Positioning Dance Within Health Care Systems

Reflections From Dance Well And Tools for Dialogical Art-Based Collaborations

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Introduction

In the last decade, the idea of integrating artistic practices into healthcare has gained increasing recognition, with dance, music, theatre, and visual arts widely acknowledged for their positive impact on physical, cognitive, and emotional wellbeing. However, beyond this growing interest - often dubbed as "cultural welfare" the structural and institutional realities of embedding artistic practices within healthcare systems remain deeply complex. While policy discourses increasingly advocate for holistic, patient-centred care, the practical implementation of such approaches is constrained by bureaucratic, epistemological, and professional tensions. These tensions become particularly evident when research explores in greater depth the relationship between dance and health, where artistic practice is frequently expected to adapt to biomedical paradigms of evidence and accountability—a demand that risks compromising the creative, relational, and processual nature of artistic practice.

This chapter draws on research conducted within the Dance Well European Project, which investigates how dance practices are translated and contextualised across varied institutional and cultural settings. Through ethnographically inspired qualitative research, we have examined the diverse strategies adopted by partner organisations in integrating Dance Well, the stakeholders involved in its promotion and the ways in which organisational needs shape its value. This research is based on 50 semi-structured interviews with dancers, artistic directors and healthcare professionals involved in the project, as well as on-site fieldwork in each of the partner organisations across Europe.

Between August 2023 and August 2024, research visits were conducted across six partner organisations, each lasting an average of 8,5 days. These visits allowed for direct observations of Dance Well sessions, informal interactions with staff and participants, and analysis of local institutional dynamics. This comparative, multi-sited approach has made it possible to identify patterns of institutional engagement, differences in how Dance Well is positioned within local health and social care networks, and the role of key cultural and healthcare stakeholders in shaping its implementation.

A participatory research approach was adopted, ensuring that local case studies were observed and actively explored through dialogue with the communities involved. The methodology combined content analysis of interviews and field notes with survey data, which was collected at the beginning and end of the project to assess the extent to which Dance Well served as a bridge between the dance sector and the healthcare system in different local contexts. This comparative research has led to the identification of **five key macro-categories** that influence the adaptation of Dance Well across different settings:

1. The legacy of the European project – whether and how the project fosters sustainable, long-term change beyond its initial funding period.
2. Prior projects in health and care – the extent to which each partner had existing collaborations with healthcare institutions before implementing Dance Well.
3. The availability of artistic venues – the role of physical spaces, such as museums and cultural centres, in shaping the artistic and social dimensions of the practice.
4. The recognition of contemporary dance – how local cultural policies and artistic networks influence institutional acceptance of the practice.
5. Presence of Interpersonal relationships - the role of individuals able to navigate sectoral boundaries through personal connections and foster cross-sector collaborations.

This empirical foundation provides the basis for a broader discussion on the institutional, epistemic, and professional challenges of integrating dance into healthcare. One of the central tensions that this research highlights is the question of accountability. As observed across the partner organisations of the Dance Well project, conventional evaluative frameworks often fail to accommodate the lived, embodied, and relational dimensions of dance,

instead prioritising quantifiable indicators of impact. This chapter builds on concepts of narrative medicine, socialising accountability, and hybrid professionalism to propose alternative models of evaluation and governance that allow dance to coexist with, rather than be absorbed by, healthcare structures. Rather than treating dance as a clinical intervention, we explore how narrative-based, reflexive, and participatory forms of accountability can better capture its processual and communal nature.

Building on the understanding gained through an ethnographic engagement with the realities of institutional collaboration observed in Dance Well, this chapter offers a Toolkit for Collaboration, offering a practical framework for artists, healthcare professionals, and policymakers. This toolkit is designed not as a prescriptive model but as an adaptable set of tools that offers strategies for negotiation, institutional adaptation, and cross-sectoral engagement. It provides concrete mechanisms for facilitating mutual understanding between dance and health, proposing flexible evaluative frameworks, and creating the conditions for artistic integrity to be preserved within healthcare settings. By proposing a deeper reflection on accountability, evidence, and professional boundaries, our research with the Dance Well project invites us to move beyond rigid institutional constraints in order to make sure that dance retains its artistic and social integrity while contributing meaningfully to healthcare provision.

1.

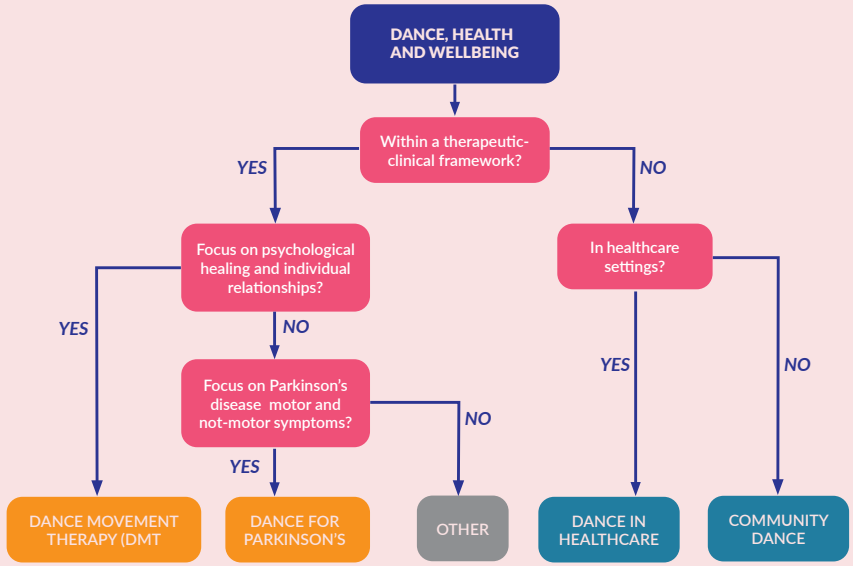
Setting the Stage:

Dance, Health and Wellbeing

How is dance integrated and institutionalised within the healthcare system? What are the possible interpretations, and how is it valued?

In the effort to present preconditions for facilitating dialogue between the dance sector and the health and social systems, the first part of the research presents a framework to illustrate the current landscape of cross-sectoral collaboration and fertilisation possibilities between dance language and healthcare.

We created a table and diagram to visualise and map the significant movements, practices, and conceptualisations that have led to the recognition of dance in health and care realms since the 1940s.



This mapping process aims to enhance our understanding of how dance is perceived by the healthcare system today, particularly in terms of disease prevention, therapy, and treatment. Secondly, the framework is designed to be helpful in comprehending Dance Well practice and its institutionalisation possibilities considering today's scenario.

Four main domains of application of dance aimed at promoting health and wellbeing are identified:

1. **Dance as Therapy**, primarily represented by the Dance and Movement Therapy recognised method;
2. **Dance in Healthcare**, which is part of the broader Arts in Healthcare Movement;
3. **Community Dance**, which addresses - explicitly or implicitly - the social determinants of wellbeing;
4. **Dance for Parkinson's**, where dance practices are specifically designed for individuals living with Parkinson's Disease.

Feature	Dance Movement Therapy (DMT)	Dance for Parkinson's	Dance in Healthcare	Community Dance
Definition of "Dance" in the Field	**Dance as a psychotherapeutic tool** – Movement as a way to process emotions, trauma, and psychological challenges	**Dance as neurorehabilitation and exercise** – Used to improve motor and cognitive function through movement	**Dance as an expressive and healing practice** – Used to reduce stress, enhance resilience, and support healing	**Dance as a form of social participation and artistic expression** – Emphasizes creativity, inclusion, and cultural engagement
Main goal	**Psychological healing**, emotional processing	Improve **motor function, quality of life, and wellbeing** for people with PD	Enhance **patient care**, emotional wellbeing, and holistic healing through the arts	Inclusion, creativity, **social engagement**
Structure	Guided by **psychological frameworks**	Uses **structured movement exercises based on dance techniques** (e.g., ballet, modern, tango)	Can include **structured or unstructured dance activities**	**Open**, flexible, and creative
Practitioners involved	**Certified Dance therapists**	Trained **dance teachers and movement specialists**, often in collaboration with medical experts	**Artists-in-residence**, healthcare professionals, art therapists, creative facilitators	**Dance artists**, facilitators, educators
Clinical focus	**Targets trauma,** anxiety, neurodiversity, etc.	**Targets motor symptoms** (rigidity, balance, coordination) and **non-motor symptoms** (depression, isolation)	Supports **physical and emotional healing**, pain management, and stress reduction in patients and caregivers	**No structured clinical interventions**
Key benefits	**Emotional healing**, trauma processing, body-mind integration	Improved **mobility, coordination, balance, cognitive function, and mood**	Reduces anxiety, enhances emotional resilience, supports communication, and **improves overall patient experience**	**Social connection**, self-expression, wellbeing
Scientific Backing	Grounded in **psychotherapy and neuroscience**	Supported by scientific **studies on movement and neuroplasticity**	Supported by growing research in **healthcare and neuroscience** on the effects of the arts on healing	**Limited formal research**
Common Settings	**Hospitals**, therapy centers, rehabilitation clinics	**Parkinson's support groups, hospitals, dance studios, community health programs**	**Hospitals**, hospices, rehabilitation centers, mental health facilities	**Community centers**, schools, public spaces
Main Target Group	Individuals with **mental health conditions**, trauma survivors, neurodivergent populations (e.g., autism, PTSD, depression, anxiety)	**People living with Parkinson's disease (PD) and their caregivers**	**Patients in medical settings** (e.g., cancer patients, people with chronic illnesses, individuals in palliative care), caregivers, and healthcare workers	**General population**, marginalised communities, older adults, youth, and individuals with disabilities
Prevention & Promotion or Treatment & Management?	**Mainly Treatment & Management** – Used as psychotherapy for mental health conditions, trauma recovery, and emotional processing	**Primarily Treatment & Management, but also Prevention** – Improves mobility and mental health, reducing Parkinson's symptoms and enhancing wellbeing	**Both Prevention & Promotion and Treatment & Management** – Supports patients' emotional wellbeing while also being used in clinical care for symptom management	**Mainly Prevention & Promotion** – Enhances wellbeing, social inclusion, and quality of life
Type of Scientific evidence	**Level 1b–2:** Mostly **quasi-experimental studies and some RCTs** (randomised controlled trials), along with systematic reviews supporting efficacy	**Level 1a–1b: RCTs and meta-analyses** show strong evidence for benefits on motor and cognitive function	**Level 2–3: Quasi-experimental and case studies**, some meta-analyses in arts & health research	**Level 3–4:** Mostly **case studies, qualitative research**, and expert opinions
Most Common Healthcare Professionals Involved	**Psychologists**, psychiatrists, occupational therapists, neurologists	**Neurologists**, physiotherapists, movement disorder specialists, rehabilitation therapists	**Doctors**, nurses, palliative care specialists, psychologists, therapists, rehabilitation specialists	**Few healthcare professionals involved**, but sometimes partnered with social workers and educators
Prevailing Assessment Models	**Biopsychosocial and psychodynamic** – Focus on mental health, trauma, and emotional processing	**Biomechanical and biopsychosocial** – Evaluates motor improvements (gait, balance, flexibility) along with wellbeing and quality of life	**Biopsychosocial and holistic** – Looks at emotional, social, and physical wellbeing	**Sociocultural and participatory** – Measures impact in terms of community engagement and social belonging

In this examination, we aim to clarify what we mean by "dance" in each context, distinguishing between categories that can sometimes appear blurred. In our final analysis, as summarised in the following table, we considered several transversal variables, including the main goals of the movement, the professionals involved, the setting, the clinical focus, the scientific backing, the target group, the type of scientific evidence and the prevailing assessment models.

Furthermore, we adopted the distinction between Prevention and Promotion and Treatment and Management, as offered by the WHO Scoping Review titled *"What is the evidence on the role of the arts in improving health and well-being?"* (Fancourt et al., 2019), along with the standards of evidence-based medical practice (Sackett et al., 2000) to better understand the differences between the four domains.

What emerges clearly from this comparison is that the artistic aspect of dance within the healthcare context is underreported and undervalued. Although several studies are beginning to demonstrate the significant impact of the aesthetic dimension of artistic interventions (Yoeli et al., 2020; Fontanesi et al., 2021; Houston, 2019; Chappell et al., 2021), measuring art without compromising its essence remains a challenge (Putland, 2008).

Moreover, the dance styles included in the therapeutic-clinical frameworks are based on the technical repetition of codified movements. Integrating improvisation and creativity into Dance and Health protocols presents another challenge yet to be explored.

In connection with these issues, at the end of this chapter, we will focus on different measuring traditions and what "evidence" signifies in each context. Art practices, particularly dance-based interventions, present substantial obstacles regarding measurement and evidence collection, as this process risks undermining the integrity of the intervention. Despite these challenges, the domains of research and practice in arts and health are expanding. What are the concerns related to evaluation? Furthermore, why is scientific measurement crucial in determining what is valuable?

The general prioritisation of randomised control trials (RCTs) as the "gold standard" of evidence (Timmermans & Berg, 2003) has often led to the exclusion of arts in health within National Medical Systems. This has resulted in professional artists and art therapists being viewed as "lone workers" with limited access to the resources necessary for conducting RCTs. Compared to other professions, RCTs are still relatively rare in arts in health, community health, and arts therapies. Although the publication of rigorous qualitative research is on the rise, building a progressive body of knowledge that can provide a basis for future 'evidence-based' practice in health care and public health remains challenging (Clift, 2012).

What level of effort is needed to align artistic interventions with the medical standards of the scientific community? How legitimate is this effort?

If artists become integrated into the ethos, culture, and governance of the health sector, they may risk losing their creative integrity, effectiveness, and identity in the requirement of being aligned with the mechanism of evidence-based practice (Reason, 2017). By changing their goals and values to fit those of the health organisations they collaborate with, dance initiatives focused on health may lose their outsider perspective, which often drives radicalism, activism, and the ability of artistic practice to challenge the existing frameworks of health services (Raw et al., 2012). At the same time, robust evidence becomes central to any effort to translate promising artistic projects into sustained work programmes through commissioning by the public sector (Clift, 2012).

With this awareness, the following section will present four key examples of integrating Dance and Health to enhance the comprehension of Dance Well practice's innovative contributions.

1.1 Dance as Therapy

Even though throughout history, people have utilised dance as a form of healing, just from the 1940s, Dance Therapy started to be acknowledged as a formal professional field in the USA, where it began to incorporate dance as a therapeutic tool within healthcare environments (Goodill, 2016). This movement, linked to humanism, was embraced by symbolic figures such as Marian Chace and Liljan Espenak, who began working with disabled and mentally ill individuals. In particular, the establishment of dance as a therapy and profession occurred in the 1960s, starting with the American Dance Therapy Association founded by Marian Chace.

This activism was essential for the institutionalisation of the dance therapy field, which has grown globally. Dance therapists operate in most nations under the official designation of "Dance Movement Therapy" (DMT), even though worldwide, there is no real consensus regarding a universal name for the profession. Labels such as dance therapy, dance/movement therapy, and dance movement psychotherapy (DMP) are also spread.

Thus, Dance Movement Therapy (DMT) within the creative arts therapies disciplines is contemporarily recognised as a psychotherapeutic discipline that uses movement and dance to promote psychological, emotional, and physical wellbeing. As reported by the EADMT - European Association Dance Movement Therapy:

'DMT consists in the therapeutic use of movement to further the emotional, cognitive, physical, spiritual, and social integration of the individual. Dance, as body movement, creative expression and communication, is the core component of Dance Movement Therapy. Based on the fact that the mind, the body, the emotional state and relationships are interrelated, body movement simultaneously provides the means of assessment and the mode of intervention for dance movement therapy"
EADMT Ethical Code 2010

DMT considers dance as a non-verbal tool to express and process emotions, trauma, and psychological change, and nowadays, it is mainly used in clinical settings (hospitals, mental health centres, special education, and rehabilitation) to support individuals dealing with psychological, neurological, or physical disorders.

Since its inception, Dance Movement Therapy (DMT) has developed its distinct professional path, blending innovative theoretical frameworks with evidence-based therapeutic methods and movement assessment techniques. Recent scientific research (De Tord & Bräuninger 2015; Bräuninger, 2012; Ho et al., 2020; Esmail et al., 2020) enhances the theoretical foundation of DMT, validating the dance-movement therapeutic relationship that engages diverse, creative processes to promote transformation and personal development.

DMT can be experienced in a group setting or through individual therapy sessions, where the therapist invites the client(s) to explore the space through simple movement exercises and playful interaction. The therapist works with the client's embodied experiences and memories in a playful, person-centred, safe, and respectful way.

In Europe, despite the establishment of professional organisations and training programs, the recognition of these professionals remains a work in progress as the system for registering therapists with government bodies varies depending on the country.

In response to the existing heterogeneity in training, the European Association of Dance Movement Therapy (EADMT) has initiated a regulatory framework to establish the essential standards for education and training required to become a dance movement therapist in the EU. This progress can be traced back to the EADMT's adoption of a specific European training standard at the master's level in October 2017, which set minimum criteria for national accreditation and recognition of dance movement therapy training programs. As a result of this effort, only certified dance movement therapists who have received specialised training in psychotherapy and movement analysis are permitted to conduct DMT sessions.

