Towards a caring practice: reflections the processes and components of arts-health practice

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Towards a *Caring* Practice: Reflections on the Processes and Components of Arts-Health Practice

Background: Many studies in arts and health have focused on evaluating the impact of participatory arts activities, but few have considered the processes and components shaping the wellbeing outcomes of participants. This paper uses a relational approach to health to explore the processes and components at play during art making that helps foster the wellbeing of participants. *Methods:* The study uses an action-research case study of a 12-week visual art programme in a nursing home with 10 participants. Data collected were analysed and interpreted using grounded theory to obtain general themes and to facilitate focused analysis. *Results:* The study identifies the participants, wellbeing outcomes, the environment and the quality of activities as key concerns of arts-health practice. In addition, it reflects on the link between caring and arts-health practice to highlight several caring attributes that promote a caring arts-health practice. *Conclusions:* The study findings provide a practice framework that can guide decision making and action to foster a caring arts-health practice.

Keywords: Arts in Health; Care; Practice Framework; Assemblage theory; Critical Arts-Health Practice

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Introduction

Many studies in arts and health have focused on evaluating the impact of participatory arts activities (Castora-Binkley et al., 2010; Cohen et al., 2006; Fraser et al., 2014; Patteson, 2013), but few have considered the processes and components at play in shaping the wellbeing outcomes of the participants. This paper explores and identifies the processes and components at play during art making that help to foster the wellbeing of participants. Drawing on empirical findings, it offers a practice framework

that may promote effective arts-health practice and address the current need for clearer guidelines (Moss & O'Neill, 2009). This paper adopts the simplified term arts-health practice, instead of more commonly used terms such as arts-in-health, arts for health, or arts in healthcare (Dileo & Bradt, 2009; Macnaughton et al., 2005; White, 2009) to connote the synergistic potentials when the field of arts and health intersect. An arts-health practitioner is a person with an interest in using participatory arts activities as a pathway to mitigate the unfavourable effects of circumstances or places on personal wellbeing and to promote flourishing. Unlike art therapy or other forms of creative therapy practice in which the art-making process is intended primarily for healing and emotional release, arts-health practice is not therapy-based. Arts-health practice focuses on artistic products, and it seeks to support the development of artistic competence, skill and knowledge. Arts-health practice is therapeutic because it provides a supportive social environment that encourages communication, expression of ideas and self-development (Secker et al., 2011; Staricoff et al., 2002). Although it may have overlapping benefits with other forms of creative therapies, it is focused on creative collaborative exchanges rather than supporting functional performance, assessment and treatment planning (Brown, 2006; Swindells et al., 2013; van der Vennet, 2011).

This study used a unique mode of practice-led research (Smith & Dean, 2009; Sullivan, 2009), which combined an arts-health practice with a qualitative action-research case study. Embedding research within arts practices is useful for its ability to provide insight, to enhance knowledge about the effect of arts practices on people's lives, policies or organisation, and to develop practice (Fox, A. & Macpherson, 2015; Leavy, 2009). Such an approach can be useful to provide insight and to address the current lack of guidelines for arts-health practice (Jensen, 2014; Moss & O'Neill, 2009).

A case study is concerned with examining the phenomenon of interest as it occurs within a real-world setting (Yin, 2003). In this instance, the case is a visual art programme intervention in a nursing home. To enable myself, the arts-health practitioner, to reflect on and obtain insight into ways to improve my practice in a systematic manner, I incorporated action research in the study. Action research aims to fuse "action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concerns to people, and more generally the flourishing of individual persons and their communities" (Reason & Bradbury, 2001, p.1). This systematic way of inquiry and practice is distinguishable from practices that focus solely on the design and delivery of an art programme. I refer to this systematic inquiry and practice as critical arts-health practice. Critical arts-health practice involves undertaking a systematic investigation to evaluate the impact of one's practice and activities on the participants, to analyse and to reflect on the processes to develop an insider view and insights that can lead to improvements in current practice and professionalization.

A Relational Approach to Health and Wellbeing

In recent years, the concept of assemblage (Deleuze & Guattari, 1988) has inspired a turn towards a relational approach to health and wellbeing. According to Deleuze and Guattari (1988), life and its events are framed as a "constellation of singularities and traits deducted from the flow – selected, organised and stratified – in such a way as to converge (consistency) artificially and naturally" (Deleuze & Guattari, 1988, p.406). Our experience of the world and aspects of living is afforded and affected by assemblages – encounters with a collection of animate and inanimate things. Similarly, a relational approach views health and wellbeing as states constituted by, afforded by and amendable to a network involving the body's relation and its interaction

with other bodies, materialities and processes (Andrews, 2014; Andrews et al., 2014; Atkinson, 2013; Daykin et al., 2017; Duff, 2014; Fox, N.J., 2002; Mol, 2002; Williams, 2003). From a relational approach, health and wellbeing are also momentary states that are situated, emergent effects (Atkinson, 2013), constantly taking place (Andrews et al., 2014) or co-evolving and co-created (Andrews, 2014). In this sense, the gain or depletion of subjective health and wellbeing is affected and effected by encounters, networks and associations according to the availability of enabling resources (Duff, 2011; Fox, N.J., 1998, 2002). In other words, as much as an assemblage affords the body its capacities, it is also capable of delimiting its capacity for action, feeling and desire.

