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Embodying Health:

a review of the work of dance and somatic practitioners working in NHS hospitals

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Cover Photo: Kerstin Wellhöfer, UCLan

Introduction & Executive Summary

Section 1

There are many examples of dance initiatives, companies and individuals working in NHS hospital settings such as, People Dancing: Foundation For Community Dance, Aesop (Dance to Health), Dr Richard Coaten, Victoria Hunter, Helen Payne, Miranda Tufnell, Rambert Dance, English National Ballet, Birmingham Royal Ballet, Dance for Parkinsons, and Akademi. Their contributions in practice, writing and research have developed dance and health, and contributed more broadly to the field of arts and health, and are a topic of heightened concern and interest at a time when our bodies are expressing the effects of illness, social distancing, and isolation.

This report identifies the work of dance and somatic movement practitioners within NHS hospital settings[1] in the UK. It collates the views of over 50 dance artists working specifically with somatic-informed movement practice in hospital settings. The report does not include many other valuable arts practices in hospitals but seeks to focus on this area where there has been little research to date. It aims to be of interest to dance and somatic movement practitioners, students, academics and healthcare professionals involved in arts and health. Being the first of its kind, it sets out to define this growing and vital field of participatory arts practice by collating data on the working patterns and scope of practice.

The report draws upon evidence from a national survey of 47 practitioners, and a series of semi-structured interviews with six leading UK practitioners between 2017 - 2020. These practitioners were selected because at the time of their interviews they each held positions (temporary or permanent) in hospitals in different regions around the country. The semi-structured interviews expanded on questions asked in the survey enabling us to refine themes further and update findings over the 3-year period of investigation. The rationale for this research grew out of concerns by practitioners seeking to understand how embodied practice is taking place in hospitals, in order to develop more informed dialogues with commissioners and healthcare professionals, and ways the profession might establish approaches where the practice can be grown and sustained.

Somatic-informed movement practice (SIMP), as defined in this report, foregrounds an approach to the body and movement that uses improvisation, sensory awareness, imagination

[1]The review was undertaken at the University of Central Lancashire (UCLan), in the Faculty of Culture and the Creative Industries. It received ethical approval, and was conducted between 2017 and 2020. It's been led by Penny Collinson, a senior lecturer at UCLan and Nicola Herd, associate lecturer in Staffordshire University. Both are registered Somatic Movement Educators with the International Somatic Movement Education and Therapy Association (ISMETA), and steering group members of the Knowing Body Network, an online resource for practitioners working in health.

and touch (Eddy 2016). It emphasizes sensing and moving, developing internal awareness and a sensitive engagement towards ways in which we experience our living bodies. Embodied movement processes hold the potential for subtle and substantial impact on a person's subjective wellbeing affecting change in mood, motivation, pain relief, stress reduction, relaxation, coping skills, and quality of life (APPGAHW 2017; Dowler 2013, 2013b, 2016; Gersten Roberts in Karkou, Oliver & Lycouris 2017; Payne in Karkou, Oliver & Lycouris 2017; Pereira-Stubbs 2017; Tufnell 2017).

The impact and benefits of the arts for health and wellbeing have been rigorously evidenced through 'Creative Health: the arts for health and wellbeing' (2017[2]) and more recently the Health Evidence Network Synthesis Report 67 (Fancourt & Finn 2019[3]). Both of these reports stress the role of the arts in creating a more person-centred, health-focused care service, and the need for a patient's subjective, embodied experience of health.

Somatic-informed movement practice is an area of growth in health settings. Its relational approach foregrounds the subjective experience differently from other arts and wellbeing interventions because it involves ways that support others to sense their bodies and observe the smallest shifts and changes, from which movement may be expressed. Developing a person's awareness of these internal sensations and movements can relax, settle and resource people. Working in hospitals is an important context because through illness all aspects of a person is changed, causing distrust and disconnection with our bodies and to what we know and value in our lives.

[2]All-Party Parliamentary Group on Arts, Health and Wellbeing, 'Creative health: the arts for health and wellbeing', Inquiry Report, 2nd edition; July 2017. Available online at: http://www.artshealthandwellbeing.org.uk/appg-inquiry/

[3]Fancourt, D & Finn, S (2019), 'Evidence Network Synthesis Report 67, What is the evidence on the role of the arts in improving health and well-being? A scoping review', World Health Organisation Regional Office for Europe.

Section 1

Overall, the findings of the research show there are many individual ways of working which share common principles. Practice is viewed as holistic, out of which lies a central objective to support people to the presence of their bodies through movement, imagination and creativity. Most practitioners describe their remit as one of support for patients in their recovery/rehabilitation; for fitness and exercise; and for arts participation. The varying artistic approaches hold, what one interviewee referred to as, the potential to meet the language of the medical model with the poetic.

Discussions with the interviewees highlight the lack of shared understanding between practitioner and commissioner/ward teams. A general picture shows that there are a few hospitals employing practitioners around the UK, and many regions appear to have no provision at all. Practitioners have short-term, temporary contracts, with just a few hospitals maintaining long-term practitioner provision. Where the inclusion of arts intervention is more embedded, patients are referred to practitioners who contribute to their care plans.

Whilst economics plays a large part in sustaining provision, practitioners suggest that there is a breadth of possibility to the benefits of their work with patients which is under-explored and they want greater agency to evaluate what are seen as 'soft targets'. The report suggests a lack of resources (funding, time, adequate and appropriate spaces) to undertake long-term study and to evaluate and evidence the practice taking place.

Following the commentary and observations of the data, this report goes on to suggest that in order to sustain and develop this work it needs to be nurtured, strategically developed, and have greater visibility. The report finishes with key recommendations for future development in the field, which include the documentation, archiving, research and dissemination of practice; and, the need to support practitioners through advocacy, mentorship, and Continuous Professional Development (CPD) in related fields. Such developments could support a paradigm shift in thinking and practice in ways that supports a patient-centred, health-focused approach.

