

Art as a Determinant of Health

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Aging gratefully in Antigonish, John and Dorothy continue their appreciative inquiry with artists and care partners, when they are not co-journaling, co-cooking, co-gardening, walking their black and brown foster dogs, and building a potato labyrinth.

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DEDICATION

To the Care Partners in the first Art for Health program in Antigonish

Those seven weeks in the autumn of 2007 at the Royal George
were magical. You are our Muses for this report.

The Milling Frolic (Guest Artist, Kolten MacDonnell)



Failte!

In the work and play of the afternoon
sixteen sets of hands link up in the rhythm
of the band that circles the trestle table
and feel together the cloth's softening
beneath their kneading knuckles' drum.

Some in the circle have lost this sense or that:
his sound, her sight, her speech, his gait.
but all can still touch, and be touched in turn,
as hands and feet rat-a-tat-tat in freestyle scat,
uniting in the frisk and frolic of the milling.

- John Graham-Pole, May, 2008

Abstract

Introduction

We define *art-for-health* as (a) art-based activity and/or experience of any kind created/performed with healing intention; and/or, (b) art-based activity/experience for professional and popular education and social activism; and/or, (c) evidence of therapeutic and/or social benefit in quantitative and qualitative research.

Background & Rationale

The WHO's list of the fundamental determinants of health does not specify art by name, and the CSDH stresses the deficit language of disease and social inequities. The 1986 Ottawa Charter for Health Promotion, however, calls health "a positive concept emphasizing social and personal resources, as well as physical capacities ... go[ing] beyond healthy life-styles to well-being." Matarasso's (1997) UK study on the health impact of the arts showed significant benefits for societal and individual health.

Findings from Current Study

- We highlight the significance of art in global health promotion, education, research, activism, and therapy with curative and/or palliative intent.
- We substantiate the global presence of arts activities/experience in healthcare and society at large. The evidence that we are *hard-wired for art* accounts for the universal, while paradoxical, slowness to declare art a cardinal health determinant.
- This underlies global governmental failure to take far-reaching action to reflect the compelling evidence of art as a health determinant.

We document systematically physical and psychological healing and health education and social activism. We use the qualitative methodology of *exemplars* to represent subjects' and researchers' testimony, because the quantitative methodology of evidence-based medicine is unsuited to assess the premises and practices of art-for-health.

Specific Recommendations

- *Implement* far-reaching, multi-cultural, professional and popular education and research in health and educational settings and global communities
- *Motivate* health professionals, educators, artists, and policy-makers to conduct funded local and national *art-for-health* projects
- *Activate* a movement to *name* art a social determinant of health, endorsed by health professionals, educators, researchers, and policy makers
- *Distribute* the findings of this report to those responsible for societal and individual health determinants

Executive Summary

Introduction

Art and health are both broad concepts defying easy definition. The literature to date contains minimal review, let alone recognition, of art as a determinant of health. This report addresses this deficiency.

We define *art-for-health* as (a) art-based activity and/or experience of any kind created/performed with healing intention; and/or, (b) art-based activity/experience for professional and popular education and social activism; and/or, (c) evidence of therapeutic and/or social impact of art-for-health in quantitative and qualitative research. We contend that these three crosscutting expressions of art-based human creativity can, and should, be collapsed into a single overarching and unifying concept of art-for-health.

Background & Rationale

The World Health Organization's list of fundamental conditions and resources for determinants of health does not specify art by name. WHO's Commission on Social Determinants of Health (CSDH) emphasizes the deficit language of disease, ill health, and social inequities. However, the association of art with community, celebration, festival, and healthy human pleasure of all kinds, as featured in this report, is a vital positive reconfiguration of the CSDH. The 1986 Ottawa Charter for Health Promotion endorses this much more favourable orientation toward societal and individual health, defining it as "a positive concept emphasizing social and personal resources, as well as physical capacities ... go[ing] beyond healthy life-styles to well-being." This charter was a prime motivation underlying both the Canada-wide Healthy Cities project and the Canadian Index of Wellbeing.

Matarasso's (1997) study in the UK on the health impact of participating in the arts is to our knowledge the only comprehensive evidence-based research on this subject conducted to date. This study's findings furnished substantial evidence that participation in art-based activity/experience has significant benefits in terms of both societal and individual health and wellbeing. In direct accord with this evidence, arts-based activity/experience was the major focus of the May 2008 celebration of "human universals" entitled Pangea Day (www.pangeaday.org). Art took the form of multimedia events, story-telling, documentary films, and global cross-cultural interactions. Also in May 2008, art-based activity, in the form of dialogue and case study, was the driving force for the WHO-funded UNESCO Forum of Intellectuals of the Horn of Africa, which brought together researchers, policy-makers, and the private and public sectors of society from around the world.

Findings from Current Study

- This report summarizes a large body of evidence that underscores the significance and profound value of art as it infuses the global work of health promotion, education, research, activism, and individual therapies with curative and/or palliative intent.
- Our findings substantiate the ubiquitous and pervasive presence of arts-based activity/experience throughout the world, both in healthcare settings and society at large. The substantial evidence that humanity is *hard-wired for art* accounts for the

universal, although seemingly paradoxical, slowness to declare and celebrate art as a cardinal determinant of health.

- This unawareness underlies the almost universal failure of national, regional and local governments of all countries, whatever their level of social and economic development, to frame healthcare policy and to take far-reaching action to recognize and reflect the compelling evidence of art as a determinant of health.

Although our evidence and analysis of art as an integrating force in global health address the *overall* concept of art as a health determinant, we place particular emphasis on art as a *social* determinant. Our study uses throughout the arts-based qualitative methodology of *exemplars*, that is, explicit and relevant data representing subjects' and other researchers' own voices and testimony. This participatory methodologies informing art-for-health research contrast directly with the strictly quantitative methodology of evidence-based medicine (EBM), in which researchers evaluate very specific and often narrow physiological and/or psychosocial outcomes. Our rationale is that EBM is unsuited to evaluate the key holistic premises and practices of art-for-health.

To address our definition of art-for-health as a crosscutting manifestation of human creativity, this report includes systematic documentation of local and national exemplars of art-for-health to reinforce its premise. Specifically, our research exemplifies both (a) direct demonstrations of physical and psychological healing of societies and individuals; and (b) effective community and professional health education and social activism.

Specific Recommendations

- *Develop* and *implement* far-reaching, multi-cultural, professional and popular education and research in health and educational settings and global communities, to deepen societal and individual understanding of *art-for-health* as a positive determinant of health and wellbeing
- *Identify* and *motivate* health professionals, educators, artists, and policy-makers to design, coordinate and promote adequately funded local, regional and national *art-for-health* projects and programs
- *Activate* a national, then global, movement to vigorously *name* art as a social determinant of health, endorsed by health professionals, educators, researchers, policy makers, and social justice practitioners
- *Distribute* the findings of this report to individuals and organizations concerned with and/or responsible for all aspects of societal and individual health determinants

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Art as a Determinant of Health

Prelude

As we craft this report in the spring of 2008, instances of art as a determinant of health come at us daily, without ever having to leave our rural home in Nova Scotia. On May 10, 2008, starting at 18:00 GMT, “a small group of thoughtful individuals” — as Margaret Mead famously described agents for change — spent 4 uninterrupted hours on a Saturday afternoon in Antigonish watching the Pangea Day documentary films on a wide screen, in community with 1000 other events and parties around the world, moving from locations in Cairo, Kigali, London, Los Angeles, Mumbai, and Rio de Janeiro (see www.pangeaday.org). The live program, along with the Pangea Day web site, blog, and self-organized local events was created to overcome divisions and to “help people see themselves in others through the power of film.”

Pangea Day is testimony to the subtly pervasive power of art as a social determinant of health. US film distributor Larry Daressa (2000) accounts for “the strategic role of media in social change. ... because it represents, or rather presents, society as something already under discussion, in the here and now, by media users, joined into transformative communities ... a communications infrastructure for the revolution of everyday life” (p. 5). Buddhist art and literary theorist Eleanor Rosch (2001) suggests that the purpose and role of art is not always strategic. As she puts it: “The arts can do a great job of getting through to us because they can slip it to us sideways” (p. 247). The “appreciative mode of knowing one’s experience, whether it be positive or negative experience, as it immediately occurs in its full vividness” (p. 246), defines the contribution of art to evidence-based medicine (EBM) and evidence-based practice (EBR) (see Lander & Graham-Pole, 2006).

Health promotion was not the primary focus of Pangea Day films,¹ but it was slipped to us sideways, right from the opening film, *The Ball* (Orlando Mesquita, filmmaker). We became witnesses to boys in Mozambique buying up condoms, and making them into footballs. The “serious play” of this film embodies art as a determinant of health: buying and using condoms is normalized for boys at an early age. Only at the end of the film in the text-over did we learn the significance of the older man’s consternation with the boys; condoms are available only to one-fifth of the male population.

Speakers took to the stage in between films, including anthropologist Donald Brown, the leading researcher on human universals (Brown, 1991). Pangea Day organizers anticipated that the stories told on and beyond the day would leverage these universals to build bonds among cultures. As Brown talked and as hundreds of these universals (English text) flashed on screen as if on the night sky, it quickly became evident that the arts predominated, e.g., storytelling, humour, dance, ritual, body decoration, ceremony,

¹ The Pangea Day mission and purpose is to bring the world together through film. “In a world where people are often divided by borders, difference, and conflict, it’s easy to lose sight of what we all have in common.” (www.pangeaday.org/aboutPangeaDay.php)

drumming, feasts and festivals. The concept reminded us of evolutionary anthropologist Ellen Dissanayake's (2001) notion of *homo aestheticus*, based on her research into mother-infant interactions. "Babytalk is not only a multimedia performance, but a multimedia *duet*. ... Mothers or caregivers subtly adjust rhythmically patterned and dynamically varied visual, vocal, and gestural behaviors to the infant's own changing visual, vocal, and gestural expressions of emotional state" (p. 86).

Drum circles for community health, which adult educator Jane Dawson introduced to the Art for Health program in Antigonish (see dedication page this report; Dawson, 2008), build on the earliest aesthetic experience of synchronizing to another's heartbeat when individuals interact. The Institute of HeartMath (2008) reports studies showing that the baby's heartbeat can be detected in the mother's brain waves. When the mother placed her attention on the baby, she became more sensitive to the subtle electromagnetic signals generated by the infant's heart. So it is that art as a determinant of health begins with our earliest experiences of care and of art — and, in combination!

To model the subject of our inquiry, our **Prelude** features a story — our local participation in Pangea Day — and the **Coda** to our report raises a challenge by way of another story. Between these two stories is the body of the report organized in four sections: Section 1 is the **Introduction**, which outlines the purpose and direction of the report; Section 2 is **Theory and Practice**, which serves as a literature review; Section 3 offers the **Evidence** of art as a determinant of health that contributes to evidence-based practice and evidence-based medicine, drawing exemplars from popular media as well as research; and, Section 4 offers suggestions for **The Way Forward**, including some potential audiences for circulating this report.

Section 1: Introduction and Purpose

Both art and health are broad concepts that defy easy definition. We have not found anywhere the phrase or declaration "art is a determinant of health," either in the literature or in everyday conversation. This definition and declaration will therefore unfold in this report. As a departure point, we can elaborate the commonly used concept of **art-for-health**. Any creative human act can be seen as: (a) a work of art created or performed with healing intention for a care recipient and caregiver; and/or, (b) a description and analysis of art-based activity for educational and activist purposes; and/or, (c) a piece of evidence for inclusion in a quantitative or qualitative research study. We find it helpful to "collapse" these three diverse but crosscutting expressions of human creative potential into the overarching and unifying concept of art-for-health (see Lander & Graham-Pole, 2006 on the appreciative pedagogy of palliative care).

Art for Integrative Healthcare

Matarasso's (1997) UK study of the social impact of participation in the arts, perhaps the most comprehensive evidence-based research on this subject to date, asks: "Could it be done without the arts?" The study concludes that, although some of the benefits could be achieved through other means, "arts projects are different because of those whom they engage, and the quality of that engagement. ... The roots of this ability to draw in bystanders, skeptics and even adversaries lie in the other fundamental social difference between the arts and other activities: they trade in meanings" (p. 89). In this report, we present evidence of the pervasive meanings of art in everyday care work, to support our argument that the very seamlessness of art and life and caring — *homo aestheticus* — accounts for the universal slowness to declare art as a determinant of health, and to take action or frame health care policy to recognize and reflect this.

Matarasso (artfully) contrasts state support for sport to our anti-cultural political values that subject the arts to "regular fitness checks. Sport is rightly seen as a public good which promotes health, confidence and teamwork, while enriching society as a whole. ... Art on the other hand, belongs to the cast of usual suspects rounded up by the police chief in *Casablanca*: disreputable, untrustworthy and assumed guilty, unless it can talk its way out again, probably with the help of a dodgy lawyer" (p. 89).

Yet peace comes first in the World Health Organization's list of fundamental conditions and resources for health (WHO, 1986, p. 1), and art is slipped in as the driving force in the news of May 2008 from the Sector of Social and Human Sciences at UNESCO (www.unesco.org/shs/e-news) — Making Sport and Research Work Towards Peace-Building. "With the support of this program, Djibuti will house from 26 to 30 May 2008, the Forum of Intellectuals of the Horn of Africa, which will be a framework for exchange and *dialogue* between researchers, policy-makers, the private sector and civil society. A panel of experts will focus on a *case study*: "The Great Horn of Africa" (emphasis added). Art, especially narrative art, is always part and parcel of both dialogue and case study. The initiative that brings athletes from the Arab world and Asia together for the project "Play for Peace" was approved by UNESCO and the Olympic Council of Asia. What it seeks through sport — "to promote peace, solidarity and brotherhood among peoples, which require respect for life and the human person" — applies just as readily to art. This report therefore serves a dual purpose: to provide overwhelming evidence that art is a determinant of health; and to suggest how we could start a "revolution of everyday life" (Daressa, 2000) on the basis of this evidence, in healthcare practice, in research, and in formal and informal teaching and learning.

We need not go further than the daily newspaper to show that art is accomplishing care work right under our nose. We drew on a recent interview with Bruce MacKinnon, editorial cartoonist for *The Chronicle Herald*, to support our ongoing research into the art of palliative care, including care for the bereaved (Lander & Graham-Pole, 2008-2009). Bruce's art has often served the purpose of public and private mourning. His sketches that responded to September 11, and to Swiss Air 111, which crashed into the waters just outside Halifax, Nova Scotia in 1998, exemplify public mourning. And the response from

grown up children was overwhelming, when he sketched a saddened Finnegan and Casey, to mourn the passing in 2001 of Mr. Dressup (Ernie Coombs in the TV show for children). Rarely getting direct feedback on his art, Bruce noted this exception — heartfelt messages were coming into *The Chronicle Herald* for weeks after. Most recently, he helped his public grieve the loss of world champion pumpkin grower, Howard Dill. The cartoon for May 22, 2008 was poignant in its simplicity: a Giant Pumpkin is surrounded by smaller jack [jill] o’lantern companions, all with looks of total dejection carved into their faces (MacKinnon, 2008, p. A10).

Dorothy can recount a personal experience of drawing on Bruce’s cartoons in a time of grief (see Lander & Graham-Pole, 2008-2009). When Dorothy’s jazz-loving husband Patrick, the consummate CBC radio interviewer, died in 2004 on the same day as Broadway composer Cy Coleman², Dorothy found comfort in Bruce’s 1991 cartoon of a conversation on a heavenly cloud between Dr. Seuss and jazz trumpeter Miles Davis, who died in the same week:

Miles Davis: “So you’re Dr. Seuss?”
 Dr. Seuss: “So you’re the cat in the hat?”

Remembering the delight on first viewing this with Patrick, Dorothy shaped her own heavenly conversation. She imagined Patrick, microphone in hand, asking Cy Coleman, “So What *If Your Friends Could See You Now?*”

The artist as public witness performs the loving service more commonly associated with the intimate caregiving that we describe in our self-study of love medicine for the dying and their caregivers (Lander & Graham-Pole, 2008). Bruce told us that he has to be particularly sensitive in his sketches that respond to national or international tragedies such as 9-11 or the Swiss Air disaster (see Lander & Graham-Pole, 2009).

We lead off with a potpourri of local exemplars as evidence that art is proving essential to human flourishing, corresponding to the broad definition of health in the Ottawa Charter for Health Promotion, as “a state of complete sense of physical, social and mental well being and not merely the absence of disease” (World Health Organization, [WHO], 1986, p. 1). This positive concept of health developed at WHO’s first international conference on health promotion in Ottawa in 1986, has been sustained, and continues to be the reference of choice to support health promotion, education, research and practice. Our exemplars also support First Nations’ spiritual definitions of health, complementing the preceding list of political and socio-ecological approaches to health, specifically: “the need to encourage reciprocal maintenance — to take care of each other, our communities and our environments” (p. 2). Jeannette Armstrong, an Okanagan writer, poet, and educator asserts that “those who have the widest identification (Self, family, community, land, all beings) are thought to be the healthiest” (Gerity & Bear, 2007, pp. 239-240).

² Cy Coleman composed the music for the Broadway musical *Sweet Charity*, which Patrick and Dorothy saw in New York. One of the songs in this musical is “If My Friends Could See Me Now.”