There have been few applications of assemblage theories to the field of arts and health (Atkinson & Scott, 2015; Fox, N.J., 2013; Raw, 2013). Moreover, scholars' interest has to a large extent focussed on the processes of becoming and emergence through an assemblage on the nature of health or wellbeing seen as relational effects of the assemblage (see Atkinson and Scott, 2015; N. J. Fox, 2013). Daykin et al. (2017) referred to such interdependent health-determining moments as mediated affordances in their work on music making for the youth justice population. Research attention to the arts practitioner or the artist as part of the assemblage and the nature of an assemblage-based practice is negligible (see Raw, 2013). N. J. Fox, N.J. (2013) examined the health-transforming potential available in creative production and reception in a broad context that encompasses art therapy and non-therapy based creative activities. He explicitly treated such contexts as assemblages and connected them to creativity in a hybrid concept of the *creativity- assemblage*. Within the creativity assemblage, creativity is a flow of affect between bodies, things and ideas rather than being an attribute of the body. The new capacities engendered and the affective power of

creative activities and products affect health as the body engages with the creativity-assemblage. Atkinson and Scott (2015) drew on the concept of assemblage to unpick the processes through which wellbeing, when seen as relational, may be stabilised, disrupted or changed. The arts intervention, in this case a dance and movement intervention in a primary school, disrupts the routines of the classroom through reorganising space, materials and conduct. The authors also drew on Deleuze and Guattari's (1988) lines of flight to describe how arts participation not only disrupts, but also throws those involved into new encounters and relations. It is, then, within the disrupted assemblage that a space emerges that is yet to be contoured or marked with prescripted habits, and that enables the exploration of new possibilities, including identity and wellbeing. These analyses by N. J. Fox, N.J. (2013) and by Atkinson and Scott (2015) bring insight into the gentler transitions and the disruptive, creative or inventive characteristics of assemblage through which wellbeing emerges, stabilises and is amended. However, their study focus was primarily on the transforming processes of and for health and wellbeing, and they gave only limited attention to the concerns, experiences and practices of the artists involved in these processes. There is an exception in the work of Raw (2013), who, in examining the processes of community-based art, identified six recurring and interrelated elements in participatory art practice: intuition, personal commitment, framework of value, spatial framework, relational framework and creativity. She coined the term of a *practice assemblage*, which not only emphasises the interrelatedness of elements that shape and affect participatory art outcomes, but also draws analytical attention to the centrality of practice. While current explorations of assemblage in the field of arts and health have acknowledged the network of human, material and process elements at play in shaping health and wellbeing outcomes with art activities, existing considerations have not actively

considered the conduct of the arts-health practitioner and the quality of the immediate physical environment as elements of the assemblage and their influence on wellbeing. Thus, this paper offers reflections on the processes and unpicks the components at play in shaping personal wellbeing outcomes in participatory art sessions. The findings suggest the basis of a practice framework that may promote a caring practice.

Methodology

This study took place over nine months in 2014 in a Singapore nursing home. It involved the delivery of *Let's Make Magic with Art Today!* a participatory visual art (PVA) programme involving 10 residents. The participants were recruited through purposive sampling (Patton, 2005) with the help of the nursing manager, who publicised the programme to the ward staff, who then identified and referred interested residents to participate in the programme. As part of the selection criteria, participants needed to be willing to participate in an interview and to be able to converse in one of the research languages (English, Mandarin, Teochew or Hokkien). They did not need to have previous experience in visual art making. Prior to the start of each session, the participants had an opportunity to clarify any doubt, and they were informed that they had the option to leave the project at any stage. With limited financial, human and time resources, the programme could only accommodate 12 participants. However, keeping in mind that the participants were susceptible to ill-health and the normal drop-out rate, 17 residents were initially recruited. The number of participants later fell, and it stabilised at 10 participants in the third week of the programme. The reasons for attrition included poor health and a lack of interest.