Section 1.2

Somatic-informed movement practice (SIMP) is used here to describe an approach to dance which views a person as holistic, physical, emotional, mental, social and spiritual - and that perceives the interconnectivity of these aspects as essential to health and wellbeing. There are many different methods which share common components, the practice will:

- be participatory and experiential
- have an emphasis on wellness rather than illness
- involve spontaneous and improvised activities which support movement and rest
- develop consciousness towards the sensory and felt-sense of the body, and the potential of subtle modalities of communication and being in the world
- involve the imagination
- be relational and involve a co-creative approach
- hold the potential for the presence of affect, memory and dream
- offer regulatory support of the autonomic nervous system

Movement approached in these ways seeks to connect people to their 'lifeworlds', a term used in philosophy and in some social sciences, which reflects immediate bodily lived experiences and subjectivity from which personal meanings arise. Miranda Tufnell suggests this approach is a creative process of 'seeking out the particular and personal and in so doing, strengthening what is well.' (Tufnell 2017[5]: 104). She points out,

> *This is not 'dance' in the conventional sense, but rather communication through movement and the body. Somatic approaches train a bodily listening that is highly sensitive to these bodily movement tones and patterns. Developing a person's awareness of these subtle inner movements relaxes and stimulates blood flow, bringing about a settling and whole body reorganisation. (p.105)*

Tufnell's stance towards a practice which strengthens what is well in a person, is a view of health shared by Filipa Pereira-Stubbs, whose work with elderly patients working at Addenbrooke's Hospital, is focused on exploring what they can do, rather than their symptoms and what they can't do (2017). Pereira-Stubbs, describes her movement classes as helping people 'remap their awareness of their body landscape' (p. 188).

The holistic lens is emphasised in Lisa Dowler's work at Alder Hey Children's Hospital, as being 'an important part of the patients' recovery and also their experience of being in hospitals' (2013a:10). Dance and somatic practitioner, Dowler described the benefits for three patients on the neuromedical ward as, (1) exploring senses and movement in a playful way; (2) to express, let off steam and explore memory and attention deficiency through improvisatory games and movement, and (3) to play and explore moving and making connections and relationships (ibid).

Creativity, memories, connection and relationship are interwoven as themes and approaches in somatic-informed practice. How sessions are facilitated one-on-one, and in groups is dependent on the context and intentions of the practitioner and the resources available in the hospitals, therefore this report aims to pull together a picture of how practitioners consider their practice and working patterns within the parameters of busy, economically focused hospital environments.

[5]The work of movement artists on wards is illustrated in Miranda Tufnell's most recent book, When I Open My Eyes: Dance, Health, Imagination (2017)

Photo: Lisa Dowler, Alder Hey Hospital Trust

Data & Findings

Section 2.1

National Survey

An online survey undertaken in the first phase of this research (March-July 2017) targeted dance and somatic practitioners. The survey was anonymous and had a total of 47 respondents.

Informal interviews with six leading practitioners

Semi-structured interviews with six leading practitioners working in the field took place between July 2017 - February 2020: Lisa Dowler (Liverpool/France), Stella Howard (London), Lucinda Jarrett (Oxford/London), Filipa Pereira-Stubbs (Cambridge), Susie Tate (Northumberland/Cumbria), Cai Tomos (London/Wales)

The research inquiry and questions are compiled into 4 areas:

1. How do practitioners identify their role in hospitals? What is their scope of practice? What is their remit?

2. Where in the UK are practitioners based? On which wards is the work happening?

3. How are practitioners contracted /what is their employment status?
   How is the work evaluated and why?

4. In which ways do practitioners find support for their professional work?

What follows is a summary of the data for each survey question, and includes both quantitative data, in which some questions invited multiple responses and others a yes/no response, and qualitative data, including thoughts and opinions recorded through informal interviews, and commentary to draw out the findings.