Our exemplars position arts and culture as the integrating force for all the determinants of health, making these distinctions: 1) art as a *therapeutic* determinant of health is twofold: a) the art therapies focused on outcomes related to traditional risk factors (biomedical, lifestyle and behavioural) such as cholesterol, body weight, physical activity, diet, and tobacco use; and, b) the gift economy of artist-caregivers, focused on lifting mind and spirit rather than on specific health outcomes; and, 2) art as a *social* determinant of health emphasizing the ways that art brings attention to how a society distributes economic and social resources, and to the attendant policies that enhance health. Art as a social determinant of health focuses on social justice and health equity, and is explicitly political.

In both these dimensions — therapeutic and social — art serves as an integrating force in securing the fundamental conditions and resources for health, and as a measure of health and well-being in the broadest sense.

The established therapeutic art modalities, such as drama therapy, art therapy, dance therapy, play therapy, and poetry therapy, are associated with a psychotherapy credential and professional association, and are committed to providing quantitative measures of their efficacy (e.g., Snow et al., 2003). Impact studies of art for health, which tend to operate in the gift economy and emphasize art for overall care rather than therapeutic outcome, are sparse (see however, Lander et al., 2006; Lander & Graham-Pole, 2006, 2008, 2008-2009, in press b). The art of family care partners, community arts, and hospital/hospice artist-in-residence programs is an open field for conducting this research. The HeArts and Hope studies at University of Florida are part of the larger arts-in-medicine (AIM, www.shands.org/aim) program that John Graham-Pole and others at University of Florida initiated in 1991. These studies break new ground in incorporating a sophisticated electronic system to measure and evaluate the use of state-of-the-art, multimedia computer technology at the bedside (see Graham-Pole, 2007, p. 14; Klein et al., in press), specifically the efficacy of offering hospitalized patients access to online multimedia environments of virtual-reality visual art accompanied by surround-sound music.

Art is not identified explicitly in the plethora of approaches to supporting and/or measuring the *social* determinants of health (sometimes coupled with happiness and well-being), which are outlined in the following initiatives:

- The UN-generated Millennium Development Goals are enumerated as combating hunger, poverty, disease, illiteracy, environmental degradation, and discrimination against women, supported by new models of economic and political reform (progress can be tracked at www.mdgmonitor.org);
- First Nations communities' initiatives build connections to others and to the land (see Gerity & Bear, 2007); the Aboriginal perspective symbolized by the Medicine Wheel, incorporates spirituality and actualizes healing through the principle of holism, a continual process for individuals, families, communities, and nations (Verniest, 2006)

- The *Canadian Index of Wellbeing* (CIW) “measures what matters” in eight domains: civic engagement, living standards, healthy populations, community vitality, time use, educated populace, ecosystem health, and arts & culture (www.atkinsonfoundation.ca/ciw);
- The Second *International Conference on Gross National Happiness*, Rethinking Development, Local Pathways to Global Wellbeing, St. Francis Xavier University, Antigonish, Nova Scotia, Canada, June 20-24, 2005;
- The *Beyond GDP* Conference (www.beyond-gdp.eu), Brussels, November 2007, identified the need for societies and policy makers to reach consensus on the economic, social and environmental indicators of the well-being of nations. This is viewed as vital to meet the challenges of environmental sustainability, new social risks, migration and security. To accomplish this requires exploring the full potential of existing measures and decision-support tools, such as the CIW, Human Development Index, Ecological Footprint, Genuine Savings, Index of Sustainable Economic Welfare, Calvert-Henderson Quality of Life Indicators (www.calvert-henderson.com/health.htm), Happy Planet Index³ (www.happyplanetindex.org);
- The World Health Organization (WHO, 1986) lists social determinants of health as: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity (p. 1); the WHO’s Commission on Social Determinants of health emphasizes unemployment, unsafe workplaces, urban slums, globalization and lack of access to health system.
- The Genuine Progress Index (GPI) for Atlantic Canada (www.gpiatlantic.org), founded in 1997, is an independent, non-profit research and education organization committed to the development of the GPI as a new measure of sustainability, wellbeing and quality of life. A GPI Atlantic study in Kings County and Glace Bay (Pennock, Pannok, Panozo, & Coleman, 2008), two Nova Scotia communities with very different socio-economic profiles, revealed that Nova Scotians value friendship and generosity over material wealth.

A Potpourri of Local Exemplars

Even as we lament that art is getting short shrift in these policy statements and directives for the health of our communities and planet, we extol the multitude of exemplars of art for health appearing in our very own community and province over the past few months of writing this report.

- *Art for Health*, a 7-week course targeted to care partners, October 7 – November 15, 2007, was sponsored by Antigonish County Community Education and held in the Royal George’s Health Connections suite. Brendan Dunbar included a half-page story in our local (Antigonish) newspaper *The Casket* (see Dunbar, September 19, 2007; see dedication page this report).

³ The (un)Happy Planet Index, an index of human well-being and environmental impact affiliated with the New Economics Foundation. We were drawn to the link for calculating our own HPI, and present this as an exemplar of art (play and games) engaging world citizens in reflecting on how their everyday practices affect their own health and happiness and in comparison to others who inhabit our planet.

- *The Casket* of April 9, 2008 featured “Picture Perfect: Drawings Allow Impaired Artist to Share Life Experiences,” Brendan Dunbar’s headline for his article on 43-year old local artist Kelly Farrell, who had some of her pastels on display at the Tall and Small Café. She is visually and hearing impaired, and uses art as “her main way of sharing her experiences with others” (p. 5A).
- In *The Casket*’s leisure and living section, also on April 9, Corey LeBlanc reported on a participatory play and health workshop, “Are We There Yet?” written by Jane Heather, and dealing with responsible decision-making and sexual health for 14-16 year olds to be presented by the Guysborough-based Mulgrave Road Theatre on a 10-school tour of Northeastern Nova Scotia in April.
- Laura Fraser from the Cape Breton Bureau of *The Chronicle Herald* (April 28, 2008) reported on the drum circle that Shelley Allen led during a session about music therapy at the Cape Breton Health Research Symposium. Shelley, who works with disabled adults across the municipality, attested: “Even just hearing the rhythm can lift a lonely person’s spirits. There was an older woman who used to come in and just be very angry. Now she’ll pick up a tambourine and smile” (p. B4)
- Stephen Pederson, Arts reporter for *The Chronicle Herald* (May 2, 2008) gives the story behind the Atlantic premiere of Diane Benjamin’s Breast Cancer Oratorio, *Where I Live*, performed by the Aeolian Singers joined by the Halifax Women’s Chorus, at the Rebecca Cohn Theatre in Halifax. Benjamin said she wanted to be the voices of women with cancer; a cancer survivor told Benjamin she “got it” when she heard this oratorio. *Where I Live* covers different pieces of the journey, “some of the hard and some of the more pleasant things. ... I wanted to get in the concept that we’re living in a world that contributes to our ill health, and we need to take care of that as well as take care of our bodies” (p. E2).
- Andrea Nemetz, entertainment reporter for *The Chronicle Herald* (May 3, 2008, p. C3) out of Halifax, included a half-page of colour photographs of the porcelain plates designed and autographed by celebrities, including Anne Murray, Muhammad Ali, hockey player Sidney Crosby, MP Peter MacKay, and Toronto R and B singer Deborah Cox, which the Parkinson Society Maritime Region auctioned off in its second annual Plates For Parkinson’s campaign.
- Elissa Barnard, the arts reporter for *The Chronicle Herald* (May 8, 2008) headlines her article on the world premiere of a new play at the Super Nova Theatre Festival “*In Pink* Explores Life Beyond Anti-Bullying Crusade” (p. E1). The two-man, one-act play is the story of the two Grade 12 students at a rural high school in Nova Scotia who in the fall of 2007 led half of the school’s 830 students in wearing pink tank tops after a Grade brought was threatened on the first day of school for wearing a pink shirt.
- Elissa Barnard reported in *The Chronicle Herald* (May 11, 2008) that “flowers from the past ... dance in line and pastel colour in [Nova Scotia artist and poet] Rose Adams’ latest exhibit” *As Memory Fades* (p. B3), which closed May 17, 2008. Adams’ exhibit drew on her artist-in-residence experience in the Memory Disability Clinic at the QEII Hospital in Halifax as well as family experiences of memory loss.

- In July, 2008, Rose Adams' exhibit, *Working Memory*, at Anna Leonowens Gallery in Halifax, also features a series of 65 manipulated relief prints that respond to a symptom of Alzheimer's disease. Her drawings investigate the relationship between anatomical representation of the brain and organic plant forms (The Chronicle Herald, July 10, 2008, p. E5)
- Cathy Von Kintzel reported in *The Chronicle Herald* (May 13, 2008) on a student-designed backpack with a springy, elasticized interior pouch that takes the load off the lower back by evenly distributing the weight. Senior biology students at St. Francis Xavier University developed this artistic design in a seminar-based course on biomechanics led by professor and visual artist Dr. Edwin Demont.
- *What about Trees?* The Guysborough Antigonish Pictou Arts & Culture Council (GAPACC) and St. Francis Xavier University Art Gallery are collaborating to present a multipart show around town and campus June 9-27, 2008. The show invites community engagement, linking trees to ecological and health engagement (e.g., knit "sweaters" for trees; visit our "tree houses"). The Call for Submissions for local art pieces (unjuried call) to accompany a Canadian-Italian exhibition about trees, *The Forest for the Trees*, elaborates: "How do trees participate in our lives as metaphors and signs for ideas from strength to escape, even tenderness? In what ways can we re-value trees?"
- Laura Fraser from the Cape Breton Bureau of *The Chronicle Herald* (May 30, 2008) and Sue Bailey of the Canadian Press reported on the activities marking the National Day of Aboriginal Action. "The rhythmic thumping of the drums symbolized the heartbeat of the Mi'kmaq people who gathered Thursday to demand that Ottawa live up to its treaty promises" (p. B4). After the rally in Sydney, NS, Elisabeth Marshall, spokeswoman for the Eskasoni Treaty Beneficiaries Association, spoke of the 90% of Eskasoni residents living off welfare payments. "Ribbons in sacred Mi'kmaq colours of red, yellow and white blew in the wind as aboriginal dancers moved in time to the drummers before the group snaked its way along Kings Road to the heart of downtown Sydney.
- Monique Muise reported in *The Chronicle Herald* (May 30, 2008) on the keynote address delivered by Dr. Jerry Nielsen, a National Science Foundation physician, at an evening in Halifax's Cunard Centre, organized by the Canadian Breast Cancer Foundation to honour 50 Atlantic Canadian women over the age of 50 who have made a significant impact in their communities. The American physician, who made headlines, when she discovered a lump in her breast and had to perform the biopsy and cancer treatment herself while in the Antarctic, said: "I use the South Pole to tell a story, but the story is really about what's important in life. It's important to make choices about our lives rather than just being taken by the tide" (p. B4).
- Tom McCoag's (2008, June 12) report in *The Chronicle Herald* on the Miners' Memorial Day services in Springhill is headlined "Trapped Springhill miners survived on songs and hope" (p. B1). Former CBC reporter Jack McAndrew remembered miner Caleb Rushton, who died Tuesday June 10, 2008 at age 85, as one of the men who, in 1958, kept up the spirits of the trapped miners. "After the men ran out of food and water, Mr. Rushton persuaded them they could survive on songs and hope" (pp. B1, B9).

- Monica Graham (2008, June 18) reports in *The Chronicle Herald* on the efforts of the Butterflies and Blooms non-profit group in River John, Nova Scotia to integrate mental health services clients, disabled people, lonely elders, children and others by bringing them together at the Royal Canadian Legion garden in River John. Joan MacKeigan recounted examples of people she felt left out until they began sharing time in the garden, saying “Something magic happens” (p. B5). Beginning January 2009, Norman Goodyear will teach a course on horticultural therapy at the Nova Scotia Agricultural College. Mr. Goodyear noted the psychological, physical and vocational implications of horticultural therapy: “The psychological benefits of gardening include the socialization of working in groups, while the activity also encourages exercise and dexterity, and helps develop useful skills” (p. B5).
- Arts reporter for *The Chronicle Herald*, Elissa Barnard (2008, July 11) reflects on her conversation with multi-media artist Andrew Forster on his solo show *Duet/Trio/Quartet* at Saint Mary’s University Art Gallery to August 3, 2008. Two artworks based on movement include footage with dancers exploring the invisible socio-political background of personal trauma. The inspiration for the movements in the dance piece of the exhibit, an incident when a would-be suicide bomber, Palestinian teenager Hassam Abdo, surrendered to Israeli forces — “the movements grow increasingly agitated and violent then slow down again” — as readily apply to “a caregiver dealing with an Alzheimer’s patient [as] the boy disarming himself” (p. E5). Forster wrote a fictionalized account of the words of a First Nations homeless woman, who began shouting angrily in response to the dancers performing these movements in a park in Montreal; he felt her voice needed to be part of this installation and this account entitled *Sorry* is presented as a translucent screen that opens the Halifax exhibit.

A Medley of National Exemplars

As a preliminary to preparing this report, we also undertook a Canada-wide inventory of both academic and popular media to identify instances of art in its various forms as a determinant of health. Opportunities for teaching and learning, practice and research, in the creative arts and health — in both formal and informal healthcare settings — are proliferating. Some upcoming events and recent offerings give a flavour of the range and diversity in the art-for-health movement:

- Creative Responses to Death and Bereavement, offered on line and in class through Continuing Studies, University of Western Ontario, London, Ontario, Spring 2008 (<http://www.uwo.ca/studies>)
- *Abilities Arts Festival: A Celebration of Disability Arts and Culture* held over 2-3 days in Toronto, will produce in 2008 a film/video series of works by artists with disabilities, including multidisciplinary, visual, performing and media arts, based upon works presented at two previous PROJECTIONS International Disability Film Festivals (see www.abilitiesartsfestival.org)

- The third international conference on *Creative Expression, Communication and Dementia* (CECD), hosted by The Society for the Arts in Dementia Care, the Institute of Neurosciences, Mental Health and Addiction, at Emily Carr Institute of Arts and Design on Granville Island Vancouver, May 30-31, 2008. Mindscapes 2008, an exhibition of art produced by seniors with dementia will be featured June 2 -16, 2008 at Emily Carr Institute.
- *Engaging Reflection in Health Professional Education and Practice*, an interdisciplinary conference, May 13-15, 2009, Faculty of Health Sciences, University of Western Ontario. The Call for Papers includes as key topics “Engaging Reflection through Narrative” and “Engaging Reflection through the Arts and Humanities.”
- *End Notes: A Symposium on Death and Dying*, Saturday, May 15, 2:00-5:00 p.m., at The Grey Zone of Health and Illness, The Culture of Cities Centre, Bloor Street, Toronto. “An afternoon of reflection in mixed media — talk, music, film, song, spoken word — on the meanings and cultural expressions of death and dying. ... This symposium brought together speakers from the Grey Zone project, performing artists, and presenters whose professions require familiar and close relations with death and dying.” The aim of this ongoing series is to treat such questions as symptoms of the modern city and its hopes and fears for well-being.
- *Celebration of Creative Aging Symposium* June 3, 2008, Edmonton, Alberta. Held in conjunction with the Edmonton Creative Age Festival, this Symposium will showcase presentations and workshops that explore the significance of arts-based involvement over the life course (<http://creativeagefestival.ca>);
- *A Grandmother’s Tribe* (Documentary by Borderless Productions, about the lives of two Kenyan grandmothers who have found themselves in the middle of the African AIDS pandemic). Grands & Friends, a group of local Ottawa women with the Ottawa Catholic School Board and affiliated with the Grandmothers to Grandmothers Campaign (the Stephen Lewis Foundation: <http://www.stephenlewisfoundation.org>), hosted a viewing of this film on April 21, 2008, and introduced guest speaker Elaine Munro, the film’s Executive Director. Elaine was in Ottawa presenting the film to the Canadian Association of Nurses in AIDS care.
- The Request for Proposals (RFP, deadline May 30, 2008) from *The Canadian Index of Well Being: Measuring What Matters* (www.atkinsonfoundation.ca) is commissioning a *Literature Review and Domain Report* by one or more experts in the field of Arts, Culture & Recreation, “providing a comprehensive survey of the ‘things that matter’ in the domain.”
- *The Community-University Exposition* (CUexpo) held in Victoria, British Columbia, May 4-7, 2008, addressed many of the fundamental conditions and resources for health that the WHO (1986) has identified, e.g., “community-engaged scholarship, knowledge exchange for making a difference in areas of sustainability poverty, housing and homelessness, healthy living, climate change, community economic development, social economy, food security,

arts-based activism, Aboriginal leadership in research” (see www.cuexpo08.ca/assets/CUexpo%20proceedings.pdf).