This initiative aims to enhance the professionalism of DMT across various countries, fostering a connection among diverse educational backgrounds while celebrating the richness and heterogeneity of all European member states. Currently, DMT training is offered in private and university settings across the EU, including nations such as Austria, Estonia, Germany, Greece, Hungary, Italy, Latvia, the Netherlands, Poland, Russia, Spain, and the United Kingdom.

The institutionalisation of the DMT professional field was needed to differentiate the therapy's unique contributions from those of community arts and other arts and health initiatives (Shafir et al., 2020).

Institutionalisation was made possible even by producing recognised evidence-based research in DMT.

In this effort, it was essential to translate dance and artistic movement into something comprehensible by

an evidence-based biomedical approach. As previously mentioned, this approach primarily relies on experimental scientific methods, such as randomised controlled trials (RCTs), to evaluate the validity of the evidence even though they cannot capture the experiential, aesthetic, and artistic dimensions of dance practice.

In this sense, biomedical models have been adopted to validate the effectiveness of Dance Movement Therapy (DMT) within the contemporary scientific framework. In this context, dance was recognised as a form of treatment and rehabilitation, primarily aimed at addressing specific illnesses and implemented in medical settings. Although the institutionalisation of the Dance Therapy movement was initiated historically by professional dancers and choreographers, today, Art Therapists —whether specialising in dance, visual arts, drama, or music therapy— are considered firstly mental health experts and not more artists. In this sense, during the institutionalisation process, the creative aspect of the profession was sacrificed for the sake of codification, measurability, and scientific recognition. Implementing evidence-based research was crucial for the survival and thriving of the clinical field of DMT (Bräuninger, 2012; Dunphy et al., 2021) in the worldwide healthcare systems. In particular, evidence-based quantitative research on the effectiveness of DMT has led to its recognition as a specialised profession in psychotherapy, influencing both professional and public perceptions of its scientific validity.

1.1.1. Overview of Dance and Movement Therapy in Partners' Countries

As mentioned, Dance and Movement Therapy (DMT) is recognised and integrated into healthcare systems to varying degrees across different European countries.

France

In France, Dance and Movement Therapy is not yet fully recognised as a standalone profession in the healthcare system. However, professionals and associations are making efforts to achieve formal recognition and integration.

While some practitioners may offer DMT in private settings or through specific programs, it is not widely available as a standard public health service. The reference association is the Société Française de Danse Thérapie, created in 1984 in the wake of the Higher Education Program in Dance at the University of Paris-Sorbonne, on the initiative of its manager, Mr. Jean-Claude Serre and the dance therapists participating in its teaching. Its objective is to develop and promote dance therapy practice in France by encouraging exchanges based on different experiences and activities (training, conferences, discussion groups, and information). It is a member of the European Dance Therapy Association (EADMT).

Italy

Dance Movement Therapy (DMT) is officially recognised as a profession in Italy, and training programs adhere to national laws and standards. Organisations such as Art Therapy Italiana offer professional training that prepares therapists to work in various settings. Graduates can earn a diploma after completing a three-year program with 1200 hours of training. However, DMT has not yet been integrated into the Italian public health services.

The Italian Professional Association of Dance Movement Therapy (APID®) was established in 1997. To become a member of APID®, individuals must attend a recognised training school. As of 2021, APID® has 260 and 280 members and nine accredited educational institutions of DMT across Italy.

Czech Republic

The Czech Republic has made significant strides in Dance Movement Therapy. The Czech Association of Dance Movement Therapy (TANTER) was established in 2002 under the patronage of ADTA (American Dance Therapy Association) and has been instrumental in supporting and connecting therapists. The association has about 50 members, and the profession is gaining recognition, with therapists working in various settings. The TANTER association is one of the founding members of EADMT, and its membership dates back to 2010. The mission of TANTER is to create and maintain an appropriate level of standards of professional competence for dance therapists.

Lithuania

In Lithuania, the National Ministry of Health officially recognised Dance Movement Therapy as a legal profession in 2020, thanks to the advocacy activity of The Lithuanian Dance Movement Therapy Association (LtDMTA), established in 2011 and which continues to develop the profession and aims to implement DMT services in

various state and non-state institutions. Since 2020, LtDMTA has also been a member of EADMT. Lietuvos šokio-judesio terapijos asociacija is continuing to develop Dance Movement Therapy as a profession, science, service and discipline to unite and coordinate the activities of its members, to represent and defend their interests.

Germany

Germany has a well-established framework for Dance and Movement Therapy. The profession is recognised, and therapists often work in clinical settings, including hospitals and rehabilitation centres. The German Dance Therapy Association, named "Berufsverband der TanztherapeutInnen Deutschlands e.V." (BTD), was founded in 1995 in Frankfurt am Main and has played a significant role in promoting and regulating the profession. It is also one of the founding members of the European Association of Dance Movement Therapy (EADMT), established in 2007 under German law and headquartered in Munich, Germany. The Association aims to protect, represent, and promote the interests of dance therapists by developing and establishing dance therapy as a method of psychotherapy that preserves and enhances health.

1.2 Dance in Healthcare

The Arts in Healthcare movement is an interdisciplinary field incorporating artistic practices into healthcare settings to enhance healing, wellbeing, and patient care. Dance plays a crucial role in this movement, which fosters the organisation of dance residencies and activities within hospitals, hospices, and rehabilitation centres (Karkou et al., 2022).

The Dance in Healthcare movement shares therapeutic principles with DMT and Dance for PD® but applies a broader artistic approach in medical settings. It recognises the healing power of creative expression, making healthcare environments more humane, supportive, and engaging.

More generally, Arts in Healthcare provides various arts experiences by visiting artists and artists in residence, arts programming developed in partnership with community arts agencies, art collections, and art exhibits in healthcare settings.

Early forms of involvement of the arts in the healthcare system have been documented as early as the 1970s in the USA, shortly after dance/movement therapy was standardised and established through the founding of the American Dance Therapy Association in 1966 (Brandman, 2007).

As highlighted by the Global Alliance for Arts and Health, the scope of arts in healthcare is extensive, encompassing five primary areas: creating healing physical environments in healthcare facilities, promoting community wellbeing through arts initiatives, supporting professional and family caregivers via artistic engagement, educating healthcare practitioners through the arts, and enhancing patient care through participatory arts programs.

As indicated on the University of Florida - Center for Arts in Medicine website, this type of collaboration must be distinguished by art therapy professionals, who play distinct and specialised roles in healthcare settings and undergo a formal professionalisation process (Sonke, 2015). The involvement of artists in healthcare entails the participation of professional artists from various artistic disciplines such as visual arts, music, dance, theatre, or writing to facilitate the creative process within their specific art forms in healthcare settings to create art rather than function in a clinical capacity or conducting mental health assessments.

The success of arts programs in hospitals largely relies on support from senior management, even though many staff members have a limited understanding of the arts' role in healthcare settings. This common issue likely arises from challenges in interdisciplinary dialogue due to a lack of shared language between the healthcare and arts sectors. Furthermore, artists often lack clear guidelines for engaging in this transcontextual field and generally have limited experience in hospital environments (Jensen, 2017; Daykin, 2019).

1.3 Community Dance

When discussing community dance concerning health and wellbeing, it generally refers to a broad concept that involves a participatory form of dance aimed at diverse community members. In particular, there is growing international acceptance that participation in the creative arts can enhance overall wellbeing, foster social connections, and encourage self-expression without adhering to a structured therapeutic framework (Clift, 2012; Putland, 2008).

In fact, while community dance offers significant therapeutic benefits, it differs from formal therapies like Dance Movement Therapy (DMT), prioritising collective engagement, creativity, and accessibility over formal treatment or professional performances.

The general philosophy emphasises participation over performance, focusing on creativity, collaboration, and personal expression.

Community dance activities that emphasise wellbeing are typically offered in educational, recreational, or artistic environments and are designed to address people of all ages, backgrounds, and abilities.

This approach emphasises the significance of social determinants of health, recognising dance as an essential tool for enhancing collective and individual wellbeing while fostering mental health through cultural participation (Putland, 2008). In this direction, community dance activities adopt a biopsychosocial approach, developed by George Engel in 1977, emphasising the significance of psychological and social factors in determining overall wellbeing (Fancourt, 2017).

Because of these, people leading the activities are not necessarily trained psychotherapists but are commonly dance teachers, movement educators, or wellness professionals.

At the same time, artists are increasingly adopting a more community-oriented approach in their work. They become socially engaged through their creative processes and collaborate with people from local and underserved communities. This involves them implementing inclusive and accessible practices, which significantly influence their professional and artistic development (EDN, 2024).

This social turn in the performing arts (Bishop, 2005; Belfiore, 2006) has also been extensively promoted by a growing awareness of the holistic approach to health, creating new job opportunities for artists in various fields.

This has encouraged professional dancers to collaborate with non-professional community members to develop their artistic work. However, sometimes, these collaborations occurred under superficial and instrumental conditions, leaving no space for the artist's poetics (Yoeli et al., 2020).

Because of this, the sometimes mandatory involvement of communities in artistic projects for the sake of wellbeing has sparked criticism from the cultural sector. They argue that in these community-based collaborations, the artistic value of the process is frequently overlooked, and the professionalism of artists is undervalued (Daykin, 2019). This is evident in particular in the 2008 WHO Commission on the Social Determinants of Health report, which does not include creative arts or broader cultural issues and overlooks the practices and participatory characteristics that distinguish arts and cultural activities from other forms of social engagement (Putland, 2008; Belfiore, 2006).

Instead, it is argued how the principle of "art for art's sake" should be central, even when operating in non-artistic contexts, to uphold the artist's creative freedom and distinguish artistic activities from mainstream healthcare or therapeutic practices (Macnaughton et al., 2005; Raw & Mantecón, 2013). This perspective asserts that the artistic aspect should be an essential or equally significant goal alongside healing or health improvement.

In fact, professional dancers working with communities adopting this principle identify themselves foremost as artists and wish to be recognised as distinct from healthcare professionals, taking pride in the absence of explicit clinical goals in their artistic practice (Stickley et al., 2018). They want to emphasise the process of doing and making, rather than being outcomes-based, and place themselves in a relationship with participants as collaborators and co-creators who already have creativity and ideas to offer rather than fitting into a hierarchical client-patient dynamic. This horizontal approach valorises what the person brings to a process, embracing the lack of standardisation and clinical goals, even if they are generally criticised for being difficult to measure.

Ideological resistance to individualised biomedical models of health and evidence-based practice is central to this perspective (Daykin, 2019), which promotes the intrinsic value of community practices and their effectiveness unbundled from the measurement mechanisms.

1.3.1 Prescribing Dance with Social Prescribing

As described in the Toolkit published in 2022 by the World Health Organization Regional Office for the Western Pacific, Social Prescribing connects patients to a range of non-clinical services in the community to improve their health and wellbeing. This mechanism was designed to cost-effectively enhance community health and wellbeing by decreasing demand in the health sector and utilising the existing non-clinical services.

More precisely, the WHO toolkit presents the steps required to introduce a social prescribing scheme in a local context by involving community healthcare organisations, long-term care facilities, and the community and volunteer sectors. It is based on the evidence that tackling social determinants of health, including factors like socioeconomic status, social inclusion, housing, and education, is crucial for enhancing the population's health outcomes.

Nowadays, social prescribing is gaining traction across Europe, with various countries exploring and implementing models tailored to their specific healthcare contexts and community needs. The United Kingdom is a pioneer in this field, integrating social prescribing into its National Health Service (NHS) as part of the NHS Long-Term Plan. Other European countries, such as Ireland, Portugal, Germany, Denmark, Sweden, the Netherlands, Finland and Spain, have also adopted social prescribing initiatives (Morse et al., 2022).

In these countries, primary healthcare providers can refer patients to activities and communitarian services that align with their interests. These providers are identified as "like workers", the professionals responsible for developing personalised wellness plans and guiding patients to suitable community-based services offered by the community or voluntary sectors. The key element of this service delivery is the focus on person-centredness, integration, and the ability to track the referred experience with ongoing follow-up.

The workforce that assesses individual needs and facilitates connections to non-clinical support varies by country. In many cases, existing healthcare staff—often from primary care—have been repurposed to implement social prescriptions. Social workers, allied health professionals, nurses, and volunteers take on these responsibilities in other

instances. Currently, there is no professional registration for link workers and social prescribing professionals; however, competency frameworks and training curricula are being developed in England, Wales, and the Netherlands (Morse et al., 2022).

Link workers can also prescribe artistic activities within this network of individual and group activity options. Consequently, by engaging with healthcare trusts and other local health and social care organisations, art practices such as community dance and dance programs for people with Parkinson's are possibile to be referred to patients as potential complementary activities within their healthcare plans (South et al., 2008).

Although social prescribing is presented as a way to promote a more holistic approach to health care, strengthen community-based integrated care, and help demedicalise health service provision, this approach has several downsides when considering its impact on the cultural sector.

Critiques raise concerns about funding opportunities and the potential for overburdening an already under-resourced and under-financed sector (Morse et al., 2022; Fortier & Coulter, 2021).

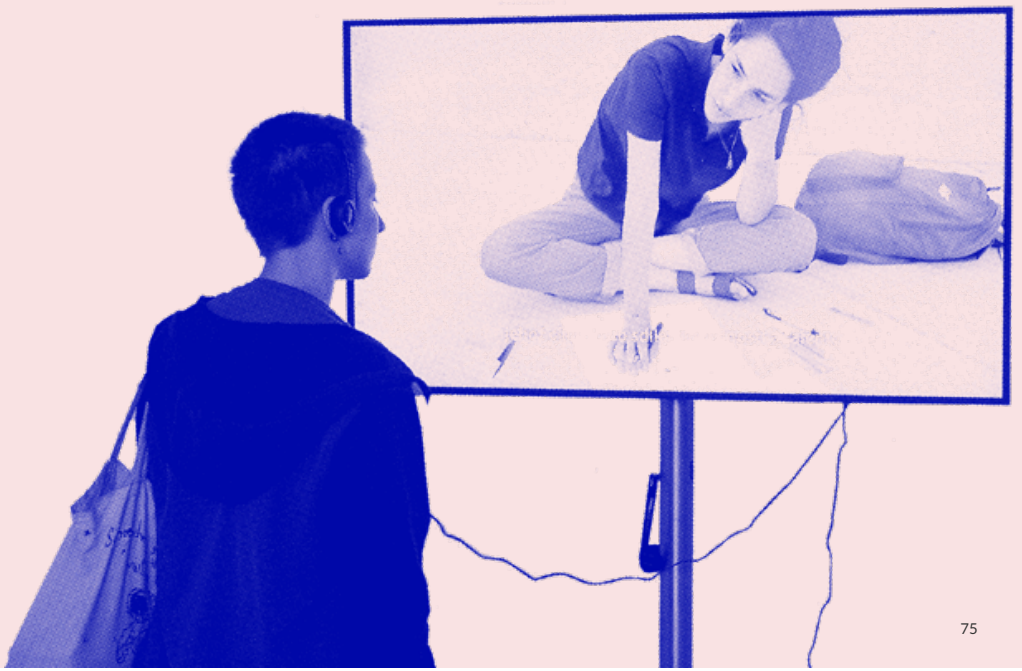
Moreover, researchers have shown that link workers' personal involvement in various activities influences their referral patterns. This can limit patients' access to cultural activities, as link workers who are not engaged in these experiences are less likely to refer individuals to the cultural sector (Amadea Turk et al., 2024; Tierney et al., 2020; Tierney et al., 2022a; Tierney et al., 2022b; Ebrahimoghli et al., 2023).

Generally, the success of social prescribing largely depends on the presence of a link worker who possesses a strong understanding of the community development principles, and the thriving local voluntary, community, and cultural sectors. However, preliminary research indicates a general lack of interaction between link workers and the cultural sector regarding how cultural activities could support social prescribing. Specifically, link workers often perceive cultural activities as elitist and fail to view them as accessible, appropriate, adequate, affordable, and available. This perception affects their willingness to refer individuals to cultural offerings as part of social prescribing (Tierney et al., 2022a; Tierney et al., 2022b).

Tensions also exist regarding labelling these activities, categorising them more like sports and social activities than artistic endeavours. Moreover, the term "intervention" is problematic because it undermines artistic practices' fundamental, process-oriented nature, especially in Social Prescribing, where activities are typically prescribed with a formal beginning and end.

On the other hand, Social Prescribing seems to be becoming more popular as a way of moving the healthcare system toward a more holistic approach and is increasingly being reconceptualised as a resource for "personalised care" for people living with long-term medical conditions (NHS, 2019).

In conclusion, social prescribing can help patients connect with the right specialists and healthcare providers, ensuring they receive optimal care for their medical conditions. However, cultural activities, such as dance, are often not prioritised within these frameworks, leading to challenges in their funding opportunities and recognition as artistic practices.



1.4 Dance and Parkinson's: A Specific Scenario

Parkinson's disease (PD) is a progressive neurodegenerative condition that impacts motor skills, cognitive function, and emotional wellbeing, ultimately affecting overall quality of life (QOL) (Gros et al., 2024; Houston, 2019; Ventura et al., 2016; Westheimer et al., 2015). Recently, PD has been recognised as a systemic disease characterised by motor and non-motor symptoms. These symptoms arise from impaired nerve pathways in the basal ganglia due to a dopamine deficiency and the spread of pathological Lewy bodies.