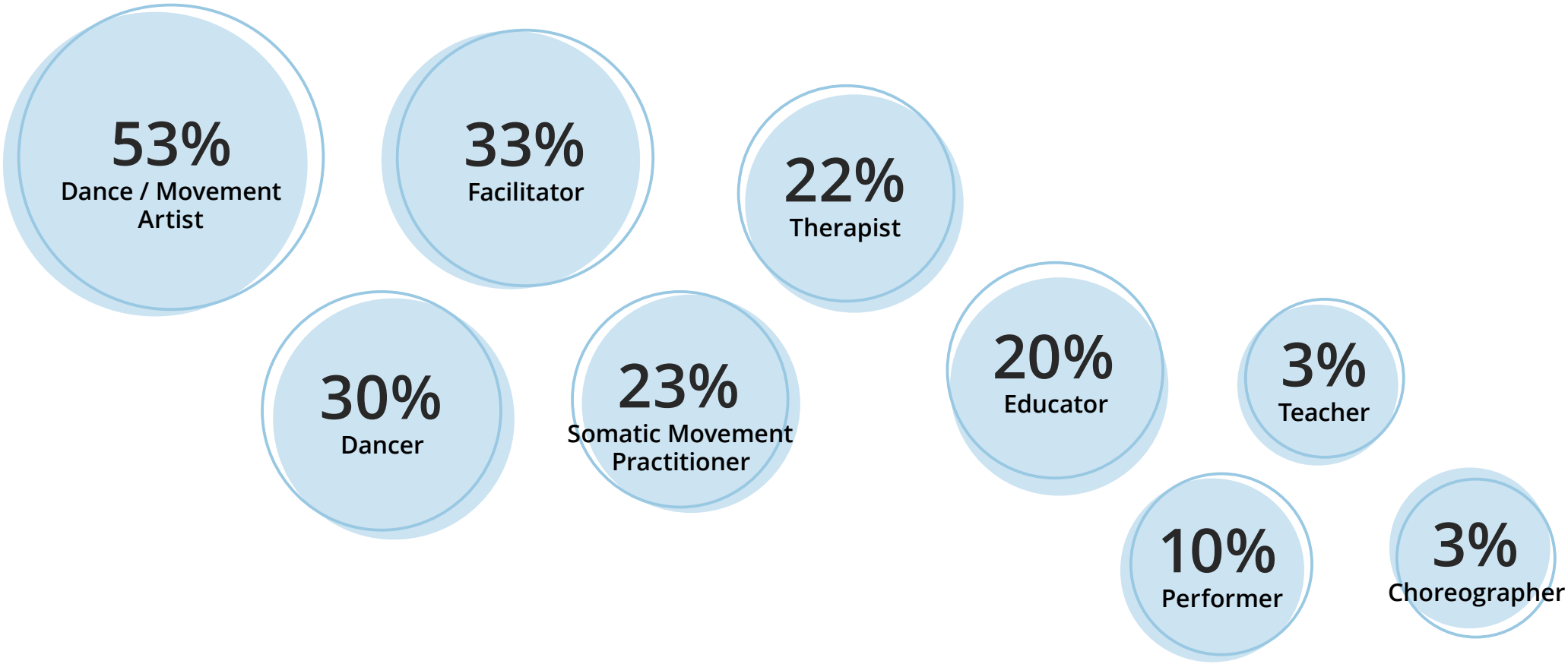
Section 2.2.1

Practitioners were asked what they call their role in the hospital setting.

It was a multiple-choice question, including the option to add “other”, some people marked a number of choices. All 47 respondents replied:

We see that there is no one defined name for their role. Interviewees suggested that different titles enabled them to define the subtlety of their intentions and was useful in different contexts, though Dance or Movement Artist enabled versatility in approach.

These terms also define the interactions as creative learning processes, and interviewees emphasised the artistic nature of their practice as offering people a chance to be in the experience and imaginative realms of movement and their bodies.



Section 2.2.2

Respondents were asked to name the various practices they use

Respondents were asked to name which practices, i.e. approaches, tools, methods or techniques, they use with patients. It was a multiple-choice question, including the option to add “other”. All 47 respondents replied:

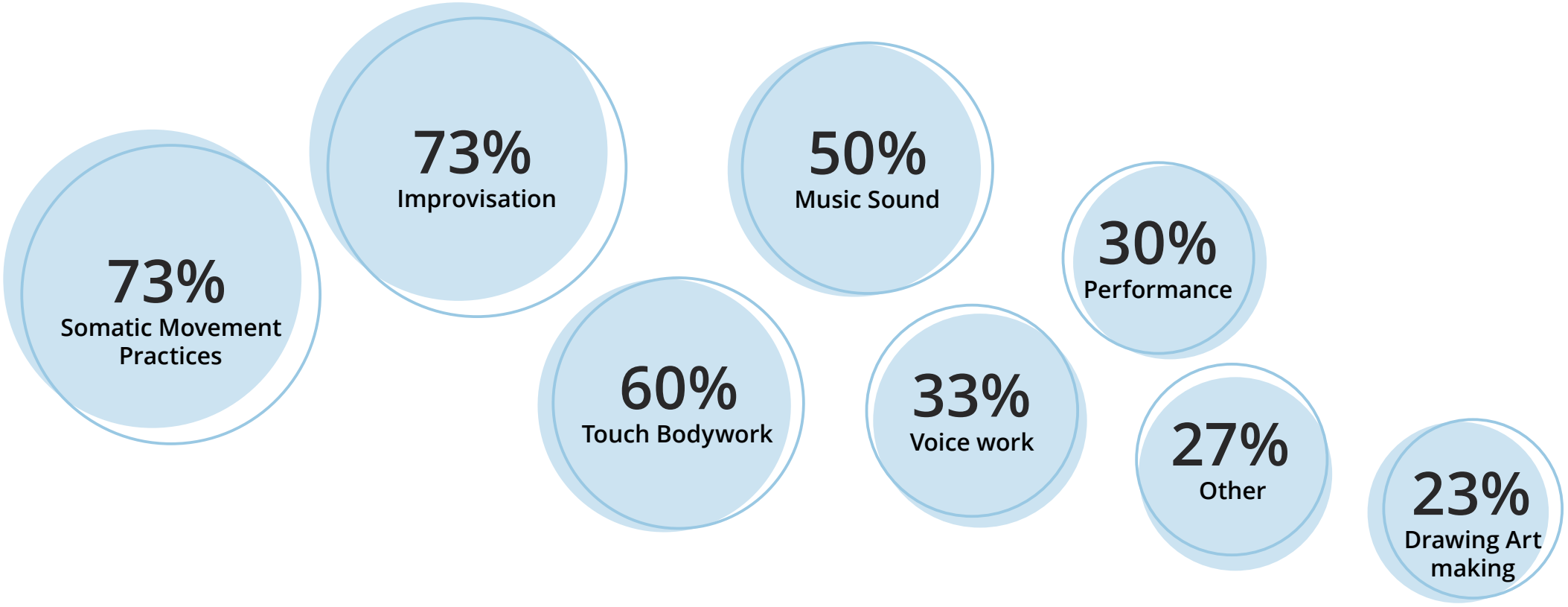


Photo: Cai Tomos, Chelsea and Westminster Hospital

Section 2.2.2

The interviewees elaborated on ways in which their practices are framed. Each shared their approaches, from group to one-on-one bedside practice, and some with an emphasis towards performance. The empathic, co-creative approach underpins much of their work. The quality and spaciousness of the practitioner's presence profoundly affects what happens with the patient. It is not essential for patients to understand the process of co-creation, but rather that the practitioner guides/is awake to the creative potential of the encounter and aware of the affective responses taking place in his/her self and the patient, while holding a safe containment of space and time:

To guide perception of sensation, to awaken minute shifts and changes in proprioception

The patient chooses a track of music on the iPad, I start with touch to help to reconnect to body, I start slowly and carefully, always seeking permission …"where in your body would you like a hand?" it's usually a part which feels tense…I take people to different parts, shoulder, spine, limbs…[I ask them]…"what does it take to find movement there?"