Over 12 weekly sessions, participating residents were introduced to a total of eight creative visual arts projects involving a variety of two-dimensional and three-dimensional medium. Semi-structured interviews and focus group sessions were used

to gather opinions and responses from the research participants, including participants of the art programme (n = 10) and staff who were highly involved in the provision and delivering of daily recreational activities and care (n = 7). Interviews and focus group discussions were conducted with the participants and staff before the start and after the completion of the programme. Interviews are useful ways to gather data on the experiences and viewpoints of individuals in their everyday settings; their strength lies in their sensitivity to provide factual, descriptive information, as well as disclosing nuances of the meanings participants attached to particular situations in their lived, everyday world (Kvale, 2007). By contrast, focus group discussions enable a range of viewpoints, and they explore the attitudes and issues that are of importance to people. The dynamic evolving from the discussion has the ability to reveal information that may lend new insights not anticipated by the researcher (Kitzinger, 1995). Informed consent was sought from all participating residents verbally in the presence of a staff member, while the consent of staff members was obtained via signed consent forms. Ethical approval for this study was granted through Durham University. The names of the interviewees are pseudonyms to protect their identity. Data collected were analysed and interpreted using a grounded theory (Charmaz, 2006) approach to obtain general themes and to facilitate focused analysis.

Results and Discussion

Arts-Health Assemblage

The venue for my PVA programme was a passageway outside the physiotherapy room at the nursing home. The passageway had no specific function other than to facilitate the movement of people and objects in and out of the physiotherapy room. However, following my arrival, the passageway was repurposed weekly by my intention and presence to amend the lifestyle and wellbeing of the residents through a

participatory visual art programme. My intention guided how I arranged the furniture at the venue and my choice of art materials and art activities to be introduced to the participants. The gathering and collecting of things in the activity venue not only physically occupied the space of the communal passageway, but it also gave rise to an opportunity and experience that destabilised the routines of the residents by engaging their bodies and minds with a different set of actions. The network of elements I engaged also provided residents with time and space to escape from established routines into unchartered space with the possibility of the emergence of new social and personal states of being as suggested by Atkinson and Scott (2015) (in turn drawing on Deleuze and Guattari (1988) concept of assemblage and the emerging lines of flight). As the participants arrived and engaged with the art material and the art activities, the transitory and fleeting non-place (Augé, 1995) characteristic of the communal passageway was transformed into a therapeutic landscape. The different set of actions that engaged the residents through the art programme, such as creating forms with art materials or the exploration of texture and colour, led them into a journey of play that tapped into their creativity.

My findings about the lifeworld of residents and the effects of the art session suggest that the network of elements engaged by care staff and the arts-health practitioner have engendered different experiences and opportunities for residents. Although the care staff members attended satisfactorily to the residents' physical needs, the materials and activities involved lacked the capacity to provide engagement opportunities for residents and to foster their personal development. Residents had only limited physical, cognitive and social stimulation in their daily life, while care staff members got on with their routine tasks.

> Alice: They [the staff members] take care of our meals.… They would walk around, ask us if we are doing alright. Nothing much. They don't offer us colouring,

> nothing. Yours is better; you teach us do to things. You teach us how to make art, teach us to colour.

This reflects an established care home assemblage in which a passive lifestyle has compromised the personal wellbeing of residents through reinforcing the sick role, eliciting boredom and diminishing self-esteem. However, the assemblage fostered by the arts-health practitioner, whilst only constituting a temporary alternative space, had an animating quality that was not apparent in the everyday spaces of the home or the interactions with the care staff. Jess, a care staff member, observes:

> Jess: They [the residents] usually don't respond much when we see them. It is good to have this kind of programme; it breaks their daily routine life and engages them to see and do different things other than laying on their beds. I can see that they enjoy the programme.… If you ask them to do normal exercise, they don't. You lead them to discover and show their talents with using the colour, the clay, the paintings. You can see the difference. Clare doesn't like to exercise, but [she] enjoys the art, but she didn't realise that she [was] using her hand. Her mobility has improved.

As such, the assemblage of the PVA was itself infused with a very different kind of care offered by the arts-health practitioner compared with the assemblages of care entrenched in the care home and in the practices of the staff members. The new relations that residents had with art materials, art making activities and myself through the PVA programme have not only deregulated their routine, but also led to new possibilities that supported personal development and engendered their positive emotions such as fulfilment and improved confidence. In this sense, the disruption to routine and new possibilities fostered by the collection and interplay of elements brought on by an arts-health practitioner offered a *line of flight* (Deleuze & Guattari, 1988) that amended the mood of and invigorated the participants.

> Clare: It [the art session] exercises our hands, brain and eyes. It [is] very good. Otherwise I sit here every day like a block of wood. It is not advisable to sit on the bed daily.

The assemblage of the PVA also conjured up a sense of purpose and accomplishment for the participants, as staff members observed the commitment and determination they put into realising their art pieces.

> Matt: Because they start the programme, they want their job to be finished so that they can see how much they can do, how well they can do. And that is very important.
>
> Agnes: It gives them a purpose. A purpose of forming something out of nothing. Even though they knew it wasn't perfect, but yet they were proud of what they have done, to have created something out of nothing. I have never seen them feel so proud before. I think it is fantastic!