- Devin Stevens reported in *The Chronicle Herald* (June 8, 2008) on a photo exhibition called *Young and Fearless: Inspiration of Cancer Survivors*, which opened June 1 at Queen Street Studios in Dartmouth to mark national Cancer Survivor Day. An Ontario photography group PhotoSensitive, which aims to raise awareness of critical worldwide issues with photography, contacted Shari Tucker, a photographer and owner of Queen Street Studio, with the idea for their Cancer Connections project. Cancer survivor Nora Gross, whose photos are part of the exhibition, states that “the photos are there to remind people that cancer involves more than just statistics. ... It’s a connecting disease” (p. A3).
- Embedded in Helen Branswell’s obituary for Sheela Basrur, who was the public health officer for the city of Toronto, and gave a face and hope to the SARS crisis in Ontario in 2003 (she died June 2, 2008 after a 17-month battle with cancer), is her art of communication. Dr. Bonnie Henry who served as an associate medical officer of health in Toronto during Basrur’s tenure “marveled at Basrur’s easy turn of phrase. ... ‘I used to ask her if she practiced those — ‘We’re fighting the fire while we’re building the bucket,’ ... [was] a famous Basrur description of what it was like trying to contain SARS with antiquated disease surveillance tools” (*The Chronicle Herald*, June 8, 2008, p. A11).
- *TAKE heart: Prescriptions for ArtCare*. A celebration of the 5th anniversary of B.C. Artists in Healthcare Society on Saturday, November 8, 2008, at the City of Port Coquitlam’s Arts Village. An invitation to participate in ten “best of ArtCare” projects for community, cancer and palliative care settings. Create Simple paper projects with origami artist Makiko Morelli, participate in an installation of Bandanas of Hope, create unique greeting cards.

Section 2: The Dialectic Dance of Theory and Practice

Paul Camic (2007), a clinical psychologist and co-editor of the new *Arts & Health Journal*, highlights how the arts and art therapies focus on the *process* rather than the final *product*, which tends to take precedence in Western culture. He has coined the acronym, CISMEW — “Creating Images, Sound, Movement, Enactment, and Words —... [to help] us move away from associations with formal artistic training, styles of expression, and critical analysis, and place our focus on the creative and therapeutic processes involved within sound making, image producing, movement, ritual, and writing, all of which were the forerunners to the arts as we know them today” (p. 261). Our own experience, empirical research, and recent survey of the media offer exemplars of the enfolding of both process and product in art modalities that are illness or disease-specific as well as at the level of population health, associated with social determinants of health such as peace, poverty, and social justice. This waltz of process and product parallels the dialectic dance of theory and practice that we elaborate in this section.

Following Canadian social theorist Edmund Carpenter, we distinguish between the gift economy of evanescent art associated with service workers — gardeners, hairdressers, cooks — and the market economy of preservable art (Lander & Graham-Pole, 2008). Art critic Suzi Gablik (1991) laments that our models of art, typically oriented to autonomy and mastery, are uncongenial to the importance of relationship and harmonious social interaction (p. 125). Gablik (1995) calls for a connective aesthetic, one that heals, rather than confronts, shaped not by its relation to the market place, but by its commitment to social practice. “The old specializations of artist and audience, creative and uncreative, professional and unprofessional — distinctions between who is and who is not an artist — begin to blur” (p. 86). This echoes medical sociologist Arthur Frank (2004), who considers the telling and receiving of stories between caregiver and cared for a gift relation rather than a professional exchange regulated by the marketplace. To emphasize this, he draws on the story of another Canadian, Michael Ignatieff (1984), who, in *The Needs of Strangers* laments the state-regulated and mediated quality of his relationships with the elderly poor, who are his neighbours in London, to ask “How did we [in the Canadian and other publicly funded systems, or by some private insurer as in the United States] get to this form of mediated generosity?” (p. 124). Our exemplars support the evanescent art of loving service as a powerful determinant of health in therapeutic contexts as well as political and policy change contexts that constitute social determinants. We propose that art forms located in the gift economy are an under-valued and under-researched determinant of health (p. 209).

The theory of the connective aesthetic in practice is the work of experienced mask-, puppet- and story-makers, Lanity Gerity and Ned Bear (2007). In response to the suggestion from The Canada Council for the Arts, they made a formal grant proposal, securing funding for a week-long art camp for approximately 25 intergenerational participants from Malisset native communities in New Brunswick to encourage healthy ways of doing and “being in which the whole Self feels bonded with the community and with the land (perhaps similar to what Freud called the ‘oceanic’ feeling)” (p. 239) This intergenerational art-making culminated in a puppetry narrative to the larger community.

The World Health Organization’s Commission on Social Determinants of Health (CSDH, Introduction, p. 1) emphasizes social factors to ill health and inequities, and identifies these determinants using the deficit language of unemployment, unsafe workplaces, urban slums, globalization and lack of access to health systems (http://www.who.int/social_determinants/en). The association of art with pleasure, appreciation, celebration, festival, and community is a positive reconfiguration of social determinants of health, more closely allied with the Ottawa Charter for Health Promotion (WHO, 1986), in which health is declared as “a positive concept emphasizing social and personal resources, as well as physical capacities ... go[ing] beyond healthy life-styles to well-being” (p. 1). In Chapter 8 of his study, Matarasso (1997) couples health and well-being in elaborating the benefits of participation in the arts in five areas:

- Have a positive impact on how people feel
- Be an effective means of health education
- Contribute to a more relaxed atmosphere in health centres
- Help improve the quality of life of people with poor health
- Provide a unique and deep source of enjoyment (p. 75)

The creative process, which Kuhn (1996) equates with the human propensity for cooperation, is a powerful social and personal resource that enables the artist in all of us to “*sustain a point of view, despite the flux of events, bolster an image of who [we] are, and maintain a vision of what [our] world (that complex network of interrelations) is and what it can become*” (emphasis original, p. 223).

We build extensively and gratefully on Nancy Cooley’s (2003) survey research paper on arts and culture in medicine and health, which was carried out in 2002 and draws principally on secondary sources. Her research remains the most comprehensive Canadian resource that connects arts and culture to the determinants of health outlined in *White Paper, A New Perspective on the Health of Canadians* (Lalonde Report), published in 1974. These key determinants include:

1. income and social status (including personal control and discretion);
2. social support networks;
3. education;
4. employment/working conditions;
5. social environments;
6. physical environments;
7. personal health practices and coping skills;
8. healthy child development;
9. biology and genetic development;
10. health services;
11. gender, and
12. culture

Cooley’s survey stops short of declaring art as a determinant of health: “There is growing evidence that arts and cultural activities and institutions can and do play important roles in positively affecting at least seven of these [Health Canada’s] key determinants of health. The report does not address employment/working conditions, or the economic contribution and impact of the arts, as “it is widely recognized and extensively documented elsewhere” (p. 19). This report preceded the WHO’s Commission on Social Determinants of Health (CSDH), and the growing awareness of SDH as a focus of research. Our report will present evidence that the research on the correlation between the arts and poverty, low income and unemployment is under-theorized and under-researched. Cooley’s report focuses on six determinants of health, grouping them into three research clusters:

- ❖ Personal Confidence, Control and Social Connectedness: 1) Income and social status (personal control and discretion); 2) Social support networks; 5) social environments; 12) culture
- ❖ Education
- ❖ Supportive Physical Environments

Cooley summarized the research and reported experience in Canada, the United Kingdom, the United States and elsewhere as “clear evidence that participation in a variety of arts and cultural activities can support and positively contribute to these key determinants” (p. 36).

Cooley’s and other research also provide clear evidence that both **Viewing** and **Doing** art are determinants of health. First, the doing: Community arts are clearly connected to social inclusion/exclusion as a determinant of health. Second, the viewing: Being a member of an audience in live arts performances, going to museums and galleries, and exposure to aesthetic environments — “hospital lobbies may now have gardens, waterfalls, and piano music” (Postrel, 2008, p. 119) — also affects social inclusion and, in Cooley’s research “is shown to contribute to individual health through a variety of mechanisms, including: supporting the expression and sharing of emotions, ... strengthening the sense of social connection; and taking action, reaching out for stimulation and growth by going to a performance or cultural event” (p. 37). Recent studies of community gardens suggest added health impact from viewing and doing in combination (see Bartlett & Kinsella, 2008; Frey, 2007; Hazen, 2008).

Putland (2008) draws attention to the tensions and preoccupation with the biomedical, deficit-centered model of evidence-based medicine and evidence-based practice, and the “curious absence of a focus on ‘pleasure’ in public health,” given the substantive evidence of participants’ intense experience and physical sensations of pleasure that accompany participation in arts and cultural activities. Like Matarasso, she advocates that “a place should be made for hedonism” in health care, and attributes the neglect “to a combination of the biomedical preference for studying illness and its causes, and the more deep-seated assumptions in western ideas about what constitutes ‘serious’ scientific pursuit” (p. 272).

An accompanying “curious absence” of a focus on cooperation, or the gift economy is addressed in Lander and Graham-Pole’s (2008) evidence of love medicine as the essential creative process of care. Evanescent art exists only in the process of loving care, which becomes art as care partners together “create meaning, construct form, recognize patterns, and place values on their relationships with others” (Kuhn, 1996, p. 223). Matarasso (1997) concludes his impact study of art for health and well being with one comment to serve as a summary of “people’s expressions of enjoyment *ad infinitum* ...

‘Meeting other people, and being a small part of the whole, gives me pleasure — an important element in anyone’s life’” (p. 78)

Highlighting art as a *positive* determinant of health does not gloss over the structural determinants of global disease: socio-economic, biotechnological, political and environmental (Marmot, 2006). Although infection has long been dominant, non-communicable illness is now in the ascendant. In combating these non-communicable diseases, including heart disease, cancer, diabetes and neuro-degenerative diseases, the key factors of poverty, lack of education, social exclusion, inequity, and environmental devastation demand that health promotion takes a positive focus on opportunity, empowerment, security and dignity. An emphasis on social inclusion as a key positive health determinant for improving outcomes at a population level invites the powerfully inclusive nature of art practices (crafts, dance, digital arts, drama, music, narrative, ritual). These practices evoke primal interdependent ties, and the human universals for building bonds among cultures, so evident in the Pangea Day films. Their communal and overlapping physical, social, psycho-spiritual and environmental benefits have led in the past 20 years to their implicit recognition in high-income nations as health determinants. Meanwhile, indigenous tribal cultures have stayed constantly aware of their rich traditions of art and ritual in healing and spirituality (see MacNaughton et al., 2005).

Our sources of evidence and analysis identify art as an integrating determinant of health that underpins existing social and structural factors and addresses human, technical, and financial resources, implementation processes and barriers, differential availability, acceptability and accessibility, socio-economic context, and structural effects to date. The arts effectively create supportive environments for health “as a resource for everyday life, not the objective of living” (WHO, 1986, p. 1), insofar as they unblock even if momentarily “the self-involved habits of mind with which people normally relate to what they consider the real world. ... By the very fact of being perceived as representational rather than real, ... [they] may free people to experience themselves in an alternative mode, the mode of natural identification with the possibilities of existence in a larger world that contains everyone” (Rosch, 2001, p. 245). “The appreciator of the arts [and the participant in] ... always knows, at some level that (s)he is not the character in the art work. Thus (s)he can fully identify with and participate in the vividness of that character’s life and world without the pervasive filter of self interest” (Rosch, p. 246).

The power of art “to awaken a form of knowing [and healing] of a different quality with different implications than does its scientific expression” (Rosch, p. 241) stands in contrast to the biomedical, evidence-based model of healthcare that seeks to control nature. Too often the effect is that people are treated as “*mere* products of nature and as such without value or meaning. ... When the underlying human knowledge of oneself as part of nature is evoked, ... a positive understanding with links to a sense of inherent connectedness and values — as expressed in Mary Oliver’s [poem] ‘Wild Geese’” (p. 241) — mediates suffering and engenders hope.

Catherine Belling (2006) describes an art intervention with medical students, which addresses medical uncertainty and illusions of control head on. They undertake a simple in-class exercise of writing their own endings for a short narrative “Perspective Shift,” about an ambiguous CT scan, taken from the *Journal of the American Medical Association*, which prompts them to apply literary-critical techniques of close reading both to the content and the form of a story that enacts the challenges of making decisions in the face of uncertain knowledge.

Anne Kinsella (2007), teacher and researcher in health professional education in the Faculty of Health Sciences at University of Western Ontario, draws attention to the use of the literary arts to stimulate practitioner consciousness, to promote “awareness of life’s ambiguity and contextuality, as opposed to a false sense of certainty” (p. 43). She describes a work of fiction, *Cereus Blooms at Night* (Mootoo, 1998), a narrative of Mala Ramchandin’s life as told through the eyes of a male nurse, Tyler, as a way of helping practitioners “recognize the partiality of their knowledge as opposed to infusing a false sense of one’s view of the world” (p. 43).

Arts-based researchers Jon Prosser and Donna Schwartz (2003) also describe a different quality to the knowing and healing that images can awaken, specifically photography:

Through our use of photographs we can discover and demonstrate relationships that may be subtle or easily overlooked; we can communicate the feeling or suggest the emotion imparted by activities, environments and interactions, and we can provide a degree of tangible detail, a sense of being there and a way of knowing that may not easily translate into other symbolic modes of communication. (p. 116)

A visual illustration of this different quality to the knowing and healing, “poignant in its simplicity” (Clarke, 2007) is *60 Day Free Trial*, a series of relief prints that Rose Adams, as artist-in-residence at the Queen Elizabeth II Health Sciences Centre, Memory Disability Clinic in Halifax, developed in response to the Symptom Guide™ a web tool for caregivers to track the progress of Alzheimer’s disease (available at www.dementiaguide.ca). Dr. Kenneth Rockwood, Professor of Alzheimer’s Disease Research at Dalhousie University and staff physician at the QEII, founded the artist-in-residence program at the Memory Clinic, and gave Rose permission to use the website as the stimulus for the prints. In each of the images, the red and white print of the brain is marked with images or words that illustrate a specific symptom.

In conversation with Rose about her work, she drew our attention to the images becoming progressively murkier as the symptoms accumulated. The series ends with a print representing autopsy, which remains as the definitive mode for positive diagnosis of the disease. This series was one of the central pieces for Adams’ exhibition *Mind Works*, at the Craig Gallery in Dartmouth, May 3-26, 2007. We present here the series, as well as the print of a fragmented map of Halifax and

Dartmouth imposed on the brain, to “re-vision” the symptom and diagnosis of “disorientation to place.” It is in this way that art trades in meanings, as Matarasso puts it, and measures what matters, which the Canadian Index of Well-Being seeks.

Figure 2: *60 Day Free Trial*, Courtesy of Rose Adams



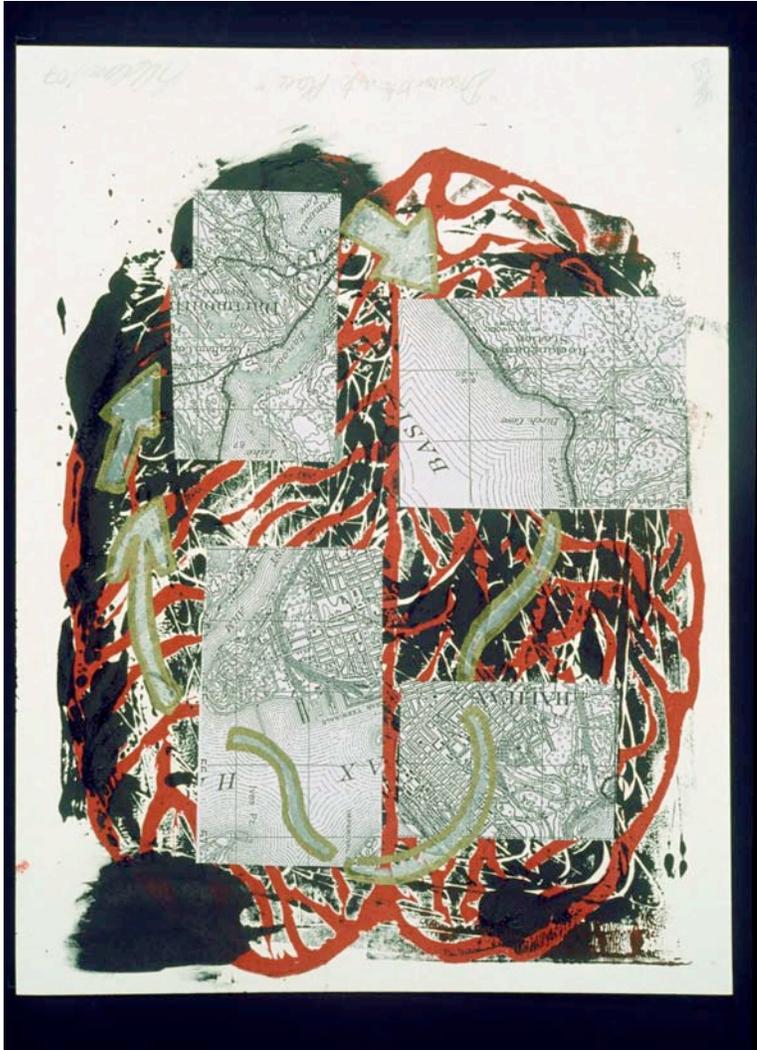


Figure 3: Disorientation to Place (Symptom in 60 Day Free Trial, Courtesy of Rose Adams)

Pratt and Thomas (2005) locate the diverse forms of art for health in three areas: arts in healthcare settings; community arts in health promotion; and the medical humanities focused on incorporating arts into professional healthcare education and practice. Graham-Pole (2007) includes arts-based health research as another category and qualifies the three areas as applicable to modern Western healthcare: (1) *practice*: personal and professional care; (2) *education*: higher and continuing education for health professionals, personal caregivers, and care partners; and (3) *research*: arts-informed health research methodologies; and, the evaluation of art and art therapies as holistic healing modalities (p. 1).