I started with touch work and encouraged a little sensation through his body, this developed to squeezes, moving and encouraging his movement. He didn't have much movement at all. I had a small hand solo which I performed around the child with calming music. He started to follow my hands with his eyes and by week 4 he was reaching for my hands. I was doing a full improvisation with the baby, with him moving and surprisingly pushing to lift up his hips to join in

It's co-facilitation

The work started out as pure movement…on the one hand movement is very helpful as it works from a positive model of what people can do and not from the deficit model of health, but it also didn't address the lack of confidence [stroke patients] had with speech, because we'd stay silent

We're doing co-creation

It's improvised and always co-produced

Those who can't move…instead they tell me somewhere they love…What do you notice about that place in your body? Can you imagine walking there, what's the ground like?

I explain it simply to the child or parents as an approach which is very gentle, taken from you or me and however you want to move

It will sometimes start with ideas around breath, filling their lungs and expanding their body, floating, reaching…or I start a game of mirroring with fingers, and see where that leads…a subtle finger movement, or a confident gesture, in that moment I'm following the child's choices, but also intently sensing their energy, physical choices, movement range, and potential range in our relationship together

The results of this question reveal the hybrid of skills and approaches used and how practitioners can adapt to the patient's mental and physical needs and abilities.

Section 2.2.3

Respondents were asked to describe their working remit, what they were in the hospitals to do.

Eight main categories were identified and 17 respondents replied, all gave multiple responses:

Survey respondents elaborated on their remits:

to support recovery through offering different ways into moving - that is creative and expressive rather than 'to fix an area of the body', social interaction through work within a group & for long term patients in particular

to offer [staff] new ways into supporting their patients - specifically OT's and physios

The interviews with practitioners shared examples of their working remits;

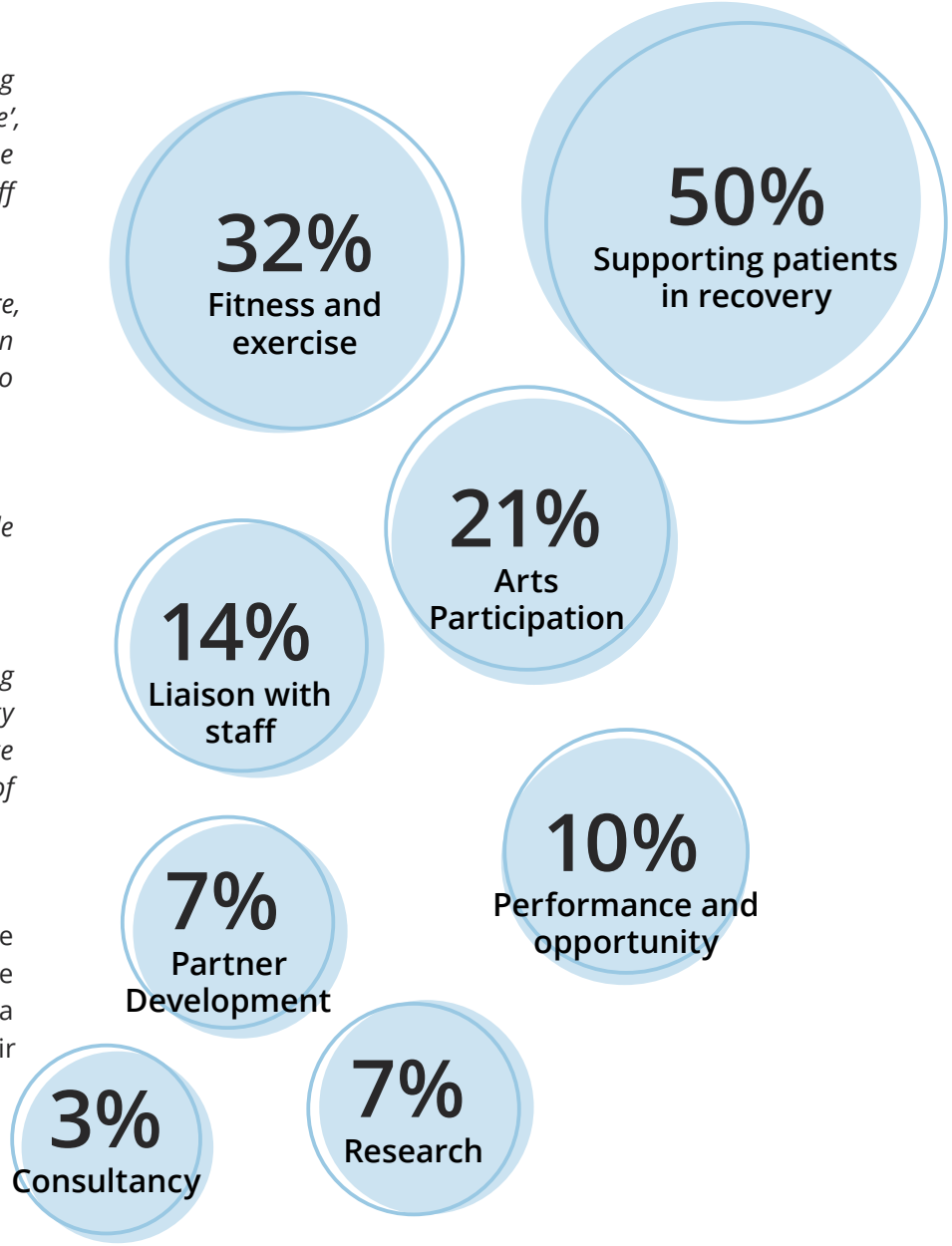
I currently work on a palliative care unit and my work has a set of intentions: (i) supporting social engagement, (ii) offering bodily resources (sensory, touch, movement, creativity), (iii) increasing mobility/physicality, (iv) engaging in 'the narrative', i.e. the personal subjective experience of the patient. Patients are often referred to me by staff

to create time for them to come together to explore, create, socialise and take part in exercise that can support their physiotherapy programmes; ...to relieve boredom

to support patients struggling with pain, alongside their medication

To offer an arts-based intervention, incorporating song, dance and performance ... reducing anxiety and depression in people who have had a stroke and [for] their quality of life and their sense of mastery of self and body

These different frames identify the importance of encouraging the patients to see or experience themselves differently within the confines of a hospital environment and in relation to their wellbeing.