But, while pharmacological and surgical interventions can partially alleviate motor symptoms of PD, addressing the cognitive and emotional challenges remains a complex issue with current treatments (Rocha et al., 2021; Fontanesi & DeSouza, 2021). This complex clinical picture has drawn significant attention from the artistic approach to health and wellbeing, participating in the devising of alternative interventions that can simultaneously address motor, cognitive, and emotional symptoms associated with PD, thereby improving daily functioning and quality of life (Gros et al., 2024; Volpe et al., 2013; Westheimer et al., 2015; Romenets, 2015).

The connections between artistry and the dopaminergic system make arts-based therapies particularly suitable for PD. In particular, arts-based interventions have been recognised to offer a holistic approach to managing contemporary various motor and non-motor symptoms of PD while also addressing self-esteem, fostering problem-solving, and enhancing overall wellbeing (Houston, 2024; Gros et al., 2024; Rocha et al., 2021; Fontanesi & DeSouza, 2021).

Dance, along with music, offers external auditory and visual cues to the brain, which are diminished when the basal ganglia are damaged (Batson et al. 2016). Most importantly, considering the gradual harm that Parkinson's inflicts on an individual's body, dancing can serve as an embodied practice for rebuilding a more affirmative connection with oneself joyfully and pleasantly.

Moreover, dance is associated with enhanced activation of movement-related areas, such as the frontoparietal action observation network and the cortico-striatal pathways involved in posture and movements. In addition, group activities can foster a sense of belonging, self-value, and cognitive engagement, allowing persons living with PD to express themselves as creative individuals rather than patients.

The popularity of Dance for people living with Parkinson's is also backed by the clinical trials that are increasingly showing its multi-dimensional impact (Ventura et al., 2016).

First, experiments have shown that dance improves motor symptoms, particularly problems with balance and mobility, as well as overall physical fitness. Dance improves motor function by getting patients to stretch their muscles, perform steps, and maintain balance (de Natale et al., 2017; Westheimer et al., 2015; Hashimoto et al., 2015).

It is not a case if most research analyses the benefits of Dance for Parkinson's has concentrated on dance's effect on motor skills, such as walking, sitting to standing, turning, static and dynamic balance, and motor symptoms. These assessment areas operate under the assumption that dancing is primarily a physical activity; thus, exercise and potential mobility are expected to provide the most significant impact (Houston, 2011). Motor function is also easier to assess than other elements with standard verified clinical measures, such as the Timed Up and Go test and the Berg Balance Scale.

However, as already mentioned, dance may also improve cognitive functioning—including executive functioning, visuospatial cognition, working memory, action planning, and attention—because it requires connecting one movement to the next and executing complex motor plans.

On the side of emotional wellbeing and quality of life, some studies have shown that dance participants report improved moods after sharing the dance experience with others and feeling more accepted and understood. In fact, as a social activity performed with others, dance also works on emotions by encouraging the dancers to express their feelings, increasing motivation, and providing enjoyment through greater ease of movement.

These non-motor symptoms are significant to record and measure because cognitive impairment and mental symptoms such as depression and apathy have a considerable effect on daily life (Westheimer et al., 2015).

In this direction, dance works on cognitive function by requiring patients to plan and execute imagined movements, follow music and signals, remember repeated actions, and be aware of their bodies (Gros et al., 2024; Houston, 2019; Ventura et al., 2016; Westheimer et al., 2015).

The type of movements also depends on the dance style implied in the interventions. Experiments were conducted to analyse the benefits of tango, Irish dance, and Dance for PD® method, among others (Volpe et al., 2013; Westheimer et al., 2015; Romenets, 2015).

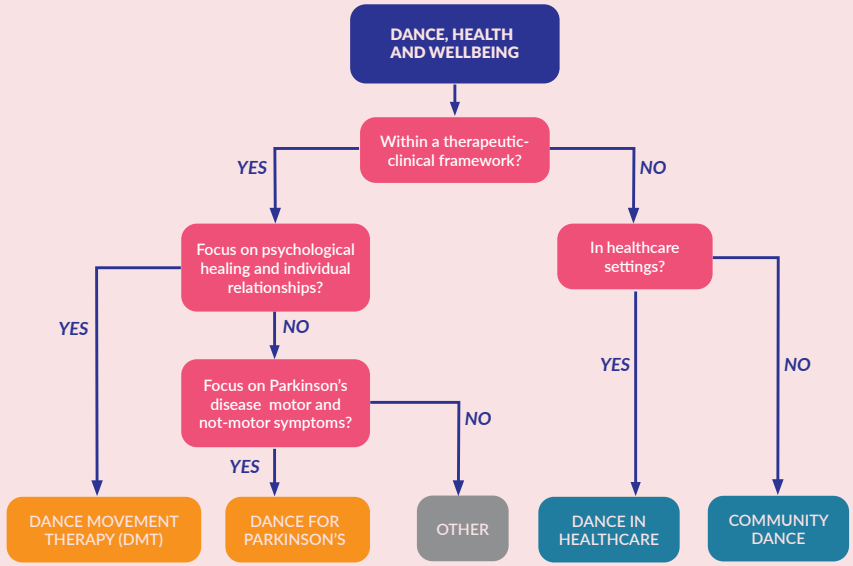
In particular, the Dance for PD® program founded by the Mark Morris Dance Group in Brooklyn, New York, 20 years ago has been fundamental in promoting the formal recognition of the benefits produced by dance for individuals living with Parkinson's, promoting diverse evidence-based experiments. Thanks to this effort, Dance for PD® is formally considered today a non-pharmacological complementary therapeutic intervention for people living with Parkinson's (Lihala et al., 2021; Moţ & Almăjan-Guţă,2022; Westheimer et al., 2015).

However, studies conducted so far have had relatively small sample sizes, and only a few randomised controlled trials are available. Additionally, few studies have simultaneously examined the effects of dance on motor symptoms, cognitive function, and emotional wellbeing in a single research effort (Houston, 2011).

In summary, dance has proven to be a valuable therapeutic approach for individuals with Parkinson's disease (PD). Although it is not a traditional form of therapy, dance activities provide meaningful non-pharmaceutical interventions that prioritise a person-centred philosophy (Houston, 2024). Although these initiatives are increasingly attempting to achieve more clinical validation and recognition through trials and evidence-based experiments, they continue to foster creativity, imagination, and social interactions for their inherent value.

1.5 Wellbeing as a Gateway of Hope...

The evolution of DMT highlights a fundamental tension in contemporary healthcare systems: the apparent necessity to translate creative, embodied, and non-verbal therapeutic practices into the language of evidence-based medicine



to ensure their legitimacy. This process reflects a broader paradox within healthcare—while the very definition of health, as articulated by the World Health Organization (WHO), is ostensibly welcoming of non-formal, non-conventionally scientific approaches, the systems tasked with delivering health services often operate within rigid frameworks that prioritise quantifiable, clinical validation. The challenge is conceptual acceptance and structural and institutional readiness to embrace diverse wellbeing modalities.

The WHO defines health as "a state of complete physical, mental, and social wellbeing," a formulation that explicitly moves beyond the biomedical model's focus on disease and pathology. This definition inherently creates space for interventions that do not fit precisely into conventional scientific paradigms but contribute to individual and collective wellbeing. The biopsychosocial model, which emerged as an early critique of biomedical reductionism, underscores the necessity of this broader perspective by incorporating psychological and social determinants into the understanding of health (Engel, 1977). The recognition of wellbeing as an integrative, multidimensional concept

allows for practices such as dance therapy, community arts, and other embodied interventions to be considered legitimate pathways to health (Huber et al., 2011).

Critical reflections on biomedical reductionism have highlighted its tendency to fragment the human experience into isolated physiological components, often neglecting health's broader socio-cultural and psychological dimensions. The biomedical model, which has dominated Western medicine since the 19th century, is founded on Cartesian dualism, which separates the mind from the body and treats disease as a mechanical failure of biological processes (Rose, 2007). The scientific perspective has significantly contributed to the progress of medical science; however, it has progressively marginalised the complexities of human wellbeing. This is particularly apparent in cases where social, environmental, and psychological factors significantly influence health outcomes (Illich, 1975).

One of the most profound limitations of biomedical reductionism is its exclusion of social determinants of health, which have been increasingly recognised as crucial in shaping health disparities and individual wellbeing (Marmot & Wilkinson, 2006). Socioeconomic status, education, employment conditions, and social support networks significantly influence health outcomes, but despite this, these factors are often treated as externalities rather than fundamental components of medical practice. The failure to integrate these broader determinants has led to what some scholars describe as a crisis of medicalisation, in which complex social and psychological issues are reframed as individual medical problems, often addressed through pharmacological or surgical interventions rather than structural changes (Conrad, 2007).

Also, the psychological and emotional dimensions of health tend to be overlooked in the biomedical discourse. The reductionist approach tends to privilege measurable physiological changes over subjective wellbeing experiences despite growing evidence that psychological resilience, emotional regulation, and social connectedness play fundamental roles in health outcomes (Antonovsky, 1987). The theory of salutogenesis has been developed as a counterpoint to the pathogenic focus of conventional medicine to direct attention to the importance of coping mechanisms and a sense of coherence in maintaining health. This alternative framework shifts attention from disease and pathology to factors that promote wellbeing and resilience. Central to this theory is the idea of "coherence", which is further composed of comprehensibility, manageability, and meaningfulness. Comprehensibility refers to the perception of life as structured and predictable, manageability reflects the belief in having resources to cope with challenges, and meaningfulness involves viewing life's demands as worthy of engagement. Research has consistently demonstrated the relevance of salutogenesis in various contexts. A strong sense of coherence has been linked to better health outcomes, including reduced stress, improved mental health, and enhanced quality of life (Eriksson & Lindström, 2006). The salutogenic model has also been applied in public health, which informs interventions to foster resilience and wellbeing at individual and community levels (Mittelmark et al., 2017).

Despite this conceptual openness, the integration of such approaches into formal healthcare structures remains uneven. The history of DMT makes clearly visible how

a field rooted in artistic and embodied expression was progressively aligned with scientific paradigms to gain professional recognition. The process of institutionalisation required a translation of dance into measurable outcomes, often at the cost of its original creative and experiential essence. Such a way to become institutionalised reflects a broader trend in healthcare, where practices that originate outside of clinical medicine must be reformulated within evidence-based frameworks to be acknowledged as legitimate (Wengrower & Chaiklin, 2008; Bräuninger, 2012). Despite their limitations in capturing movement-based interventions' aesthetic and subjective dimensions, the reliance on randomised controlled trials to validate DMT illustrates the constraints imposed by dominant scientific methodologies (Dunphy et al., 2019).

Yet, if health is understood as a multidimensional state of wellbeing, then how it is achieved must also be allowed to reflect this plurality. The growing emphasis on person-centred care reinforces this argument, recognising that wellbeing is deeply contextual and cannot be reduced to standardised clinical measures alone (Mezzich et al., 2010). Artistic, cultural, and community-based interventions are particularly relevant in this regard, as they offer flexible, adaptive, and socially embedded pathways to health. Research on psychological wellbeing, for example, highlights dimensions such as autonomy, environmental mastery, and life purpose—factors often nurtured through creative engagement and social participation rather than strictly medical interventions (Ryff, 1989). However, even when they proclaim the importance of these other components of wellbeing, healthcare organisations remain constrained by structures that privilege clinical expertise and biomedical outcomes, limiting their ability to incorporate such interventions effectively.

Integrating practices such as DMT and other artistic interventions demands healthcare institutions to develop frameworks beyond clinical validation and to allow for more diverse forms of knowledge production. The process of institutionalising DMT underscores this need, as the field has had to align itself with dominant scientific paradigms to ensure its survival. Being truly committed to a more inclusive healthcare model would require reevaluating what constitutes valid knowledge in health practice and acknowledging that experiential, qualitative, and community-based forms of evidence are equally relevant to understanding and fostering wellbeing (Huber et al., 2011). This shift would also require rediscovering professional boundaries within healthcare, moving beyond rigid distinctions between medical and non-medical expertise. The history of DMT illustrates how creative professionals were needed to reframe their work within psychotherapeutic and clinical discourse to gain institutional legitimacy. A more expansive view of health would allow for a greater diversity of professional roles within healthcare settings, recognising that wellbeing is not solely the domain of medical practitioners but is also shaped by artists, community facilitators, and cultural practitioners who contribute to holistic health systems (Kirmayer, 2012).

1.6 ....Thwarted by Evidence-Based Medicinal Management

The institutionalisation of DMT and other artistic interventions within healthcare highlights a profound paradox at the heart of contemporary health systems. While the conceptual openness of the WHO's definition of health invites to accommodate diverse, non-conventional approaches, the structures governing healthcare delivery have increasingly been shaped by principles that constrain this very possibility. The rise of New Public Management (NPM), emphasising efficiency, standardisation, and financial accountability, has embedded managerial logics that prioritise measurable outcomes and economic rationality over more holistic and context-sensitive understandings of health. At the same time, the diffusion of evidence-based medicine has provided a seemingly neutral, scientific framework for evaluating interventions, reinforcing a hierarchy of knowledge that privileges quantifiable, protocol-driven, and statistically validated practices while marginalising those that do not conform to these standards.

Despite the explicit inclusivity of the WHO's definition—one that acknowledges the multidimensional nature of health and wellbeing—healthcare institutions have been restructured around governance models that, in practice, limit their capacity to embrace non-clinical and experiential forms of care. The institutional mechanisms that claim to ensure rational decision-making and evidence-based practice have led to the exclusion or marginalisation of artistic, cultural, and community-based interventions, not necessarily because they lack efficacy but because they do not fit within the prevailing metrics of clinical validation and financial accountability. The convergence of NPM and EBM has thus produced a system that is both formally open to diverse health interventions and structurally resistant to their meaningful integration.

New Public Management (NPM) emerged in the late 20th century as part of broader neoliberal economic reforms aimed at reshaping public administration by introducing private sector principles. Developed in response to perceived inefficiencies in bureaucratic governance, NPM sought to replace traditional, hierarchical models of public service provision with market-oriented mechanisms that emphasised competition, cost-effectiveness, and performance-based accountability (Hood, 1991; Ferlie et al., 1996). Influenced by economic rationalism and managerialism, NPM framed public services as enterprises requiring efficiency-driven management techniques, where success was determined by measurable outputs, financial discipline, and consumer-driven service models rather than professional discretion or public value (Pollitt & Bouckaert, 2011).

This shift in healthcare was particularly important, as NPM reforms introduced performance targets, output-based funding, and competitive contracting, all of which transformed how health services were organised and evaluated (Miller & Power, 2013). Hospitals and healthcare providers were increasingly expected to function as quasi-market entities, competing for resources based on efficiency metrics rather than broader equity considerations or community wellbeing (Bevan & Hood, 2006). These managerial imperatives promoted standardisation, benchmarking, and audit cultures, reinforcing that health systems should be governed by the same principles of productivity, performance management, and financial oversight that structured corporate enterprises (Power, 1997).

The rise of Evidence-Based Medicine (EBM) during this period provided an epistemic framework that aligned seamlessly with NPM's emphasis on quantification, standardisation, and economic efficiency. EBM, initially conceived as a method for improving clinical decision-making through rigorous scientific validation, became institutionalised as the dominant paradigm for assessing medical interventions (Timmermans & Berg, 2003). This shift reinforced a hierarchy of knowledge in which randomised controlled trials (RCTs), meta-analyses, and cost-effectiveness studies were privileged as the primary basis for healthcare decision-making, while qualitative, experiential, and patient-centred approaches were devalued or excluded (Black, 2001; Greenhalgh et al., 2014).

This convergence of NPM and EBM was based on a deeper ideological alignment between managerial logic and scientific rationality. NPM postulated the centrality of mechanisms to evaluate performance, justify resource allocation, and optimise service delivery. At the same time, EBM provided a means to measure and standardise healthcare practices in ways that could be subjected

to external scrutiny, audit, and financial accountability (Timmermans & Berg, 2010). The emphasis on efficiency and accountability in public sector reform reinforced the dominance of EBM, as healthcare administrators increasingly relied on cost-benefit analyses, clinical guidelines, and evidence-based protocols to legitimise funding decisions, regulate professional autonomy, and ensure compliance with performance targets (Dent, 2005; Numerato et al., 2012).

As a result, healthcare governance became increasingly characterised by a technocratic and economistic orientation, where scientific evidence and financial efficiency became mutually reinforcing pillars of decision-making. The clinical authority of practitioners was gradually subordinated to protocolised medicine and managerial oversight, as adherence to best practice guidelines and standardised care pathways became key performance indicators within audit and reimbursement systems (Evetts, 2011). This shift led to the institutionalisation of top-down regulatory frameworks, which promoted compliance with efficiency-driven targets but often constrained the discretionary space required for context-sensitive, patient-centred, and holistic approaches to care (Freidson, 2001; Greenhalgh & Wieringa, 2011).

By embedding market rationalities within healthcare systems, the combination of NPM and EBM fundamentally altered how health systems operate, prioritising standardisation over complexity, measurable performance over professional judgment and financial over relational aspects of care. While these reforms were justified to improve quality, reduce inefficiencies, and make healthcare more accountable, they also narrowed the epistemic and institutional space available for non-conventional, community-based, and culturally embedded approaches to health and wellbeing.