Our recent investigation supports an additional overarching category: (4) art as *health activism*: advocacy for systemic change at a policy and legislative level subsumes other categories, and recognizes art as a social determinant of health, and art for health as a social movement (see Lander, 2007). Reflecting First Nations' approaches to art for health that bind Self to community and the land (Gerity & Bear, 2007), art as health activism deliberately builds in "advocacy for those aspects of individuals and society that are disenfranchised" projecting "an awareness of the interconnectivity between individual and collective, between a person's suffering and social imbalance, as well as an active commitment to personal and social transformation" (Hocoy, 2007, p. 31).

Art as a *Social Determinant of Health*

Art as health activism assumes that justice is good for our health (Daniels, Kennedy, & Kawachi, 1999) and that diverse art forms commonly underpin health promotion and social change as social policy and public policy.

The rationale for the Social Determinants of Health List-Serv⁴ (SDOH@yorku.ca) initiated in January, 2004, and moderated by Dennis Raphael, Professor at the School of Health Policy and Management, York University, draws attention to social injustice related to poverty but not access to the arts and creative self-expression:

There is increasing recognition in the health promotion field that the factors that are the prime determinants of health are outside the health care and behavioural risk arenas. Many of these factors involve public policy decisions made by governments that influence the distribution of income, degree of social security and quality and availability of education, food, and housing, among others. These non-medical and non-lifestyle factors have come to be known as the social determinants of health. In many nations — and this is especially the case in North America — recent policy decisions are undermining these social determinants of health.

⁴ To subscribe: Send the following to listserv@yorku.ca in the message section:
subscribe SDOH yourfirstname yourlastname

To send a message to the list, address it to: SDOH@yorku.ca [no attachments]

To find out more, visit <http://quartz.atkinson.yorku.ca/QuickPlace/draphael/main.nsf>

As another exemplar among many in this report, art as a social determinant of health is slipped to us sideways. The SDOH bulletin of November 26, 2006 (<http://tinyurl.com/yltpdf>) quotes Bertolt Brecht from *The Threepenny Opera* to critique the choice of the Ontario medical officer to highlight the growing “obesity epidemic” rather than poverty as a root structural cause. “People receiving social assistance CANNOT have healthy diets.”

Food is the first thing, morals follow on. So, first make sure that those who now are starving get their proper helpings when we all start carving.

Raphael’s (2002) earlier research for the Centre of Social Justice Foundation for Research and Activism (see www.socialjustice.org), entitled “Social Justice is Good for Our Hearts” makes the point that societal factors, not lifestyles are major causes of heart disease in Canada and elsewhere. People die younger in societies with greater inequalities in income. Art is folded into Raphael’s Message 3 on social exclusion, which is the means by which low income causes cardiovascular disease; he notes that individuals suffering from “material deprivation also have less exposures to positive resources such as education, books, newspapers and other stimulating resources, attendance at cultural events ...” (p. 21).

Bread and Roses

Associating art and culture with the claim that “social justice is good for our health” evokes the imagery of *bread and roses*. This slogan was first used by women garment workers in New York in 1908 when they marched after the death of 128 women in a factory tenement fire. It later became the campaign song for textile workers throughout New England. The lyrics written by James Oppenheim and published in 1911, subverts the old phrase “bread and circuses,” which implies that by both feeding the people and entertaining them, you can control them. Rather, bread and roses signals that people need both “to enhance the quality of their lives in ways that are relevant to their urgent problems and real concerns and which lift their spirits in difficult and troubled times” (Thompson, 2002, p. 30).

The singer and activist Mimi Fariña, of lesser fame than her older sister, Joan Baez, was the first to turn Oppenheim’s poem into a song in 1974 at the same time as she founded the organization *Bread and Roses* (see www.breadandroses.org), presaging the art-for-health movement in bringing music to places that are usually not exposed to it, like nursing homes, hospitals and prisons. Celebrity art for health came to the world’s attention with Bob Geldof and LiveAid in 1985. Although Live Aid wasn’t the first (remember Beatle George Harrison’s concert for Bangladesh in 1971?), it was the biggest: an estimated 1.4 billion of the planet’s five billion people watched Geldof’s “global jukebox.”

A common thread between *Live Aid* and *Bread and Roses* is that both Geldof and Fariña were responding to a message slipped to them through art. In 1984 Bob Geldof

had seen a BBC documentary about the famine in Ethiopia — which claimed more than one million lives in 1984-85. Mimi had attended a B.B. King concert with her sister at Sing Sing, the infamous prison in New York, and was reminded of the time she had seen Joan perform for mental patients. Remembering that the patients, some of them catatonic, began to hum and move to the music, Mimi was moved to produce free concerts for the institutionalized. She recalled this moment that spawned the organization:

It was an incredible moment. ... It was probably the first time I saw the impact music could have on a person confined to an institution.

By the time of Mimi's death from cancer in 2001, *Bread and Roses* was giving over 500 shows annually, in which sister Joan as well as Paul Simon, Van Morrison, and Canadian musicians Neil Young and Joni Mitchell participated. Joan's tribute to Mimi serves as testimony that social justice delivered through art is especially good for health.

Mimi filled empty souls with home and song. ... She held the aged and forgotten in her light. She reminded prisoners that they were human beings with names and not just numbers.

“We want roses too” is a call for the pleasure and joy that Putland (2008) finds missing in public health policy and research. Bread and roses framed an arts-based learning and knowledge mobilization project for [low income] street-involved women in Victoria, presented by adult educators Darlene Clover and Corrinna Craig (2008) at CUexpo. “The women were valued not simply for ‘what’ they knew but how they creatively produced that knowledge through symbol, metaphor, and imagery. ... While many members of society have the opportunity ... to engage in artistic and cultural activities, homeless/street-involved women are expected to forgo this in favour of getting their problems ‘fixed’ and obtaining marketable skills” (p. 62). Although this project directly relates to “shelter” — one of the fundamental resources and conditions for health identified by the WHO — overwhelming evidence for art as determinant of health emerges in the finding that the “paint, tile mosaic, fabric and laughter ... offered a path to a greater sense of humanness in the women's own and those of others” (p. 62).

The Spread the Warmth Art Show and Sale at Nova Scotia Community College in Truro, Nova Scotia in December, 2006 is a quintessentially Canadian exemplar of Bread and Roses. The invitation to “warm your body with hot cider and your spirit with works of art ... [was] a novel way of allowing people to help the needy as they come out to an art show” (The Chronicle Herald, 2006, p. B2). Catherine Atkinson, the art show coordinator, worked with the local food bank to distribute new or gently used blankets available to those who might need the extra warmth.

Toronto street nurse Cathy Crowe (2007) supports her “nursing epiphany: Homelessness is a *man-made* disaster” (p. 19, emphasis original) with an excerpt from Bertolt Brecht's “A Worker's Speech to a Doctor.” The question in the last line of the poem — “Where does the damp come from?” — shapes her job description: “I'm a nurse, a street nurse, and what I see ‘downstream’ in society necessitates that I look

‘upstream’ to find the root of the problem. The necessity for street nurses necessitates that our nursing be concerned with politics” (p. 6). In conjunction with the Toronto Disaster Relief Committee, the Church of the Holy Trinity holds a Homeless Memorial each month “on the church steps in the shadow of the Eaton Centre, followed by a meal inside the church. ... [T]he service varies but candles are always lit, poetry is read, a song is sung, and political statements are made. Names of homeless men and women who have died since the last month are added to the board” (pp. 38-39).

Trevor Hancock, a public health physician and health promotion consultant, was the force behind the WHO’s Healthy Cities project as a means of operationalizing the Ottawa Charter for Health Promotion (WHO, 1986). He is the leader associated with Healthy Toronto 2000 project, and most recently, the re-establishing of the BC Healthy Communities initiative. Art is implicated in Hancock’s examples of ways in which we can build a healthy community — one that has high levels of social, ecological, human and economic “capital,” which in combination he names “community capital” (Hancock, 1999). Without directly naming art as a social determinant of health, or claiming the community gardens that have sprung up in Toronto and other North American cities, *as art*, he nonetheless provides compelling evidence of how these gardens, which provide an “oasis of greenery, flowers and even habitat for various insects and birds” (p. 279) build the four aspects of community capital.

Community gardens build social networks across ethno-racial divides (*social capital*). Community gardens often grown organic food and provide an opportunity for composting (*ecological capital*). People learn about gardening, cooking, and nutrition alongside cross-cultural and intergenerational learning (human capital). Community gardens often provide cheaper sources of food in low-income communities, and may even become a source of income and employment (*economic capital*).

Finally, Hancock offers evidence of the impact of art, its potential to spread to other forms of social and economic activity, giving as an example, one community garden in California, which was set up for and with homeless people, to help them with “access to food, job skills, social networks and links to the neighbouring residents. Participants may become interested in broader aspects of the food system and may get involved in bulk-buying groups, food co-ops or community-supported agriculture” (p. 279).

Grandmother grad student Jane Hazen (2008) enlisted the university in her town (California State University, Chico) to conduct community-based, participatory research on Nature Arts in The Park. The project, which she presented at CUexpo in Victoria in May 2008, began with a focus on her urban home garden with her auntie, expanded to the local garden club, and nature programs, setting into motion her graduate research, using art (community garden stewardship) as the lens in which to unmask other determinants of health, such as age, class and ethnicity. Her research adds a fifth category — political capital — to Hancock’s four dimensions of community capital. She looked to the university in her town to help her with her research question on the “feminization of age”: “What does it mean if our community stewardship of parks and culture is

maintained by elderly women with little or no economic or social structure to mentor upcoming stewards, cultural knowledge bearers or advocates?” (p. 108).

Hancock embodies the impact of art in its “potential to spread” — to start an epidemic, in Gladwell’s (2000) terms. The Healthy Cities initiative in Noarlunga, Australia, identifies the importance of visits from the WHO Europe Healthy Cities Projects (including Dr. Hancock) in legitimizing the “approach to local actors and in providing encouragement to those implementing the project” (Baum et al., 2006). Hancock is among those stressing the value of a social health vision. A community arts project featured in the pilot project in Noarlunga. A series of workshops on establishing a community vision, and attended by government agency representatives and community members led to a community arts project, “The Dream Machine”: the writers assert that this three-dimensional display of the community vision “provides a strong basis” (p. 261) for Healthy City Noarlunga (HCN).

The draft program for “Engaging Reflection in Health Professional Education and Practice” at University of Western Ontario in May 2009 (Bartlett & Kinsella, Conference Co-Chairs, 2008) includes Salvador Simo-Algado (University of Vic, Spain) presenting a slide show of a community garden project as “critical reflection on therapeutic interventions for community health in Spain” (p. 2). Frey’s (2007) exemplars of healing environments for integrative healthcare, recognize their importance in hospitals (e.g., The Leitag Family Healing Garden at the Children’s Hospital and Health Center in San Francisco) as well as our homes and communities (e.g., The Village of Arts and Humanities, Philadelphia). “Gardens are active neuroscience. The potted geranium embodies the range of our known sensory capacities: the flower stimulates sight, while the fragrance activates the olfactory system; the petals, stems, and leaves provide various tactile sensations, and the plant moves with each respiration. Geranium petals are edible and make a tasty summer sorbet, and insects respond to the sounds of the plant’s vibrational frequencies. Geraniums are human connectors, and the experience of one is often transcendent” (p. 68).

Geraniums as human connectors immediately sparked an image for Dorothy of her mother’s kitchen, where it was the rule rather than the exception to have a “slip” from a neighbour’s or family member’s geranium taking root in a glass of water on the windowsill. This adds new meaning to the notion of art *slipping* it to us sideways!

Grassroots Activism Through Art

Richard Wilkinson, Professor of Social Epidemiology, University of Nottingham Medical School in the UK, states baldly that “inequality kills.” His public lectures and writings could be considered an exemplar of epistolary art⁵ (see Lander & Graham-Pole,

⁵ The epistolary art of Cicely Saunders, often called the founder of the modern hospice movement, is a largely untold story of the role of the “connective aesthetic” in the *contagion* of the hospice movement internationally. Letters back and forth of letters between Cicely Saunders in the UK and Balfour Mount at the Royal Victoria Hospital in Montreal (Clarke, 2005) reveal the art of mentorship in Canada’s hospice movement.

in press a, b on this art form) playing a formative role in raising public awareness about health inequalities; in 1976 his letter to the British Labour government — “Dear David Ennals”⁶ — led to the first national report that focused on these ideas. Wilkinson’s research suggests powerful structural determinants of the health of whole populations that are amenable to public policy. Rather than relying on more police, prisons, social workers or doctors, he concludes that we must tackle the corrosive effects of hierarchy and large income disparities at their roots.

The foreword to Minkler and Wallerstein’s (2003) edited volume *Community-based Participatory Research for Health*, is written, not by a health professional, but by Canadian adult educator and poet Budd Hall, known internationally for his leadership in social movement learning and participatory action research (PAR), and the interim officer for the Pan-Canadian Coalition on Community-Based Research that grew out of the Community-University exhibition (CUexpo) in Victoria in May 2008. The principle of involving people at the grassroots level in community action through art and cultural activities is consistent with health activism as well as health promotion, as stated in the *Ottawa Charter for Health Promotion* (World Health Organization, 1986) — “the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health” (“Health Promotion in Action,” 1986, p. 187).

Popular or empowerment education converges with participatory action research, evolving from Brazilian educator Paulo Freire’s approach of codifying “generative themes into a physical form (using pictures, videos, role-playing and so on) so that participants can “see” their reality with new eyes and consequently develop alternative ways of thinking and acting” (Wallerstein & Duran, 2003, p. 42). Photovoice, a Freirian approach to documentary photography, was used with the homeless in Ann Arbor, Michigan, enabling them to photograph their everyday health realities, providing a resource for critical dialogue and knowledge about an important community issue, and a medium to reach policymakers and others who can be mobilized for change (Wang, 2003, p. 179). Carlson, Engebretson and Chamberlain (2006) also used photovoice as a social process of critical consciousness in a lower income, African American, urban community. The researchers’ findings support the storytelling component of photovoice as a necessary key ingredient for communal healing.

For aboriginal grandmothers in Saskatchewan, art forms incorporated into participatory action research included healing circles where the blessed stone was passed from speaker to speaker, sweet grass was burned, and soup and bannock (traditional baking-powder bread) was served. These ordinary people acting as artist-researchers looked at health and social topics, such as diabetes, domestic abuse, community policing, and proposed nuclear waste dumping (Dickson, 2000, pp. 191-192), and secured funding to publish a photo calendar and a book of stories. The findings, which were both gathered and represented through art (the academic researcher, Geraldine Dickson, presented her musings on the grandmothers’ words into poetry) “argue for respectful, sustained, and

⁶ David Ennals was the UK Secretary of State for Social Services. Lander and Graham-Pole (in press a, b) write about the power of epistolary art for health improvement and health activism.

culturally appropriate supports to foster personal and community resiliency, restore traditional roles and responsibilities, and allay early disease and death” (p. 211). ‘

The Breast Drum Project at the St. Francis Xavier University Art Gallery through the month of June, 2007, evoked similar images of art as a social determinant of health, collapsing the categories of activism, research, and education. Storytelling as oral tradition is at core of The Breast Drum Project, and catalysed around the metaphor of *beating ones own breast* made literal by a large drum made of hide, spun steel, and bronze. Sculptor Marlene Hilton Moore says of this art installation, “Over a period of six years, from 1994 to 2000, I traveled across Canada from Newfoundland to the Yukon collecting and recording the stories of women ages 27 to 93. The stories cross an amazing spectrum of experience and reality, including the death of a child; surviving breast cancer; loss of work; the ticking biological clock; a near death by fire; the fear of an illegal immigrant; pride of culture; a stockbroker turned moose hunter; and the passion for place and home” (Guysborough-Antigonish, Pictou Arts and Culture Council [GAPACC] e-bulletin, Friday June 8, 2007; www.gapacc.ns.ca). Ray Dillard, percussionist performer in jazz and classical idioms, and on the faculty of the Royal Conservatory of Music in Toronto, interacts with the rhythms and cadences of the stories, which include “Diana’s breaking whispered voice, daring to utter a truth about the aftermath of her son’s death, held in for so long. I hear Elane’s guttural laugh, the air sucked in through her tracheotomy to create the sound.” The Breast Drum Project carries healing intention: “Like the storyteller before us, we are invited to beat our own breast, to beat the breast drum and when the invitation is accepted a closure occurs between artist-storyteller and listener. For that brief time heart beat and drum beat become synonymous.”

The World Health Organization includes safe communities in their broad definitions of healthy communities. WHO guidelines qualify the community approach, saying it “will not replace other initiatives but will complement them, creating a new way of tackling the ever-changing pattern of accidents and injuries and dealing with problems which have proved insoluble using traditional top-down approaches by utilizing the strengths of the people to bring about necessary changes in awareness, behaviour and environment” (Moller et al., 1989).

Echoing Michael Murray’s arts-based, participatory research with fishing communities in Newfoundland (Murray & Tilley, 2006), filmmaker Anuradha Vittachi (Center for Social Media [CSM], 2002) reported on the efforts of a young Dalit woman from the Pondicherry area of South India to get the storm warnings from the US navy satellite to the fishermen on a timely fashion and in the local language Tamil. Exemplifying the art of translation and perseverance, Pakkialouchme goes online at a public access point (telecentre) and voices the gist of the data — particularly wave heights that predict storms at sea — onto an audio file, “and each afternoon, at the time the fishermen sit on the beach to check and mend their nets, her storm warnings pour out through a series of loudspeakers planted along the shore.” It is not often that art as a social determinant gleans such dramatic and unambiguous results; someone at the telecentre told Vittachi that “there used to five to ten deaths every year from drowning.