Section 2.2.4

The survey asked respondents to say where in the country they work. All 47 respondents replied, and some said they work in more then one area.

Regional differences are apparent, with the majority of work being carried out in the North West (29%) and Greater London (29%).

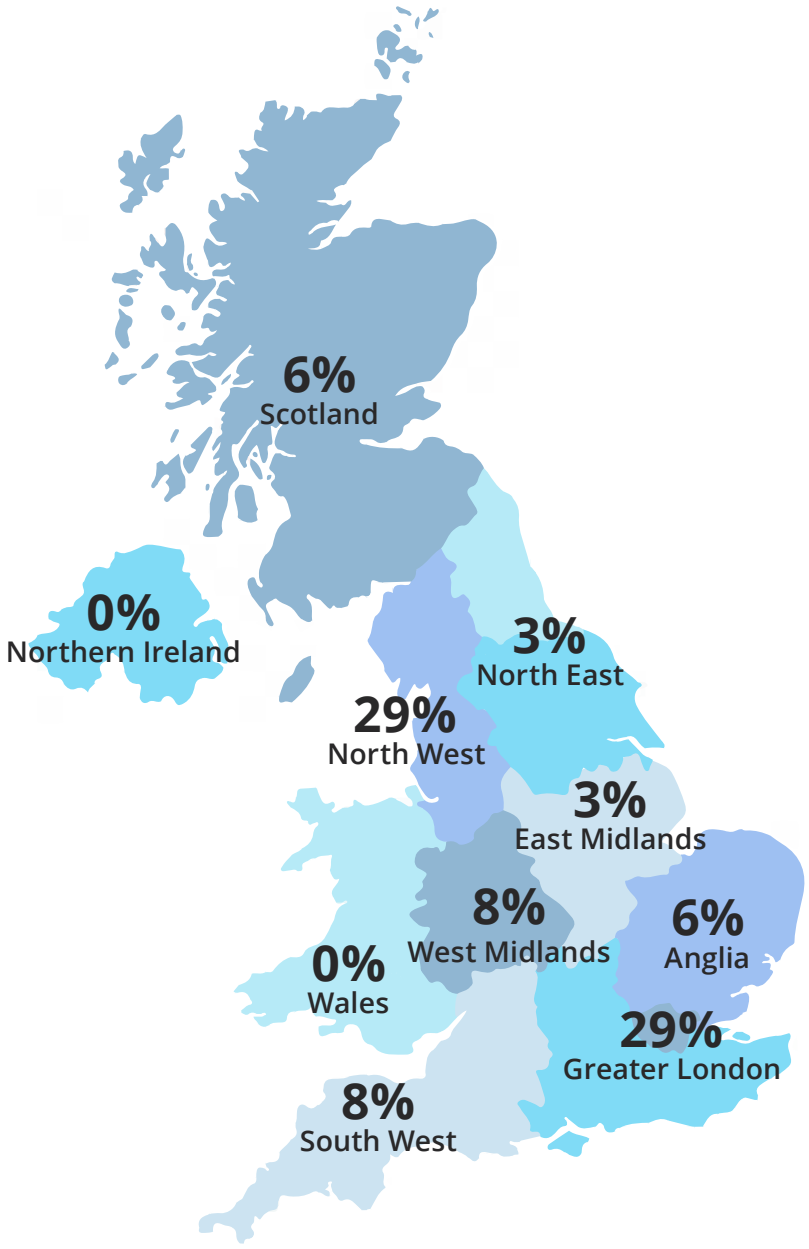


Photo: Filipa Pereira-Stubbs, Addenbrooke's Hospital

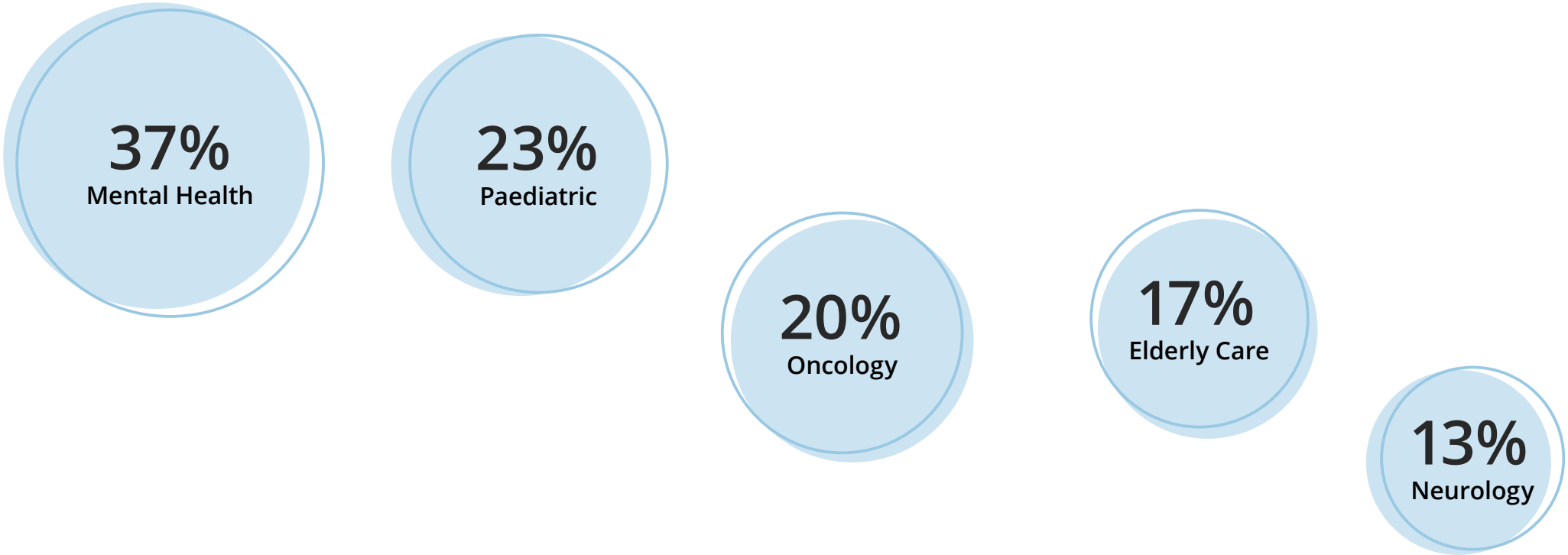
Section 2.2.5

Top 5 wards where SIMP is taking place

Work has taken place on a variety of wards, see illustration below for the top 5 wards. Other wards named include Orthopaedic Rehabilitation, Dementia Care, Stroke and Stroke Rehabilitation, Palliative Care Ward, and Cardiology.