The dynamic and contingent flow I experienced as an arts-health practitioner when conducting the art sessions for this study seemed to differ from the linear progression of interaction among elements suggested by Raw (2013) practice assemblage. In addition, although Raw offered insights to the commonality found in participatory arts practice, the elements identified: intuition, personal commitment, framework of value, relational framework and creative key provided little clarity on the conduct expected of the arts-health practitioner. Furthermore, while the practice assemblage draws attention to the interrelatedness of elements, the term does not readily connote the health and wellbeing transforming potential of the arts. Thus, I am interested to explore more explicitly the nature of an assemblage involved in participatory arts and to offer a term that better clarifies where practice and the arts practitioner fit within the health and wellbeing amending capability of the arts.

Given the limited attention to the concerns of the artist involved in the assemblage, which I argue has influence on wellbeing outcomes, I next explore the components involved in the assemblage of the arts-health practitioner. In addition, I discuss the manner in which I managed and negotiated the challenges and tensions arising from the encounters and interactions between these elements that have implications for the atmosphere and the participants' experience, and which support the emergence of personal wellbeing among the participants.

Participants and Wellbeing

Findings from my study suggest that the way I conducted the art sessions affected the participants' experience. Participants perceived certain characteristics of how I worked, which I am capturing by the terms 'adaptable' and 'patience' as forms of support exhibited during my sessions. This put the participants at ease and encouraged them in their exploration and creative making.

> Betty: As an elderly [person], I can be slow with [my] work. But you take your time to guide me. I hope to improve more!

Reflecting on the manner in which I facilitated the art sessions in this study, the arts-health practitioner, in my view, is at best analogous to a bee tending to a field of flowers. When an art session was in progress, I found myself having to manage interactions simultaneously on two levels: the micro (my interaction with individual participants) and the macro (the atmosphere and dynamic of the art session). As an arts-health practitioner, I found myself constantly attuned to the flux of needs, responses and reactions of participants, as well as to elements of the environmental context. As such, my role was, in part, to hold the space for participants in terms of ensuring that the ambience was conducive, supportive, nurturing and affirming. I noticed how my attention and the salience of the participants' needs and concerns would shift and vary dynamically according to the demands of the tasks and activities emerging in an art session. For example, while supporting disabled participants, such as Clare, to ensure that she did not encounter much difficulty while working with a single arm, I also had to stay attuned to other participants who might require my assistance.

It appears that the art material, activities and immediate physical environment involved can also present participants with difficulties and issues that can elicit unfavourable experiences and feelings. For example, the feeling of self-doubt experienced by Clare due to her disability did create some anxiety and affected her self-

belief during the initial phase of the programme. Similarly, Betty's lack of reach and strength due to her short physique also created some frustration and challenges when making art. However, it is part of the artist's practice in facilitating the creative space to maintain an observant attitude to be able to address the problems and to assist the participants in overcoming their constraints. I would respond by learning from the participants themselves what the matter was before proposing adjustment and improvisation. For example, when Joe found it challenging to stabilise his hand to join different clay pieces, the little adjustment I suggested to him to rest his arm on the table enabled him to have more control. Besides being observant, I aimed to maintain an approachable attitude, which also encouraged participants to voice their concerns and difficulties to me. In this sense, it is important to consider that human, material and process concerns may not necessarily be the only elements present in the assemblage of the arts-health practitioner. It seems that the conduct of humans can also shape and shift the experience for participating individuals and their wellbeing.

Environment

While N. J. Fox, N.J. (2013) creativity assemblage and Atkinson and Scott (2015) destabilisations make us aware of the health and wellbeing promoting capability of creative engagements afforded by a network of human materials and activities, neither considers the effect on the wellbeing of participants of the immediate external environment in which the art session takes place. The environment of my art programme affected both the participants' experience and their concentration. For example, the multi-purpose hall in which the programme was initially held did not have good ventilation, and the stuffy environment made the participants warm and distracted. The overlapping schedule between my art programme and the staff's preparation for dining activities in the multi-purpose hall also distracted the participants and put

pressure on them to finish their work. In contrast, when the art programme was relocated to the communal passageway outside the physiotherapy room, the cool and airy environment offered participants a more comfortable and conducive environment in which to work. Without the pressure of needing to complete their work, participants found the passageway more relaxing and less distracting. The setting of the arts participation is a critical element in an assemblage.

