INTRODUCTION

Citizenship Theory and Health Practices: Creative Work in Care and Rehabilitation

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Arts and crafts have a long, rich, and sometimes controversial relationship to the health professions and health care. A central component of "moral treatment" in nineteenth-century mental health hospitals,[1] arts and crafts appeared alongside or as a part of larger-scale "work cure" programs dotting the institutional landscape since the early part of that century.[2] The nineteenth century revivalist movement for pre-industrial arts and crafts made an indelible mark on such programs, emphasizing the value and joy of artisanal mastery as important to recovery and rehabilitation in a variety of settings.[3] For instance, arts and crafts played a central role in managing populations of

[1] Jennifer Laws, "Crackpots and Basketcases: A History of Therapeutic Work and Human Occupation," *History of the Human Sciences* 24, 2 (2011): 65–81.

[2] Gerald Grob's classic study of the Worcester State Asylum contains many details of mid-nineteenth-century therapeutic arts and crafts programs, as well as a therapeutic farm and garden program, used to emphasize the melioristic and humanitarian intentions behind the asylum's creation. Gerald Grob, *The State and the Mentally Ill: A History of Worcester State Hospital in Massachusetts, 1830–1920* (Chapel Hill: University of North Carolina Press, 1966). A generation of subsequent institutional asylum histories has interrogated such care since then, and most point to the decline of such programs in the late nineteenth century, as they became increasingly difficult to execute due to patient overcrowding.

[3] The utopian claims of arts and crafts revivalism include protecting and salvaging both the bodies and the dignity of workers from the "violences of the factory" and its dehumanizing assembly line. See Jackson Lears, *No Place of Grace: Antimodernism and the Transformation of American Culture* (University of Chicago Press, 1981), esp. chapter 1. This influenced early occupational therapy proponents. See Laws, "Crackpots and Basketcases." Herbert J. Hall, an early president of the American Occupational Therapy Association (AOTA), originally designated his handicraft programs as part of a "work cure." For Hall, and his various sponsors, the benefit derived from the acquisition of high-grade handicraft skills in weaving and ceramics in studios guided by expert artisans. The skill acquisition was central to the therapeutic benefit. See, for instance, Herbert J. Hall, *The Work Cure* (Marblehead, MA: privately printed, 1905). This was also a part of early Canadian programs for rehabilitation, though they tended to be more influenced by Swedish and Scottish "manual training" (albeit these two foregrounded heritage handicrafts in their programs). See Thomas B. Kidner, *Educational Handwork* (Toronto: The Education Book Company, 1910).

chronic care patients, such as those recovering from tuberculosis, those disabled by industrial accidents, or veterans injured by war. Indeed, early occupational therapy wholeheartedly embraced the therapeutic arts and crafts.[4] But wherein lies the essential value of creative work for rehabilitation and patient care? Who or what entities have developed, sponsored, and funded such programs? For what purposes and whose benefit? What potential might artistic and creative work projects offer for health care today?[5]

In this Special Issue we offer a critical examination of diverse health programs and initiatives in British Columbia that use arts and crafts to heal and rehabilitate, or focus on work and collective action to enhance health care. Arts and crafts programs may be seen as a bellwether, for the goals and orientation of a provincial health care system reflect the wider goals and expectations the state has for citizens. Investigating from where, and on what terms, creative arts and crafts programs derive their support – health care institutions, government sources, or private foundations and donors – reveals the degree to which each partner aligns with the goals of productive and/or social citizenship. This examination helps scholars understand how such citizenship theories are interpreted in real life experiences. Is there "value" engaging people with dementia in artful expression if they will never live outside of a care facility? Does the creation of art-full objects for children on reserves help Indigenous prisoners connect with communities, and, if so, how does this inform or advance their "rehabilitation"? The authors who contributed to this volume engage with these problems and prospects of citizenship as they examine programs to rehabilitate, support, and reform British Columbians from the mid- to late twentieth century into the twenty-first. They draw from case studies, through collaborations with Corrections Canada, as facilitators of Arts Studio programs for mental health clients, as clinicians drawn into the care of dementia patients in long-term care facilities, and as historians of mental health programming that increasingly drew on the talents and labour of peer support.