24% of practitioners identified working on more than one type of ward

17% of practitioners did not state which department they had worked in



Section 2.2.6

How are practitioners contracted, what is their employment status?

47 respondents replied, saying their work was identified as 'project based', and 'part-time', with one person working 'full-time', and all contracts were 'temporary'.

The number of hours in a week in the hospital was mainly between 1-10 hours (83%), 11-15 hours (7%), 20+ hours (10%). Some practitioners identified working variable amounts of hours.

The data below was gathered through the semi-structured interviews, and gives examples of the practitioners employment details, including funding sources:

- Two and a half hours a week over an 8-week duration. This practitioner commented that the project ends just as a dialogue begins to open with hospital staff. They identify the difficulty of being able to build the work into the culture of the ward and recognise a need for time to establish new ways of working, which are supportive to staff and patients
- For the past 2 years, half a day per week on the palliative care ward; funding from the hospital arts charity
- In 2017-18, employed as the Arts Coordinator at a hospital, working on the Older Adults Ward, Special Care Baby Unit and Children's Ward, funding was from the Trust's charitable funds. 2018-19 involved one-off projects in various roles: Arts coordinator & project manager and as an artist. A lot of unpaid time as well. Projects were funded by ACE & Tesco's 'Bags of Help'. In February 2020 this position is no longer funded
- Working in four hospitals across London and in Oxford. Contracts are varied, dependent on funding. In 2017-18, work included a large research project involving a national tour of a performance with participants
- A long-standing 14 year involvement with the hospital to the equivalent of one day a week, for three practitioners
- Based in a hospital for 6 years and is lead dance artist, currently working 2 days a week. Funding has come from a medical trust and has in the past been supported by the hospital charitable trust
- Half a day per week, over 2 years

In the interviews, each practitioner talked of the relationship with the arts/ward teams as being central if their work is to be of sustained benefit on a ward.

Section 2.2.7

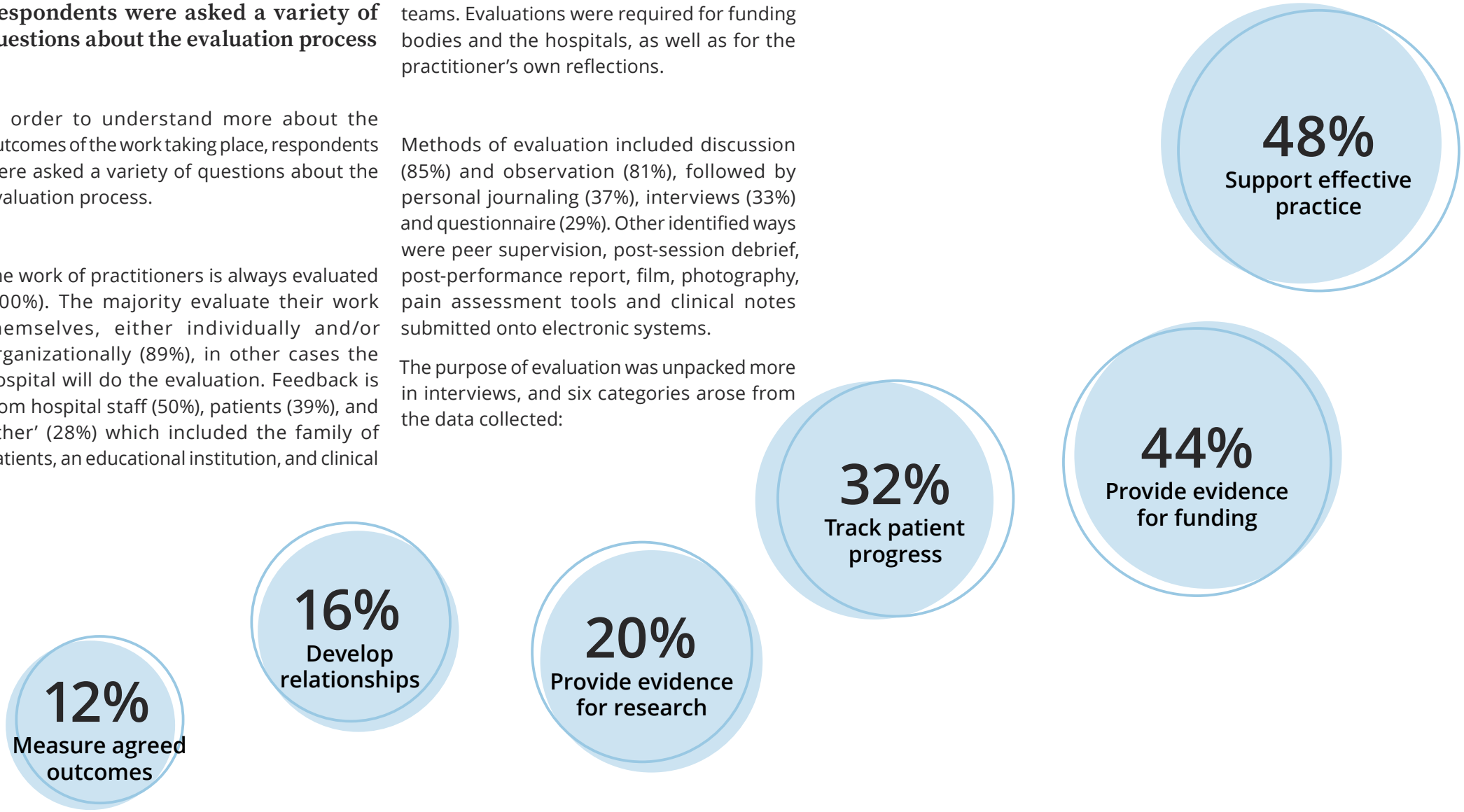
Respondents were asked a variety of questions about the evaluation process

In order to understand more about the outcomes of the work taking place, respondents were asked a variety of questions about the evaluation process.

