All Party Parliamentary Group on Arts, Health and Wellbeing

Meeting to discuss *Creative Health* Recommendations 9 & 10
Monday 14th May 2018
House of Lords Committee Room 3
4-5.30pm
Notes and Actions

Chair: Lord Howarth of Newport, Co-Chair of the APPG
Attendees:
Baroness Lister of Burtersett
Participants:
Professor Paul Camic, Professor of Psychology and Public Health, Canterbury Christ Church University
Professor Helen Chatterjee, Professor of Biology, University College London
Dr Simon Chaplin, Director of Culture and Society, Wellcome
Professor Geoffrey Crossick, Professor of Humanities, School of Advanced Study, University of London
Dr Fiona Glen, Programme Director National Institute for Health and Care Excellence
Professor Martin Green, CEO, Care England
Gary Grubb, Associate Director of Programmes, AHRC
Professor Richard Parish, Executive Chair, National Centre for Rural Health and Care
Anne Sofield, Associate Director of Programmes, AHRC
Professor Jane South, Professor of Healthy Communities, Leeds Beckett University

APPG Secretariat, Partners and Members of the Next Steps working group and audience
Alex Coulter, Secretary to APPG
Faith Biddle, APPG Assistant
Nikki Crane, Arts & Health Consultant
Julia Puebla Fortier, Health Services Research and Policy, London School of Hygiene &Tropical Medicine
Dr Rebecca Gordon-Nesbitt, APPG Researcher, King's College London
Richard Ings, Arts Council England
Alex Kavanagh, DCMS
Kate Phillips, University of Derby
Alex Pleasants, Researcher to Ed Vaizey MP
Alex Talbott, King's College London

Recommendations 9 & 10
9. We recommend that Research Councils UK and individual research councils consider an interdisciplinary, cross-council research funding initiative in the area of participatory arts, health and wellbeing, and that other research-funding bodies express willingness to contribute resources to advancement of the arts, health and wellbeing evidence base. We recommend that commissioners of large-scale, longterm health surveys include questions about the impacts of arts engagement on health and wellbeing.

10. We recommend that the National Institute for Health and Care Excellence regularly examines evidence as to the efficacy of the arts in benefiting health, and, where the evidence justifies it, includes in its guidance the use of the arts in healthcare.

1. Welcome and apologies

2. Recommendation 9

2.1 The UK is leading on this agenda. There is more per capita research coming out of this country than any other. When we consider other health research, arts and health has received very little funding, but the contributions that the arts have made to health have been significant. There is substantial funding for research

such as CBT, which has gained 70 billion dollars world wide, to set the context. So, although arts and health has been around for about 30 years, the research is in very early days. The best arts and health research has been interdisciplinary. In 2012, the NIHR had a call for arts and health research, short-listed three projects, but ended up funding none. In 2013 ESRC funded, with £15,000, a network of arts and health researchers, which has gone on to be the RSPH Special Interest Group. AHRC has been a leader in this area. Wellcome has funded lots of projects, including current funding for the Hub which is a two-year residency. Arts Council have had two calls. Several charities have made a large impact – Esmée Fairbairn, Baring, Alzheimer's Society. We need a method of pulling this together, research council funding and possibly charitable funding.

2.2 There is a broad evidence base around the value of arts and health – particularly looking at community assets such as cultural organisations and museums. But the lack of acceptance of that research is partly due to the level of research funding. This has led to small scale research, involving small groups of people (often less than 100) and often qualitative methods. This means that opportunities to use mixed methods, including health quantitative measures, have been limited. The amount of funding for RCTs, for complex, non-clinical arts based interventions, has been limited. That has had an impact on the perceptions of the quality of arts and health research, particularly in persuading scientists and clinicians. We are also concerned about the lack of longitudinal data, which requires longer term funding. At the moment, funding limits our ability to focus on targetting specific conditions to show the arts have an impact on health. There is also an issue about what constitutes a control group for a cultural activity. Then there are issues with what constitutes arts and health. Sitting on the Global Challenge Research Fund (GCRF) and other panels you notice that when you bring arts and humanities together to tackle public health problems they're doing what we would call arts and health, but it isn't called that. There are lots of people doing really excellent work tackling global health problems, and they're funded by cross-governmental research. We need cross-council and interdisciplinary work.