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4 For several other Canadian examples, see Judith Friedland, "Why Crafts? Influences on the Development of Occupational Therapy in Canada from 1890–1930," *Canadian Journal of Occupational Therapy* 70, 4 (2003): 204–12.

5 These questions were first raised at an interdisciplinary workshop on the linkages between arts, crafts, healing, and history initiated and organized by the guest editors in March 2017. At this initial workshop an interdisciplinary working group of health scholars, historians, writers, and community artist came together and met again in March 2018 to present and discuss the papers and practice exemplars out of which this special issue was formed. The UBC Peter Wall Institute for Advanced Studies provided a development workshop award for the initial workshop, and we acknowledge the financial support of the UBC Consortium for Nursing History Inquiry for the subsequent phase of the project.

Citizenship theory offers insights into such questions regarding the ultimate purpose and benefit of arts and crafts in healing, care, and rehabilitation contexts: elder care, mental health programs and facilities, as well as prisons. Health care services promote productive citizenship ideals when the therapeutic goal, and perhaps the very definition of "health," is linked to a return to work. Work programs offer tangible benefits to hospitals and health facilities in the short term. Having patients work while at such an institution offsets the costs of treating protracted or prolonged illnesses; and such programming can "distract" patients so that they require fewer staff to manage. It also benefits the state in the long term by adding to the skills and abilities of patients so they have more and better means to avoid mendicancy upon discharge or release. At the very least they inculcate and emphasize the values of productive labour during an extended stay in care. But in this special issue, we assert a different kind of value for art, craft, and healing work: in a context of social citizenship, an action or activity is valued not in terms of the wage it commands but in terms of its interpersonal value, its ability to create and maintain connections and community, and to offer respite and rehabilitation in the process. The ability to undertake, enjoy, share, and benefit from creative arts and crafts can thus be seen as a keystone element of social citizenship.

Citizenship can be defined many ways.[6] Often, it is defined in its most basic form: as a theoretical concept and political practice, a status that comes with a set of rights and duties. This basic definition of citizenship fails to acknowledge the ways in which citizenship functions as a civil, political, or social idea. The idea of citizenship does not merely gain power when speaking of access to and participation in a national labour market.[7] Historically, an emphasis on productive citizenship in rehabilitation medicine and social work influenced the ideals and goals

[6] Health historians such as Dorothy Porter use the term "health citizenship," akin to the term "biological citizenship" used in medical anthropology, to categorize and understand collective demands for access to resources and care made on a "biological" basis. Citizens' "vital rights" might be evoked in the aftermath of injury, or because of a shared genetic status or disease state, and citizenship may be deployed to understand and interrogate the history and sociology of public health. While such terms emerged from, and are particularly useful, when considering forms of health advocacy, we explore broader socio-political notions of citizenship that relate more directly to the productive status of the individual. See Dorothy Porter, *Health Citizenship: Essays in Social Medicine and Biomedical Politics* (Berkeley: University of California Press, 2011); Nicholas Rose and Carlos Novas, "Biological Citizenship," in *Global Assemblages: Technology, Politics and Ethics as Anthropological Problems*, ed. Aihwa Ong and Stephen Collier, 439–63 (Malden, MA: Blackwell Publications, 2005).

[7] See, for instance, T.H. Marshall, "Citizenship and Social Class," in *Class, Citizenship and Development* (Garden City, NY: Doubleday, 1964), 65–122.

of vocational education.[8] Judith Friedland and Beth Linker show how the Canadian and American armed forces, albeit at different times and using different methods, seized control of occupational therapy programs for First World War veterans to both shorten the time spent in costly programs and to ensure that activities like metalworking and carpentry were not eclipsed by frivolous artisanal handicrafts. They sometimes went against the wishes of clinicians on either side of the border who understood all arts and crafts to restore not only physical capacity but also emotional and spiritual recovery after conflict.[9] The boundary between vocationalism and therapy often became blurred.