The work of practitioners is always evaluated (100%). The majority evaluate their work themselves, either individually and/or organizationally (89%), in other cases the hospital will do the evaluation. Feedback is from hospital staff (50%), patients (39%), and 'other' (28%) which included the family of patients, an educational institution, and clinical teams. Evaluations were required for funding bodies and the hospitals, as well as for the practitioner's own reflections.

Methods of evaluation included discussion (85%) and observation (81%), followed by personal journaling (37%), interviews (33%) and questionnaire (29%). Other identified ways were peer supervision, post-session debrief, post-performance report, film, photography, pain assessment tools and clinical notes submitted onto electronic systems.

The purpose of evaluation was unpacked more in interviews, and six categories arose from the data collected:



Section 2.2.7

Interviewees described some of the challenges within the evaluation process as:

meeting the language of the medical model with the poetic…

a difficulty in acquiring the data that satisfies funding bodies and retains relevant subjective participatory feedback complimentary of this dimension of care

the data they like is the health economic data, which evaluates the cost effectiveness

we just keep coming back to measurements which aren't addressing the dance, you wouldn't know it was about dance or movement

[I am concerned with] hand/eye coordination, … if they feel sensation…looking for independent responses, if they have confidence to shift their posture to be more comfortable..[the hospital's evaluation] isn't really about the effects of embodiment…

In speaking to each practitioner, we hear their concern and interest to liaise with the arts teams and devise a relevant and specific way to measure the impact and effects of their interventions, which can meet the needs of the hospital, and evidence their practice more effectively.

Section 2.2.8

Respondents were asked if they have professional supervision, and a place to discuss their work confidentially. Of those who responded, 84% said they do have supervision, with 50% of them having it privately and others having it as part of their job/contract.

One interviewee makes a point of having supervision because 'there is a lot of trauma in hospitals' and 'I feel like I need a bit of a frame [...], to hold me'.

There's nothing available in terms of supervision from the hospital... Writing becomes an internal supervision just to recount and reflect and also to discharge some of the charge of the work...I go privately outside for supervision, it's essential, it's one of the most important things, alongside the work.

Training and CPD

Section 2.2.9

Finally, the survey asked about the training and Continuous Professional Development (CPD) needs, to discover more about which particular areas/types of training practitioners undertake. A substantial list of examples were given including, workshops, symposiums, conferences, and training programmes, but of interest, the list named very few courses which are specific to hospital work, which may imply there is a gap in provision here.

Photo: Filipa Pereira-Stubbs, Addenbrooke's Hospital

Commentary on data, Conclusions & Recommendations

Section 3.1.1

This section is an observation and further thoughts on the data, and includes discussion of particular themes drawn from it.

Scope of practice affirms a breadth of methods and approaches, which highlight the improvisatory and relational principles and values underpinning the practice.

Improvisation as opposed to a goal oriented interaction creates the space for meeting the relevant needs of each individual or group, we see this in data, such as, 'those who can't move... instead they tell me somewhere they love... What do you notice about that place in your body? Can you imagine walking there, what's the ground like?' and 'space for relaxation, calm, and to be with the body in a different way'.

Practitioners draw on their own somatic/bodily awareness to attune and guide a process which can awaken people to their own resources, for example, 'I'm following the child's choices, but also intently sensing their energy, physical choices, movement range, and potential range in our relationship together.' Timings and rhythm within a process can't be known in advance, and each session is unique and varied (Dowler, 2013: 6) suggesting that improvisation allows the practitioner 'to work outside of form and allow the session to evolve through intuition and relationship' (ibid). By describing practice as supporting people to 'connect to their bodies', 'a place to be themselves' and 'remember who they are', practitioners reveal how body-based artistic interventions treat more than the physical and view patients holistically. Whilst the practitioner holds an overall frame for the interactions, the very nature of these approaches seeks to build autonomy and agency in the patient.

Overall, based on the data, the essential qualities and skills a care team might expect to see in practitioners offering somatic-informed movement practice, includes:

- Ways of working, with groups and/or individuals, which include methods to support spontaneous and improvised movement / voice activities, appropriate to patients with different physical and cognitive health conditions
- Awareness of somatic sensations and responses, and ways to facilitate people towards their own bodily experiences (intuitive, creative, imaginal) and ways to share this
- Emotional awareness and the presence of affective responses in the body, and methods of containment and safe practice
- Relational skills attuned to the principles of co-creation and intersubjectivity
- Awareness of the social and psychological benefits of practice
- Adequate experience in self-practice, methods of self-care and a capacity to reflect and evaluate on the contribution their practice brings to the patient's overall care

Section 3.1.1

We are struck by the relatively low number of practitioners responding to the question to describe their remit on the wards. This could suggest that some hospitals are vague about the dance artist's contribution to patient care, and there is useful information to share from those with an established arts programme. Indeed the interviews suggest that the more established artists have been able to trial and evaluate their scope of practice and its effects for patients, and many of these practitioners have embedded their practice in ways which they consider integral to the rehabilitation and recovery process of patients, rather than an adjunct to healthcare (Dowler 2013a).

In discussions, practitioners remarked on the important work of physiotherapists and occupational therapists on the wards, and on the strength of the relationships made whilst recognising that their remit, language and approach are different. What hospital staff expect of artists on the wards is worthy of research, and Amans asserts the importance of clarifying roles and professional boundaries in the setting up of hospital projects, as 'the dance artist is something of an unknown element' (2017: 761).