But in the two years she has been doing this work, there have been no more deaths” (CSM, p. 23).

Closer to home, *In Pink* exemplifies art as community-based health activism, beginning with the initial risk-taking act of Travis Price and David “DJ” Shepherd (Barnard, 2008, p. E1). Their colourful [and artful] act captured the imagination of the province. They were subsequently appointed youth ambassadors for Democracy 250; the pink-shirt anti-bully campaign swept schools throughout Nova Scotia (Premier Rodney MacDonald declared a pink-themed Stand Up to Bullying Day); the dramatic representation will offer the “discussion catalysts” of popular education.

The Art-for-Health Movement: The Tipping Point

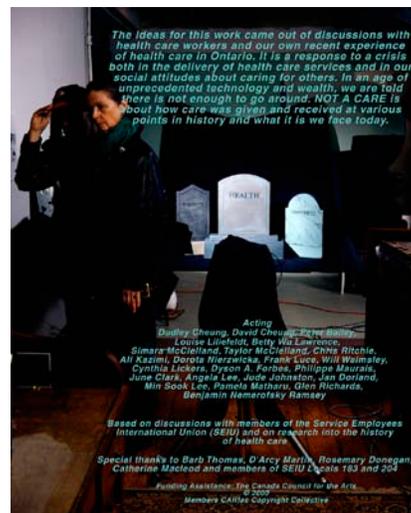
The Tipping Point (Gladwell, 2000) is a dance of the dialectic of theory and practice that helps us understand the biography of the art-for-health movement. Malcolm Gladwell, a Canadian journalist based in New York, uses the metaphor of an *epidemic* to introduce the three characteristics of the tipping point: “one, contagiousness; two, the fact that little causes can have big effects; and three that change happens not gradually but at one dramatic moment — ... the same three principles that define how measles moves through a grade-school classroom” (p. 9). Gladwell’s compelling evidence of the tipping point applies to epidemics of crime and of fashion as readily as health-related epidemics such as suicide, teen smoking and the outbreak of syphilis in Baltimore, Maryland in the mid-1990s.

Gladwell’s own artful writings can be enfolded as exemplars into our fourfold taxonomy of art for health — practice, research, education, and activism. His model for using art to “make messages more contagious” (p. 25) — informs our choices of exemplars of art as a determinant of health. Following Gladwell, our report illustrates how art itself contributes to the “stickiness” of the art-for-health movement, and the potential for its staying contagious. Our exemplars show that art is *infectious*: virus-like, it aspires to contagious behaviour, that is, it can potentially start a pandemic of art for population health.

We deliberately chose this — a pandemic of art for health — in the context of pandemics of disease (e.g., HIV/AIDs) or deficit determinants of health (e.g., pandemic of childhood obesity) — to model art for health, through humour and irony. Patch Adams, M.D., portrayed by Robin Williams in the 1998 film *Patch Adams*, arguably the most visible representative of the arts-for-health movement (see Lander, 2007), states in his mission statement for the Gesundheit Institute in Virginia (www.patchadams.org) that humour, clowning, and the healing arts in concert with traditional medical treatment, aspire to a snowball effect of activism that supports sustainability of individual and community health. Patch Adams’ Gesundheit Institute grew out of recognition of the health care crisis in the US, and embodies an artful provocative stimulus to a peaceful revolution, opposing the “for-profit-not-people” health care system (see Adams with Mylander, 1998).

Carole Condé and Karl Beveridge, community artists and health activists based in Toronto, also use large doses of humour and irony in their photography and performance art, as a means of engaging caregivers and healthcare recipients, and then re-presenting them to the wider audience of educators and policy makers. Their work opposes the spread of the American for-profit health care system to Canada (see www.workingimage.com). *Not a Care: A Short History of Health Care* came out of discussions with health care workers and their own recent experience of health care in Ontario (Condé & Beveridge, 1999-2001), and consists of a series of ten photographic images depicting how people were cared for at various points in history. Presented here are the frames for the series, the title image showing a cradle and the final credit image showing a grave. They evoke the early Canadian dream of socialized medicine, that of universal care from “womb to tomb.”

Figure 4: *Not A Care: A Short History of Health Care*
Title Image and Final Credit Image, Courtesy of Carole Condé and Karl Beveridge, www.workingimage.com



In conversation with us, Condé and Beveridge characterized their art as a response to a crisis both in the delivery of health care services and in our social attitudes about caring for others. The photographic concepts for *Ill Wind* (Condé & Beveridge, 2001) emerged out of a series of visual workshops with health care workers in Kingston (kitchen staff), Guelph (home care workers), Hamilton (maintenance and clerical staff), and Oshawa (clerical staff and nursing assistants). The images express care workers' frustration and anger over not being able to provide the care their patients needed. *Theatre of Operations* (Condé & Beveridge, 2000) is a look at health care in the US and consists of 11 portraits of health care workers in different job categories, each accompanied by a quote from the worker about their working conditions.

The Paradox of Art for Health

In identifying Canadian and international exemplars of art as a social determinant of health, we were struck by a paradox in this global outbreak. In every corner of this country, in every healthcare setting — rural and urban; home and community; hospitals and long-term nursing care institutions — Canadians are reporting that art is central to their well-being. Our investigation identified art as an integral component of health promotion, health education, health research, health activism, and healthcare practice and policy. It spans storytelling, poetry, performing arts, creative writing, dance, and music, as well as lesser recognized art forms of play, ritual and ceremony, fashion, culinary and horticultural arts.

The impact of the arts-for-health movement is implied rather than stated in the three simple and basic tenets that Janice Palmer, an American leader in the movement, including the founding of the Society for the Arts in Healthcare, identifies: Bring beauty into the space around us; celebrate community; and touch the spirit (Milner, 2003, p. 4). These are the tenets that frame artist-in-residence programs in institutional health care settings in Canada. The Friends of University Hospital in Edmonton, Alberta have provided one-on-one Artists in the Wards program and an onsite art gallery since the mid 1980s. Manitoba Artists in Healthcare (MAH, www.mahmanitoba.ca) healing arts program centered at St. Boniface Hospital in Winnipeg was founded in 2001 and received charitable status in 2001; it offers arts programs at hospitals and outreach programs throughout the city. Inspired by MAH, British Columbia Artists in Healthcare (www.artcare.ca) was founded and registered as a charitable organization in December, 2003. The Canadian Music Therapy Trust Fund supports hundreds of programs in facilities across the country, including the BC Burn Unit at Vancouver Hospital.

Dalhousie Medical School pioneered the medical humanities and an arts-in-medicine program beginning in 1981 under the leadership of Dr. Jock Murray. For Murray, training in art, poetry and literature makes better doctors because “they help students understand the human condition” (Gillingham, 2006, p. 30). Robert Pope, a visual artist suffering from Hodgkins disease, was the school's first artist-in-residence, creating more than 90 pieces of artwork, many depicting the patient's experience with illness, hospitals, visitors, family, and physicians (p. 30). Linda Clarke, an artist-in-residence in 2001, has since

founded and facilitated the narrative medicine program. For Clarke, storytelling “helps the student develop an eye and an ear for the intimate and the subjective, which not only creates a more perceptive student but also helps build a more trusting and caring patient-doctor relationship” (p. 30). Linda Clarke and Jeff Nisker’s (2007) edited volume, *In Our Hands: On Becoming a Doctor*, bears testimony to the impact of storytelling on medical education in schools across Canada. Jeff Nisker (2008), Coordinator of Health Ethics and Humanities, Schulich School of Medicine and Dentistry at the University of Western Ontario, and Writer-in-Residence and Staff Physician, London Health Sciences Centre (LHSC), has assembled *From the Other Side of the Fence*, which includes stories, poems, plays, and other art work that symbolize “the beauty inside our patients, which ... always beckons to be seen ... [and] the beauty inside health professionals, frequently confined by coats of time-efficiency, but always craving to emerge in compassion” (p. 14). Mary-Jane Egan (2008) reporting in the *London Free Press* on the book launch at LHSC, reminded readers that Nisker made headlines in the mid-90s “when he chose to use theatre as an unlikely weapon in the battle against a loss of compassion in health care. ... Nisker travelled the country promoting a series of plays called *The Yellow Brick Road*. ... He said: ‘I think of the last line in the first play ... ‘Help compassion happen every day.’”

Storytelling is embedded in the Community Health Impact Assessment Tool, a community development mechanism to empower communities, in the context of People Assessing Their Health (PATH) in Nova Scotia as a community response to the restructuring of the health care system (see www.antigonishwomenscentre.com). Leaders and facilitators of this tool, Lucille Harper, Colleen Cameron, and Susan Eaton, describe the methodology as “deconstruction of stories to draw out the factors that affect health in the community — often resemble Health Canada’s Determinants of Health” (Harper, Cameron, & Eaton, 2005). The PATH network working in 10 communities in Nova Scotia and in India, focuses on such factors as “affordable housing; Sunday shopping, eliminating the distribution of infant formula at hospitals” but not the opportunities for storytelling itself. Presenting research on the Community Health Impact Assessment Tool at the annual conference of the Centre for Regional Studies at St. Francis Xavier University, The Urban-Rural Dynamic, June 26-28, 2008, Colleen Cameron reported from a recent international conference on population health in Australia, that the Nova Scotia-based tool for assessing community health is the only one that is developed in the community by community members, and on the basis of health factors unique to that community, as raised in the stories they tell each other.

Despite the immediacy and pervasive presence of this phenomenon, it is rare for health researchers, educators, writers, activists, and policy makers — not to mention caregivers and recipients — to directly declare art as a determinant of health. Why is this? The Pallium Report (Alberta Cancer Board) identified “health education culture as a systemic barrier” (Aherne & Pereira, 2003, p. 40) when introducing professional development innovations in palliative care. We contend this also afflicts art-for-health initiatives. Art-for-health, like hospice palliative care, faces the challenge to “debunk” myths that these practices are “soft stuff” (p. 41). Deeply enfolded in this systemic cultural barrier, exemplified by the prevailing biomedical model, is the “hard” approach to contemporary health care that equates evidence-based medicine and evidence-based

practice with rigour, science, and the “gold standard” of randomized controlled trials (RCTs).

The subject index to Raphael’s (2004) *Social Determinants of Health: Canadian Perspectives* makes no mention of art or creativity or any art forms, yet Labonté’s chapter on social inclusion/exclusion draws on the metaphor of dancing the dialectic, describing Carnival in Brazil — the world’s biggest dance festival — as momentarily obliterating “the social incohesion of that country’s skewed wealth distribution” (p. 263). Advocates of reflexive practice in health promotion, Marie Boutilier and Robin Mason (2007) recommend as further reading Labonté and Feather’s (1996) *Handbook on Using Stories in Health Promotion Practice*, and it is a key resource for the People Assessing Their Health (PATH) in Nova Scotia. This report presents substantive evidence in support of declaring art as a determinant of health, especially for integrating other established determinants such as social inclusion, health promotion, public education, literacy, shelter, income security, food security, workplace safety, and social policy.

The Canadian Tipping Point in Art-for-Health

The incorporation of the arts as an integral component of health care was formalized with the founding of the Society for the Arts in Health (www.theSAH.org) in 1991. SAH’s growing international membership — it tripled between 2004 and 2008, to its current standing at 1700 — has also diversified from its beginnings in hospitals and other health institutions to establish a strong base in communities and non-governmental organizations. Canada came to its own tipping point in the year 2005, as art-for-health projects sprung forth in different parts of the country, addressing different aspects:

- March 2005, the first Canadian Forum on Arts and Health, Vancouver, University of British Columbia
- June 2005, the annual conference of Society for the Arts in Healthcare held for the first time in Canada, in Edmonton
- June 2005, the model program, “Dragonflies of Hope: ArtCare at Inlet Centre Hospice” was presented by invitation at the International Society for the arts in Healthcare Conference in Edmonton, and was honoured with a Blair Sadler 2005 International Healing Arts Award of Excellence. This program emerged from a client’s dragonfly “pop-up” cared and transformed into a contest of school children’s art work.
- July 2005, Multidisciplinary committee at The Juravinski Cancer Centre (JCC) and Henderson Hospital in Hamilton, Ontario to establish a “Therapeutic Arts Program,” which would include humour, visual artistry, writing and music
- October 2005, The National Arts Centre (NAC) Roundtable on Music and Medicine, first in a series of three roundtables on music and health, held in Ottawa
- November 2005 issue of *University Affairs* includes an article on creative arts therapies in university curriculum

The British Columbia Arts Council, in partnership with Health Canada and the University of British Columbia (UBC) hosted the first Canadian Forum on Arts and

Health in March, 2005. The majority of the 120 participants came from the western provinces along with at least one representative from every province and from Yukon and Northwest Territories. A number of initiatives flowed from the Forum discussions (see Cooley, 2005, Forum Evaluation Report). Nancy Cooley, the Forum Director and coordinator of the follow up effort to create a national network for arts and health, compiled the Forum Evaluation Report, A Survey Research Paper and Catalogue of People and Activities at the Intersection of Arts and Health in Canada, all available from the Web site of the British Columbia Arts Council (www.bcartscouncil.ca).

The *National Arts Centre Roundtable on Music and Medicine* convened on October 1, 2005, the first in a series of three roundtables on the subject of health and the arts. The second NAC roundtable on *Mental Health and the Arts* took place in 2006. The third NAC Roundtable on *Healing and the Arts: Healthy Mental Development for Children and Youth* took place on September 29, 2007.

The November 2005 issue of *University Affairs* elaborates the “pioneering” presence in the university curriculum of art, drama or music as tools for healing, often linked to internships and careers with local therapeutic services in institutional and community settings (McDonagh, 2005). Concordia University’s department of creative arts therapies, the only graduate program in art and drama therapies approved by the American Art Therapy Association is the focus of this article, which also references Wilfred Laurier’s master’s program in music therapy since 2003, and UQAM’s (Université du Québec à Montréal) music degree with concentration in music therapy, which opened in 1985.

In June 2005, SAH’s international annual conference was held for the first time in Canada, in Edmonton, Alberta. SAH’s partnership with Johnson & Johnson to Promote Arts and Healing Grant Program made \$20,000 available in 2005 for projects in Canada. Art for health was *infecting* Edmonton in particular. Art-in-medicine (AIM) was not new to Canada or Edmonton, so what “little thing” started the epidemic? If we were providing evidence for Malcolm Gladwell’s tipping point, we would present a confluence of “little things” that centered on the SAH conference organizing. In 2005, projects and organizations and artists that had not until that point “named” their practice as art for health were declaring themselves. We narrow our focus to Edmonton in 2005 to illustrate Gladwell’s (2000) three criteria for starting an epidemic: The law of the few; the stickiness factor; and, the power of context.

The law of the few. *Connectors, mavens, and salesmen*, as Gladwell calls them played a role in the organizing moments of the Art-in-Medicine program at the University of Alberta (of which the Cross Cancer Centre and University Hospital are a part) and in the lead up to holding the SAH conference in Edmonton. Gladwell’s (2000) exemplars of Paul Revere’s midnight ride among the far-flung anti-British forces of New England (p. 56) or his own experience of his friend Jacob setting in motion the series of connections that led to thirty of his forty friends (pp. 37-38), provide a model for tracing the primary connectors in a word-of-mouth epidemic. Susan Pointe, art advisor for the Friends of University of Alberta Hospital’s Art in Healthcare program, aptly fits the description of connector: “the kinds of people who know everyone” (Gladwell, p. 38).

Connectors are important not simply for the number of people they know but who they know. Like Paul Revere, they are intensely social “with an “uncanny genius for being at the center of events” (p. 56). In 2004, Susan Pointe and her colleagues had visited the Art-in-Medicine program at the University of Florida and met with John Graham-Pole, co-founder of the program, and the 13 paid artists-in-residence, to guide her in shaping the program at University of Alberta Hospital. Within a year, she had started her own program and brought together a steering committee to host an international conference in Edmonton.

Gladwell tells us that Maven comes from the Yiddish, meaning one who accumulates knowledge. They are willing teachers but even more, voracious learners, likely to have a formidable database. Poet and essayist John Graham-Pole began writing extensively on art-in-medicine in North America, drawing on the experience at University of Florida, and sharing that experience with individuals and organizations throughout North America, including the University of Alberta. The maven closer to home, with whom the University of Alberta consulted widely, is Nancy Cooley of Victoria, British Columbia; just two years earlier in 2003, she compiled a comprehensive survey and database of arts and culture in medicine and health from a Canadian perspective (see Cooley, 2003), relating arts, culture and health to Health Canada’s Determinants of Health, drawing in relevant experience in the United States, United Kingdom, Australia, and Sweden.

The salesperson “infects” others with emotions; that is, “emotion is contagious.” Edmonton-based visual arts writer and broadcaster Gilbert Bouchard’s (2005) report of his conversation with Susan Pointe reveal her talent for intermingling emotion and value with the facts of science — the mark of a persuader par excellence. Bouchard’s abundant use of Pointe’s quotes is evidence that she is a highly contagious “carrier” (Gladwell, p. 85) of this epidemic.