Productive citizenship was rivalled in the twentieth century by a more expansive and inclusive idea of social citizenship, arising in a postwar environment that places emphasis on the intrinsic rights of the citizen. With the rise of the postwar welfare state, ideals of social citizenship challenged many of the precepts of productive citizenship. After 1945, nation-states embraced ideals of universal human rights and began to emphasize state obligations to their populations, including the entitlements of new or expanded welfare state provisions and programs. This transition influenced the orientation of health services, and certainly the creation of universal health insurance programs like medicare, the keystone of the Canadian welfare state. While this is now seen in Canada as a "right" of citizenship within settler Canada, we acknowledge, and explore in this volume, the complicated and shifting health care systems that served First Nations people and Inuit.[10]

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[8] S.A. Gutman points out that vocational technical trainers challenged occupational therapists' involvement in veteran rehabilitation during the First World War, but the productive ethos persisted, even though it was mediated by a desire to effect general reintegration into community, not just work. See S.A. Gutman, "Occupational Therapy's Link to Vocational Re-education," *American Journal of Occupational Therapy* 51, 10 (1997): 907–15. According to Lohman and Peyton, however, re-vocational training remained a part of OT work well into the mid-century. See Helene Lohman and Claudia Peyton, "The Influence of Conceptual Models on Work in Occupational Therapy History," *Work* 9, 3 (1997): 209–19. The tension between occupational and vocational training is captured by Virginia Metaxas Quiroga, "Eleanor Clarke Slagle and Susan E. Tracy: Personal and Professional Identity and the Development of Occupational Therapy in Progressive Era America," *Nursing History Review* 8 (2000): 39–70.

[9] Beth Linker, *War's Waste: Rehabilitation in World War One America* (University of Chicago Press, 2011); Judith Friedland, *Restoring the Spirit: The Beginnings of Occupational Therapy in Canada, 1890–1930* (Montreal and Kingston: McGill-Queen's University Press, 2011).

[10] The Canadian history stands in contrast to the United States, where, before the Affordable Care Act (2010), the right to health care was historically linked to employment and rationed otherwise to vulnerable populations. See Beatrix Hoffman, *Health Care for Some: Rights and Rationing in the United States since 1930* (Princeton University Press, 2012). For a historical synopsis of later twentieth-century health care policies that guided First Nations and Inuit, see *Looking for Aboriginal Health in Legislation and Policies, 1970–2008: The Policy Synthesis Project* (Prince George, BC: National Collaborating Centre for Aboriginal Health, 2010).

In countries like Canada, the emergence of the modern social citizenship idea has served as a tool of both economic *and* social integration. While productivity is a component of social citizenship, it is only one component of a broader set of goals that seeks to remove contingencies from integration and inclusion, and grant full and unencumbered access to all benefits of the nation-state, including the benefits of culture and community. In the words of Peter Dwyer, social citizenship "means that a level of decommodified support becomes available to all citizens, that is, there is a range of benefits and services that people can access because of their status as citizens."[11] Ideals of social citizenship drove the mid-century expansion of wide-ranging welfare state service programming, and many programs, though not all, were used by citizens independently of their value as workers. Arts and crafts are welcome in care facilities and rehabilitation programs where the new goal is to restore participants not only or necessarily to a functional capacity in a workplace but also to a state where they may participate fully as part of a community. The goals reorient to support social connection and cultural integration. Enriching the lives of participants through creative expression, arts and crafts facilitate the return to full membership of society.

But the focus on productive labour as the ultimate definition of "health" is persistent. The expanding purview of industrial medicine at the turn of the last century, and the programs for workers' compensation to which it gave rise, initiated a process that created new and expanding categories of bodies as objects for rehabilitative biomedicine, including war veterans (as mentioned above). We are only beginning to capture the patient experience within this new twentieth-century rehabilitation infrastructure and economy.[12] Following the evolution of rehabilitation programs into these decades, we see productive citizenship, a persistent and malleable concept, express itself. And problems of equity arise and persist when productive citizenship is emphasized because the value of a citizen's labour is mediated and informed by a citizen's social class and identity. Mary Jane McCallum, for instance, explains how traditional arts and crafts making was a part of long-term care for Indigenous patients throughout western Canadian TB sanatoria well into the mid-twentieth century. Programs of so-called "Indian rehabilitation" encouraged, or even required, the creation of traditional craft items with remunerative

[11] Peter Dwyer, *Understanding Social Citizenship: Themes and Perspectives for Policy and Practice*, 2nd ed. (Bristol: Policy Press, 2010), 93.