The survey results suggest that many practitioners have supervision. Anecdotal evidence also shows that many practitioners are members of professional bodies– International Somatic Movement Education and Therapy Association (ISMETA), People Dancing, the Foundation for Community Dance (FCD)- within which they follow the standards of practice and ethical guidelines. ISMETA, as a registering body, does not insist that practitioners have supervision, but the authors would advocate that this will support and sustain the wellbeing of the artist and their ongoing work in beneficial ways.

Section 3.1.2

Reflecting on how this work might grow, discussions with practitioners emphasised the following:

- The importance of remaining free artistically to explore and discover more deeply the effects of their practice, and to establish appropriate methods for measuring outcomes. Facilitation of this kind, requires the practitioner to be flexible, adaptive, grounded in her own practice and able to be present to the shifting needs of those they are with.
- The development of training for artists, which has evolved out of collaboration and consultation with the care team
- Funded support for artists for supervision, mentoring and training opportunities

Fancourt and Finn (2019) state that arts interventions can provide multiple health-promoting factors within an activity to support both physical and mental health, and have the ability to be tailored to individuals with certain health conditions and from various cultural backgrounds (p. 53). We see this evidenced through the breadth of wards on which practitioners work, and in some cases the interventions having a clinical impact (Dowler 2016).

Within the clinical environment the artistic lens offers a different paradigm; approaches are creative, receptive and responsive. They are intentionally non-invasive and instead encourage a personal reconnection to self at a time when trust in the body can be in doubt, diminishing a sense of self. An invitation to sense and move can awaken ways to express beyond the verbal, and within which feeling and imagination can emerge spontaneously. Patients can feel the effects on personal, social, emotional, mental as well as physical levels.

Section 3.2

Arts interventions sit well with the current trends of health promotion (Fancourt & Finn 2019) and embodiment and intersubjectivity are accepted by many health professionals who understand the benefits of a care system which values bodily presence, therapeutic touch, and nervous system regulation in patients (Bruyneel 2019; Dahlberg, Todres, & Galvin 2009; Draper 2014; Galvin & Todres 2013; Sakalys 2006). Dance artists have much to offer these aspects, and could perhaps be seen as an integral member of the care team, adding to the holistic, person-centred salutogenic approach considered essential in building a health-based system of care (APPGAHW, 2017: 17).

Currently however, somatic-informed movement practice in hospitals is present in pockets of the UK with some regions appearing to have no provision. There is a prevalence of short-term, one-off, project-based employment which reduces opportunities to trial and evaluate the effects of the work with healthcare professionals, potentially affecting growth and recognition (Amans, 2017).

There is a growing evidence-base of practice in this field. Dowler (2013b), emphasises the need for practitioners to document, evaluate and evidence their work, using both qualitative and quantitative data to satisfy various funders and commissioning bodies.

The reality of working on wards alongside health professionals requires skilled movement practitioners, able to adapt and fit within the clinical demands of the hospital wards, whilst remaining rooted in their artistic practice. Practitioners are reliant on funding to carry out their work in the hospitals, and are not always financially supported by the hospital directly.

Moreover, it takes (unpaid) time to establish partnerships within NHS hospital departments, and to write funding bids. Referencing the more widely accepted salutogenic[6] and or lifeworld-led healthcare models[7], could provide a framework within which stronger dialogues can emerge.

[6]Potential areas of support into health research are through two models that we align with, the salutogenic and the Lifeworld-led model, in which wellbeing is measured against concepts such as coherence, manageability, meaningfulness, or measurements of vitality. The Salutogenic model of health is widely used in health promotion, and we recognise a strong alignment to it as movement artists (Antonovsky 1996, 1979, Eriksson 2010). It orientates towards the health pole of the 'ease/dis-ease continuum', emphasising "seeing the person, not the disease" (Antonovsky, 1996: 16). The model suggests the development of a strong 'sense of coherence (SOC)', as being "a way of viewing life as comprehensible, manageable and meaningful" (Antonovsky 1996: 15).

[7]The lifeworld-led care approach focuses on what makes well-being an experiential possibility, and considers 'vitality, movement and peace as cornerstones, as well as the idea of meaningful life projects' (Dahlberg et al, 2009: 267).

Section 3.3

Whilst this study highlights significant findings, we acknowledge that it is has limitations. For example, although the survey was shared as widely as we were able through networks, associations, agencies and individuals, the results are indicative and may not be an accurate representation of practitioners' views across the UK. Moreover, whilst the work in different regions is apparent, the responses are not exhaustive, and we acknowledge that the numbers reflect where responses came from rather than the amount of actual work happening in a region. All the practitioners who were interviewed, stressed that their work can only grow if they have the support and understanding of the teams on the ward. Longer term funding provision is needed to establish projects and their evaluation, further to this, artists need support to share their existing evaluations and artistic modes of measurement.

In light of these findings, this report recommends the following:

1. Develop a network which offers support, advocacy and specialist training in order to sustain and support practitioners who often feel isolated.
2. To provide accountability for funding, by establishing appropriate remits for the work, and encouraging practitioners to document, share and publish their findings so it is more widely understood.
3. To strengthen partnerships between practitioners, researchers and healthcare settings to evidence and archive practice-based research.
4. We recommend that commissioners offer long-term health surveys so that adequate research on the effects and benefits of embodied practices and dance can take place.
5. To support the inclusion of arts and creativity within the training of healthcare education.
6. In line with the APPGAHW inquiry report (2017: 156), we recommend that individual and UK research councils consider an interdisciplinary, cross-council research funding initiative which focuses on embodiment in patients and staff.

Photo: Filipa-Pereira-Stubbs, Addenbrooke's Hospital

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The review was undertaken at the University of Central Lancashire (UCLan), in the Faculty of Culture and the Creative Industries. It received ethical approval, and was conducted between 2017 and 2020. It's been led by Penny Collinson, a senior lecturer at UCLan and Nicola Herd, associate lecturer in Staffordshire University. Both are registered Somatic Movement Educators with the International Somatic Movement Education and Therapy Association (ISMETA), and steering group members of the Knowing Body Network, an online resource for practitioners working in health.

This review is the first phase of a broader research inquiry of somatic-informed movement practices in health and wellbeing settings.

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