A key feature of this transformation has indeed been the translation of medical decision-making into calculable, risk-based, and performance-oriented metrics. Healthcare providers are increasingly required to align their practices with protocolised guidelines, cost-benefit analyses, and pay-for-performance schemes, all of which prioritise treatments and interventions that can be demonstrated to yield statistically significant, replicable outcomes (Dent, 2005; Miller & Power, 2013). This has led to consolidating standardised clinical pathways to ensure predictability, efficiency, and resource optimisation in patient care. However, these imperatives often create friction with professional judgement and patient-centred approaches, as clinicians are forced to follow pre-established protocols rather than adapting treatments to the nuanced needs of individuals (Numerato et al., 2012).

The reliance on EBM as an instrument of healthcare governance has also led to the institutionalisation of accountability regimes, in which compliance with best practice guidelines is enforced through audits, benchmarking exercises, and performance evaluations (Strathern, 2000). Hospitals, consultants, and individual practitioners are increasingly assessed based on patient outcomes and compliance with standardised protocols, reinforcing a bureaucratic culture of documentation and external oversight (Evetts, 2011). While presented to ensure quality and transparency, this audit culture has contributed to the intensification of bureaucratic labour, shifting attention away from relational aspects of care and towards administrative compliance with performance targets (Power, 1997).

Objectification, standardisation, and commodification have shaped care organisation and delivery (Timmermans & Almeling, 2009). These tendencies have been critiqued for their role in making careless personnel, increasing managerial rationality and prioritising efficiency over holistic wellbeing. However, they have also been presented as necessary for expanding and institutionalising medical knowledge, enabling the efficient replication of medical interventions (Timmermans & Berg, 2003).

Objectification, in particular, refers to the fragmentation of healthcare practice into measurable, discrete units—an approach aligned with both the EBM's emphasis on clinical trials and the NPM's focus on performance metrics. Through the lens of medical governance, objectification transforms patients into data points, risk profiles, and standardised treatment pathways, allowing for their integration into audit systems and cost-benefit analyses (Timmermans & Almeling, 2009). While this abstraction facilitates evidence-based decision-making and the consequence of "rational" resource allocation, it also generates tensions by reducing illness's individual and experiential dimensions to statistical probabilities.

At the same time, standardisation has been central in aligning clinical practice with managerial control, a development reinforced by both EBM and NPM. Standardised clinical guidelines, care pathways, and performance indicators ensure comparability, accountability, and administrative control. Still, they also constrain professional autonomy and marginalise alternative epistemologies of care, particularly those rooted in qualitative, patient-centred, or community-based interventions (Lambert, 2006). The rise of evidence-based thinking has led to the marginalisation of individual judgment, patient narratives, and contextual knowledge, all considered insufficiently "scientific" compared to quantitative trials. This logic of exclusion is epistemic and political, legitimising healthcare governance through technocratic and depersonalised means.

Perhaps the most significant transformation is the one of healthcare in a commodity aligned again with NPM's focus on market mechanisms, competition, and cost efficiency. Commodification within healthcare extends beyond the privatisation of services; it includes the monetisation of medical knowledge, the transformation of professional expertise into managerial functions, and the increasing role of financial incentives in clinical decision-making.

EBM has become a key mechanism for governing healthcare through a managerial rationality that prioritises economic efficiency over holistic care at the intersection of these three processes. Rather than merely improving patient outcomes, the institutionalisation of EBM has helped legitimise new forms of accountability, surveillance, and financial discipline within clinical practice. In doing so, it has also facilitated the expansion of bureaucratic control, the erosion of professional discretion, and the marginalisation of alternative, non-clinical understandings of health (Ferlie & McGivern, 2013).

Healthcare has thus been converted into a performance-driven enterprise in which the legitimacy of both clinical and managerial decisions relies on their accordance with economic rationality and statistical objectivity. Medical interventions that cannot be easily quantified - whether due to their complexity, subjectivity, or reliance on social and relational dynamics - tend to be systematically marginalised within policy and funding structures (Greenhalgh et al., 2014). The emphasis on measurable indicators as the main method to assess healthcare quality and effectiveness has resulted in a decline of alternative approaches that are sensitive to context and resist standardisation. This has reinforced a model of healthcare governance that prioritises efficiency over care, focuses on measurability rather than complexity, and values cost-effectiveness over professional judgment.

2.

Out of the “Dance, Health and Wellbeing” Box: Dance Well

After analysing the current situation regarding the integration and institutionalisation of dance in the health and wellbeing sector, as well as the contemporary significance of Evidence-Based Medicine (EBM) in healthcare research and management, it is clear that the Dance Well practice is notably different from the previously discussed situation.

Dance Well functions as an artistic community practice with therapeutic benefits specifically designed for individuals living with Parkinson’s disease. This endeavour aspires to amalgamate diverse characteristics of community dance and specialised dance interventions for Parkinson’s without conforming to the constraints of biomedical health models and evidence-based paradigms.

Through this effort, Dance Well embodies the transformative power of artistic expression while actively engaging in a dialogue with the most progressive and innovative scientific communities, which have recognised Dance Well’s intrinsic value, even if it differs from traditional “Dance and Health” institutionalised approaches.

This scientific recognition was already crowned in 2019 when the World Health Organization listed Dance Well as one of the best dance practices for people with Parkinson’s disease in the scoping review “On the Role of the Arts in improving health and wellbeing.”

However, the aesthetic and experimental dimensions in Dance Well remained central and safeguarded by different artistic legitimation tools and actions, which we will present in the following sections.

2.1 Professional Dancers

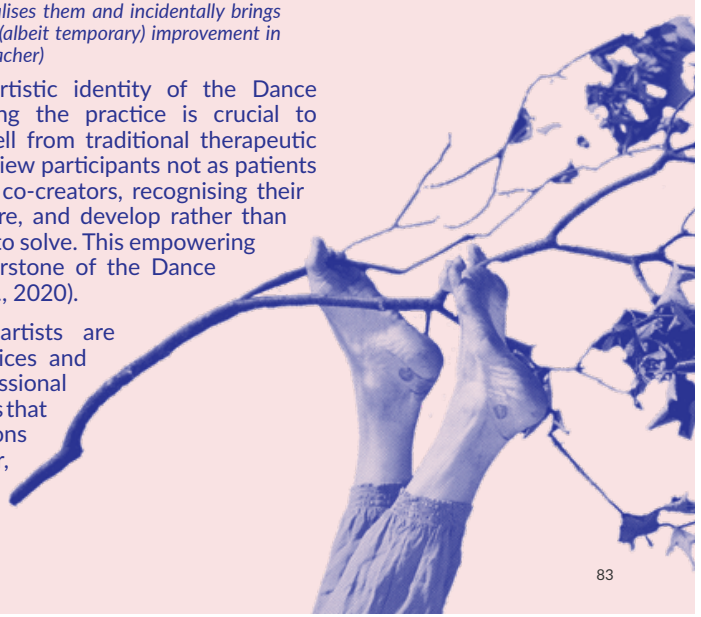
Dance Well practice is uniquely led by professional dancers who can propose various approaches, techniques, and styles through their artistic proposals. To be formally recognised as Dance Well teachers, these dancers must undergo a specific training course organised by the CSC | Comune di Bassano del Grappa. They also participate in annual meetings for updates and networking opportunities with different cultural institutions hosting Dance Well practices in their contexts.

The organisation decided to open the training course only to professional artists to preserve the artistic quality and integrity of the experience offered. In line with the philosophy of “art for art’s sake,” this approach asserts that the arts are inherently beneficial to individuals and society and are deemed therapeutically valuable simply because they are arts (APPGAHW, 2017; Macnaughton et al., 2005).

> *“Dance Well teachers have not to be loving or charitable; they have to be dance professionals, and that’s also what our dancers (participants) are looking for: they’re not looking for Parkinson’s experts to help them get well, they’re looking for dance experts to allow them to have an artistic experience that incidentally also socialises them and incidentally brings physical wellbeing, has an (albeit temporary) improvement in symptoms” (Dance Well teacher)*

More precisely, the artistic identity of the Dance Well Teachers conducting the practice is crucial to differentiating Dance Well from traditional therapeutic sessions. These dancers view participants not as patients but as collaborators and co-creators, recognising their potential to create, inspire, and develop rather than seeing them as problems to solve. This empowering “artistic gaze” is a cornerstone of the Dance Well approach (Yoeli et al., 2020).

Thus, by definition, artists are outsiders to health services and do not conform to professional regulations or conventions that impose rigid expectations concerning behaviour, ethics, or culture (Jensen, 2019; Putland, 2008).



Their outsider status fosters the playfulness and eccentricity of their creativity. This perspective enables the distinctive insights and challenges their work can bring with a level of perspective that can be difficult to maintain while working within healthcare professional frameworks (Raw & Mantecón, 2013).

Because of this, Dance Well practice is firstly defined as an artistic practice, supporting the general assumption that "*Good health outcomes cannot be achieved without arts outcomes*." (EDN, June 2021).

2.2 Artistic and Inspirational Settings

Another significant aspect of Dance Well practice is that it is happening in inspiring venues, such as museums, art galleries, or public parks during the summer. This artistic backdrop sets Dance Well apart from conventional therapeutic dance practices arranged in dance studios, like Dance for PD®. The museum environment, in particular, distinguishes this practice and creates a clear separation from other dance therapy programs aimed at individuals with Parkinson's disease. This choice also enhances the artistic dimension of Dance Well, as highlighted in interviews: "*In Italy, everything inside a museum is considered an art*."

Thus, the Dance Well initiative has evolved to fully embrace this distinctive contextualisation, with museums serving as a continual source of inspiration for its dancers. The surroundings become integral to the practice, informing movement, offering improvisation tools, and providing a beautiful setting for expression. Additionally, the possibility of spontaneous interactions with museum visitors adds another enriching layer to the experience.

By opting out of conventional spaces typically associated with specific expectations, such as dance studios or medical facilities, Dance Well has introduced a "dance activity with therapeutic effects" in an environment where such initiatives are generally not found. This approach enhances the context by incorporating symbolic and value-driven dimensions, preventing the practice from being narrowly categorised. The context may change throughout the year, introducing an element of unpredictability that further enhances the creative opportunities available to participants.

Finally, the decision to step outside the confines of traditional healthcare settings was also made to address the needs of people living with Parkinson's disease who are seeking experiences that are not solely tied to medicalisation. Instead of focusing exclusively on treatment goals or outcomes, Dance Well engages individuals looking for artistic exploration.

2.3 Improvisation-Based Dance Practice

Dance Well is an artistic practice based on collective improvisation. It is typically performed without mirrors or specific choreography, allowing community dancers to improvise and create their movements based on verbal and visual cueing.

> *"Dance Well adapts to imagination and language and is accessible from an artistic and personal point of view. In Dance Well, there is no rule, no right or wrong, and only personal answers to tasks that are offered. The practice remains accessible at any time and in whatever psychophysical state you are, very simply, because you decide whether to give one hundred or fifty per cent." (DW staff member CSC | Comune di Bassano del Grappa)*

From a neurological perspective, working without structured routines or repetitive movements is essential for individuals with Parkinson's disease. In particular, improvisation stimulates new pathways for motor learning by enabling them to respond to unexpected environmental conditions and develop new physical solutions in the moment (Batson et al., 2016). Additionally, improvisation scholar Danielle Goldman argues that it allows dancers to enter a state of "readiness," which is fundamental for people with motor disorders.

Even though the benefits of improvisation are well-known, they are challenging to measure in a large population and through an evidence-based approach. Specifically, it would be impossible to gather detailed data on changes in individual movements (Houston 2011, 2019).

Dance Well has a general structure but allows significant room for improvisation and experimentation for both the teachers conducting the practice and the participants; this aspect is part of its constitutive identity.

2.4 Names and Terms

An essential and transformative aspect of the Dance Well practice is its deliberate use of specific names, definitions, and terminology. The organisation primarily underscores the critical distinction between Dance Well and Dance Therapy. This differentiation is frequently misconstrued, especially among stakeholders external to the Dance Well community who engage in dialogue regarding the practice.

Moreover, participants are referred to as "dancers" rather than clients (as happens in the Dance and Movement Therapy field) or patients (Jensen, 2019). This choice of terminology is intentional, as it aims to humanise individuals living with various diseases. In particular, participating in the Dance Well community signifies a departure from the conventional language associated with healthcare and scientific discourse. The phrase "*there are no patients, only dancers*" epitomises a recurring theme throughout numerous Dance Well classes, emphasising a preference among participants to transcend medicalised identities.

Additionally, Dance Well practice does not neatly fit into the intervention or method categories. Research in Narrative Medicine has demonstrated that the careful selection of vocabulary can profoundly affect individuals' psychological and emotional healing trajectories and shape their perceptions of illness (Charon, 2022).

Consequently, it is imperative to characterise Dance Well as "an artistic practice with therapeutic effects" underlining that the therapeutic effects are not the central focus of discourse but instead treated as a side-effect of the experience. In fact, the term "therapy" may invoke connotations associated with the medical realm, which is why it is consciously eschewed. Instead, Dance Well presents an alternative vocabulary that empowers individuals to reclaim their identities as persons rather than being solely defined by their medical conditions.

2.5 Mixability and Inclusion

A significant distinction that differentiates Dance Well from other dance activities designed for therapeutic purposes is its inclusive approach, welcoming the entire community rather than solely individuals with Parkinson's disease. In a contemporary landscape where interventions are often tailored to specific demographic groups, providing an inclusive experience for all community members represents a revolutionary effort, mainly when the initiative aims to support individuals living with Parkinson's disease:

> *Many projects I follow are dedicated and exclusive to specific groups, while Dance Well is open to the public. This unique opportunity to conduct a class with a diverse group—people living with Parkinson's, amateurs, and dancers—is truly meaningful. The chance for such varied participants to attend the workshop together, at the same time and for free, is significant. - (Briqueterie Staff Member)*

Another essential feature of Dance Well is its commitment to being free of charge and accessible to all community members, including family members, elderly people, citizens, students, asylum seekers, immigrants, and dancers. As stated, "Dance Well is aimed primarily, but not exclusively, at people living with Parkinson's," indicating no differentiation based on health status, professional experience, or age. Consequently, all individuals are encouraged to participate.

Furthermore, ensuring accessibility is a strategic method to engage individuals who may otherwise be detached from dance. This approach fosters a gradual increase in participation and connection to the art form, aligning with audience development objectives.

In alignment with the Dance Well organisation's emphasis on vocabulary and the humanisation of the healing experience, participants are not required to disclose their health status or any existing illnesses. This approach effectively shifts the focus away from disease, allowing participants to engage with their bodies in a manner attuned to their capabilities.

> *"Thanks to projects like Dance Well, people can experience a social context instead of staying at home on their own. A project like this offers two things: It allows you to express yourself on an individual level while being part of a social environment, where people respect you for what you are, and you respect the others for what they are" - (Tanec Praha staff member)*

The practice of not requiring illness disclosure is a distinctive feature of Dance Well; however, it also poses challenges for conducting rigorous studies to evaluate the practice's therapeutic benefits. Research endeavours typically necessitate the identification of participants with specific health conditions and the selection of an appropriate control group that corresponds with the hypotheses and research questions of each study.

The criteria for group selection are contingent upon the nature of the trials being devised. For instance, pragmatic trials aim to assess interventions within real-life, routine practice settings, whereas explanatory trials focus on evaluating the intervention under optimal conditions (Sedgwick, 2014).

The inherent heterogeneity of the Dance Well participant group significantly complicates the feasibility of conducting such experimental studies while preserving the integrity of the overall dance experience.

2.6 Not an Intervention but a Long-Lasting Dance Practice

As previously indicated, the Dance Well initiative resists classification as a conventional artistic intervention. Instead, its value lies in its processual dimension, emphasising the experiential aspects of participation rather than predefined outcomes. Participants in the Dance Well practice are encouraged to nurture and sustain their connections with the community over time. This artistic practice is intentionally designed to be perpetually accessible to the community, devoid of specific guidelines regarding the "appropriate duration of engagement".

In contrast to typical Social Prescribing schemes, which often delineate participation in social activities for fixed periods and incorporate informal check-ins between healthcare providers and link workers biweekly or monthly, Dance Well's approach encourages a more fluid and continued participation in the artistic practice. Its impact on overall wellbeing is multifaceted and context-dependent, making it challenging to define it simply as an artistic intervention, which commonly implies a specific beginning and end.

Nevertheless, this philosophy presents again some challenges for scientific research, which typically favours specialised applications and targeted interventions. Such a focus allows for more specific and tailored studies, a necessity when advocating for integrating dance and artistic practices within medical settings or as preventative measures against illness (Sara Houston, 2024).

Dose, duration, and adherence to the intervention are essential variables to indicate, especially for clinical trials testing pharmacological interventions. Because of this, art-based interventions are requested to conform to this paradigm, even if the greater emphasis on active participant engagement poses challenges for standardisation. For example, the degree of physical exertion during a dance practice depends on the individual's efforts. Moreover, the potential effectiveness is difficult to analyse for long-term interventions in a progressive condition like Parkinson's disease, which is associated with ongoing new challenges for individuals (Sara Houston, 2024).

> *"Arts are not just another form of medicine that makes you fit in a couple of years. Instead, it's a process that allows and helps people to maybe not fall ill or to live with their illness in a better way." (Briqueterie Staff Member)*

In conclusion, if empiricism relies on observing outcome measures, much of the value of the arts remains unexplored because it manifests through its process. The arts have the capacity to influence individuals aesthetically and emotionally, often leading to fundamental changes in their lives that extend beyond mere artistic intervention and challenge the ability of human language to articulate. As a result, empirical methodologies of evidence-based practice likely will always struggle to acknowledge the complexity and nuances of the holistic artistic experience.

