory provides a useful reminder that research and evidence do not exist independently of social relationships, interests and experiences.

### Social movements, propagation and scale

Issues of propagation and scale are highly relevant to arts, health and wellbeing, where fragmentation serves as a barrier to sustainability and may also reinforce health and wellbeing inequalities, since the geographical areas, sectors and population groups that benefit from high quality arts may not be those with the greatest need. Many examples of propagation can be seen in the field, for example, in arts on prescription and social prescribing, where successful delivery models have been piloted, disseminated and adopted in different geographical areas and settings including the UK, Denmark and Sweden (Chatterjee, Camic, Lockyer & Thomson; Jensen et al., 2017). Other examples include the Dance for Parkinson's Disease model, which began in New York in 2011 and has spread to many countries (McRae et al., 2018), and the notion of singing for wellbeing, which has proliferated following popular TV programmes and media reports.

On the one hand, there are equity-based arguments for scaling up successful arts interventions to ensure that their benefits are available to wider populations. On the other, there are many barriers to scaling, including the embedded and context-specific character of many arts projects and the fact that arts organisations are small and often struggling with intense competition for resources, with few mechanisms and resources to support collaboration. According to Burbidge (2017), social movements propagate and grow across two dimensions: of action, by replicating strategy and tactics; and of ideology, by spreading ideas and framing of issues. Both are dependent on successful management of relationships, including interpersonal connections and informal networks.

A recent study by NESTA based in interviews of people at the heart of successful global HSMs provides practical insights about how these movements grow (del Castillo et al., 2017). The data reveal the importance of early actions in getting movements off the ground, including cultivating the right members and leaders, developing clear messages, utilising assets and resources creatively and coordinating activity within and outside of the movement. They emphasise the need to engage and harness the passions of key constituencies, including people with lived experience, people with expert knowledge, advocates and institutional supporters. The research also highlights barriers to social movement growth, including institutions, funders, dissenters, public opinion, the media and competing interests.



This suggests that successful propagation of arts in health and wellbeing relies on the spreading of a shared vision as well as the fostering of collective actions. This does not bode well for those seeking the top down replication of standardised interventions or programmes. The propagation of arts-based HSMs needs to be flexible and responsive to specific needs and local circumstances, even while concerns about equity are at the heart of the wider movement. Further research is needed to understand how propagation works most effectively in arts, health and wellbeing.

### Boundary work and boundary objects in arts, health and wellbeing

Related to social movement theory is the field of boundary studies, which has been developed in organisational research on education and health. Early researchers focused on the way in which organisational, political or symbolic boundaries frame health and care work by demarcating knowledge, roles and tasks, often serving to preserve the professional autonomy, status and control of resources of powerful groups (Gieryn, 1983; Jones, 2009). The recognition of the role of boundaries in health and care has given rise to an extensive body of work in the sociology of health professions (Dingwall & Lewis, 1983; Friedson, 1988; Stacey, 1988; Gabe, Kelleher & Williams, 1994; Chamberlain, Dent & Saks, 2018). To date, only limited attention has been paid to the role of artists as professionals in health and care (see Waller, 1991), although boundaries are a defining feature of interdisciplinary work in arts, health and wellbeing (Matarasso, 2019).

While energies often support the preservation of hierarchies, boundary crossing can help to bridge organisational and professional divisions (Gieryn, 1983; Star & Greisemer, 1989). It does this by highlighting shared concerns, empowering disadvantaged voices and creating space for transformation of identities and practices (Akkerman & Bakker, 2011; Aungst et al., 2012; Cramer et al., 2018; Edwards & Fowler, 2007; Wang, Piazza & Soule, 2018). Increasing attention has been paid to the characteristics of people who successfully cross boundaries, and new boundary spanning roles within health and care have been developed in recent years, an example being link workers, who play an important role in social prescribing schemes (Gilburt, 2016; Polley, Fleming, Anfilogoff & Carpenter, 2017).

Artists often act as boundary spanners: in schools, hospitals, mental health environments, communities, prisons and military settings. In these contexts they must build bridges, forge relationships of trust and navigate power relationships with a complex web of stakeholders including project participants, frontline staff, managers, researchers, funders and members of the public. Successful boundary crossing in arts, health and wellbeing can draw together diverse groups of stakeholders and can highlight the limitations of existing forms of organisation (Matarasso, 2019). Few empirical studies have examined the experiences of artists as boundary spanners in health and care contexts. However, it is acknowledged that boundary spanning work can be difficult and slow, often impeded by professional resistance, cultural differences, lack of shared language, knowledge and role demarcation, siloed training of professionals and lack of training and resources for boundary spanning roles (Aungst et al., 2012; Cramer et al., 2018; Gilburt, 2016).