Quality of Art Activity

Besides invigorating the sense of the participants with a change of scene from their ward life and engaging residents in new sets of action, the arts-health assemblage I fostered appears to have had an animating quality that stimulated the residents physically, cognitively and socially, and that even inspired them. While participating in the art-making session, participants were engaged in an assortment of movements such as pinching, rolling, turning and extending their arms as they manipulated the art material to create their artwork. Movements of the participants' arms filled empty sheets of with a myriad of colours, turning them into various landscapes. Blobs of clay were enlivened and transformed to mimic fruits or creatures. Besides inducing physical actions, the art materials, and activities present in the assemblage of the arts-health practitioner also engaged the participants cognitively. While creating their work, participants had to conjure ideas for their artwork. They are also required to make compositional and aesthetic choices such as the colour, form and proportion of their piece, to shape their work to achieve the impression they anticipated for it. In their pursuit of realising their artwork, the wandering and preoccupation that participants experienced while manipulating the art also presented a capacity to shift the participants' focus and to amend their mood. Betty, for example, spoke of how the art-making process gave her a sense of release and an outlet for her to vent her moodiness.

She appreciated how the act of fiddling with the art material and the concentration she needed to realise her idea in physical form could move her into a more relaxed state in which she felt free and unburdened.

> Betty: Sometimes we are not in the mood, we can express out. Very relaxing [making art]. Can forget everything. I feel so free!… No burden at all.

This distractive capacity of art making can also be found in Joe's experience. As Joe's concentration for his creative pursuit deepened, it diverted his attention away from his meandering thoughts.

> Joe: When I am making things [creating art], I am focused on the making; it stops me from thinking about other things.

In other words, the challenge and creative pursuit initiated by the presence of the art material, art activities and myself seems to have also created a sense of purpose. The interplay of art material, activities also inspired new self-images. For instance, Clare's discovery of her ability to create artwork led her to overcome her initial self-doubt, and it gave her confidence and inculcated self-belief. These shifts emerging from the art programme have helped to demonstrate the positive impact art making can have on the personal wellbeing of participants.

> Clare: At the beginning, I wondered how am I going to do it with one arm. I didn't dare imagine. Now looking at my work, I am very happy and excited that I can produce thing[s] of such standard. For a disabled person to be doing this, I consider this not bad an achievement [Laughs]!

The artworks produced by participants are affective. The creations sparked conversations amongst participants, as they would exchange words of admiration with each other, fostering socialisation. This opportunity and witness of their ability to turn imperceptible vision and imagination into tangible artwork also inspired the participants to develop themselves further. This is visible in the desire and aspiration expressed by participants. We can see, for example, the sparking of desire and curiosity about the

new skills to be learnt from each art session expressed by Elaine and Peter, and how Betty avowed that she would challenge herself to improve further.

> Elaine: Nobody teaches me in here [the nursing home]. How can the nurse teach me this [art]? They distribute medicine. You let us learn and find things for us to learn. I will learn where possible. This is good. […] It will be good if we have this three times a week!
>
> Peter: Every week I look forward to the session. At least I can learn something from you. Although I may not be very good, it is good for me to learn something new. This makes my mind more active.... It is not so good for our brains to be inactive for long. It feels difficult at the beginning, but as the course goes on I began to grasp the whole idea and [I have] got used to the idea on how to create something. You passed some knowledge to me, the value of the art. I am happy. This is why I am longing for another course.
>
> Betty: Besides making our own work, we can learn something from other people also by looking at their work. Some creations are better than mine. I want to challenge myself to improve!

Participants have spoken about how they appreciate having opportunities to enrich themselves by developing new skills and gaining new knowledge. Besides enabling the participants to flourish, the assemblage of the arts-health practitioner also made visible the untapped and disregarded capabilities and energy of ageing people and their vibrant imagination and creative impulse.

The atmosphere of the participatory arts sessions often felt relaxed, light-hearted and animated by the intermittent socialising and the unique creations of the participants. It was not hard to spot episodes of enjoyment, deep concentration and conscientiousness while the participants were making their work. The art sessions also encouraged staff-resident interaction. Curious about the art session, staff members would drop by to interact with participants by engaging them in brief conversations revolving around their creations. Impressed or surprised by the residents' abilities, their encouraging comments would elicit smiles from participants. The PVA programme also challenged and changed staff members' previous assumptions and views on the ability and potential of the residents.

> Susie: When we saw their work, we went Woah! They can do such a thing. We never think that they can do like this way, so I also appreciate your effort.

Matt: I didn't think [laughs] the things come out form them can be so … so good. […] Never expected.

Agnes: I was expecting a lot of prompting going on, but seeing it wasn't the case. The imagination came out, just like that and it is wonderful! [Chuckle]. The smiles on their face from their final creation[s] [were] fantastic! One of them can even describe that [a] can should be holding a fish, because the cat is eating a fish.