3.

Working on Cross-Sectoral:

The Case of Dance Well European Project

As members of the research team for the Creative Europe Project Dance Well (DW), we conducted ethnographically inspired qualitative research to investigate the translation and contextualisation of the Dance Well practice across the EU project's partner organisations. This inquiry focuses on the diverse strategies dance organisations employ in implementing the DW practice, identifying key stakeholders involved in its promotion, and examining how the multifaceted value of Dance Well manifests according to specific organisational needs.

To address the research questions, 50 semi-structured interviews were conducted throughout the development of the European Project. Additionally, from August 2023 to August 2024, a research visit was carried out for each dance organisation partner, lasting an average of 8,5 days. During these visits, data was enriched through direct observations and informal interactions with staff members and dancers involved in the Dance Well project, enhancing the understanding of each cultural context.

A participatory research approach underpinned this investigation, highlighting the significance of individual local case studies, which were explored through research visits and interviews. Content analysis methodology was utilised to interpret the resulting phenomena (Nowell et al., 2017), emphasising the subjective meanings derived from interviews triangulated with the contextual information gathered during visits.

Moreover, the analysis specifically emphasised the role of the healthcare sector and its stakeholders within each contextualisation process, assessing how Dance Well served as an enabler for new collaborations and connections with the medical community. To capture this information, we submitted an initial and final survey aimed at exploring the extent to which the Dance Well project triggered a dialogue between the dance sector and the health and social care system in the local contexts of each partner.

In the chapter's concluding section, we provide a comparative analysis summarising the key similarities and differences in the partners' experiences with the Dance Well contextualisation. This analysis is structured into four main categories: the legacy of the European project, the availability of artistic venues, previous initiatives in health and care, the recognition of contemporary dance, and the role of interpersonal relationships.

The tables below presents the collected data:

ONLINE PRELIMINARY INTERVIEW	
Day	**Organisation**
02/02/2023	CSC Centro Scena Conteporanea/ Comune di Bassano del Grappa (Roberto Casarotto, Tiziana Rigoni, Alessia Zanchetta, Greta Pieropan)
07/02/2023	K3 | Tanzplan Hamburg (Kirsten Bremehr)
10/02/2023	LDIC (Gintarė Masteikaitė, Ieva Pranckūnaitė)
13/02/2023	Tanec Praha (Markéta Perroud, Katarina Ďuricová)
17/02/2023	La Briqueterie (Elisabetta Bisaro, Arina Dolgikh)
24/02/2023	Le Gymnase (Laurent Meheust, Shruti Iyer)

INTERVIEW WITH HEALTHCARE PROFESSIONALS		
Day	**Site**	**Professionals**
02/02/2023	Fiesole (Italy)	Dr. Daniele Volpe and Dr. Monica Norcino
07/02/2023	Online	Dr. Andrea Pilotto
10/02/2023	Online	Giulia Baldassarre (physiotherapist and Dance Well teacher)

Visiting Period	Organisation	City	On-site Interviews	Other Activities
4th - 13th January 2024	La Briqueterie	Vitry-Sur-Seine	• Clint Lutes- DaPoPa (Dance Well Teacher) • Elisabetta Bisarro (Staff Member) • Arina Dolgikh (Staff Member)	• 3 days Dance Well training Course (from 6/01/2024 to 8/01/2024) • Participation in Dopamine Class (6/01/2024)
18th -24th February 2024	K3 | Tanzplan Hamburg	Hamburg	• Collective Interview with Peter Sampel and Florence Rist in K3 (Staff members) • Kerstin Evert (Artistic Director) • Sahra Bazyar-Planke (Dance Well Teacher) • Peter Sampel (Staff Member) • Florence Rist (Staff Member) • Fernanda Ortiz (Dance Well Teacher)	• Participation in Dance Well Club (19/02/2024) • Participation in Dance Well Open Class (23/02/2024)

Visiting Period	Organisation	City	On-site Interviews	Other Activities
11th-22nd of March 2024	Tanec Praha	Praha	• Roman Zotov Mikshin (Dance Well Teacher) • Yvona Kreuzmannovà (Artistic Director Tanec Praha) • Barbora Látalová (Dance Well Teacher) • Markéta Perroud (Dance Well Coordinator) • Markéta Vacovská (Dance Well Teacher) • Cécile Da Costa (Dance Well Teacher) • Katarina Ďuricová (Staff member) • Anna Gazdíková (Staff member) • Interview Kristina (staff member) • Hana Polanská (Dance Well Teacher)	• Participation in Dance Well Class (12/03/2024) • Participation in Dance Well class (19/03/2024)
18th -24th February 2024	K3 | Tanzplan Hamburg	Hamburg	• Collective Interview with Peter Sampel and Florence Rist in K3 | Tanzplan Hamburg (Staff members) • Kerstin Evert (Artistic Director) • Sahra Bazyar Planke (Dance Well Teacher) • Peter Sampel (Staff Member) • Florence Rist (Staff Member) • Fernanda Ortiz (Dance Well Teacher)	• Participation in Dance Well Club (19/02/2024) • Participation in Dance Well Open Class (23/02/2024)
22nd-30th of March 2024	Le Gymnase	Roubaix, Lille	• Scheherazade Zambrano Orozco (Dance Well Teacher) • Louise Flores-Garcia (Staff member) • Laurent Meheust (Artistic Director) • Shruti Iyer (staff Member) • Alejandro Russo (Dance Well Teacher)	• Participation in Dance Well Workshop - performance preparation/ Istitut pour la Photographie (23/03/2024) • Participation in Dance Well Workshop - performance preparation /Ballet Du Nord (24/03/2024) • Participating in Dance in Society Event (EDN Meeting on the theme of "well-being") at l'Oiseau-Mouche (Roubaix) 2 days (from 28/03/2024 to 29/03/2024) • Attending the Dance Well final performance (29/03/2024)
6th - 12th of may 2024	Lithuanian Dance Information Centre	Vilnius, Kaunas	• Erika Vizbaraitė (Dance Well Teacher) • Agnietė Lisičkinaitė e Greta Grinevičiūtė (Dance Well Choreographers) • Mantas Stabacinskas (Dance Well Teacher) • Marius Pinigis (Dance Well Teacher) • Adrian Carlo Bibiano (Dance Well Teacher) • Goda Laurinavičiūtė (Dance Well Teacher) • Gabija Blochina (Dance Well Teacher) • Gintare Masteikaitė (Artistic Director) • Ieva Pranckūnaitė (staff member)	• Participation in Dance Well Class, Čiurlionis Museum of Art (8/05/2024) • Museums visits where Dance Well classes take place (9/05/2024)
17th - 20th of august 2023 22nd - 30th of august 2024	CSC - Centro per la scena contemporanea	Bassano del Grappa	• Mia Habib (Dance Well Choreographer) • Chisato Ohno (Dance Well Choreographer) • Collective Interview with Operaestate Staff • Roberto Casarotto (Staff Member) • Greta Pieropan (Staff member) • Alessia Zanchetta (Staff member) • Giovanna Garzotto (Dance Well Teacher) • Rosa Scapin (Artistic Director)	• Partecipation in Operaestate Festival 2023 with the Dance Well community, watching the Dance Well choreographic project (form 17/08/2023 to 20/08/2023) • Participation in the conference/ Event for 10 years of Dance Well (11/11/2023) • Partecipation in Operaestate Festival 2024 with the Dance Well community, watching the Dance Well choreographic project (from 22/08/2024 to 30/08/2024)

3.1 Dance Well Project - Partners Overview

To Before introducing our overview analysis of each partner, it is imperative to underscore the distinct case of the CSC - Centro per la Scena Contemporanea compared to the other partners involved in the project.

Dance Well practice was inaugurated in Bassano del Grappa in 2013, and the CSC functions as the "home" where this initiative initially took shape. Accordingly, the European project within this context cannot be dissociated from the rich history of Dance Well activities that have thrived here for more than ten years.

In contrast, the implementation of Dance Well represented an innovative and unique endeavour for the other five partners in the EU project, who were invited to incorporate Dance Well into their respective contexts primarily due to this European initiative. Thus, the subsequent section will provide a comprehensive overview of both the lead partner (CSC - Centro per La Scena Contemporanea) and the five additional partners in the project (La Briqueterie CDCN; Le Gymnase CDCN; Tanec Praha; Lithuanian Dance Information Centre (LDIC); K3 | Tanzplan Hamburg – Zentrum für Choreographie) examining the challenges and opportunities encountered during the implementation of Dance Well practices in each distinct organisation.

CSC - Centro per la scena contemporanea

Leading the EU project for the CSC—Centro per la Scena Contemporanea has significantly increased Dance Well's recognition within the leading organisation, the Municipality of Bassano del Grappa. This project has enabled the organisation to secure additional human resources for its initiatives, further solidifying Dance Well's identity.

Additionally, the organisation was the first to take steps toward establishing a scientific community around the project, a development made possible through previous collaborations fostered over the years.

To enhance the relationship between the Dance organisation and the medical sector, they founded a Dance Well national scientific committee composed of esteemed healthcare professionals and researchers leaders in Parkinson's studies and research. Currently, the committee

includes Dr Andrea Pilotto, University of Brescia/Ospedali Civili; Dr Monica Norcini and Dr Daniele Volpe from the Fresco Parkinson Institute Italia Onlus; and Dr Luisella Carnelli, Fondazione Fitzcarraldo. The committee aims to promote Dance Well's values and benefits to the scientific community.

Moreover, the organisation conducted a series of video interviews with healthcare professionals and scientists worldwide to raise awareness about dance's positive effects on people with Parkinson's disease. These interviews are available online and use accessible language to effectively communicate the scientific perspective on dance's benefits.

CSC organisation is also at the forefront of research, being involved by the University of Brescia (Italy) in conducting a study on Dance Well led by neurologist Dr Andrea Pilotto.

Moreover, Bassano's Dance Well has been invited to several events organised by the scientific community throughout the years. For instance, in 2023, Dance Well participated in an event organised by the South Tyrolean Health Authority and the Neurology Department of the Bolzano Provincial Hospital to celebrate National Parkinson's Day. Additionally, in 2024, they participated in the International Association for Dance Medicine and Science (IADMS) annual conference. At both events, all attendees were invited to engage in the Dance Well practice, and the core principles of Dance Well—such as Mixability, Improvisation, and artistic venues—were highlighted.

Based on the interviews, the organisation found that the most effective strategy for engaging with the local healthcare system was establishing personal connections with key professionals in the field. Generally, the first step for this engagement was inviting them to join the Dance Well class.

The establishment of these contacts was motivated by various factors: to promote the Dance Well Class, develop new, future cross-sector artistic projects, and explore new evaluation protocols for dance's impact.

The CSC communication office also established a good relationship with a national TV program, Generazione Bellezza, which already dedicated a TV segment to the Dance Well practice in 2023.

La Briqueterie CDCN

La Briqueterie integrated Dance Well into its existing framework of wellbeing projects, building on established shared knowledge and strong relationships with the healthcare system and its professionals. The National Choreographic Development Center was already accustomed to collaborating with choreographers to investigate topics such as illness, disabilities, and the ageing body through workshops within hospitals and therapeutic, educational, and pedagogical institutes.

Thanks to these activities, collaborative relationships have been established with several healthcare organisations, including the CATTP at Paul Guiraud Hospital in Villejuif, the ITEP Le Coteau (Therapeutic, Educational, and Pedagogical Institute), the CATTP Minute Papillon at Robert Ballanger Intercommunal Hospital Center in Aulnay-sous-Bois, Paul Klee College, and students in the ULIS TFM MI (Motor Function Disorders and Disabling Diseases) program in Thiais, as well as IFSI Henri Mondor at CHU de Créteil.

Moreover, since 2018, La Briqueterie has organised the annual "Danse et Soin" Day, a regional event focused on Dance and Care. This event, held in collaboration with the services of DRAC Île-de-France, targets a diverse audience from the fields of culture and health, offering training sessions and meetings focused on designing choreographic and artistic projects in collaboration with healthcare institutions.

The training opportunities have fostered a valuable network of dedicated wellness, healthcare, and somatic arts professionals, creating a strong basis for welcoming Dance Well within La Briqueterie. On the other hand, pre-existing projects in health and wellbeing have presented challenges to establishing a distinct identity for Dance Well, which sometimes was confused with the other various activities offered.

More precisely, la Briqueterie was the only partner in the EU project that organised the Dance Well workshops in collaboration with a pre-existing association already offering a program for people living with Parkinson's disease: DaPoPa association, led by Clint Lutes.

Active since 2016 in Paris and Grenoble, DaPoPa played a crucial role in promoting Dance Well, as most of the people participating in the workshops were participants

of DaPoPa classes. This connection helped build a target community interested in engaging in the Dance Well workshop, especially at the beginning.

Consistent with this genealogy, the Dance Well workshops were named “Dopamine!” and designed similarly to the Dapopa classes.

> *“Initially, the core group of participants came through Clint’s organisation, DaPoPa, primarily for the DaPoPa classes. Currently, those who join generally understand the different contexts of Dance Well. However, there are instances where individuals say things like, “I come for the DaPoPa class,” “I come for the Dopamine atelier,” or “I come for dance classes.” (Briqueterie Staff Member)*

Considering that both Clint Lutes and Inés Hernández were simultaneously Dance Well and DaPoPa teachers, underlining Dance Well’s distinctiveness was initially challenging.

During the project’s second phase, another vital connection with the France Parkinson Association, the largest organisation in France dedicated to supporting individuals with Parkinson’s disease, was established. Although it took over a year to build this partnership, it has enabled La Briqueterie to reach new people living with Parkinson’s. As a result, several of them have begun participating in “Dopamine!” workshops.

As part of the Dance Well project, La Briqueterie rekindled its collaboration with the MAC VAL - the contemporary art musuem of Val-de-Marne in Vitry-sur-Seine, having previously worked together on the Dancing Museums EU-funded project. As a result of this partnership, the “Dopamine!” workshops had the opportunity to take place occasionally in the MAC VAL museum.

> *“The MAC VAL museum is always pleased to welcome us, although they don’t contribute financially to the project. The museum can, therefore, be an incentive, but what is interesting is that people love coming here to the Briqueterie. In France, we have places created for dance, and they are equally part of the cultural heritage.” (Briqueterie Staff Member)*

Thus, Mac Val Museum served as a significant source of inspiration for the Dance Well classes, while most of the “Dopamine!” workshops took place at La Briqueterie, an important industrial heritage site with a rich history, having been rebuilt from the Gournay brickyard, a former factory established in 1868.

Moreover, in January (2023, 2024, 2025), as part of the European Dance Well project, La Briqueterie was the sole EU partner organising a certified professional Dance & Parkinson’s training programme for dancers, choreographers, and individuals working in the medical and social sectors. This initiative was started by Clint Lutes, who had previously offered an annual training course in this area through his DaPoPa association and proposed incorporating this training opportunity into the Dance Well project. Thus, In collaboration with the DaPoPa association, three editions of the Dance Well training course were organised, where participants were instructed on how to combine their knowledge and skills in dance with the specific needs of people living with Parkinson’s disease, understanding the symptoms, and finding a balance between educational and artistic dimensions.

> *“In an intensive training course, we decided to prioritise dancers; however, we also recognised the significant need for this type of offering in our area for individuals who may not be dancers but are interested in practices related to movement, touch, and the various qualities developed in a dance context.” (Briqueterie Staff Member)*

Although la Briqueterie positioned itself outside the therapeutic dance world, it opened a dialogue with professionals from that field, becoming a territorial reference point in Dance and health, offering certified and recognised educational opportunities.

> *"It's not surprising that professionals involved in somatic practices are drawn to the Dance Well classes. I believe this is the right fit for them, especially since there aren't many similar workshops available in Paris. The options for this type of training are quite limited"(Briqueterie Staff Member)*

In the medical sector, a collaboration was established with physiatrist Dr Denis Obert, who participated in training courses to offer specialised classes on Dance and Parkinson's disease.

As the other UE partners also emphasised, having a personal connection with an open-minded healthcare professional, as in this case, was one of the most critical factors in promoting Dance Well and enhancing its credibility from a scientific perspective.

Regarding the future of the EU project and its financial sustainability, although there are local financial resources available to develop projects in the Dance and Health area—supported by open calls from the Region, the Ministry of Culture, and the Ministry of Education—recent funding cuts in healthcare and a shortage of medical staff in French hospitals have made the arts seem less of a priority. On a positive note, Clint Lutes expresses optimism about the potential for ongoing collaboration between DaPoPa and other projects, such as Dance Well, offering a solution for continuity to all participants currently attending the *Dopamine!* Atelier.

Le Gymnase CDCN

Unlike La Briqueterie, Le Gymnase had no prior connections or relationships with the healthcare system, and their initial attempts to establish contacts with hospitals, neurological services, and nursing homes were ineffective. This was possibly due to the fact that in France, alternative art-based therapies are not yet formally recognised or widely implemented:

> *"The medical sector doesn't want to establish a connection to maintain medical privacy. Additionally, they are not interested in the project and might not inform their patients about it, as they do not consider practices like dance to be classified as therapeutical." (Le Gymnase Staff Member)*

Le Gymnase attempted to reach out to private, non-profit, and public organisations related to Parkinson's disease, as well as personally contacting healthcare professionals to promote the practice and make them suggest DW classes to their patients. However, they did not receive much enthusiasm from this community, and even when healthcare professionals recommended the practice as their personal choice, they never attended the DW classes themselves.