Describing the arts-in-healthcare movement as being both “so simple and so powerful,” Pointe says recent neuro-immunological studies have shown that “joy, peace, and calm” felt by a patient not only release endorphins into the blood system, they also lower blood pressure, underlining a measurable medical reason to support arts-in-healthcare programs. Pointe adds that art programs like hers are vital because of their ability to combat boredom (“a major problem in the hospital environment”) and help alleviate depression and improve communication between healthcare providers and patients — all of which can shorten the length of a hospital stay and even reduce dependence on pain medication. (p. 51)

The stickiness factor. *Sesame Street*, as one of Gladwell’s exemplars of the stickiness factor in a “learning epidemic to counter the prevailing epidemics of poverty and illiteracy,” is also an exemplar of art as a social determinant of health. The stickiness does not lie in the inherent quality of the ideas presented but in how they are made memorable and tailored to the way we learn in order to stick. In the case of *Sesame Street*, repetition and warm fuzzy characters work for children. (When the producers included humour for an adult audience in one episode, the children stopped watching.)

We speculate that the stickiness factor in the arts-for-health movement in Edmonton, and in the run up to the SAH conference, was the move by the SAH organizers to capture the imagination and participation of the entire city and extend art for health from the hospital to the streets and communities.

Connector and salesperson, Susan Pointe, emphasized that the SAH gathering was “a validation of the city’s pioneering ways” (Bouchard, 2005, p. 51); the SAH event belonged to everyone, not just the University of Alberta or University Hospital. Arts-in-medicine (AIM) was not new to Edmonton. The Cross Cancer Institute is one of Canada’s oldest AIM projects, and since 1997 has pioneered innovative art forms. For example, “sculpting ... help[s] people transform and understand their loss, especially body-altering surgery. ... Five or six weeks spent in the art process often does the work that would take a year in another form of therapy” (Bouchard, 2005, p. 49). Friends of University of Alberta Hospital’s Art in Healthcare program has been on the go since 1986; the program boasts a collection of original art as well as the McMullen Gallery and the Artist-in-the-Wards program has a steady stream of poets, musicians and visual artists assisting long-term patients in creating works of art. In 2005, poet-in-residence Shirley Serviss published her book of poems *Hitchhiking in the Hospital*, based on her experience with Artists-on-the-Wards.

Here’s a clue to the tipping point in Edmonton in 2005 that Bouchard (2005) dropped in his write-up. Edmonton’s Camp He Ho Ha (Camp Health Hope Happiness) is a 45-year old, year round, rural, *recreation* camp devoted to children and adult with physical and mental disabilities. In 2005, the “small and seemingly trivial” (Gladwell, p. 96) act of naming Camp He Ho Ha an *art* camp accomplished big effects. The language of art rather than recreation infected Ellen Green, the Camp’s Director of Fund Development, who describes the Camp’s purpose: “We’re *entering a phase* where we’re no longer dismissing art produced by people with disabilities as childlike or naïve, but seeing it as art with a different slant on our world and art that can make us think. ... Much of art tells a story, and since many of our clients are nonverbal, if it were not for art they wouldn’t be able to tell their stories at all” (Bouchard, p. 51, emphasis added).

Other art-for-health events after the SAH conference suggest that the city stayed infected. Edmonton’s Nina Haggerty Centre for the Arts, a full-time, professionally facilitated arts centre and gallery devoted to developmentally challenged adults, occupies the liminal space of art and health. In September 2005, The Nina Haggerty Centre for the Arts in Edmonton showcased “David Huggett, POWERFUL PROTAGONISTS, The Creative Spirit and the Challenge of Cancer,” described as an “exhibition celebrating the life of an inner-city artist, poet, thinker through his mixed media paintings and words.” The flyer for the exhibition elaborates that the exhibit follows “the artist’s journey from pre-diagnosis with cancer to his ultimate death. There are also panels with excerpts from his journals” (www.ninahaggertyart.ca).

The Alberta Social Health Equities Network (ASHEN) established in 2005 started as a small group of broad-based provincial partners who wanted to collectively address poverty, social inequity and public policy. ASHEN organized a two-day provincial

conference, Reality Check 2005: Inequity and Well-Being in a Debt Free Alberta, which “utilized the arts as a way to share experiences and enhance understanding.” One of the goals was to initiate development of an Alberta Charter on Social Determinants of Health. The ASHEN youth project was launched on June 21, 2005, with the stated purpose of “engaging experienced youth in four Alberta locations in policy and advocacy initiatives surrounding the Social Determinants of Health, using the arts as a vehicle for engagement and a tool for broader social change.”

The arts were a strong presence, when The Canadian Hospice and Palliative Care Association held its annual conference in Edmonton in September, 2005. Angela Conrad and Sandy Johnson from Hospice Saint John & Sussex presented: “Laughter is the Best Medicine: The Use of Therapeutic Care Clowns in End-of-Life Care.” A musical tribute was held one evening in the McDougal United Church, “Memorial Service – A Celebration of Life.” Kent Hanwell performed “Through the Rainbow – A Caregiver’s Musical Journey” – a musical tribute to a mother and daughter who died tragically within weeks of each other. Kaichiro Tamba presented a poster “An Old and New Technique of Poetry Therapy for Palliative Care.”

Following the CHPCA conference, the co-author of this report (Dorothy Lander) as well as health researchers Anne Kinsella from University of Western Ontario, Carol Amaratunga from University of Ottawa, and Jane Dawson from St. Francis Xavier University, ran an arts-based workshop supported by the Institute of Health Services and Policy Research (IHSPR) of the Canadian Institutes of Health Research (CIHR). Entitled “An Appreciative Inquiry Workshop: Creating a Sustainable Future through the Best Practices of Hospice Palliative Care Workers,” the workshop attracted artists, and formal and informal palliative/hospice caregivers. The photo captures *art in action*.

Figure 5: Art in Action: Hospice & Palliative Care Workers, September 2005



Staying Infected

In the following year, 2006, the contagion for art for health spread across the country and the world via the Internet. In March 2006 Cheryl MacLean published the first issue of the eNews/journal *Canadian Creative Arts in Health, Training and Education* (CCAhte) (<http://www.cmclean.com>) free to subscribers and distributed widely via the internet across Canada, the US and UK. As described on its home page, the CCAhte offers information about creative arts approaches in staff health and wellness, arts raising awareness about social issues and health, information and resources that will benefit those involved in gerontology and education, nursing education, social work, medical education & health training. The eclectic content of CCAhte, and its use of popular internet tools such as a blog, and videos on its web site make it distinct from the range of academic journals in the Medical Humanities that have been flourishing for four decades, or the information on the Literature, Arts, & Medicine database (<http://litmed.med.nyu.edu>), which also targets health professionals.

Also in 2006, the University of Alberta launched the Arts and Humanities in Health and Medicine Program. Co-director Pamela Brett-MacLean (2006), writing in the CCAhte journal describes the purpose of the program as “engendering a balance of scientific knowledge and compassionate care among students, residents and faculty. ... It is also aimed at extending and enriching opportunities of students and faculty across the university, as well as those in the Edmonton community regarding intersections between the arts, humanities, health and medicine.”

Also in 2006, health was the theme of the online *Journal for Learning through the Arts: A Research Journal on Arts Integration in Schools and Communities*. The guest editor, Johanna Shapiro (2006), draws attention to the growth in the medical humanities, “to the extent that over half to three-quarters of all U.S. and Canadian medical schools (depending on one’s definition) have some sort of curricular offering in the medical humanities” (p. 1). The only Canadian content in the journal is our article on the appreciative pedagogy of palliative care (Lander & Graham-Pole, 2006), in which we broaden the definition of the medical humanities to include the art of care practiced by the dying and their formal and informal caregivers.

Underscoring this epidemic is the exploding presence of the art-for-health movement in the popular and the academic press, in both print and electronic media, in conferences and professional education, where quantitative research and the biomedical model have dominated. Three performances of the play *Sarah’s Daughters* by Canadian physician-playwright Jeff Nisker featured at the third annual Education that Works Conference at Hiram College in Ohio on September 28, 29, and October 3, 2007, as part of *Stages: Cancer and the Arts*, a fall series presented by The Center for Literature, Medicine, and Biomedical Humanities, one of the College’s six Centers of Excellence. As reported in Hiram College’s magazine *The Harbinger* (September 24, 2007), the lead role of a woman who lives for 20 years in fear of developing her mother’s breast cancer was played by a senior theater major accompanied by a cellist. The play explores the many personal and family issues of breast cancer, and the genetic inheritance susceptibility of

the disease. During Convocation on October 4, Nisker discussed the use of theatre to raise audience awareness of health care issues that may impact their lives, referring to *Sarah's Daughters*, and also to his play *Orchids*, which is about pre-implantation genetic diagnosis (PGD) that allows prospective parents to select for embryos that do not carry certain genetic diseases. Also at Convocation, cancer-survivor Laurie Frey, and award-winning Cleveland playwright Eric Coble discuss their musical play *Unbeatable: A Musical Journey*. The lead character Tracey, an energetic businesswoman and stage-three cancer survivor, portrays the trials and triumphs of living with breast cancer, based on Frey's personal journey.

The significance of Nisker's play *Orchids*, performed across Canada, in helping the government determine public policy about PGD is taken up in Nisker's chapter, "Theatre as a health-policy research tool" in Knowles and Cole's (2008) *Handbook of the Arts in Qualitative Research*. In 2008, SAH launched its own journal: *Arts & Health: An International Journal of Research, Policy and Practice*, with Canadian-based educators, researchers and practitioners on its editorial advisory board. The invitation to potential reviewers of manuscripts includes areas to tick off in research design and methodologies, both quantitative and qualitative, notably "arts-based methodologies involving innovative projects using the arts as methodology/evidence."

The March 2008 special issue of *Journal of Health Psychology* on the arts is edited by Ross Gray and Michael Murray, both of whom have conducted extensive research into the arts and healthcare in Canada. Their introduction, framed as a conversation, seeks a "broader and fuller understanding of health" suggesting that the arts "can provide a way forward," that demonstrates that "there is much more to health than the absence of disease," (p. 150) which the strong reliance on biomedicine has reinforced. Murray, a long time professor of Social and Health Psychology at Memorial University of Newfoundland has conducted a number of studies on fishing vessel safety, including a community arts project focused on a dedicated Fishing Safety Week in a community in Newfoundland (see Murray & Tilley, 2006).

In 2008, Murray's name popped up as a keynote speaker at The Narrative Practitioner Conference, 23-25 June, 2008 (www.thenarrativepractitioner.co.uk). Murray is now Chair in Applied Social and Health Psychology at Keele University in the UK. The companion keynote speakers at the narrative practice conference are Dr. Thomas Janisse, Editor of *Soul of the Healer: Art and Stories* (USA) and Georgina Wakefield, Trainer, Former Service User, and Author of *Schizophrenia: A Mother's Story*. The promise of this practitioner conference to focus on the power of narrative in diverse practice settings, including "ethical narratives; organizational narratives, narratives of the body; therapeutic narratives; academic narratives; pedagogical narratives; healing narratives; childhood narrative" underscores the integrative role of art in practice, education, and research (see Lander & Graham-Pole, 2006). The Web site for The Narrative Practitioner Conference includes a short video presentation of the inaugural conference in 2007.

Section 3: Re-Crafting Evidence

In this section, we present evidence of art as a determinant of health, using the approach in arts-based and qualitative research of “exemplars.” Exemplars, unlike examples, which suggest one choice is as good as another, are those most relevant to the phenomenon, representing it in an artful and embodied way and animating subjects’ and researchers’ own voices (Lindlof, 1995, p. 268).

Evidence-based medicine (EBM) dates back to the mid-19th century and is defined as “the conscientious, explicit and judicious use of the best evidence in making decisions about the care of individual patients” (Sackett, Richardson, Rosenberg, & Haynes, 1998). The glossary to a research project on issues and barriers related to Canadian population and public health (PPH) knowledge generation, dissemination and exchange, alters and broadens this definition: “the conscientious, explicit and astute use of the best-available evidence from relevant fields to inform practice and policy decisions regarding health care, health systems, and population and public health programs. The evidence on which decisions are made should be systematically collected, reviewed for quality and relevance, and synthesized” (Kiefer et al, 2005, p. I-14). Exemplars imply “best” evidence, which, by the PPH definition, do not preclude art. Exemplars in this report draw as readily from arts-based research as from RCTs and give art the edge in addressing barriers to dissemination and exchange of knowledge.

Art before Science?

In *Proust was a Neuroscientist*, Jonah Lehrer (2007), a neuroscientist himself, provides evidence of art as a determinant of health to bring home an important message to health practitioners, educators, and researchers: Evidence-based medicine (EBM) and evidence-based practice (EBP) need both science and art: “Science needs art to frame the mystery, but art needs science so that not everything is a mystery. Neither truth alone is our solution for our reality exists in plural” (p. xii). Lehrer traces the process of eight [research] subjects — Walt Whitman, George Eliot, Auguste Escoffier, Marcel Proust, Paul Cezanne, Igor Stravinsky, Gertrude Stein, and Virginia Woolf, — who “by exploring their own experiences ... expressed what no experiment could see [or measure]. ... Proust was right about memory, Cézanne was uncannily accurate about the visual cortex, Stein anticipated Chomsky, and Woolf pierced the mystery of consciousness” (p. xi).

Quantitative research more commonly supports art as a determinant of health focused on science — biomedical, lifestyle and risk factors — allowing for concrete measures that span the physiological (e.g., body-mass index, cholesterol levels, blood pressure, breathing patterns) and lifestyle/behavioural changes (e.g. sustained tobacco cessation, weight loss, exercise, workplace safety). Many of our exemplars of explicit art interventions in health combine quantitative and qualitative evidence of the efficacy of the intervention. Lehrer (2007) uses Virginia Woolf’s novel *To the Lighthouse* to illustrate, that “if science breaks us apart, art puts us back together” (p. 188). Similarly

evidence of art as a determinant of health draws on analysis (focused on parts) as well as synthesis (focused on the whole).

Drama therapy professor at Concordia University, Stephen Snow, is featured in Patrick McDonagh's (2005) article on the pioneering practitioners of creative arts therapies in higher education. Snow and others in this department conduct research with Concordia's Centre for the Arts in Human Development, which runs a 3-year program for people with developmental disabilities. What these researchers knew holistically through art, they measured and legitimized through science (see Snow, D'Amico & Tanguay, 2003). Their scientific evidence of drama as a determinant of health includes: increases in the participants' socialization and communication skills; enhanced senses of responsibility and maturity; and reduced feelings of stigmatization. With support from the Social Sciences and Humanities Research Council, Snow has also developed arts media as psychological assessment tools.

The HeArts & Hope studies at the University of Florida (Graham-Pole, 2007) began with art but is one of the rare science-oriented studies that measures the efficacy of an arts-in-medicine intervention, conducted by artists-in-residence, as distinct from the explicitly therapeutic art modalities, associated with arts therapy, poetry therapy or drama therapy, which often build in psychotherapy. A sophisticated electronic system allows researchers to record every patient usage of the varied menu of media available at the bedside, and to instantly analyze their online recordings of change in symptoms. The study funded by the National Cancer Institute focuses on the data from participating patients undergoing stem cell transplantation, which Graham-Pole (2007), pediatric oncologist and pioneer in pediatric stem-cell transplants in North America, observes is "a form of treatment that inevitably causes at least as severe effects as the underlying condition for which it is used" (p. 14). The on-screen visual analogue scales quantify the degrees of physical pain, anxiety, and relaxation the patient is experiencing, which are compared with simultaneous standard paper-and-pencil measurements to establish the statistical validity of electronic recordings (p. 14).

Postrel's (2008) article on the art of healing reports that "results were striking" for medical facilities in the US that have moved to "evidence-based design, which draws its principles from controlled studies, ... and follows a seminal 1984 *Science* article by Roger S. Ulrich. ... Patients with a view of the trees had shorter hospital stays (7.96 days versus 8.7 days) and required significantly less high-powered, expensive pain medication" (p. 121). A 2005 study compared patients recovering from elective spinal surgery whose rooms were on the sunny side of the ward with those on the dimmer side and found that "those in the sunnier rooms rated their stress and pain lower and took 22 percent less pain medication each hour" (p. 21).

An explicit exemplar of art "slipping it to us sideways" before measuring impact through science is the study of women's health response to a story line in the UK television's soap opera *Coronation Street*. A study was conducted to retrospectively analyse the usage of the NHS cervical screening program in the north west of England. "Alma" in the story line is diagnosed with cervical cancer, succeeded by revelations that

there has been a “mistake: at the lab, and then that she has missed previous smears (Howe, Owen-Smith, & Richardson, 2002).

What Counts as Evidence?

The prevailing biomedical discourse is that the “best” evidence is that of randomized controlled trials (RCTs), as the term “Gold Standard” underscores. Several Canadian policy analysts suggest specific strategies to support evidence-based decision-making in population and public health (Kiefer et al., 2005), including addressing the knowledge and methodological gap that neglects the body of evidence that is observational and experiential (p. I-6). As Janice Palmer, program administrator of the art-for-health program at North Carolina’s Duke University Medical Center, asks: “Is it possible to place a number value on the gratitude felt by a family with a dying mother visited by a musician in her hospital room, or the consolation experienced by a nurse who reads — or better still writes — a poem about a suffering child?” (Milner, 2003, p. 5). This report addresses this methodological gap and specifically the neglect of the body of evidence that is arts-based and emerging from lived experience (see Lander & Graham-Pole, 2008).