2.3 It's an important area for AHRC which has been funding a lot in this space, including work that has come through open calls. We are limited by the scale of our budget. Co-operation between funders would help. There is optimism for the outcome from the call on mental health that AHRC was part of. Clearly the creation of UKRI encourages calls that join up across councils. Collaboration with other funders will be very important in the future as we look at bigger issues. Research on cities, for example, and how we can bring arts and health together with other areas like transport and the environment and think in a much more joined up way. I think there are many areas such as prevention where the arts can be more central.

2.4 From a more public policy aspect, the focus in the report on culture change is very interesting. At AHRC, we are interested in how we can take evidence to the different departments in Whitehall and charities that are funding more on the science side.

2.5 Many funders have dipped into this area– some from the research side and some from the arts practice side. Wellcome has supported projects through our research fellowships and work in public engagement. There are issues of setting - the correct or valid places that research can be done. This is important because some funders may link themselves to kinds of organisations rather than kinds of work. We have seen that through the Arts Council call, which is aimed at the organisations they support. Academic research is more likely to be based within academic communities. Some universities are better placed to do co-located research, for example, UCL is good at using their museums, and the Wellcome Hub is set up specifically as an interdisciplinary research space to overcome some of these divides. The second is an issue of categorisation and review. Peer review mitigates against interdisciplinary research and research which goes beyond the academy. The Peer reviewers may feel uncomfortable in this space. We might agree that the peer review process is conservative, but it is the one which we use, and we don't have other methods of quality assurance. Scaling up research activity is about categories. When we scale up an arts research intervention we double the cost. People argue we could do more with qualitative research for less money so they are less inclined to support mixed methods approaches. From the science side, projects that are small scale are easier to fund because they're small scale, but once we see arts moving into costs that are closer to science research, there may be a degree of territorialism. That leads us to consider whether it might be more helpful to frame this as an issue of translation, one in which we look at scaling up into real world activity. At Wellcome, we distinguish between research and translation. We tend to rely less on academic settings for translation and less on conventional peer review processes and are open to a much wider range of methods to allow promising interventions to be scaled up. Arts as a category may be off-putting to some. With WHO, we worked hard to look at how arts might inform health and called it the cultural context for health, which arts sat within. This is embodied in the WHO European report. It helped negotiate territory to describe it as cultural context.

2.6 Some of the most substantial surveys we have are not just about health. Many of our long-term cohort studies, 20-30 years, are funded by the ESRC. They can be invaluable for considering the health benefits of engagement with the arts over the long term. The problem is the questions tend to be changed so there is no stability. The reason why really long term studies are important is exemplified by the Nordic studies which identified long-term health outcomes in relation to participation or attendance at arts and cultural events. These show complicated but positive associations. Rebecca Gordon-Nesbitt's research for the Cultural Value project looked at this. More recently, Daisy Fancourt's work at UCL, which she presented to the DCMS Science Advisory Council, has got a lot more out of the data sets in this country. There are some very strong associations which can be found in existing data sets. If we are to better understand the relationship between the arts and culture and benefits to individual and society, then we need to go beyond the targeted clinical studies. Last week the ESRC published its review of work on longitudinal studies and have committed to cohort studies going forward.

2.7 Much of what is in the report chimes with many of the challenges of trying to get community-based interventions taken seriously. Just because community intervention is harder to measure, and messier, doesn't mean it should be ignored. Epidemiology helps because it sets out associations and shows art can be a determinant of health. We know that the methodology of RCTs is insufficient to pick up what is happening in our communities. We need different designs and methodology, including participatory designs, telling a community story. A strong message about the value of mixed methods is important. We need to change the political mindset of what we think of as health. This means we start to look at what really matters to our citizens, however difficult it is. The arts are shown to be valued very highly. We need to define health outcomes as social capital. It's a major shift of mindset.

2.8 An area where we could pilot this is dementia, in dementia-friendly communities, looking at place and wellbeing. We need a mindset change around success criteria, too often the research community wants the big study, something that's tangible and clinical, rather than being concerned about people's wellbeing. The NIHR has a school of social care research and that's a place we could address some of our ideas, they are much more flexible in relation to social care research. It requires many major institutions to change what they do from their current paradigm and move it into a 21st Century one that is holistic, about people's lives rather than specific health outcomes. There will be tangible, clinical measures that come out of that.