However, with the passage of time and the consolidation of the project, the organisation reached new stakeholders in promoting Dance Well, such as the Café Jeune Parkinson, France Parkinson, Jeunes Parkinson Association, CCAS de Roubaix, Maison Des Aidants Feron-Vrau, Centre de santé l'espoir, Clic Riv'age, Les papillons blancs, Bureau d'inspiration partagées, and the Centre Hospitalier Universitaire Roger Salengro.

To engage with them, Le Gymnase participated in special events such as a forum on Parkinson's disease and local networks for young people with Parkinson's.

Despite this considerable improvement, the interest remained stable over time, and these connections have not transformed into collaboration opportunities. The contact with the healthcare system ultimately served a promotional purpose, advertising the classes to patients.

On the other hand, Le Gymnase received increased interest from social workers, inviting them to participate in the Dance Well Classes and reached through word of mouth.

Consistently, Le Gymnase has strongly promoted the

social aspect of Dance Well. From the beginning, it aimed to position the Dance Well project as a tool for social empowerment through dance rather than as an artistic practice with therapeutic effects for individuals with Parkinson's disease. In this framework, Dance Well adopted a more community-oriented approach, emphasising the importance of social determinants of health.

This decision was made considering the unique situation of Roubaix, the poorest city in France, which faces significant challenges related to alcoholism and immigration.

> *"In Roubaix, life expectancy is eight years lower than the national average due to the impact of mining and the textile industry. This has harmed people's health. Additionally, there is a high level of alcoholism. As a result, in this specific place, people are just trying to live, and wellbeing is left as a dream concept."(Le Gymnase Staff Member)*

Due to this, Le Gymnase did not want to launch a new "care project" but aimed to expand the community and foster connections with various marginalised groups.

> *"The aim is not to focus on specific projects related to migrants, Parkinson's disease, or alcoholism. Instead, the goal is to promote the idea of mixed abilities, where individuals from diverse backgrounds come together. In such an environment, stigmas associated with various identities or challenges are no longer stigmas." (Le Gymnase Staff Member)*

In alignment with this philosophy, the classes were designed to be accessible to everyone, regardless of their physical ability or financial situation. Instead of categorising participants, all individuals, including those with Parkinson's disease, find value in being part of a collective experience.

Moreover, Dance Well workshops were organised both in Lille and Roubaix in inspiring cultural locations, such as the Institut pour la Photographie (Lille), the Ballet du Nord (Roubaix)at the Palais des Beaux-Arts in Lille, the LaM Museum (Villeneuve d'Ascq), Bazaar St So (Lille), and the Lille Opera...

Looking at the funding perspective, La Gymnase identified the Direction Régionale des Affaires Culturelles Hauts-de-France as a primary funding source to ensure the project's future sustainability. However, similar to the situation experienced by the Briqueterie, the significant cuts to public services in France, especially in healthcare, have had serious repercussions for Art & Health collaborations, raising challenges for arts organisations seeking public funding for artistic projects that intersect with health initiatives.

As noted by other partners, establishing personal connections with medical professionals in alternative medicine and wellbeing practices, such as physical therapists, was considered a crucial condition for initiating collaboration with the healthcare system, especially in the presence of scarce financial resources.

Tanec Praha

Tanec Praha has successfully established strong and meaningful relationships with healthcare institutions over the years. The DW project specifically allowed them to map the institutions associated with Parkinson's disease, engage with them, and establish a solid foundation for potential future collaboration.

This achievement can largely be attributed to connections with open-minded professionals in the sector. For instance, Tanec Praha connected with MUDr. Barbora Klusoňová, a neurologist at INEP, a private clinic in the Czech Republic, as well as at the Neurological Clinic of the 3rd Faculty of Medicine at Charles University (LF UK) at the University Hospital Královské Vinohrady (FNKV). Since 2022, she has been a consultant for the Dance Well project, promoting it within healthcare institutions.

Additionally, in 2024, the Extrapyramidal Disease Center (EXPY) at the General University Hospital in Prague was approached for potential collaboration, appearing as a promising partner for future initiatives.

Within social institutions, Tanec Praha began collaborating with the Elderly Day Care Center Háje in February 2023. This partnership, aimed at promoting Dance Well classes, has developed into an annual collaboration to celebrate World Parkinson's Day (2023, 2024, and next April 2025). On this occasion, Tanec Praha organised special Dance Well interventions, which included an introduction to Dance Well, a class, and a discussion for the community affected by Parkinson's disease. This event was also attended by social and healthcare workers and family members of individuals with Parkinson's disease.

Since the beginning of the project, Tanec Praha has also sought to establish a connection with the Prague Parkinson Community, initially reaching out to the Parkinson's Help Association. Communication started in 2022, and a partnership was established in February 2023. They have played a crucial role in promoting the Dance Well practice to members of the Parkinson's Association, utilising their website and distributing printed materials.

Ultimately, the most effective way to build the community was through word of mouth and the personal connections of both the dedicated Dance Well dancers and the Dance Well teachers.

DW dancers were particularly effective in establishing connections with healthcare professionals and in promoting Dance Well. Notable examples include Mrs Marcela Šachová, a nurse and DW dancer with Parkinson's disease who has supported the project from the beginning. Furthermore, the existing network of Dance Well teachers was crucial in promoting Dance Well, as they have all previously worked with community dance.

Additionally, the cultural spaces that hosted the Dance Well practice throughout the project provided a final boost in promotion. Despite initial challenges in finding a partner to ensure regularity of activities, Tanec Praha successfully formed fruitful partnerships with several cultural institutions that actively collaborated in promoting the project through their social media and websites. The institutions they partnered with included KC Vozovna, an intergenerational centre that organises cultural, social, and educational events in Prague's 3rd District; National Gallery Prague and the Prague City Gallery, which was already a partner in the Dancing Museums UE-founded project.

In this promotional activity, it was emphasised how crucial it was to explain the distinction between Dance Well and a Dance Therapy Method, which posed a challenge for the organisation:

> *"Many people seem to consider Dance Well a therapeutic method that we learn during training and then simply apply. I found it quite challenging to explain that it's not just a methodology; rather, we are essentially dance artists in what we do." (Tanec Praha Staff Member)*

For Tanec Praha, a significant concern was maintaining the artistic integrity of the project while engaging with the therapeutic world. Even from the Dance Well teachers' perspective, they reported that they needed to emphasise on various occasions that they were not therapists.

From a financial perspective, the unpredictability and inconsistency of the Ministry of Culture's funding significantly limited the organisation's planning abilities. Specifically, Tanec Prague experienced consistent reductions in funding compared to previous years, leading to various financial and liquidity challenges. In this crisis, seeking new funding opportunities became even more critical. To expand funding opportunities, interviewers emphasised the importance of activating scientific collaborations to enhance the understanding of the impact

of dance on health, particularly concerning conditions like Parkinson's disease. Establishing a preliminary dialogue and connection with healthcare professionals and research centres was considered essential. This includes organisations like the Extrapyramidal Disease Center at the General University Hospital in Prague, which was already reached, as well as other research centres collaborating closely with Marcela Šachová, a dancer from Dance With Parkinson's, and MUDr. Barbora Klusoňová. In particular, universities were viewed as potential mediators that could provide research, resources (such as research programs), and innovative ideas to bridge the gap between the health and arts sectors. Establishing common ground, cultivating mutual respect, and integrating perspectives from both sectors were perceived as crucial steps to produce meaningful research and partnerships.

The necessity of establishing trust within the group before implementing scientific measures was also emphasised in the context of producing evidence for the project. It was noted that a strong and cohesive community is essential for conducting experiments without compromising the creative atmosphere fostered by the practice. In general, scientific evidence and collaborations were viewed as reliable tools for securing funding and institutional support for cross-sector artistic projects.

Finally, Tanec Praha also operated these years at a policy and advocacy level as a member of Vision for Dance, a cultural association that unites independent professionals and organisations working in the dance and movement arts field in the Czech Republic.

In particular, Dance Well was invited to present at two events focused on dance and wellbeing, organised by Vision for Dance in 2023 and 2024. These events include the Conference Art in Health and Health in Art (2023 in Brno) and the Symposium on Moving Towards a More Resilient and Well-being Society (2024 in Prague).

Lithuanian Dance Information Centre (LDIC)

The Lithuanian Dance Information Centre (LDIC) was unsuccessful in establishing connections with the local healthcare system, which was viewed as distant and unresponsive. Dr. Ramunė Dirvanskienė was the only medical professional they managed to contact, but this connection did not result in any new partnerships, collaborations, or agreements with health institutions and hospitals.

On the other hand, they successfully reached the Parkinson's Society of Kaunas County, which collaborates to promote the Dance Well classes within the association.

The M.K. Čiurlionis National Museum of Art played a crucial role in establishing this connection as it previously collaborated with the Parkinson Association as part of the Kaunas 2022 European Capital of Culture initiative. As a result, Dance Well classes were organised within the museum's facilities until 2024, and the museum staff were already familiar with the association's members.

As a result, Dance Well was built upon the legacy of the European Capital of Culture project:

> *"Without the European Capital of Culture program, the process would have been more challenging. The EU project undertook five years of preparation, organising numerous programs aimed at collaborating with cultural institutions to promote openness. This involved fostering contemporary thinking and emphasising the importance of audience participation within the community. They invested significant effort into this preparation work." (LDIC Staff Member)*

Although the European Capital of Culture project funded by the EU concluded in 2022, it provided opportunities for Dance Well to flourish within the context of Kaunas as the Culture Capital project has helped familiarise the audience with specific types of research and artistic practices.

> *"Audience development is one of our goals, and bringing the Parkinson community onto the stage means changing the audience's mindset about how they watch performances. Additionally, we aim to welcome them as part of our audience for the dance festival." (LDIC Staff Member)*

Dance Well was then recognised as an opportunity for audience development, promoting the participation of the Parkinson's community in contemporary dance events. Additionally, the Dance Well project successfully encouraged registrations in the Parkinson's Association,

leading to a noticeable increase in membership. This illustrates the program's success in bridging gaps between different community groups.

Secondly, participation in the Dance Well project provided a significant opportunity to raise awareness about contemporary dance and its various facets. The Lithuanian Dance Information Center (LDIC) embraced the Dance Well initiative to enhance the value of dance, mainly due to its social impact.

However, Dance Well's social and therapeutic impacts were always presented as secondary effects, as there was a continuous effort to defend the artistic legitimacy of the practice. Nevertheless, the LDIC organisers and dancers found this a challenging task, especially considering the Lithuanian cultural context, which may resist the idea of non-professionals engaging in dance as a form of art.

The interviews highlighted the importance of involving skilled artists in leading creative activities to uphold the artistic value of dance. Ultimately, an emphasis was placed on finding a balance between artistic research, social work, and therapy.

From a professional development point of view, The Dance Well program was recognised by DW teachers as an occasion to enhance their scientific knowledge to better address community needs. It allowed them to develop a hybrid professional identity combining artistic and therapeutic skills while enabling continued engagement in the artistic sector outside of performance activities after achieving a certain level of artistic and professional maturity.

Considering the project's future and sustainability, LDIC applied for the Social Prescribing Programme. Although their application was rejected, they expressed interest in presenting their proposal again to secure additional funding and continue their activities in Lithuania.

Furthermore, the organisation's reliance on grants and public funding highlights the importance of external support for sustaining artistic projects. Fortunately, the Kaunas City Municipality provided financial support for the project in 2024, and there is hope that this collaboration will continue in the coming years.

Overall, funding availability was considered a crucial factor for continuing the project, together with the need to increase medical professionals' awareness of dance's benefits through dedicated research on its impact on individuals with Parkinson's disease.

K3 | Tanzplan Hamburg – Zentrum für Choreographie

Throughout the Dance Well project, K3 | Tanzplan Hamburg improved its ability to engage with health professionals and establish new connections compared to the project's beginning. They contacted a neurologist, Prof. Dr Med. Björn Hauptmann from Segeberger Kliniken was invited to participate in the Dance Well final presentation and provide insights from a medical perspective after the performance. Additionally, they started an informal exchange with the Seminar Hochschule für Künste im Sozialen Ottersberg (Art in Social Contexts, Art Therapy, B.A.).

To date, however, this connection has not resulted in new collaborations or partnerships, as these actors were primarily engaged in promoting the Dance Well classes.

Dance Well teachers generally reach the Parkinson's community through direct contact and personal networking. In particular, the Dance Well teacher Sahra Bazyar-Planke leveraged her extensive network of individuals with Parkinson's due to her profession as an occupational therapist. Overall, K3 | Tanzplan Hamburg found it challenging to connect with Parkinson's associations and personal contact was viewed as the most effective approach.

Moreover, the organisation saw the Dance Well project as an opportunity to engage with new audiences, particularly those who may not have prior connections to contemporary dance.

The K3 | Tanzplan Hamburg building serves as the central hub for the Dance Well classes, and the practice was deliberately retained within this venue rather than relocated to external spaces such as museums. This choice was primarily driven by logistical considerations and the unique advantage of K3 | Tanzplan Hamburg being integrated within the Kampnagel theatre, which hosts a diverse range of artistic programs. Additionally, the presence of artists actively engaging in their work within the K3 | Tanzplan Hamburg hall fosters an enriching artistic environment that distinguishes it from conventional dance studios.

For communication purposes, K3 | Tanzplan Hamburg was also reached out by the Pharmazeutische Zeitung, an important German-speaking newspaper in the pharmaceutical field, which featured an article about DW.

Thanks to the personal connection of the Dance Well teachers, K3 | Tanzplan Hamburg also reached the "Parkinson-Komplex-Behandlung" at the Asklepios Barmbek hospital, with which they were able to inform Parkinson's patients about the Dance Well practice.

As reported by the other Partners, also for K3 | Tanzplan Hamburg throughout the project, it was challenging to underline the distinction between Dance Well and Dance Therapy:

> *"In Germany, it's really strict to call something therapy; we need to be careful about it, and so I try to explain that it's a project which works with artistic skills and with artistic methods and does not like to work in a therapeutic way…" (K3 | Tanzplan Hamburg Staff Member)*

Dance Movement Therapy is recognised as a professional field in Germany, but most health insurance policies do not cover it. This highlights the challenges involved in integrating alternative therapies into conventional healthcare systems.

However, Dance Well aims to preserve and maintain its artistic integrity. In particular, when working with individuals with Parkinson's disease, K3 | Tanzplan Hamburg's challenge in promoting and communicating about Dance Well was to avoid reducing it to merely a therapeutic practice.

> *"When I teach Dance Well, I want participants to forget their disease while in class, and then suddenly they can do many things they normally can't do." (K3 | Tanzplan Hamburg DW teacher)*

Even Sahra Bazyar-Planke expresses her desire to maintain a creative and artistic approach in her classes rather than strictly a therapeutic one. She explains:

> *"I try not to think as a therapist when teaching DW. If I did, the therapist would also point out the disease. It's likely that this would cause DW dancers to take a step back instead of moving forward."*

Maintaining strong artistic integrity while engaging with non-professionals and communities was considered fundamental for legitimising Dance Well as an artistic practice and enhancing its positive therapeutic impact.

In connection with this, scientific studies were recognised as fundamental for gathering evidence about the impact of dance as a therapeutic tool. In Germany, where there is a strong evidence-based scientific culture, it is nearly impossible for dance to gain recognition without conducting research to support its efficacy. Overall, the perception is that proving the value of the arts through evidence-based research is essential to justify allocating funds.

In fact, similar to the situations faced by other partners, funding opportunities for culture are also steadily decreasing in Germany. Therefore, alternative legitimate tools were seen as essential to provide financial support to the sector.

Ultimately, funding availability was regarded as crucial for facilitating collaboration with the healthcare system; however, both the healthcare and cultural sectors were found to lack adequate resources and capabilities.

3.2 Comparative Analysis

The partner overview shows that all five partners involved in the Dance Well initiative faced various challenges in institutionalising the practice within their organisations. A recurring issue has been the lack of funding opportunities and financial resources, highlighting the need to adopt different strategies and legitimisation tools to emphasise dance's importance in society and the Dance Well project. For example, all partners have recognised the importance of scientific evidence in enhancing the credibility and recognition of Dance Well practice. At the same time, the interviews revealed a strong cross-party commitment to maintaining and defending the artistic integrity of the practice itself, emphasising the critical distinction between Dance Well and Dance Therapy. Other enabling factors that have had a particular impact on contextualisation and institutionalisation vary according to the background and distinctiveness of each cultural organisation and are reported in the following sections.

European project legacy

Some partners saw Dance Well as being in direct continuity with previous European projects implemented by the same organisation or in the same referral territory. In particular, the interviews revealed how Tanec Praha and La Briqueterie connected Dance Well with the earlier Creative Europe-founded project, Dancing Museum, recognising the distinctiveness and high quality achieved when working and researching within a European project framework. At the same time, both organisations leveraged the relationships previously established with museums during Dancing Museum to explore partnership possibilities for the Dance Well project.