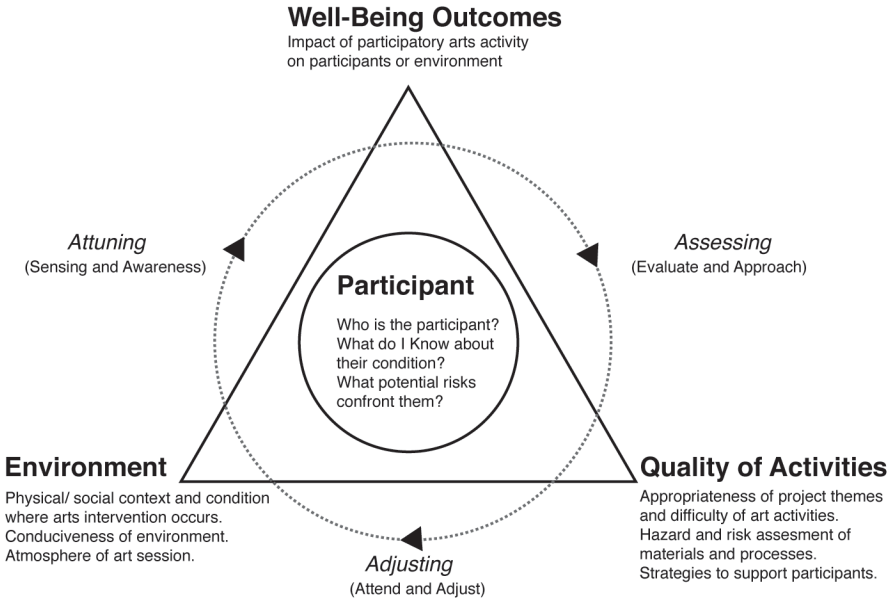
I have used the notion of assemblage to explain the conduct of a PVA session, because my research suggested that successful sessions depended on the way an arts-health practitioner manages a range of elements coming together often in unexpected ways. The notion of *line of flight* expressed for me the inventive capacity of a PVA session to disrupt routine, creating new possibilities that led to improving the participants' wellbeing. The discussion has extended this understanding of the relations between arts participation and wellbeing by stressing the centrality of the arts practitioner as the architect and manager of the assemblage. The arts-health practitioner constantly needs to be attentive and responsive to differentiated experiences of the participants in relation to the material, spatial, social and atmospheric elements of the assemblage.

A Caring Arts-Health Practice Framework

Although there has been a growing interest for arts-health practitioners to establish modes of approaches to facilitate better experiences for participants and wellbeing outcomes (Dileo & Bradt, 2009; Jensen, 2014; Raw, 2013; White, 2009, 2010), there have been limited conceptual models of arts-health practice that identify elements that are important to the practice that practitioners need to consider and manage to provide a pleasant and enriching experience that amends and fosters the wellbeing of participants. From the empirical findings, four components or metaparadigms emerged as governing concepts of arts-health practice: the participant, wellbeing outcomes, the environment and the quality of the activities. A metaparadigm

spells out the global concerns of a practice; it acts as the cornerstones of practice from which more restricted structures develop (Eckberg & Hill Jr, 1979). It defines the boundary of a practice and its interests, and it summarises the intellectual endeavour, social mission and recurring themes that are of interest to a practice (Fawcett & Desanto-Madeya, 2012). A metaparadigm creates a focus for a practice, which promotes its unity and facilitates communication between its practitioners. It also helps members of a practice to explain to others outside the area of practice who they are and what their special interest and contribution is (Figure 1).

[Figure 1. A Caring Arts-Health Practice Framework]



A participant is an individual sharing in the participatory arts programme whose health and wellbeing circumstance are of interest to the arts-health practitioner. The emergence of wellbeing, as indicated in preceding discussions, in part depends on the arts-health practitioner's attentiveness and responsiveness to the shifting needs and challenges of the participants. Wellbeing outcomes result from the aim of arts-health practice to amend and foster the health and wellbeing of participants. Having a

consciousness about this intention can offer the practitioner a sense of focus, and the practitioner can steer emerging outcomes towards this objective. Environment refers to the context in which the arts-health practice and activities occur. It also draws attention to the meaning of the place and the implication of the arts to the participants in that particular context. Environment also refers to the ambience and dynamic atmosphere unfolding alongside the art session. Finally, the quality of activities draws attention to the positive affectivity (Watson et al., 1988) such as enthusiasm, alertness and excitement, resulting from the creative processes, materials, and interpersonal transactions occurring in a participatory arts session.

The quality of art activities is also concerned with the appropriateness of themes and the level of difficulty of creative brief, the suitability of material and the process used in the art activities for participants, and anticipating strategies to support participants. These conceptual elements are brought together through the dynamics of a caring practice which I captured through three terms: attuning, assessing and responding which I elaborate further below. Together, these governing concepts and dynamic practices constitute a metaparadigm of arts-health practice as represented in Figure 1. The four governing concepts of arts-health practice have also usefully helped to generate a list of considerations and offered a practice framework (Table 1) that I found useful to guide me in my practice through the planning, designing and facilitating phases.