Much of the literature on boundary work has focused on healthcare organisations; however, it is also important to consider boundary spanning in community settings, where many arts projects are based. A recent study of a community enterprise project that offered arts and crafts activities to build social support and social capital for vulnerable people illustrates the complex roles of boundary spanners, such as staff and volunteers (Farmer et al., 2016). Their roles included knitting disconnected people into community life, mediating and connecting marginalised participants with health and care services, and intervening to

prevent the escalation of conflicts. The study also highlights the rewards of boundary spanning, which can include taking part in arts activities and enjoying enhanced social connections. By attracting new people, including participants and volunteers, boundary spanners can help to broaden awareness of the positive aspects of geographical areas and communities that sometimes tend to be avoided and stigmatized.

Boundary workers can experience ambiguity in their roles, which are easily defined as peripheral, that can lead to conflicts and difficulties (Aungst et al., 2012; Akkerman & Bakker, 2011). Boundary work can be highly rewarding but can also lead to stress and burnout, and the concept of emotional labour, derived from Hochschild's 1983 study of flight attendants (Hochschild, 1983) has been applied to boundary work (Caldwell & O'Reilly, 1982; Needham, Mastracci & Mangan, 2017). To date, relatively little attention has been paid to the emotional impacts of health and wellbeing work on artists and practitioners. Successful boundary spanners in health and care settings clearly need to demonstrate a wide range of skills, aptitudes and leadership qualities as well as the ability to navigate surrounding discourses and practices and maintain their own legitimacy. Further research on boundary crossing in arts, health and wellbeing would help to understand the factors that can help or hinder attempts by social movements to mobilise resources, build connections, define goals and achieve social and political change (Wang et al., 2018).

It is not just people, but also objects, that cross boundaries. Boundary objects can be artefacts, such as patient records, that carry specific meanings to different stakeholders (Cramer et al., 2018). Within organisational studies, successful boundary objects are viewed as those that address the requirements of different users while generating dialogue and new meanings as they move back and forth between different sites (Akkerman & Bakker, 2011). Boundary objects can be used to reinforce or disrupt divisions between people and practices, potentially promoting changes in consciousness and collaboration across different groups (Akkerman & Bakker, 2011; Epstein, 1995; Matarasso, 2019; Star & Greisemer, 1989; Wang et al., 2018). Boundary objects can include artistic works and processes, although they have seldom been studied in arts, health and wellbeing contexts. One study of the role of music making in hospital care for people with dementia suggested that music can serve as a boundary object (Daykin et al., 2018b). For example, a conductor's baton stimulated expressive responses and provided a focal point for discussions in which staff and carers reflected on patients' unseen capabilities and needs as well as on their own roles.

Not all boundary work is successful, and further research on the role of boundary objects may help to understand some of the mechanisms that underpin successful arts projects in health and wellbeing settings. Boundary objects can restrict as well as enable communication (Laine, Korhonen, Suomala & Rantamaa, 2016). They can be dismissed as irrelevant if they fail to meet stakeholders' requirements, and can be resisted, which may help to explain the occasional negative media reporting of hospital arts projects characterised as diverting resources away from patient care. Artworks may be weak boundary objects if they serve simply to enhance the aesthetics and value of healthcare environments, or favour the standpoints of high-status professionals. There are many instances where artistic works and processes can be used to reinforce boundaries, such as health education campaigns that seek to communicate medical ideas to the public without taking into account lived experiences. There are also instances of micro-level resistance to boundary work, such as when a proposed arts activity is rejected on the grounds that it might disrupt the workflow within a clinical setting. In our study of music in acute hospital care for people with dementia, we reported an occasion when a senior clinician entered the room while the music making was in full flow, announcing to a patient that they needed to undertake a minor clinical pro-

cedure at that moment (Daykin et al., 2018b). What was interesting about this scenario was the response of care staff, who made strenuous efforts to prevent such incursions in future, giving up time and energy and devising tactics, such as rearranging furniture, to protect the music space.

It is worth noting here that artists, as boundary workers in healthcare environments, are often in a lonely and ambiguous position. They have little influence or authority and can easily be viewed as peripheral to the key domains of clinical practice. On the other hand, by engaging the creativity of key supporters, they can help to challenge rigid role expectations for the wider benefit of patients and staff. Examining the practices surrounding arts in health and wellbeing through the lens of boundary work and boundary objects has the potential to enrich understanding of transformational change and its prerequisites in a wide variety of settings.

## Conclusion

This paper has examined arts, health and wellbeing as a social movement, exploring the notion of boundary work and suggesting areas for further research. To date, the discussions about development of the field have been dominated by consideration of evaluation methodologies and circular debates about the merits of evidence base healthcare agendas. While it is important to continue to improve the quality of evidence and to acknowledge the limitations of current paradigms, paying attention to alternative theoretical frameworks drawn from social sciences and organisational studies could help to address strategic questions regarding movement development, including its relationship to research and evidence as well as issues of propagation and scale. This paper seeks to stimulate a different kind of theoretical debate than that which usually dominates the field, offering new perspectives for further research. A focus on social movement theory and the study of boundary work in arts, health and wellbeing could help to understand the factors that shape successful arts interventions and activities. These are needed to reduce hierarchies and divisions, empower disadvantaged voices, encourage collaboration across disciplines and contribute to wider transformations in health and care policy and practice.

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