[12] Disability historians are among the first to point out this gap in the literature on rehabilitation. See, for instance, Sarah F. Rose, *No Right to Be Idle: The Invention of Disability, 1840s–1930s* (Chapel Hill: University of North Carolina Press, 2016), esp. chap. 5, 137–71.

value, which were often sold at hospital gift shops or, through art dealers' networks, at galleries across Canada.[13] The benefits and privileges of productive citizenship are informed and mediated by (in this case) not only class, race, and gender but also age and ability. And we see how the mandate of productive citizenship persists in state-sponsored health care.

State involvement in rehabilitation programs underscores the importance of local contexts as central to understanding the way work, health, and ideas about citizenship evolve over time and work for and against various groups.[14] But by the late 1970s, public health policy in Canada began to shift to an emphasis on prevention and back to individual responsibility for health. Indeed, the 1970s and early 1980s saw a move across the Anglo-American political spectrum towards a neoliberal politics and away from redistribution of wealth and opportunity, and also away from welfare state expansion, including health care.[15] The new era of retrenchment and restructuring accelerated the decentralization of management of the wide array of social policies associated with the postwar welfare state and, some argue, even a retrenchment of rights to gain access to these programs.[16] Interrogating the "state" increasingly means focusing on provincial jurisdictions to see how they manage what John Malcolmson has called the "hidden agenda of restraint" of the period.[17] Provinces like BC were and are increasingly left to determine the spending of scarce resources, defining priorities at the provincial, and sometimes regional, level. While health care has, with certain exceptions, largely fallen under provincial jurisdiction, shrinking cost-sharing from

[13] Mary Jane McCallum's forthcoming work makes a major contribution to this topic. See Mary Jane McCallum, "A Stepping Stone into Modern Society: Training and Work as Rehabilitation at Indian Hospitals in Manitoba, 1940s–1960s," paper presented at the Berkshire Conference on the History of Women, 23 May 2014; Mary Jane McCallum, "'Indian Rehabilitation' and Rehabilitation Specialists at Manitoba Tuberculosis Sanitariums, 1950–1970," paper presented at the Berkshire Conference on the History of Women, Genders, Sexualities, 2 June 2017. See also "Indigenous Histories of Tuberculosis in Manitoba, 1930–1970," (University of Manitoba, 2017). Available at: https://indigenoustbhistories.wordpress.com/.

[14] However, provincial context was important throughout the postwar period. As BC historian Penny Bryden observed, the liberal governments of L.B. Pearson and P.E. Trudeau worked in a context within which provinces allowed "centralized direction over major objectives but [required] decentralized discretion on implementation" of many elements of post war social policy (122). This allowed for a shift from a jurisdictional division of power to a functional division of power. See Penny E. Bryden, *Planners and Politicians: Liberal Politics and Social Policy, 1957–1968* (Montreal and Kingston: McGill-Queen's University Press, 1997).

[15] Paul Pierson, *Dismantling the Welfare State? Reagan, Thatcher and the Politics of Retrenchment* (Cambridge University Press, 1994).

[16] See, for instance, R. Brian Howe, "Human Rights in Hard Times: The Post-War Canadian Experience," *Canadian Public Administration* 35, 4 (1992): 464–84.

[17] John Malcolmson, "The Hidden Agenda of 'Restraint,'" in *The New Reality: The Politics of Restraint in British Columbia*, ed. Warren Magnusson, William K. Carroll, Charles Doyle, Monika Langer, and R.B.J. Walker, 75–87 (Vancouver: New Star, 1984).

the federal government has created distinctive service differences and disparities across the country, this despite the fact that national medicare is mandated to provide comparable services.