For LDIC, Dance Well was developed in direct communication with the European Capital of Culture, which provided a fertile and receptive environment in Kaunas. The Capital of Culture project created an open-minded context essential for implementing an innovative initiative like Dance Well, enabling collaboration with stakeholders with experience in a European project mindset. In particular, the M.K. Čiurlionis National Museum of Art played a crucial role in establishing the initial connection with the Parkinson Association of Kaunas, with which they had already been able to collaborate during the Kaunas 2022 European Capital of Culture initiative.

In the Dance Well project, the contextualisation process exemplified in these cases the significance of building on past collaborations and existing networks to foster artistic endeavours and continue feeding community engagement.

Previous projects in health and care

Most of the European project's partners did not have prior experience in direct collaboration with the medical sector, making Dance Well their first opportunity to explore this avenue. As organisations primarily focused on contemporary dance production, promotion, and distribution, they seized the chance to connect with the healthcare system through Dance Well. The only exception to this was La Briquterie, which was notably distinct from its other partners, having already established projects related to dance and healthcare. This foundation allowed the Dance Well project to be integrated into a network of pre-existing relationships and collaborations with healthcare stakeholders, solidifying La Briqueterie's identity as a national reference point for health and care initiatives in contemporary dance. In this context, Dance Well supported and enhanced an ongoing process that blended seamlessly with the existing organisational landscape.

The availability of artistic venues

The role of physical spaces, such as museums and cultural centres, in shaping the artistic and social dimensions of the practice has depended on the cultural context in which Dance Well was implemented. For some, moving the DW practice into a museum or external cultural institution was essential because of the lack of a dedicated space for the DW artistic practice. In contrast, other organisations had dedicated spaces for contemporary dance, which made them less motivated to leave their venues, as these spaces were seen as culturally recognised as equally relevant and part of cultural heritage, just like museums.

Since Dance Well was also regarded as a tool for audience development, relocating "the audience" was considered disadvantageous. This was particularly true in countries like France, where it was thought unlikely that museums would provide financial support for such projects. This contrasts with other cultural contexts, such as in Italy, where museums were seen as crucial partners for providing financial support and fostering the development of artistic practices throughout the evolution of Dance Well.

The differing roles associated with museums in each context created varied governance structures around the Dance Well project and led to different types of motivational relationships with cultural spaces. For all the partners involved, museums were viewed as an invaluable source of inspiration and a potential promotional tool for engaging with audiences that are typically not reached by dance organisations. However, only some partners also perceived museums as channels for financial support and long-term collaboration opportunities.

The recognition of contemporary dance

As previously anticipated, all partner organisations involved in the DW project committed to preserving the artistic integrity of the practice, distinguishing it from Dance Therapy and other non-professional artistic activities.

However, the effort to support Dance Well's intrinsic value varied slightly across different cultural contexts, leading to different strategies for justifying and accepting an artistic practice that included non-professional community members. This variation was influenced by local cultural policies and the existing artistic networks that had already fostered such activities, as well as the broader cultural context specific to each country.

In particular, Tanec Praha and LDIC were more concerned about maintaining the artistic integrity of the project while engaging with the therapeutic world. Although Dance Well's social and therapeutic impacts have always been presented as secondary effects, in these contexts, the need to emphasise the distinction between Dance Well and Dance Therapy remained crucial, and it was more challenging to convey the idea that non-professionals and individuals with disabilities could participate in dance as a form of art.

As a result, the capacity of dance organisations and practitioners to collaborate effectively and equitably with healthcare stakeholders depended on their ability to maintain their values and legitimacy in these interactions. This was considered essential for fostering a respectful exchange of perspectives.

Presence of Interpersonal relationships

Having a personal connection with an open-minded healthcare professional was one of the most critical factors in promoting Dance Well and enhancing its credibility from a scientific perspective. In particular, the Dance Well teachers played a vital role in advocating for the classes across various partner organisations. However, some teachers had stronger connections with their communities, while others were at the height of their professional careers and needed to travel more, making it challenging for them to establish a solid link with the DW local community.

Additionally, the same Dance Well dancers were instrumental in increasing the recognition of the practice within the medical sector, particularly because some were already doctors or had close relationships with healthcare professionals. This personal and emotional connection resulted as a significant tool in demonstrating the effectiveness of the Dance Well project.

Thus, the overview of all the partners involved in the contextualisation and institutionalisation process highlighted the key role of individuals who acted as facilitators through their skills and personal experiences. They successfully navigated sectoral boundaries, fostering new interdisciplinary dialogues and enhancing collaboration across the artistic and healthcare fields.

4.
Evidence Revised:
Towards Pluralistic Forms of Accountability

4.1 Quantification and the Illusions of Evidence

The drive for visibility through quantification is one of the key features of shaping healthcare and public administration in general. Numbers, metrics, and performance indicators have spread everywhere to make complex systems understandable and to allow for comparison, control, and accountability. Yet the logic of quantification - in its being not neutral - is deeply entangled with power, ideology, and the politics of knowledge. While promising transparency, it simultaneously obscures, simplifies, and disciplines, constructing a world that privileges what can be measured over what cannot (Espeland & Stevens, 2008).

At its core, quantification is a method of abstraction that reduces complex, multi-dimensional phenomena into numerical representations in order for them to be easily manipulated, compared, and acted upon. This process provides the illusion of transparency, suggesting that numbers offer an objective and unbiased reflection of reality (Miller & Rose, 1990). In organisations, performance metrics are deployed to assess efficiency, productivity, and success, creating a sense of control over what would otherwise appear as unstructured or chaotic processes. Governments use statistical indicators to evaluate economic growth, social progress, and institutional effectiveness, and in doing so, they generate an image of governance rooted in rationality and calculability (Power, 1997).

Yet, the pursuit of visibility through numbers often leads to a paradox: in making certain aspects of reality visible, it simultaneously renders others invisible. What is measured gains prominence, while what cannot be easily quantified is sidelined or dismissed (Mau, 2019). This creates a form of epistemic narrowing, where numerical representations become not just indicators of reality but reality itself. In public policy, for example, economic indicators like GDP become the dominant measure of national wellbeing, eclipsing more qualitative aspects of social progress such as community cohesion, environmental sustainability, or subjective wellbeing (Stiglitz et al., 2009).

A central critique of quantification is its tendency to produce what has been termed “invented accuracy”—the creation of precise-seeming numerical values in domains where precision is illusory (Power, 2004). When complex, ambiguous, and fluid realities are forced into rigid numerical frameworks, the resulting data often conceal more than they reveal. Rankings and league tables, so common in healthcare systems, impose artificial boundaries, giving the impression of definitive knowledge while masking the underlying uncertainties, assumptions, and contextual variations that shape the production of numbers (Espeland & Sauder, 2007).

This phenomenon is evident in the proliferation of performance management systems in organisations. Key performance indicators (KPIs), efficiency scores, and financial ratios claim to provide objective assessments of effectiveness, but they often reduce multi-faceted activities to simplistic, measurable outputs (Levay, 2020).

Beyond its epistemic effects, quantification operates as a mechanism of discipline and control. The act of measuring not only records but also structures behaviour, as individuals and institutions adjust their actions to align with numerical targets and benchmarks (Porter, 1995). This process is particularly visible in the diffusion of “audit cultures,” in which employees, professionals, and organisations internalise performance metrics, shaping their conduct in line with the demands of quantitative accountability (Strathern, 2000).

The widespread adoption of quantification in governance and management has contributed to what some scholars describe as “metric-driven subjectivity,” in which individuals come to see themselves through the lens of measurement (Espeland & Stevens, 2008). From productivity scores in the workplace to social media analytics, numerical assessments shape how people perceive their own worth and success. This activates a circle where visibility is the source of validation but, in becoming s,o generates anxiety as individuals strive to meet predefined quantitative expectations (Merry, 2016).

Furthermore, the disciplinary effects of quantification extend beyond individual behaviour to institutional and structural arrangements. Organisations end up placing more importance on what is measured, leading to the distribution of resources and attention towards achieving high scores on key indicators. This can result in "goal displacement," where pursuing metrics replaces pursuing substantive objectives (Bevan & Hood, 2006). In bureaucratic systems, for example, focusing on measurable outcomes in public service delivery can lead to strategic gaming, where agencies manipulate numbers to meet targets without necessarily improving service quality (Sauder & Espeland, 2009). In research and academia, emphasising publication metrics can drive scholars to prioritise high-impact journal publications over slower, more deliberative intellectual engagement (Burrows, 2012).

4.2 Trust in Numbers and Quantification as a Political Act

Even when it is presented as a neutral, technical exercise, quantification can be seen as inherently political. Power dynamics, institutional interests, and ideological commitments shape the decision of what to measure, how to measure it, and how to interpret results (Miller & O'Leary, 1987). The construction of evidence is never merely a matter of objective description but involves choices about inclusion, exclusion, and prioritisation. What is counted and ignored reflects broader societal values and power distributions (Rose, 1999).

The politics of quantification also play out in how numbers are mobilised in public discourse. Statistics have become used as rhetorical devices to justify policies, allocate resources, and make decisions more legitimate (Miller & Rose, 1990). The authority of numbers gives credibility to claims that might otherwise be less easy to justify, creating a sense of inevitability around certain courses of action.

The capacity of numbers to be so attractive is not accidental but rooted in the historical and institutional processes that come to celebrate quantification as the ultimate symbol of objectivity, neutrality, and legitimacy. The appeal of quantification is to be found in its ability to make decision-making seem less biased and personal, remove subjective judgment, and offer an apparent impartial basis for governance (Porter, 1995). However, this preference for numerical objectivity is full of consequences because it transforms the way authority is exercised, the knowledge is legitimised, and institutions justify their decisions. It fundamentally reshapes the relationship between expertise, accountability, and public trust.

The trust placed in "evident numbers" often arises not from their technical accuracy - as often this is not the case - but from their image of impartiality. Quantitative evidence is frequently valued precisely because it presents itself as liberated from human bias, political influence, or individual discretion. In contrast to subjective judgment or feelings, which are always open to contestation, numerical representations promise a form of knowledge that is universally verifiable and independent of personal authority. This has made them particularly attractive in settings where decisions such as health care need to be justified to a broad and diverse audience.

Yet, this very detachment from subjective interpretation and lived experiences creates a paradox. The very mechanisms that seek to ensure neutrality—tests, algorithms, and statistical models—introduce new forms of discretion and judgment, but in disguised ways. Decisions about what to measure, how to classify data, and how to interpret results remain deeply subjective, yet they are embedded within technical and bureaucratic systems that make them appear neutral (Porter, 1995). By shifting the locus of judgment from individuals to abstract systems of evidence creation, quantification can actually obscure the social and ethical dimensions of decision-making rather than eliminate them.

The demand for numerical objectivity is not evenly distributed across all governance and knowledge production domains. Certain areas of public intervention - those that are more subject to public scrutiny or democratic accountability - have to deal with pressures to justify decisions through numbers. This dynamic is particularly evident in public service settings, where quantification is often used to protect decision-makers from accusations of arbitrariness or partiality. The more a decision is visible and open to debate, the greater the reliance on numerical justification. This has led to the proliferation of performance indicators, cost-effectiveness analyses, and algorithmic decision-making systems in areas such as healthcare. These mechanisms provide an image of neutrality, but they

also function as a strategy for managing political risk rather than as a true reflection of empirical reality.

The institutionalisation of trust in numbers has significant social consequences, particularly in terms of governance, professional autonomy, and public trust. When numbers become the dominant means of justification, they restructure authority by privileging those who produce and manipulate numerical data over those who rely on experiential, narrative, or tacit forms of knowledge. This shift can be seen in the way bureaucratic and financial expertise has increasingly displaced professional judgment in fields such as medicine, law, and education.

For example, in clinical settings, decisions about resource allocation are increasingly made not by doctors exercising their professional expertise but by administrators working within numerical frameworks of cost-effectiveness and performance metrics (Porter, 1995). This transformation helps to strengthen a technocratic form of governance in which decisions are justified not by moral or philosophical reasoning but by reference to numerical thresholds and rankings.

Moreover, while quantification is often presented as a way to increase trust in institutions, it can also have the opposite effect. When people recognise that numerical assessments do not align with their lived experiences—whether in the form of manipulated unemployment figures, misleading school rankings, or inadequate patient care metrics—trust in the very institutions that deploy these numbers can erode (Porter, 1995). This paradox highlights the double-edged nature of numerical authority: while numbers can bolster legitimacy, they can also produce cynicism and disengagement when their limitations become apparent.

4.3 Reflexive Measurement and the Reconfiguration of Accountability

While critiques outlined above have extensively documented the limitations of transparency-based accountability and the distortions caused by an overreliance on numerical indicators, the challenge now is to outline pathways towards more reflexive and contextually grounded forms of measurement. Rather than abandoning calculative practices altogether, what is needed is an approach that reconfigures them in ways that enhance their responsiveness to complex social realities.

The challenge is to create accountability frameworks that are capable of sustaining pluralistic engagements with evidence rather than seeking to impose a singular, ostensibly objective regime of measurement. The proposals that have been made for accountability-based accounting, dialogical accountability, and intelligent accountability offer viable pathways for reconfiguring measurement in ways more responsive to organisational life's complexities.

These more inclusive approaches are based on the choice to move beyond the reductive assumptions of traditional ways of measuring to prefer practices that foreground deliberation, contestability, and pluralism in the construction of accountability. This shift requires acknowledging that numbers are not neutral reflections of organisational reality but socially constructed artefacts that encode certain assumptions and interests (Roberts, 1991). In these approaches, measurement is not eliminated

but understood as a process of constructive engagement, where numerical representations are actively contested, negotiated, and revised to align with the values and priorities of diverse stakeholders. Accountability can be understood beyond the lens of hierarchical control and compliance by distinguishing between individualising forms of accountability, which produce a sense of self as isolated and solitary, and socialising forms of accountability, which emphasise the interdependence of self and others (Roberts, 1991). This insight provides a foundational basis for developing more reflexive and dialogical approaches to measurement and accountability. Roberts' concept of socialising accountability is centred on the idea that accountability can be structured in ways that confirm and clarify the self through recognition of one's impact on others. This form of accountability is inherently relational, rooted in communicative action, mutual recognition, and interdependence rather than in surveillance and control. In contrast, hierarchical accountability, as enabled by conventional calculative practices, produces an individualised sense of self that is preoccupied with visibility, comparison, and compliance with externally imposed standards. The big challenge in this line of reasoning is to move beyond this dichotomy and to cultivate calculative practices that promote forms of accountability that are more reflective, relational, and socially embedded (Roberts, 1991).

A shift towards reflexive measurement necessitates a fundamental reconsideration of what counts as legitimate evidence in decision-making processes. Conventional calculative practices tend to rely on standardised indicators that create an illusion of comparability across contexts, yet this process often leads to the exclusion of localised, experiential, and non-quantifiable forms of knowledge (Roberts, 2009). Alternative measurement practices must, therefore, incorporate mechanisms that allow for greater interpretive flexibility, recognising that numerical representations are always partial and contingent. One suggestion that is possible to follow also in pur case is the development of accountability-based accounting, which prioritises the needs and perspectives of affected constituencies rather than beginning with pre-defined accounting conventions (Dillard & Vinnari, 2019). This approach recognises that accountability must emerge from the mediation between different views, even through discussion and confrontation, rather than from a static framework imposed from above.

The introduction of more dialogical forms of accountability offers a further means of recalibrating the role of measurement. Dialogical accountability approaches propose to look at calculative practices within broader deliberative structures, allowing diverse actors to engage in collective sense-making rather than merely responding to pre-existing indicators (Roberts, 2003). This perspective offers constructive criticism of the assumption that accountability is a matter of individualised compliance with external standards, conceiving it instead as a social practice in which measurement itself is subject to scrutiny and revision. In this view, calculative practices must be structured in ways that facilitate mutual responsiveness rather than functioning as instruments of hierarchical control.

One promising development in this regard is the concept of agonistic accountability, which builds on theories of democratic pluralism to suggest that accountability should be structured around the recognition of conflict and contestation rather than the pursuit of consensus (Vinnari & Dillard, 2016). In contrast to transparency regimes that promote the idea that we can achieve a singular, authoritative account of organisational performance, agonistic accountability frameworks acknowledge the multiplicity of perspectives that shape accountability relationships. This model positions calculative practices as tools for mediating between competing claims rather than as mechanisms for enforcing uniformity.

The implementation of such an approach would require institutional mechanisms that allow for the co-existence of multiple, overlapping forms of measurement. Rather than striving for a single, universally applicable metric, accountability-based accounting suggests the need for heterogeneous evaluative frameworks that are adaptable to different contexts and stakeholder concerns (Dillard & Vinnari, 2019). If we imagine implementing this in our context, it might be talking of the creation of alternative reporting mechanisms that allow Dance Well communities to articulate their own priorities and concerns rather than simply reacting to predefined indicators. These participatory accountability models can be one example of how calculative practices can be restructured to foster community engagement rather than technocratic oversight.

The integration of intelligent accountability within measurement systems further highlights the need for a more situated and relational approach to quantification (Roberts, 2009). This perspective offers a radical alternative to the belief that accountability can be fully achieved through transparency alone. Instead, adopting measurement practices is embedded within reciprocal relationships of trust and dialogue. Intelligent accountability imagines conditions in which the use of numbers can be done in ways that allow for substantive engagement rather than merely formal compliance, ensuring that the process of being held to account contributes to organisational learning and adaptation rather than defensive self-justification.