The biomedical model of evidence, emerging from RCTs, dominates understandings of EBM and EBP. But what if we valued different kinds of evidence? We chanced on an undeclared art-for-health article in the same issue of *The Atlantic* as Postrel’s “The art of healing” — how a crime-plagued mill town in Holyoke, Massachusetts has discovered the roots of urban renewal through community gardens (Kummer, 2008). In this case, the community draws its principles for evidence-based design and practice from personal testimony rather than RCTs. “We have nine community gardens in some of the toughest neighborhoods in the city if not the country ... and the incidence of vandalism has been almost zero” (p. 117). Grandfathers and fathers, many of whom grew up on farms in Puerto Rico, teach schoolchildren how to grow peppers and eggplants. Everyone in the town makes traditional Puerto Rican food all year, not all of which is healthful. “Nutritionists in the sunny teaching kitchen of the health center ... show patients how to reduce the fat in traditional Puerto Rico dishes (Holyoke has the highest diabetes rate). ... ‘It goes way beyond food. ... but it starts with food’” (p. 118). We paraphrase this to conclude: “it starts with art.” Such studies simply don’t lend themselves to RCTs.

What if testimonials counted as evidence? The web site for Manitoba Artists in Healthcare (MAH) (www.mahmanitoba.ca) includes testimonials from administrators, healthcare professionals, artists-in-residence, and patients, which could stand as the robust verbatim evidence of qualitative research. For example, Patty Findlay, Social Worker, CancerCare Manitoba St. Boniface writes: “The music the musicians play in the treatment area is not only soothing; it is more like smoothing ... it smoothes the whole atmosphere.” Cherida Olson, Cancer Patient re 8-week Clay Group led by artists Betty Smith writes: “I have opened my eyes to love, started to believe in ME and my time with others is very real. I am truly still here because of MAH. I have a difficult background and was struggling with cancer for the second time around.”

What if testimonials embedded in our daily newspaper or in our everyday encounters counted as evidence? Jenifer Milner (2003) reports on “Music that Heals” from *The Vancouver Sun* of 19 November 2001: Dr. Stephen Anderson, who works with patients at Vancouver Hospital’s burn units says, “As a psychiatrist, I am mainly looking at the emotional state and it improves significantly after music therapy.” He says patients feel less depressed or anxious after music therapy sessions, plus they are better able to handle their pain (p. 2). *The Chronicle Herald* (Nemetz, 2008) offered testimony from Executive Director Paul McNair’s report of the Plates for Parkinson’s event, which to our research-tuned ears goes beyond fundraising for the Parkinson Society (about \$15,000 raised in 2007) and stands as evidence of art as a social determinant of health: “It’s a non-threatening introduction. We’re not talking about the condition or medication or research. People will come forward and say, ‘I have Parkinson’s but I’ve never talked about it before.’” Also going on sale in the final week of the auction are limited edition photographs of Ali in his final fight on December 11, 1981 in the Bahamas against the late Halifax fighter Trevor Berbick.

Ali’s signed plate depicting a scene of mountains and water resonated with Dorothy Lander, recalling an earlier encounter of Ali enacting art for health in a different medium. Writing in the theme issue of *Convergence* on the arts, social justice, and adult education, Dorothy and her stepdaughter Susan Napier offered as an exemplar of healing art for palliative caregivers, their unexpected encounter with Ali just after they had presented on memoirs of loss and grieving at an academic conference on Educational Biography in San Antonio in 2005. They were enchanted witnesses to Ali’s handkerchief magic in the San Antonio airport lounge, performed with a deftness that belied the common symptoms of Parkinson’s Disease (Lander et al, 2006, p. 129).

Evidence of art as health activism can be found in the popular media. Social activist, Tom Hayden responded to *The Globe and Mail* journalist Evan Solomon’s monthly challenge to give a title to an unidentified image and share the ideas and experiences it evokes (Solomon, 2008, p. F8). Hayden’s caption RELIEF for the photo of Pakistani men raising their hands as they’re trying to get a piece of bread during food distribution had two possible meanings for him: “It could be a cry to a supreme being, or a cry to an administrator of food relief” (Solomon, 2008, Column 1). This image and Solomon’s question, “Are you still a rebel” evoked a comment from Hayden that allies protest with health: “rebellious, betting that people will respond to you, is a healthy way to live” (Column 6).

Hayden’s testimony supports Dalhousie University researchers Hutchinson and Wexler’s (2007) study of the Raging Grannies, based on individual and focus group interviews, which concludes: “Raging is good for your health.” Their conclusion is the same as Hayden’s but in language aligned with Dalhousie’s School of Health and Human Performance: “Health promotion strategies that focus on older women’s strengths, capacities to contribute and engagement in personally meaningful activity, and that emphasize the development of meaningful social connections, self-help, and the importance of contributing to the collective social good are relevant for promoting healthy aging” (p. 113).

What if community-based and arts-based research that focuses on established determinants of health was counted as evidence by health researchers and health policy analysts? The launch of the Pan-Canadian Coalition on Community-Based Research took place at the closing ceremonies of CUexpo; Budd Hall and the Office of Community-Based Research at the University of Victoria will serve as the Secretariat as the coalition emerges. Included in the already committed to the coalition are: Arctic Health Research Network – Yukon; Community-Campus Partnerships for Health; Ontario HIV Treatment Network. To get the word of the coalition and of the exposition out in as many new ways as possible, the organizers used youtube, facebook, wordpress.com and a powerpoint sharing site. Art for health is featured in many of the 300+ Proceedings of the event (www.cuexpo08.ca/assets/CUexpo%20proceedings.pdf), including the following Canada-wide and international exemplars:

- an arts-based learning and knowledge mobilization project for street-involved women in Victoria (Clover & Craig, 2008, University of Victoria, pp. 59-63);
- Art education students' service-learning experience of designing privacy panels for the beds of a homeless shelter (Szabad-Smyth, Beer & Hagggar, 2008, Concordia University, pp. 271-275);
- A community development and transformation participatory research proposal using the Open Studio Process (a four-step process: intention, art-making, witness, and sharing) for application with youth and vulnerable populations in Kamloops, BC (Sullivan, 2008, Thompson Rivers University, pp. 263-265);
- Improving the economic and social determinants of health in our community through development of community gardens (Rose, Barnidge, Fitzgerald, Motton, & Baker, Saint Louis University School of Public Health, pp. 235-238);
- Nature Arts in the Park: Wellness, competence and contribution (Hazen, 2008, California State University, Chico, pp. 107-111).
- Investigating HIV-related stigma within communities of gay and bisexual men: A dialogue between photovoice and visual studies (2008, Queen's University, pp. 179-183);
- Housing and home: Making the connections for women who are homeless (Walsh, Rutherford, & Kuzmak, 2008, pp. 305-308) — uses a variety of qualitative research methods, including digital storytelling, interviews, photovoice, creative writing, and a design charette, to engage, empower and generate a sense of ownership for participants.

Drawing on his experience as Co-director of California Newsreel since 1974, Larry Daressa (2000) asks if social change media is a delusion. He could be asking about health activism when he poses the problem that “we have unconsciously and uncritically applied criteria designed for one purpose, commercial entertainment, to a radically different one, civic activism” (p. 3). Looking critically at Newsreel's largest collection of film, that of African American life and history, he is struck by the absence of films on economic marginalization, family dysfunction, the psychological impact of racism, welfare and criminal justice reform, and policy debates (p. 2). These issues echo the social determinants of health itemized by the WHO's Commission (CSDH).

The questions that Daressa raises about social change media are the criteria for evaluating whether any art form is a social determinant of health. Does it direct its audiences back to their own world? Does it address them not as passive viewers but potentially active participants in civic society? Does it raise questions, reframe arguments, suggest new conversations? Daressa offers an exemplar that meets these criteria: The Soul City multi-media project, a program from post-apartheid South Africa organized around a weekly television drama, scripted collaboratively by professional screenwriters and public health professionals. “Try to imagine ER or General Hospital set in a Soweto clinic with continuing story lines around AIDS awareness, quitting smoking and child abuse. This television series is coordinated with radio programs broadcast in eight languages, features columns in daily papers and popular comic books distributed in doctors’ office and community centers” (p. 4). Another criterion for successful social change media might be: “Does it slip it to us sideways?”

The Art of Witnessing

Testimony often serves as evidence in art-based research. This leads Ropers-Huilman (1999) to frame truth in qualitative research as witnessing. She elaborates six obligations for the researcher acting as witnesses in qualitative research, of which the final is “the responsibility to explore multiple meanings of equity and care while acting to promote our situational understandings of those concepts” (p. 2).

We, as witnesses, ... are fabricating worlds, not because we are falsifying data or lying about what we have learned, but because we are constructing truth within a shifting, but always limited, discourse. . . .Discourses largely circumscribe the possibilities of our constructions. (p. 24)

As witnesses and researchers, we need the evidence of both art and science — our “reality exists in the plural,” as Lehrer (2007) puts it. Thus we present (unstable) testimonial evidence alongside (controlled) RCT evidence of art as a determinant of health, recognizing that the discourses that attend these different kinds of evidence, prescribe what will be valued and *seen* as evidence. As arts-based health researchers, we are witnesses, whose work of care is to do justice to participants’ testimony (see Lander, 2001), which sometimes reveals the “unbearable circumstances of [their] lives” (p. 17).

Brazilian literacy educator Paulo Freire (2000/1972), celebrated for his ideas of praxis (action with reflection), popular education and dialogical, participatory practices for radical social change, also wrote about the art of witnessing. Witnessing, for Freire, defines authentic and critical leadership — revolutionary leadership — and we present this as further evidence that the art of witnessing (which can embody many art forms) is a social determinant of health. “Witness is not an abstract gesture, but an action. . . . a confrontation with the world and with people — it is not static” (p. 177). This is reminiscent of Ropers-Huilman’s description of the shifting discourses and multiple meanings of witness. The essential elements of witness that Freire presents are applicable

in our four categories of practice, education, research, and activism. These essential elements include:

Consistency between words and actions; boldness which urges the witnesses to confront existence as a permanent risk; radicalization (not sectarianism) leading both the witnesses and the ones receiving that witness to increasing action; courage to love (which ... is the transformation of the world on behalf of the increasing liberation of humankind); and faith in the people, since it is to them that witness is made. (p. 176, italics original)

In *The Wounded Storyteller*, Arthur Frank (1995) calls for health professionals, and by extension personal caregivers, researchers and educators, to understand illness stories as testimony and to understand the “reciprocity of witnessing ... as a relationship of communicative bodies. ... Gail becomes a witness to her illness because she is a communicative body, but she also becomes a communicative body through her testimony” (p. 143). Frank’s call for a change in the cultural milieu “so that people like Gail are *seen* for what their bodies testify to — the demand of her testimony is for other bodies to *commune* with her in her pain” (p. 145) — echoes qualitative, and arts-based health researchers’ call for a change in the cultural milieu, so that Gail’s and others’ testimony counts as evidence that matters, and that guides practice and policy and research protocols. Former international president of Médecins Sans Frontières James Orbinski (2008) meditating on the nature of humanitarianism in his memoir, both describes and embodies the art of loving witness: “Humanitarianism is about more than medical efficiency or technical competence. ... In its first moment, in its sacred present, humanitarianism seeks to relieve the immediacy of suffering, and most especially of suffering alone.”

Testimony can enfold different art media and influences. Nova Scotia artist Robert Pope’s (1997) images of cancer combine self-reflective writing, the visual arts, and literary, cinematic arts. Medical historian and long time Dean of Medical Humanities at Dalhousie University Jock Murray highlights other influences in Robert Pope’s oeuvre (Murray, 1995): Goya, Munch, Caravaggio, Marcel Duchamp, and the Bible alongside the music of Elvis, Hank Snow and Bruce Springsteen and, the definitive influence, Elizabeth Smart’s 1945 memoir of loss and grieving, *By Grand Central Station I Sat Down and Wept*. Jock Murray continued the chain of Robert Pope’s witness by beginning the practice of giving the entering class of medical students Robert Pope’s book, as a way of introducing them to the art of witnessing to patients’ suffering. Addressing a larger public, broadcaster, journalist and author Bill Cameron, in the last story he ever wrote, offers testimony on his journey with cancer of the esophagus in his essay “Chasing the Crab” published in *The Walrus* (Cameron, 2005). He testifies to the healing dimensions of alternative, art-based interventions, including prayer, therapeutic touch, and Reiki; the Dalai Lama, who he interviewed before he “was catapulted into Cancerland” (p. 49) was praying for him along with the First Congregational Church in Halifax and Runnymede United Church in Toronto. Cameron provides commentary on the tensions between arts-based evidence and evidence-based medicine: “This kind of phenomenon does not go under the microscope easily. The philosopher argued that he might as well believe in

God, because if he was wrong it wouldn't matter, and if he was right he was ahead of the game. Maybe it's the same for distant or psychic healing" (p. 49). Kathryn Church (1995) extends her personal testimony of what it means to be a psychiatric survivor of the community mental health system in Ontario, to the research method critical autobiography. "Writing about myself is a way of writing about those others and about the worlds we create/inhabit. The process uses my life, the life of one social being, to penetrate the social relations of 'consumer participation'" (p. 5), and we would add, to penetrate the ways in which the art of witnessing is a determinant of health.

The Medical Humanities and related field of Narrative Medicine incorporate trauma testimony related to the Holocaust and other human rights abuses into medical education, as a way of rehearsing the relational act of witnessing, which health professionals will encounter in their practice and their everyday life (Clark, 2005; Spiegel & Charon, 2005). Clark's oral history interview with Dori Laub, which begins with the Holocaust and ends with the hospital, is a "rich, condensed description of the act of witnessing. ... Arriving first at the scene does not require an ambulance or the role of rescue. It requires the act of presence, of *at-one-ment* with the other. The first witness must enact the willingness to return to and be still in the moment of trauma and to enter the silence of absence with another" (pp. 277-278).

A Canadian study of adult survivors of childhood sexual abuse found that all participants ($n=93$) experienced "disrupted lives and relationships ... [causing] nausea and vomiting, as well as psychological distress" (Herman, 2003, p. 164) after giving testimony. The findings of this scientific study stand in stark contrast to the narrative evidence and "risky stories" of popular theatre (Salverson, 1996). The theatre of life and caring for others also calls upon the performer/teller and the listener/receiver to witness suffering, and to "imagine ... the dangerous task of facing both teller and listeners with the terrible literality of the emergency that demands to be named and known" (p. 188). Sarah Murphy (1997) bears witness to her research participants' unspeakable experience of sexual abuse by presenting their testimony in the form of photographs, written panels, and a pastel drawing.

In the context of art as a *social* determinant of health, which serves to challenge and change the cultural milieu and the systemic barriers to health, the art of witnessing is not confined to formal health care settings. Moving the responsibility for health to everyday life and our communities, we can think of no better [Canadian] exemplar than the witness of Romeo Dallaire in *Shake Hands with the Devil*. His 2004 autobiographical account of genocide in Rwanda, and his own post-traumatic stress disorder (PTSD) in both book and movie forms have had far-reaching effects on individual and population health. The imperative of the witness not only to listen but to remember suffuses his writing. The social impact of Dallaire's autobiography, which bears witness to Canada's and the world's failure to respond to the suffering in Rwanda in 1994, is beyond question.

Karen Brounéus's (2008) evidence based on in-depth interviews with 16 women in Rwanda who have testified in the *gacaca*, the village tribunals initiated to enhance reconciliation after the 1994 genocide, challenges the assumption that testifying in truth

and reconciliation commissions is a healing experience for survivors. “Traumatization, ill-health, isolation, and insecurity dominate the lives of these testifying women. They were threatened and harassed before, during and after giving testimony in the gacaca” (p. 55). The possibility that giving testimony will lead to re-traumatization is the cautionary tale of art as a social determinant of health.

Following on Prime Minister Stephen Harper’s apology on June 11, 2008 for the Indian residential schools, as a “sad chapter in our history” and the court-mandated Truth and Reconciliation Commission (TRC) (<http://www.trc-cvr.ca>) on June 1, 2008, sensitivity to the art of witnessing takes on added significance. The web site itself leads off with a cautionary statement: “This web site deals with subject matter that may cause some readers to trigger (suffer trauma caused by remembering or reliving past abuse)” (p. 1). Drawing on the theory-in-practice in our report, TRC would do well to connect this alert to the representations of the TRC processes represented in the TRC logo designed by Kirk Brant, an Aboriginal artist of the Tyendinaga Mohawk Territory in Ontario. “The logo is a flame that incorporates elements of the three distinct Aboriginal groups in Canada. First nations are symbolically represented by the feather. Métis people are symbolically represented by the infinity symbol and Inuit people are symbolically represented by the traditional seal oil lantern (qulliq) that the flame rests upon” (www.trc-cvr.ca/aboutlogoen.html). A flame was chosen to signal that in every culture stories are told around a flame, a campfire, a candle. The flame illuminates the darkness and has transformative properties. The logo seeks to convey that the purpose of TRC is “to shed light on a past that has been hidden away in the darkness for far too long.” Singer-songwriter and Cree Canadian Buffy Sainte-Marie, who headlined the 12th Stanfest in Canso on July 6, 2008, was addressing through her songs, issues like the residential schools in the 1960s when no one else was talking about them openly, e.g., Our Country ‘Tis of Thy People You’re Dying, and Suffer the Little Children. Sainte-Marie has this to say about the formal apology from the Canadian government and art of witnessing. “If somebody has truly hurt you, and won’t actually own up to you and the world, to the wrong that has been done, it puts a stumbling block in the way of your ability to be properly perceived by others and to find forgiveness in your own heart. ... To have someone open it up to the broken hearts that were so hurt by that period in Canadian history is a real step forward” (Cooke, 2008).