BC politics in these decades was turbulent, shifting power back and forth between the Social Credit Party and the New Democratic Party. British Columbia eventually embraced universal health care in 1972 during the final days of W.A.C. Bennett, the Social Credit leader who was the longest-serving premier in the history of the province.[18] In the final year of his leadership, Bennett compromised the free-enterprise principles of his party, and successfully managed the objections of the provincial medical society, to bring in a public universal health care program.[19] Succeeded by Dave Barrett, the first premier to lead an NDP government in the province, health care services initially benefitted from an expansion of the province's public sector. This short-lived administration, however, was replaced in 1975 with another Social Credit government under Bennett's son Bill, who led the party and governed as premier until the mid-1980s. Over three terms, his government invested significant tax dollars in infrastructure and presided over the wildly successful Expo '86, but the era was also marked by significant cuts to social services and education, and the 1983 Solidarity Coalition brought the province close to a general strike.[20]

As with the other provinces across Canada, British Columbia managed postwar financial growth and then recession by reshaping social policy agendas to suit the provincial agenda. Funding for arts and craft programs that advanced social citizenship ideals ebbed and flowed in the western province, supported by the federal Local Initiative Program in the 1980s, by the provincial government in various health sectors, and by innovations in municipal parks programming. Late twentieth- and early twenty-first-century decentralization increased provinces' institutional autonomy, eventually resulting in the regionalization and "provincialization" of health care. We need more provincial-level case studies to understand

18 David J. Mitchell, *W.A.C. Bennett and the Rise of British Columbia* (Toronto: HarperCollins 1983).

19 Gregory P. Marchildon and Nicole O'Byrne, "From Bennettcare to Medicare: The Morphing of Medical Care Insurance in British Columbia," *Canadian Bulletin of Medical History* 26, 2 (2009): 453–75.

20 For popular and insider assessments of Bill Bennett's administration, see Allen Garr, *Tough Guy: Bill Bennett and the Taking of British Colum*bia (Toronto: Key Porter Books, 1985); Bob Plecas, *Bill Bennett: A Mandarin's View* (Vancouver: Douglas and McIntyre, 2006). The labour backlash is critically examined, though from different perspectives, in Rod Mickleburgh, *On the Line: A History of the British Columbia Labour Movement* (Madeira Park, BC: Harbour Publishing, 2018); and Bryan Palmer, *Solidarity: The Rise and Fall of an Opposition in British Columbia* (Vancouver: New Star, 1987).

and evaluate how these government realignments shaped the evolution of social citizenship across the country. Geertje Boschma's work on mental health deinstitutionalization in late twentieth-century Alberta and British Columbia demonstrates how community-based mental health services sprang up in "a new but equally complex and fragmented system … [emphasizing the] role of (ex)-patients in shaping these services and their involvement in creating community resources."[21] Sometimes local institutional variations in care led to idiosyncratic advances. Megan Davies's history of Moyra Jones, a talented BC occupational therapist who pioneered geriatric music therapy in the 1970s, describes innovative humanist health care programming during years in which funding was abundant in the province. Despite the proven benefits, such programs see limited uptake in the latter half of the twentieth century, when health cost-cutting and service retraction stifle their dissemination.[22] As papers in this special issue illustrate, later twentieth-century health care restructuring often also meant that services that promoted the recovery and inclusion of otherwise marginalized citizens – people afflicted by mental illness, elderly persons, and those incarcerated in prisons – were often left vulnerable to cuts, service contractions, and sometimes even closures regardless of their benefit to the person and, by extension, to the community and the state.

Few have analyzed the welfare state as a means to effect and ensure social citizenship, enabling patients and consumers to participate fully in social and cultural institutions.[23] Our special issue begins to fill this void by examining the role of health care programs in arts and crafts rehabilitation and healing in British Columbia. We focus here on patients and prisoners, people whose status often undermines their agency and ability to exercise citizenship rights. Creative cultural expression is important to social citizenship for, as Derek Heater reminds us, citizenship requires an equality of both opportunity and personal dignity.[24] By probing their institutional experiences with clinicians and health workers, we assess

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[21] Geertje Boschma, "Deinstitutionalization Reconsidered: Geographic and Demographic Changes in Mental Health Care in British Columbia and Alberta, 1950–1980," *Social History/Histoire Sociale* 44, 88 (2011): 230.