To concretise such a model, measurement systems must be designed in order to facilitate critical reflection rather than merely dictating what the result should be. This requires a move away from rigid, target-driven performance metrics towards forms of evaluation that accommodate interpretive complexity. One possibility is the imagination of narrative-based accounting, which seeks to complement quantitative measures with qualitative accounts that provide a richer contextual understanding (Dillard & Vinnari, 2019). By allowing organisations to develop and propose their own sense-making processes rather than simply having to behave in accordance with externally imposed standards, narrative-based accounting can help recalibrate the relationship between measurement and accountability.

5.

A Toolkit for Dialogical Art-Based Collaborations

5.1 Narrative Medicine and the Reconfiguration of Accountability

The reconceptualisation of accountability through socialising, dialogical, and intelligent approaches calls for expanding evidence-based practices beyond their traditional reliance on numerical abstraction and managerial control. The integration of narrative medicine into the broader discourse on accountability, we believe, has the potential to enrich how organisations— particularly those in healthcare — construct, assess, and respond to complex realities. Narrative medicine, emphasising subjectivity, relationality, and the interpretive dimensions of knowledge, provides conceptual and practical resources for developing alternative accountability frameworks that foreground the experiential, contingent, and meaning-laden dimensions of professional practice and institutional governance.

Research in narrative medicine demonstrates that meaningful engagement with illness, care, and institutional practice cannot be captured solely through numerical representation (Charon, 2001). Narrative-based methodologies advocate for moving away from measurement towards interpretation in the belief that understanding human experience requires attentiveness to stories, lived experiences, and subjectivities that conventional calculative practices systematically exclude (Kleinman, 1988).

This cognitive transformation is particularly relevant for accountability because it sheds new light on the limitations of transparency as a way of governing. In contrast to numerical accounts, which strive for clarity and universality, narrative accounts foreground ambiguity, context, and complexity. The process of telling, listening, and interpreting stories offers a more profound occasion to make sense of organisational realities than traditional performance metrics. It allows for dialogical accountability that is more in line with human experience and social interdependence (Frank, 1995).

One of the core contributions of narrative medicine is its emphasis on relationality and the ethics of recognition. Where conventional accountability frameworks tend to individualise responsibility and reinforce hierarchical relationships, narrative accountability offers a more socialising model in which actors are called to account through shared meaning-making rather than imposed visibility (Roberts, 1991).

In clinical contexts, for example, narrative medicine has demonstrated that illness cannot be fully understood through standardised biomedical classifications alone (Hunter, 1991). The practice of listening to patients' stories—what Charon (2001) describes as "attentive listening" and "close reading"—provides a model for accountability that is fundamentally dialogical and interactive rather than rigidly metric-driven. This suggests that accountability practices in healthcare could benefit from a more narratively informed approach, in which the experiences of professionals, patients, and stakeholders are made central to processes of evaluation and governance.

The integration of narrative into accountability systems necessitates a broader rethinking of what constitutes valid evidence in governance and decision-making. The model of narrative-based medicine has already advanced this argument within healthcare, where narrative evidence-based medicine has been proposed as an alternative to the rigid hierarchies of standardised, evidence-based practice (Charon & Wyer, 2008). This shift does not reject the value of clinical trials or statistical evidence but supplements it with qualitative, experience-based accounts that capture dimensions of care that numerical models overlook (Greenhalgh & Hurwitz, 1999).

Applying this perspective to healthcare accountability suggests that narrative-based reporting frameworks could counterbalance conventional, evidence-based models. When dealing with the arts, instead of relying on formal indicators, healthcare organisations could adopt narrative-based accountability reports, where clinicians and healthcare stakeholders provide reflective accounts of their work, ethical dilemmas, and relational engagements. Such

an approach would allow for greater complexity, ethical reflexivity, and inclusivity in accountability mechanisms, shifting the emphasis from compliance-driven ideas of evidence.

5.2 The Hybridisation of Healthcare Professions

Blending narrative-based approaches into accountability frameworks has a number of important implications for healthcare professionals, particularly in building their relationship with art-based approaches. A narrative-based approach to accountability offers a means of recalibrating professional governance by reorienting measurement practices towards meaning, ethical reflection, and collective sense-making, providing more situated, context-sensitive, and socially embedded ways of understanding performance and responsibility in healthcare systems. It must be recognised that introducing narrative accountability demands a shift towards an approach that acknowledges the lived experiences of professionals and patients, reconfiguring accountability as a dialogical and ethical process rather than a mechanism of surveillance and control.

For clinical managers, this requires rethinking how performance is evaluated, how organisational learning occurs, and how professional engagement with accountability processes can be improved. Instead of relying solely on retrospective performance data, narrative-based accountability encourages prospective and interpretive forms of assessment. This involves engaging professionals in structured storytelling, reflective practice, and dialogical evaluation, ensuring that accountability mechanisms support learning, adaptation, and ethical deliberation rather than simply enforcing compliance.

A narrative-based approach to accountability reintroducing subjectivity, interpretation, and professional judgment into managerial decision-making. Rather than reducing clinical practice to quantifiable targets, managers are asked to incorporate qualitative narratives from professionals and patients into evaluation processes, creating a more responsive and adaptive form of institutional governance. This shift does not reject quantitative data but complements it with textual, experience-based accounts that provide richer insights into the realities of care delivery.

The integration of narrative-based accountability into healthcare governance is not simply a shift in how professionals are held to account— it is a transformation of what it means to be a professional within contemporary healthcare systems. By embedding socialising, dialogical, and intelligent accountability within evaluative frameworks, we suggest giving professionals a new and higher tole, pushing beyond conventional distinctions between clinical expertise, managerial oversight, and financial accountability. The transformation we are advocating signals a broader process of hybridisation within healthcare professions, where traditional boundaries between roles must be accepted as increasingly fluid, and new forms of professional identity emerge.

Hybrid professionalism has long been recognised as a response to the institutional complexity of modern healthcare, where professionals must navigate the demands of clinical care, bureaucratic control, and economic efficiency (Noordegraaf, 2015). However, the introduction of narrative-based accountability extends this hybridisation beyond a mere structural necessity, reframing it as an active professional practice. We are proposing to contest and somehow rethink the rigid separation between medical knowledge and organisational governance. Narrative

accountability encourages professionals to operate at the intersection of multiple logics, engaging in interpretation, ethical reasoning, and institutional mediation (McGivern et al., 2015).

There are, of course, significant implications for professional identity and institutional culture. For instance, clinicians, rather than passive subjects of managerial oversight in narrative-based accountability, become interpretive agents responsible for making sense of complex patient cases, ethical dilemmas, and organisational constraints. The combination of narrative reflection, participatory evaluation, and case-based deliberation push towards the constitution of a hybrid professional mindset, where expertise is not confined to clinical knowledge but extends to organisational negotiation, ethical engagement, and institutional learning.

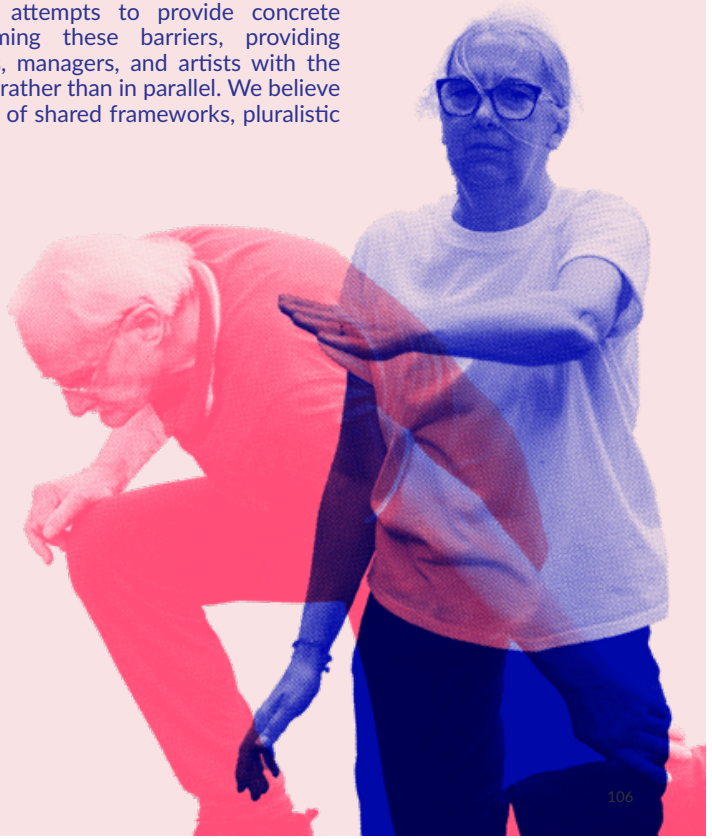
For healthcare institutions, especially when they want to genuinely encounter the arts, this calls for new governance mechanisms that supplement traditional performance indicators. Instead of relying solely on numerical targets and compliance measures, we are suggesting here that accountability frameworks should integrate narrative-based peer evaluations, structured reflective practices, and participatory governance models that allow professionals to articulate, justify, and negotiate their decisions within a shared institutional space. It must be clarified that this transition does not diminish the role of measurement but rather reorients it, ensuring that quantitative assessments are complemented by interpretive, context-sensitive forms of accountability.

Rather than resisting hybridisation as an erosion of professional autonomy, narrative-based accountability embraces it as an evolution of professionalism itself. In an era where healthcare is increasingly governed by competing logics of care, efficiency, and evidence-based practice, hybrid professionals must be equipped not only with clinical and managerial skills but also with the capacity to navigate complexity through dialogue, reflection, and ethical reasoning. Narrative accountability provides the framework for this new professional orientation, embedding hybridisation not as an institutional constraint but as a defining characteristic of contemporary healthcare professionalism.

5.3 Practical Approaches to Embedding Dance in Healthcare

One of the key messages of this publication is that the challenge of integrating dance and the arts into healthcare systems is not simply a matter of demonstrating impact. We must devote greater attention to redesigning institutional structures, accountability frameworks, and professional identities to facilitate meaningful collaboration. The tensions between artistic freedom, medical evidence, and bureaucratic governance will not be resolved through minor adjustments but require a fundamental rethinking of how healthcare values, supports, and assesses non-clinical interventions.

We conclude this chapter with a proposal for a Toolkit for Collaboration that attempts to provide concrete strategies for overcoming these barriers, providing healthcare professionals, managers, and artists with the means to work together rather than in parallel. We believe that with the promotion of shared frameworks, pluralistic



evidence models, institutional support structures, and adaptive accountability mechanisms, it is possible to create healthcare systems that fully embrace the arts not as an adjunct but as an integral component of care.

The primary challenge at the heart of this chapter has been the organisational and bureaucratic barriers that hinder the full acceptance and integration of artistic practices—particularly dance—within healthcare provision. While a substantial body of research has demonstrated the positive impacts of the arts on health, these discussions often overlook the structural, institutional, and professional tensions that arise when attempting to embed artistic approaches within medical systems. The question of evidence has emerged as a central point of discussion reflecting deeper epistemological and governance-related conflicts. If the integration of dance and the arts into healthcare is to move beyond pilot projects and isolated interventions, a more structured approach is needed. We need to foster dialogue, mutual understanding and shared accountability between artistic and medical communities.

This concluding section proposes a Toolkit for Collaboration, designed as a practical guide for both medical professionals and artists seeking to work together in healthcare settings. We propose a translation of the insights developed throughout this publication into tangible mechanisms for engagement. In so doing, this toolkit aims to bridge the divide between biomedical paradigms and arts-based approaches, fostering institutional legitimacy, professional collaboration, and sustainable integration.

Establishing a Shared Framework for Collaboration

Our research has identified as one of the primary obstacles to the integration of artistic practices into healthcare the lack of a shared language and framework between artists and medical professionals. Dancers, choreographers, and other artists often operate within an aesthetic and process-driven paradigm, valuing creativity, improvisation, and embodied experience, whereas healthcare operates within a standardised, outcome-driven framework, where interventions are expected to be evidence-based, replicable, and measurable.

If we're serious about facilitating effective collaboration, both professional communities need to develop an interest in the construction of a conceptual bridge that enables them to articulate their respective objectives while fostering a space for negotiation and mutual recognition. This framework should include:

- **Common definitions and language:** Establishing agreed-upon terminology to prevent misunderstandings. For instance, clarifying the distinction between therapeutic interventions and artistic practices with therapeutic effects can help avoid tensions around professional roles.
- **Defined roles and responsibilities:** Outlining the respective contributions of dancers, medical practitioners, and healthcare administrators to ensure that artistic integrity is preserved while respecting medical protocols.
- **Ethical and professional guidelines:** Elaborating a common ethical ground based on the acknowledgement of the autonomy and professionalism of both medical and artistic practitioners. These considerations should guarantee that artists are not expected to conform to clinical models they do not align with.

Developing a Reflexive and Pluralistic Approach to Evidence

The question of evidence has been a major point of tension in the discussion of arts in healthcare. Traditional biomedical frameworks demand quantifiable, standardised outcomes, while arts-based interventions often emphasise process-oriented, experiential, and relational impacts. This epistemological fracture has surfaced as problematic in our research because it creates barriers to legitimacy, preventing artistic practices from being fully embraced within institutional healthcare settings.

We suggest that a reflexive and pluralistic approach to evidence must be adopted—one that recognises the validity of both quantitative and qualitative forms of assessment. This approach should:

- **Expand the range of acceptable evidence:** While clinical trials and standardised assessments remain valuable, healthcare institutions should also incorporate narrative, case-based, and participatory research methods that capture the embodied and social dimensions of artistic engagement.

- **Encourage co-designed evaluative practices:** Artists and medical professionals should collaboratively develop evaluation criteria that balance the priorities of both fields. For instance, rather than measuring only physical improvements, assessments could also include psychosocial, relational, and creative impacts.
- **Promote longitudinal and process-based research:** Recognising that the effects of dance and artistic engagement may unfold over time and through relational dynamics, rather than yielding immediate, quantifiable results.

Institutional Mechanisms for Sustainable Integration

One aspect that is evident from our research is that if arts-based practices truly wish to be fully institutionalised into healthcare systems, they must move beyond experimental initiatives and become more embedded within frameworks of healthcare delivery. This requires:

- **Incorporating dance and the arts into social prescribing models:** Many healthcare systems already adopt these types of prescriptions to supplement non-medical interventions in patient care. Dance and movement-based practices should be formally recognised within these frameworks, ensuring they are not merely temporary or supplementary but structurally supported within healthcare provision.
- **Establishing formal partnerships between cultural and healthcare institutions:** Creating jointly governed initiatives where medical and artistic professionals work collaboratively, ensuring sustainable funding, professional recognition, and long-term institutional investment.
- **Ensuring professional development and training:** Equipping healthcare providers and artists with the skills needed to navigate hybrid professional environments appears necessary. This could include workshops on narrative-based accountability, embodied knowledge, and relational care.

Accountability and Governance for Artistic Practices in Healthcare

Accountability is a critical issue in integrating the arts into healthcare. Conventional accountability models tend to be individualising and compliance-driven, whereas arts-based engagement thrives on collective participation and relational meaning-making. A socialising model of accountability—informed by narrative medicine, intelligent accountability, and hybrid professionalism—offers a way forward.

To operationalise this should be promoted:

- **Narrative-based reporting mechanisms:** Instead of relying only on quantitative indicators, healthcare institutions wishing to include the arts should incorporate qualitative storytelling methods where practitioners, artists, and patients articulate their experiences, challenges, and transformations.
- **Dialogical evaluation forums:** Establish spaces where artists and medical professionals can reflect on their work, share insights, and collectively assess the value of artistic interventions.
- **Hybrid accountability frameworks:** Recognising that artistic professionals in healthcare settings operate at the intersection of clinical, managerial, and artistic logics, requiring accountability models that acknowledge their hybrid professional identities.

The proposed toolkit for collaboration is a direct response to the varied realities we encountered through our research in Dance Well, where the integration of dance into healthcare settings exists in different stages of acceptance and institutionalisation. Rather than a set of prescriptions, this toolkit is to be read as a set of resources that facilitates mutual understanding, institutional adaptation, and professional dialogue between dancers, healthcare professionals, and policymakers. It recognises that the relationship between the arts and healthcare is not uniform; in some contexts, dance is already embedded within social prescribing and community health frameworks, while in others, it remains an experimental or peripheral practice, struggling for legitimacy.

Providing practical mechanisms for engagement, the toolkit proposed a framework for navigating the complexity of interdisciplinary collaborations, ensuring the balance between artistic integrity and the demands of governance and accountability regulation of healthcare institutions. Crucially, it acknowledges that collaboration requires more than evidence of impact—it necessitates a transformation in institutional culture, professional roles, and evaluative practices.

The Dance Well project exemplifies this transformation—not by adapting to conventional healthcare models but by redefining what care itself can be. Dance's nature as an embodied and participatory practice invites critical reflection on the reductive logics of prescription and intervention, demonstrating that artistic engagement can foster wellbeing without being instrumentalised or necessarily subordinated to clinical priorities.

The toolkit for collaboration reflects this vision, offering structured yet adaptable pathways for establishing long-term, sustainable partnerships between the arts and healthcare. Our research affirms that the success of such collaborations depends not only on proving the effectiveness of dance in health settings but on cultivating institutional environments that value and sustain artistic engagement as an essential dimension of care.

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