[Table 1. Considerations for a Caring Arts-Health Practice near here]

Participant	• Who are the participants? (E.g. age, gender, experience with arts) • What are the health and well-being concerns or conditions affecting the participants? • What potential risks or challenges might the participant face while participating in the arts session? • What vulnerability might they face? What action is required to ensure that participant is treated with respect, dignity and care?

Well-being Outcomes	• What measures need to be taken to eliminate or minimise physical health and safety risks of participants? (E.g. Potential Hazard spot and injuries, Infection) • What measures need to be taken to eliminate or avoid subjecting participants to emotional risks? • How are participants reacting to the participatory art activities? • Who can the arts-health practitioner to turn for further assistance in when a participant are experiencing physical or emotional risk?
Environment	• What is the setting and its operation protocol? (E.g. Care institution, community centre, learning institution) • Is the physical environment safe for participants? • Is the physical environment conducive for participants? • What considerations need to be given to foster a vibrant atmosphere during the participatory arts session?
Quality Activities	• Is the creative task set at an appropriate level of difficulty for participants? • Does material and process possess any hazard to participants? • How are participants managing and responding to the creative task? • Are participants feeling comfortable and at ease during the session? • What alternative support strategy or mechanism is available to support participant through the creative task?

While the four concepts are central and important to arts-health practice, the demand from each component can fluctuate during the participatory arts session. Thus, in a way, a caring arts-health practice demands that the practitioner is attentive and responsive to the shifting and unpredictable dynamics as they unfold in a participatory arts session. To manage the challenges of the task to allocate attention to the four central concerns, I approached my practice using an iterative mode of action comprising *attuning*, *assessing,* and *responding*.

Attuning calls the practitioner to be present constantly and to pay attention to the event unfolding. The concept of situation awareness (Endsley, 2000) lends a useful description of the various actions involved in attuning. Situation awareness involves a process of perception, comprehension and projection. Perception involves monitoring, detecting cues leading to awareness of multiple elements such as people, objects and events, and their current states such as condition, action and locations. Comprehension involves a process of recognition and interpretation and of integrating information gathered to assess the potential impact on actions and views. Projection refers to the

anticipated course of action. Assessing requires the practitioner to evaluate the circumstances encountered or presented by participants and to understand and clarify their needs. Lastly, responding refers to the course of action required of the practitioner to attend and to assist participants to resolve their concerns by making the necessary adjustments or to introduce alternative approaches. Thereafter, the practitioner reverts to assessing participants' responses. This practice of maintaining a sense of equilibrium to foster a supportive and nurturing environment I call a practice of *holding space*.

Conceptual models articulate the purpose and scope of a practice by identifying global perspectives and concepts that are important to it; such knowledge in return facilitates reasoning processes, decision-making, evaluation and reflection that can further advance practice and its effectiveness (Masters, 2014). I hope the proposed conceptual model provides a useful reference to facilitate decision making, action and reflection on arts-health practice to advance understanding and to build knowledge of good arts-health practice.

Arts-Health Practitioner as a Caring Artist

Taking into consideration how social relations and social practices enacted in caring can have positive and negative consequences on human wellbeing (Atkinson et al., 2012; Gesler, W. M., 2009; Gesler, Wilbert M & Kearns, 2002; Kearns & Gesler, 1998; Milligan, 2005), it can be argued that the attitude and manner in which the arts-health practitioner interacts and responds to participants can have implications for wellbeing outcomes through a participatory arts activity. The significance of the conduct of an arts-health practitioner was also indicated in my discussion on arts-health assemblage. Given the significance of the conduct of an arts-health practitioner and the current lack of articulation of the attributes of an arts-health practitioner, the concluding section of this paper draws on my experience as an arts-health practitioner in this study

to reflect on what it means to be a *caring* artist. I hope this reflection can provide a way of thinking about the modes of arts-health approaches to foster a more caring arts-health practice.

To care is to recognize the lived experience of others as worthy of our attention; care suggests that we respond in ways that are helpful and that perhaps facilitate positive change and new ways of being together (Conradson, 2011). Care not only entails attending to and fulfilling the practical needs of the other; time, material resources, knowledge and skill, but social relationships and feeling are also involved, and care is expected to provide them (Phillips, 2007). Milligan and Wiles (2010, p.738) drew attention to the fact that "care-givers do not simply do things for people; they also support them with encouragement, person attention, and communication in ways that endorse a mutual sense of identity and self-worth."