[22] Megan J. Davies, "A Humanist in the House of Old: Moyra Jones and Early Dementia Care in Canada," *Journal of Canadian Studies* 50, 2 (2016): 446–81.

[23] One exception is Daniel Beland and Andrew Lecours's analysis of substate nationalism (more often referred to as provincial or regional identity) and ideas of social citizenship and belonging. See Daniel Beland and Andrew Lecours, "Nationalism and Welfare State Politics in Belgium, Canada, and the United Kingdom," in *Welfare Citizenship and Welfare State Nationalism*, ed. Andrej Martin Suszycki, 121–54 (Helsinki: Nordic Centre of Excellence, 2011).

[24] Derek Heater, *Citizenship: The Civic Ideal in World History, Politics and Education*, 3rd ed. (University of Manchester Press, 2004), 341.

their citizenship status, for "it follows that the way in which practitioners and welfare systems treat service users can have a direct influence on whether or not they can achieve full citizenship with all its attendant rights and responsibilities."[25]

Institutional case studies are ideal for the purpose of examining sites of citizenship formation within structured and routinized spaces where there is widespread communication of citizenship ideals.[26] But even programs that are sometimes seen as extraneous to the central or "core" mandate of an institution – like self-discovery, self-empowerment, or self-help through arts and crafts – also function as powerful "technologies of citizenship" and are worthy of careful consideration.[27] When examining the specificity of time and place in the development and use of arts and crafts programs, conflicting goals become evident. Indeed, they reveal the ways that the conflicting ideologies of productive and social citizenship are sometimes at odds within the institutions that provide rehabilitation medicine, social services, and even chronic and elder care.

The powerfully therapeutic connections forged by sharing crafted items occupies **Helen Brown** and **Kelsey Timler's** examination of the program Work 2 Give, a partnership program between the federal Corrections Canada and the Tŝilhqot'in Nation. Brown and Timler describe the experiences and outcomes for incarcerated Aboriginal men in federal prisons in British Columbia who participate in a prison employment and hobby program, wherein they build and create crafted objects – furniture, drums, toys, textiles, and decorated items – that are subsequently donated to Aboriginal communities. Collective creativity in the production of items they collectively describe as "art-full" expresses the ways in which therapeutic arts and crafts precipitate positive psychosocial outcomes, especially important for those whose lack of personal rights and freedoms is affected by colonial forces that shape constructions of citizenship and productivity. Indeed, they conclude that collective creativity enables "new forms of Aboriginal collective social citizenship, forged within a neocolonial era."

Natasha Damiano and **Catherine Backman** examine the history of Art Studios, an arts-based, community rehabilitation program founded in 1992 for people living with mental illness. Art Studios participants

[25] Mel Gray and Stephen A. Webb, *Ethics and Value Perspectives in Social Work* (London: Palgrave Macmillan, 2010).

[26] This has been studied at length in educational contexts. See Amy Wan, *Producing Good Citizens: Literacy Training in Anxious Times* (University of Pittsburgh Press, 2014), 2.

[27] Barbara Cruikshank, *The Will to Empower, Democratic Citizens, and Other Subjects* (Ithaca, NY: Cornell University Press, 1999).

attributed healing and recovery to their involvement in artmaking in this safe and supportive studio environment. An analysis of ethnographic data collected during a year-long program evaluation clearly illustrates how participants used artmaking programs to personally define self-worth. Through Art Studios, they connected with and fostered a sense of community, and achieved psychosocial recovery through artmaking. Arts Studios participants and their friends created the grassroots Vancouver Recovery through Arts Society, an organization that advocates and fundraises for this and related publicly funded programming. In this way, members succeed in "giving back" to their communities as social contributors and "taking back" their autonomy as productive citizens.