2.9 Complexities for commissioners, funders and policy makers result from the fact that the research activity crosses so many diverse disciplines. There isn't an immediate and obvious place to locate it, either for producers of evidence or those that consume it. For those who set policy, or are responsible for determining how resources are spent, there are types of evidence that are important. Clearly outcomes, process research and evaluation and the importance of translation of research to scale up. We increasingly understand that the industrialisation of activity from pilot to projects is not straight forward. Humans are incredibly complex and inter-relationships, dynamics and community vary enormously. We need evidence of economic impact, identifying the quality of life, health benefits and the outcomes. Scoping the vectors for change and uptake is very important, sometimes referred to as innovation diffusion, and understanding what the agencies are and what the sectors are, what's the route map for getting from a report like this to large-scale uptake. As we do so, we need to look at why things don't work and where the evidence gaps are. It's important to understand that research and evidence is not necessarily the same for those who take political decisions. Sometimes it is the evidence of public opinion that is most influential. We must remember the right evidence for the audience.

3. Recommendation 10

3.1 Yes, NICE is doing this recommendation. NICE is a user of research in order to give guidance to the sector. NICE already has guidelines in this area, for instance with older people and mental wellbeing, with participatory arts and wellbeing. Slightly watered down recommendations for children and depression, and for psychosis and schizophrenia. We do use evidence that isn't just from RCTs, but we do like RCTs. With smaller studies it is very difficult to know what parts of the intervention are effective and what is cost effective. We have an automatic system of updating our guidance. We can make research recommendations when the evidence is missing. We have 5 research recommendations for older people and one is around cost effectiveness and one is about implementing guidelines at a local level. These are to help people develop what we call '*quality standards'*. Participatory arts was one of those areas of quality standards that stakeholders felt

would be very difficult to implement. That was around funding. We produce guidance on social care, public health as well as clinical topics. There has been a new call out for social care research recently.

4. General discussion

4.1 We need to get away from a hierarchy of methods with RCTs at the top and other ranging beneath them. What has emerged from the discussion is that being rigorous is important, rather than having a hierarchy. RCTs are the best method in some areas where you need to be specific, such as clinical areas, but arts and health doesn't exist in a setting like other medicines might. Multi-methods are high on the agenda, but until we see that the importance is rigour, not hierarchy, we won't make progress.

4.2 I don't think this is a problem for research funders; it's about the research eco-system – it goes back to the peer review process and values about changing policy and practice.

4.3 In terms of policy and practice if we establish that there are much stronger connections between arts and cultural participation and health, then other areas of policy which tend to get neglected will be welcomed. The inability to provide public spaces for community arts is a public policy issue.

4.4 There is a desire to find absolute causality and it is difficult when there are so many variables, when the best you can hope for is a good association. Kant: "It is often necessary to make a decision on the basis of knowledge sufficient for action but insufficient to satisfy the intellect."

4.5 I'm a PhD student and I'm doing my ethnography at the Dragon Café. It's a one-year study and I've just started my interviews. It's really messy and complicated. Unless I understand the spaces these people are in – I can't understand the people. To understand these people I had to become one of them. I've been listening to this conversation and in quantitative studies you call it longitudinal, in my world we call it ethnography. We need people who understand this culture and we need people who understand others. We have different languages. I also work for the LSE looking at the economic impact. If someone says 'since I've been going to the Dragon Café, I've been on less medication', then we can measure that.

4.6 There is a changing funding landscape. There are international funding opportunities, Typically they are ranging from the ethnographic to the psychological strategies. It would help if we had a targeted concern we could focus on and then we know what questions to ask and the funding to target.

4.7 The government is focused on loneliness, but there are also important areas in dementia, obesity, mental health for young people, and mental health at universities.

4.8 DCMS is reshaping its research activities. They are now focusing on setting up a longer term unit. Everything is short-term in research, and we need to take a longer view. A suggestion for action is research policy fellowships between the research councils and government departments.

KEY POINTS & ACTIONS:

- Move away from a hierarchy of methods to focus on rigour
- The research eco-system doesn't encourage inter-disciplinary research and mixed methods
- Consideration of the route map from innovation to large scale up-take is important
- International funding opportunities should be considered
- Further discussion with the regulators, eg CQC could help
- Explore the potential for a research policy fellowship in DOH.