The impact of the art of witnessing that Dori Laub recounts of his experience with a group of psychiatric patients who are Holocaust survivors hospitalized in Israel, could also apply to the impact of Dallaire’s testimony (both written and spoken) in raising public awareness of PTSD, and legitimizing it as a disease that soldiers and others traumatized by war can claim *as* a disease. Laub reported “a significant reduction in symptom scales for psychosis and post-traumatic stress disorder in those patients who provided testimony, but he also examines the effect the testimonies had on the community of the hospital, on the staff of health-care providers” (Spiegel & Charon, p. xi).

In contrast to ambiguous results of “truth-telling as talking cure” (Brounéus), Sue Halpern (2008) presents overall positive results for treating PTSD (an officially

recognized condition since 1980) patients through the art of computer-simulated virtual-reality, Virtual Iraq. The portal of Virtual Iraq “was a head-mounted display (a helmet with a pair of video goggles), earphones, a scent-producing machine, and a modified version of Full Spectrum Warrior, a popular video game” (pp. 32-33). Unlike truth and reconciliation testimony, Virtual Iraq is controlled by a trained therapist, who knows “which stimuli to select” (p. 36). Combat veterans with long term PTSD who had not responded to multiple interventions, participated in a similar program, Virtual Vietnam, in 1997, and “all of them showed significant signs of improvement” but it “didn’t catch on!” (p. 33). Which factors for a tipping point were missing, and what might be added this time to make Virtual Iraq contagious?

The impact of Dallaire’s testimony has reached far beyond the corridors of hospitals, and exemplifies art as a *social* determinant of health. In keeping with art for health as a revolution of everyday life, the evidence that we have presented in our exemplars throughout this report includes healthcare institutions as well as home and community. Health policy analyst Michael Rachis (2004) reminds us in *Prescription for Excellence*, that the founders of medicare, like Tommy Douglas, envisaged a Canadian healthcare system that included preventive medicine and care in the home and in the community (see Surette, 2008). Our exemplars have spanned art for health in home, community, and institutional settings, relevant to the four categories of practice, education, research, and activism.

Section 4: The Way Forward

Echoing musician John Lennon:

You say you want a revolution

Echoing documentary film distributor Larry Daresso:

You say you want a revolution of everyday life

Echoing essayist Malcolm Gladwell:

We say we want to start an epidemic

The way forward in the art-for-health movement takes the form of a response to Malcolm Gladwell’s (2000) question in *The Tipping Point*. “What can we do to deliberately start and control positive epidemics of our own?” (p. 14).

As a result of writing this report, we have begun to apply the tipping point theory and analysis to our own experience of practice, education, research, and activism. In our own case, John is the connector and salesperson, who has the genius for being at the centre of things; Dorothy is the maven, who finds pleasure in connecting ideas, and building a formidable database.

Recommendation 1:

Identify and bring on board the connectors, mavens, and salespersons that you need to start your own positive health epidemic.

The positive results of Virtual Vietnam in 1997 were not enough for it to “catch on,” to *infect* the population of those suffering with PTSD (Halpern, 2008). Evidence-based practice that draws on clinical trials is not useful for some health interventions. What could be done differently to make Virtual Iraq contagious and sticky?

Recommendation 2:

In practice and education settings, draw on case studies (an art form in its own right) to: a) deepen understanding of the factors that start and sustain a positive health epidemic e.g., Virtual Vietnam compared to Virtual Iraq, or Gladwell’s comparison of Sesame Street to Blues Clues, which overtook its rival in the ratings in 1996; and, b) gather evidence of what is contagious, and what might start an epidemic of health, happiness, and well-being.

The World Health Organization and the Commission on Social Determinants of Health identify these determinants as peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity. But they do not “name” art as a determinant and activator to start a population health epidemic in these areas. Nor do the policy analysts and consultants on social determinants of health, including Dennis Raphael, Trevor Hancock, and Michael Rachis in Canada.

Yet activists, and community development and social justice organizations intuitively and systematically use art in practice, research and education, often in overlapping ways. Health activists use art as readily as environmental activists or peace activists but are no more likely to name art as a determinant of health. In March, 2006, the Association of Ontario Health Centres (AOHC) announced the *Determinants of Health: Taking Action on Oppression Poster Series Competition* (Canada NewsWire, 2006). A jury of Ontario-based community artists selected the five images that best visualized diverse elements of oppression and social exclusion that act as social determinants of health and well-being. Anti-cultural political values or human rights abuses that deny or regulate access to the arts and creative expression were not among the five anti-oppression categories named in the competition — ageism; ableism; heterosexism including homophobia, biphobia, and transphobia; racism and ethnocentrism; and sexism.

The following exemplars name art for social justice as a social determinant of health:

Practice: The headline “Activists launch undercover operation” in the front section of *The Chronicle Herald* (May 28, 2008) is the ironic and artful lead to Johnathan Montpetit’s story of the Canadian edition of the *Panties for Peace* campaign (www.pantiesforpeace.ca): “Canadian women are being asked to volunteer their undergarments in an international effort to shame Myanmar’s ruling junta into giving citizens greater access to humanitarian aid and human rights.” The story is strengthened by a picture of colourful panties strung on the line. Why panty art? “The campaign plays off regional superstitions that contact with women’s panties can sap a man’s power. Activists claim the fear is shared by the leaders of the country’s military regime” (p. A6).

Research: Community-based research that partners community and universities (exemplified by the CUexpo exhibition in Victoria in May 2008) routinely uses art, especially participatory art, as part of the research methodology to effect social change (see Clover & Craig, 2008). Art for health is central to the work of arts-based researchers Ardra Cole and Maura McIntyre, as illustrated in their books and the Mapping Care link of the Centre for Arts-Informed Inquiry at OISE, University of Toronto (see Cole & McIntyre, 2006; McIntyre & Cole, 2008; www.oise.utoronto.ca/research/mappingcare)

Education: Simon Fraser University’s (SFU’s) Dialogue Maker Series 2006-2007, *Animating Democracy through Dialogue and the Arts* (www.sfu.ca/dialog/Dialoguemaker0607.pdf) includes presentations that link art to many of these established social determinants of health. Judith Marcuse is the dancer/choreographer/director/producer/teacher who worked in partnership with SFU on this series and the new International Centre of Art for Social Change at SFU. Imagine Education Research Group gives details of a seminar on April 21, 2008 presented by Judith Marcuse and David Diamond on “social justice playing out through the arts and in the classroom” (www.ierg.net/seminar-items/social-justice)

In *Pedagogy of the Oppressed*, Paulo Freire (2002/1972) famously identifies “naming” as a guiding principle for social action. “To exist, humanly, is to name the world, to change it. ... Saying that word is not the privilege of some few persons, but the right of everyone” (p. 88). Naming is central to the next recommendation and the guiding principles of this report.

Recommendation 3:

Health professionals, educators, researchers, and policy analysts, especially SDH policy analysts, shall forcefully “name” art as a social determinant of health.

Artists who are caregivers and care recipients in formal and informal healthcare settings shall forcefully “name” their art form as a social determinant of health.

Community-based, social justice practitioners, educators, researchers, and policy analysts shall forcefully “name” art for social change as a social determinant of health.

Roy Romanow, Founding Chair of the Canadian Index of Wellbeing (CIW) (<http://www.atkinsonfoundation.ca/ciw>) describes CIW’s purpose of charting and providing unique insights into how Canadians’ lives are getting better — or worse — in eight areas that matter, including arts & culture. These eight domains resonate with the determinants of health identified by the WHO and others. Following the conclusion from Matarasso’s (1997) impact study that the arts trade in meanings, it follows that the arts are well positioned to accomplish CIW’s declared purpose of “Measuring What Matters.”

The 2008 Shift Report (Institute of Noetic Sciences [IONS], 2008) draws attention to new measures of well being, including the CIW, which call for governments to look beyond economics to health, social, and environmental statistics in measuring national progress (p. 51). Our report supports art rather than statistics for measuring a “national prosperity index,” such as former president of India A.P. J. Abdul Kalam is trying to institute. He said in a speech while on a tour of Northern California’s Silicon Valley that the gross domestic product would be modified “by counting reductions in the number of poor and by creating some way to assess the health of a nation’s values or character” (IONS, p. 52). Well, art is that “some way.” “We confer our values on the things, tangible and intangible, that we produce, our cultural artifacts. They become the *repositories of what matters* to us” (Matarasso, 1997, p. 89, emphasis added).

Recommendation 4:

Distribute this report to individuals and organizations, with links to relevant web sites, which focus on and or evaluate determinants of health explicitly but also indirectly, such as agencies for social justice and social change in the areas identified by the WHO: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity.

Practice

Society for the Arts in Healthcare (SAH): www.theSAH.org

British Columbia Arts Council: www.bcartsCouncil.ca

British Columbia Artists in Healthcare Society: www.artcare.ca

Manitoba Artists in Healthcare (MAH): www.mahmanitoba.ca

Alliance for Arts and Culture (Vancouver): www.allianceforarts.com
 The Canadian Virtual Hospice: www.virtualhospice.ca
 CCAHTE Canadian Creative Arts in Health, Training and Education Journal:
<http://www.cmclean.com>
 CCAHTE blog: www.ccahtecrossingborders.blogspot.com
 Concordia University's Department of Creative Arts Therapies:
<http://creativeartstherapies.concordia.ca>
 Abilities Arts Festival (project of the Canadian Abilities Foundation):
www.abilitiesartfestival.org
 Toronto International Deaf Film and Arts Festival (Toronto): www.tidfaf.ca
 Devarts (arts/social change): www.tagsstudio.net/devarts
 Workman Arts, Centre for Addiction and Mental Health, Toronto:
<http://workmantheatre.com>
 The Alberta Social Health and Equities Network (ASHEN): www.foodsecurityalberta.ca
 ASHEN list serv: www.health-in-action.org/node/37
 Community Arts Network (CAN) [arts and healthcare]:
www.communityarts.net/archivefiles/health/index.php
 Health in Action (online access to health promotion and injury prevention information in
 Alberta: www.health-in-action.org
 Art in the Public Interest manages CAN: www.apionline.org
 The Narrative Practitioner Conference: www.thenarrativepractitioner.co.uk
 The Arts and Healing Network: www.artheals.org
 The Institute for Poetic Medicine: www.poeticmedicine.org
 The Academy of Creative Healing Arts: www.creativehealingartist.com
 Centre for Arts and Humanities in Health and Medicine, Durham University, UK:
www.dur.ac.uk/cahbm
 The Center for Arts & Health Research & Education, University of Florida:
www.arts.ufl.edu/CAHRE

Activism and Social Justice:

The Barnard-Boecker Centre Foundation (Knowing is not enough; Act for peace &
 justice), Victoria: www.islandnet.com/~bbcf
 UN Millennium Development Goals (www.un.org/millenniumgoals)
 Centre for Social Justice, Toronto: www.socialjustice.org
 Wellesley Institute, Toronto (advancing urban health): <http://wellesleyinstitute.com>
 Friends of Medicare: www.friendsofmedicare.ab.ca
 Canadian Council on Social Development: www.ccsd.ca
 Canadian Health Coalition: www.healthcoalition.ca
 International Centre for Art and Social Change, Simon Fraser University (Directors
 Celeste Snowber & Judith Marcuse), new 2008; for more information, SFU School of
 Communication (www.sfu.ca/communication) and Centre of Expertise on Culture
 and Communities (: www.cultureandcommunities.ca)

Education:

Canadian Council on Learning (CCL), Health and Learning Knowledge Centre (HLKC):
www.ccl.cca.ca/CCL/AboutCCL/KnowledgeCentres/HealthandLearning/index.htm
 The Arts and Humanities in Health and Medicine Program, University of Alberta:
www.med.ualberta.ca/education/ahhm.cfm
 Centre for Health Promotion Studies: www.chps.ualberta.ca

Research, Evaluation, and Policy:

Commission on Social Determinants of Health: www.who.int/social_determinants/en
 Prairie Women's Health Centre of Excellence: www.pwhce.ca
 Institute of Population Health, University of Ottawa: www.iph.uottawa.ca
 Centre for Arts-Informed Research, OISE, University of Toronto:
home.oise.utoronto.ca/~aresearch
 Putting Care on the Map, Centre for Arts-Informed Inquiry, OISE, University of Toronto:
www.oise.utoronto.ca/research/mappingcare
 Canadian Index of Well-Being: www.atkinsonfoundation.ca/ciw
 Genuine Progress Index Atlantic Canada: www.gpiatlantic.org
 Health Canada: www.hcpssc.gc.ca
 International Laboratory for Brain, Music, and Sound Research (BRAMS), University of Montreal and McGill University: www.brams.org
 Indian Residential Schools Truth and Reconciliation Commission: <http://www.trc-cvr.ca>
 Coalition of Progressive Electors, Vancouver (www.cope.bc.ca)
 McMaster University's Health Evidence database (www.health-evidence.ca)
 Canadian Policy Research Networks: www.cprn.org
 Atlantic Centre of Excellence for Women's Health: www.medicine.dal.ca/mcewh
 Nova Scotia Health Research Foundation: www.nshrf.ca
 Healthy Balance Research Program, Dalhousie University, Halifax: www.healthyb.dal.ca
 Community-University Partnerships: Connecting for Change: www.cuexpo08.ca
 Canadian Institute for Health Information (CIHI) & Canadian Population Health Initiative (CPHI): <http://secure.cihi.ca>
 Canadian Women's Health Network: www.cwhn.ca
 Canadian Association for Community Living: www.cacl.ca
 Canadian Public Health Association: www.cpha.ca
 Public Health Agency of Canada: www.phac.aspc.gc.ca
 Social Determinants of Health Bulletin, York University: <http://tinyurl.com/yltpdf>

Coda

As promised, we began with a story and shall end with a story — and with a challenge to ourselves and others. The conventional wisdom that change in the root causes of population health inequities demand change in government policy and legislation (Al Gore's repeated message related to global climate change) fails to

acknowledge that art, which continuously “slips it to us sideways” can accomplish the “tipping” of governments and policy makers into action. Our story is about art as a “little thing that can make a big difference” in tipping to art for health and starting an epidemic of bread and roses in population health.

To mark International Day for the Eradication of Poverty, local groups in Antigonish organized a “Lunch and Learn” event in Antigonish on October 17, 2007. Similar events were taking place around the province, as part of a call to the NS government to “frame a poverty reduction strategy,” such as other jurisdictions, most notably Quebec and Newfoundland and Labrador, have put in place. Our local organizers represented the following groups: Social Justice Committee of the Sisters of St. Martha, the Antigonish Women’s Resource Center, the Antigonish Quaker Worship Group, and the Canadian Auto Workers Union Local 2107. Residents of Antigonish and Guysborough Counties were offered a “free lunch.” A guest appearance by the Antigonish chapter of the Raging Grannies was on the bill.

Our personal task was to contact the local supermarkets and corner stores, asking them for donations of food. In the first letter that we drafted, we said that we had in mind fruit trays, bread and rolls, and — for the manager of Atlantic Superstore — “perhaps some of your lovely potted plants and Pumpkin Persons, that we could give away as door prizes.” When the organizing committee reviewed our draft letter, they were uneasy, suggesting that we would increase our chances of receiving a donation if we asked only for food. We were in turn uncomfortable with this decision but succumbed to the norms of charitable giving in the community, and excised this request for flowers and art pieces from our letter.

Some weeks after this event, we were reading about Rosella’s (1998) notion of the “reluctant witness,” and recognized ourselves. Yes, we had listened to a stereotyping discourse, in this case about what the poor need and what the privileged are prepared to do for the poor. The act of listening and acquiescing to that discourse — going along for the ride — was just easier. So it was that we missed an opportunity for *a little thing that could make a big difference*, an opportunity for starting a positive health epidemic.

If enough of us responded as active witnesses to a refusal to donate bread because we had asked for roses, we might well have opened up a reflective dialogue on who is deserving of roses. Can you imagine the much greater potential for “tipping” to art for health than a one-time fix of food alone? Refusing to be a reluctant witness is tantamount to women garment workers singing Bread and Roses, which we include as the final testimony in our evidence-based report.

Figure 6: Bread and Roses

BREAD AND ROSES

As we go marching, marching in the beauty of the day,
A million darkened kitchens, a thousand mill lofts grey.
Are touched with all the radiance that a sudden sun discloses,
For the people here are singing, "Bread and roses, bread and roses."

As we come marching, marching, we battle too, for men,
For they are women's children, and we'll march with them again,
Our lives shall not be sweated from birth until life closes,
Hearts starve as well as bodies: Give us bread, but give us roses!

As we come marching, marching, unnumbered women dead,
Go crying through our singing their ancient songs of bread
Small art and love and beauty their drudging spirits knew,
Yes, it is bread we fight for – But we fight for roses too!

As we come marching, marching, we bring a brighter day,
The rising of the women means the rising of us all.
No more the drudge and idler – ten that toil where one reposes,
But a sharing of life's glories: Bread and roses, bread and roses.

Based on lyrics: James Oppenheim, 1912

Music: Mimi Fariña, Copyright © Fariña Music 1976 All rights reserved

1. As we go march-ing, march-ing in the beau-ty of the day, A

mil - lion dark - ened kitch - ens, a thou - sand mill lofts gray, Are

touched with all the ra - dianc - e that a sud - den sun dis - clos - es. For the

peo - ple here are sing - ing: Bread and ros - es, bread and ros - es.

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