Geertje Boschma and **Courtney Devane** explore the evolving role of peer supporters within the mental health system and social policy in British Columbia at a time when the provincial system embraced deinstitutionalization and responded to anti-psychiatry activism. The implementation of and then rollbacks to the medicare system put peer mentors and supporters at the centre of rehabilitation efforts. Offering new community connections, these peers fostered new work identities. Boschma and Devane explore "the community connection and collaboration" that supported patient-led initiatives and the formation of new roles in peer support. These initiatives strengthened reintegration into social and working life programs from the 1970s to the first decade of the twenty-first century. This history is offered against the backdrop of an evolving consumer/survivor movement. Such programs often included artistic engagement and uptake of arts and crafts in new patient-led initiatives. They also took on peer-counselling roles and public education on mental health challenges. Such efforts became incorporated into provincial policy from the 1980s onwards. This, they argue, "provided a social context to express new forms of citizenship."

Kelsey Timler and **Helen Brown** continue their examination of Aboriginal collective social citizenship in a second context, examining the therapeutic and rehabilitative benefits of a federal prison garden program. Their qualitative research study examines the benefits of allowing incarcerated men to grow and then donate food to rural and remote First Nations communities in the Central Interior of the province. They conceptualize a prison garden "as a *boundary object* – as a place that exists between the worlds of settler and Indigenous foodscapes in British Columbia." With this notion at the centre of their analysis, it becomes possible, they write, "to trace the impacts of colonialism on concepts of Indigenous citizenship and food sovereignty."

Gloria Puurveen and **Alison Phinney** follow in the same vein by unpacking the "tragedy" discourse so long associated with dementia, with the prospect of functional and cognitive loss firmly placing those with this condition within biomedical and/or psychological models of illness and disability. This pathologizing, they observe, often results in people living with dementia losing their rights and entitlements as citizens, being relegated to institutional care where opportunities for choice and inclusion are few. They describe "Making Art for Making Place," a project designed to challenge these very conditions. Students from Emily Carr University of Art and Design created paintings for an elder care facility in Surrey, and nurses walked with residents to look at and discuss the art. The analysis of this project shows how making art created a space for considering dementia in a different way – a way that refocuses the lens, putting it on people's capacity and ability to contribute and engage as social citizens.

Also included in this special issue are a unique series of artistic practice exemplars, edited and introduced by **Megan J. Davies**. Four digital media productions from BC community artists, writers, and health scholars are linked at the end of this issue. Set alongside connected papers by **Claire Robson** and by **Shelley Canning** and **Darren Blakeborough**, the exemplars they provide, as well as those developed by **Pauline Jardine** and **Rebecca Graham**, demonstrate how art and healing, as envisioned in the social citizenship project, emerges as the result of a shared and often transformative process of humanistic public art-craft.

As Beland and Lecours argue, "Social policy is frequently at the heart of the idea of community and is, therefore, connected with sets of collective values."[28] The retrenchment of health and social service offerings in decades past signalled a weakening of the notion of collective values and a shared commitment to mutual support as well as to the very notion of a redistributive state. And yet, sampling across a wide variety of health and rehabilitation programs from the last forty years of BC history, we see the expression of a provincial solidarity that transcends mere economic rationalism and productive self-interest in favour of a civic identity based on what UBC political scientist Richard Johnson and others call an "ethical community" of compassion and connection.[29] Our work suggests that the province of British Columbia has, despite setbacks common to other Canadian jurisdictions and countries around

[28] Beland and Lecours, "Nationalism and Welfare State Politics," 122.

[29] Richard Johnson, Keith Banting, Will Kymlicka, and Stuart Soroka, "National Identity and Support for the Welfare State," *Canadian Journal of Political Science* 43, 2 (2010): 4.

the world, successfully established templates from which we can rethink citizenship through the prism of health scholarship. Inspired by the restorative value of the therapeutic arts and crafts, the programs under investigation in this issue of *BC Studies* provide evidence that a new provincial solidarity is possible moving forward – one resting on the tenets of inclusive, egalitarian, and humane social citizenship.