The *caring* artist, first and foremost is compassionate. The caring artist takes notice of the situation of his or her fellow humans and is interested to take on the responsibility to create positive change in their situations through a creative art engagement. In this instance, I aim my project to alleviate the unfavourable impacts of the inactive lifestyle on the wellbeing of residents through art making. In this sense, the caring artist is also hopeful, and he or she sees potential in others to grow. The hopeful attribute of the arts-health practitioner is reflected in the different opportunities, expectations and challenges that Clare experienced from my PVA programme versus the art activity that she received from care staff. Clare felt stimulated because the art projects in the PVA were more challenging than the colouring sheets that care staff would provide. In addition, the sense of fulfilment she experienced from her ability to respond to the creative brief empowered her and elicited a renewed sense of amazement, pride and confidence.

Findings from the study also highlighted the high level of interpersonal engagement, demand and support involved in the process of amending and fostering the wellbeing of participants. While delivering an art activity, the potential needs and challenges encountered by participants also require the arts-health practitioner to give attention and to respond to them. I have earlier highlighted the emerging and shifting needs and emotions among participants during an art session, for example, Clare's initial self-doubt about her ability. These situations arising from the PVA sessions go to show the emotional demands in arts-health practice. The fluctuating demands and emotional reactions also call for arts-health practitioners to be sensitive and responsive. These attitudes are another attribute of the caring artist.

The findings revealed that the quality of the environment in which the programme is held can shape participants' experience and perceived quality of the art programme. Besides paying attention to the ambience such as the quality of lighting, airflow, temperature and noise, attention was given to ensure that the venue was free from hazard to prevent fall risk. Care was also taken to eliminate or minimise the potential risk of cross infection by observing good personal hygiene and wiping down or washing tools with disinfecting products after each session. Besides physical safety, I also exercised sensitivity to avoid subjecting participants to emotional risks. I tried constantly to observe and take note of the participants' reactions and responses by observing their movements, gestures and expressions throughout the arts sessions. This attention to the shifting action and reactions also called for the arts-health practitioner to be present and attentive; to have an ability to be present to self and others that is focused on an intentionality to care for and to foster positive experience for participants in an art session. In other words, a caring artist needs to be committed to lead and support the participants to discover their capabilities to grow. A caring artist needs to exercise

sensitivity by not imposing on the participants, but allowing the participants to guide themselves and to help determine what and how it is most appropriate to help. In this sense, a caring artist establishes and maintains good communication with participants, and he or she is respectful. A sense of respect, as I came to know through my practice, can be fostered through the way the arts practitioner communicates with the participants. For example, it is useful to adjust and to lower one's height to the eye level of the participant to minimise any impression of talking down to them. I would usually stoop down across or beside my participants when guiding them. Respect can also be exercised by showing a willingness to be a good listener.

Given the high degree of interpersonal interactions involved in arts-health practice, it is helpful to maintain an approachable attitude. This helps to put the participants at ease, and it makes them comfortable approaching me with any difficulty or query while making their artwork. The caring artist is also one who encourages and nurtures. When leading participants, patience also appears to be a crucial attribute of a caring artist. The opinions of participants and staff have indicated the importance of an ability to tolerate and accept the limitations participants might have. The arts-health practitioner needs to remain willing to lead and to support participants through the process.

> Agnes: Ah! That is very important. The patience that the artist can portray to the elderly is very important. Because it is through patience that you can draw the elderly out. If you do not have the kind of patience with the elderly, you will give up eventually [laughs].

By reflecting on my practice in this study, I realise that to engage and motivate residents to participate in the creative process, it is important for the practitioner to ascertain the suitability of the kind of arts activities and the level of difficulty of the creative task that are appropriate for the participants. This will not only help to ease participants into the creative work, which is likely to be a new venture for many, but

also to help them to build confidence through tasks that are manageable. It is important, then, throughout the process to pay attention to and monitor the comfort and ease of the participants while engaging in the creative task. The practitioner may also need to make modifications to the creative task or activity in response to the participant's needs and to support and encourage participants. Lastly, taking into consideration how the arts-health practitioner managed to activate and energise the bodies and minds of residents, the caring artist is also one who invigorates and inspires.

In this reflection on what it means to be a caring artist, I have identified several attributes that have significance in the process of amending and fostering the personal wellbeing of participants. Stemming from having a compassionate and hopeful outlook about others, the caring artist is also respectful, attentive, sensitive and responsive to the needs and challenges of participants. The caring artist understands that the creative journey can be potentially laborious and challenging for him- or herself and the participants, but he or she is willing to exercise patience and is committed to lead and support the participants to discover their capabilities and to grow. In other words, the caring artist encourages, nurtures, invigorates and inspires. Through this reflection on what it means to be a caring artist, four elements have emerged and suggested their salience to the concerns of arts-health practice. They are participants, wellbeing outcomes, environment and quality of activities. I hope the proposed practice framework will be a useful guide to facilitate decision making, actions and reflection on arts-health practice, and that they will result in a more caring arts-health practice.

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