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| **Checklist for submitting comments**   * Use this comments form and submit it as a **Word document (not a PDF)**. * Complete the disclosure about links with, or funding from, the tobacco industry. * Include **document name,** **page number and line number** of the text each comment is about. * Combine all comments from your organisation into 1 response form. **We cannot accept more than 1 response from each organisation**. * **Do** **not** paste other tables into this table – type directly into the table. * Ensure each comment stands alone; **do not** cross-refer within one comment to another comment. * **Clearly mark any confidential information or other material that you do not wish to be made public. Also, ensure you state in your email to NICE that your submission includes confidential comments.** * **Do not name or identify any person or include medical information about yourself or another person** from which you or the person could be identified as all such data will be deleted or redacted. * Spell out any abbreviations you use. * For copyright reasons, **do not include attachments** such as research articles, letters, or leaflets. We return comments forms that have attachments without reading them. You may resubmit the form without attachments, but it must be received by the deadline. * **We do not accept comments submitted after the deadline stated for close of consultation.**   You can see any guidance that we have produced on topics related to this guideline by checking [NICE Pathways](http://pathways.nice.org.uk/).  **Note:** We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate.  Comments received during our consultations are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by NICE, its officers or advisory Committees. |

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|  | **Please read the checklist above before submitting comments.** **We cannot accept forms that are not filled in correctly.**  We would like to hear your views on the draft recommendations presented in the guideline, and any comments you may have on the rationale and impact sections in the guideline and the evidence presented in the evidence reviews documents. We would also welcome views on the Equality Impact Assessment.  In addition to your comments below on our guideline documents, we would like to hear your views on these questions. **Please include your answers to these questions with your comments in the table below.**   1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. 2. Would implementation of any of the draft recommendations have significant cost implications? 3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) 4. Please tell us if there are any particular issues relating to COVID-19 that we should take into account when finalising the guideline for publication.   See [[Developing NICE guidance: how to get involved](http://www.nice.org.uk/process/pmg22/chapter/how-you-can-get-involved)](https://www.nice.org.uk/process/pmg20/resources/developing-nice-guidelines-how-to-get-involved-2722986687/chapter/commenting-on-a-draft-guideline) for suggestions of general points to think about when commenting. |
| Organisation name (if you are responding as an individual rather than a registered stakeholder please specify). | Culture, Health and Wellbeing Alliance; with the All-Party Parliamentary Group on Arts, Health and Wellbeing; the LENs (lived experience network), National Centre for Creative Health; WHO Collaborating Centre for Arts & Health; and University College London. |
| Disclosure (please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry). | None |
| Name of person completing form | Victoria Hume, Executive Director of the Culture, Health and Wellbeing Alliance |

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| **Comment number** | **Document**  [e.g. guideline, evidence review A, B, C etc., methods, EIA] | Page number  **‘General’** for comments on whole document | Line number  **‘General’** for comments on whole document | Comments  * Insert each comment in a new row. * Do not paste other tables into this table, because your comments could get lost – type directly into this table. * Include section or recommendation number in this column. |
| **1** | Guideline | General | General | Creative, cultural and nature-based approaches to addressing depression are not acknowledged anywhere in these draft guidelines (based on a keyword search: art, music, creative, cultural, nature). While the evidence of the effectiveness for those forms of intervention is diverse and less clinical / RCT-centric, this seems a needless oversight given that such approaches can correspond, enhance or be adapted to align with some of the main treatment options in these guidelines, and can provide support for patients experiencing significant waiting times for referrals and treatments. |
| **2** | Guideline | 11 | 9 | Include an extra bullet to the effect: “and an acknowledgment of the variety of community resources, such as arts, cultural, heritage and nature-based activities, that fall outside of these guidelines, which may enhance the recommended approaches. The **patient experience** should not be limited to their therapeutic experience but should include the wider context for that experience. Highly cited reports that draw together the extensive evidence on these factors include:  **For arts and culture-based interventions**:  All-Party Parliamentary Group on Arts, Health and Wellbeing, 2017. *Creative Health: The Arts for Health and Wellbeing*. Online: <https://ncch.org.uk/uploads/Creative_Health_Inquiry_Report_2017_-_Second_Edition.pdf>  WHO Scoping Review, 2019: *What is the evidence on the role of the arts in improving health and well-being?*. Online: <https://www.euro.who.int/en/publications/abstracts/what-is-the-evidence-on-the-role-of-the-arts-in-improving-health-and-well-being-a-scoping-review-2019>  **For nature-based interventions**:  Bragg, R. and Atkins, G., 2016. *A review of nature-based interventions for mental health care*. Online: <http://publications.naturalengland.org.uk/publication/4513819616346112?category=127020> |
| **3** | Guideline | 26, 27, 36 | [no line numbers] | **Group exercise and group mindfulness – peer support**. The ‘other things to consider’ column on these three pages says, *May allow peer support from others*… Acknowledging the ‘group’ effect on an activity’s outcomes is important. There are other physical group activities, most notably expressive dance, participatory music and nature-based approaches, that can fulfil mindfulness and physical exercise elements and also yield benefits from peer support.  We suggest that these recommendations / options can encompass other suitable group activities such as those mentioned. |
| **4** | Guideline | 42 | 20 | **Group exercise – connotations**. ‘Exercise’ can mean different things to different people (for some, there may be an implication of gyms and/or school PE lessons, which might trigger negative memories). Given the overarching patient choice rhetoric, alternative group activities such as music or dance should be made more explicit as options.  Dance in particular constitutes a popular form of aerobic exercise, is available in many community settings and includes a creative/cultural element. Many other creative interventions are inherently multisensory and include complex cognitive and physical tasks such as extensive upper body movement, hand-eye coordination, and precision grip. For these reasons, we suggest that the group exercise option is broadened to include other suitable group activities.  This suggestion does not challenge or preclude more traditional forms of physical exercise; it aims to signpost the diversity of types of group exercise and the myriad potential benefits of involvement in group activities, which include peer support, cultural engagement and specific arts-therapeutic aspects. |
| **5** | Guideline | 27 | [no line numbers] | **Group mindfulness or meditation**. Given that mindfulness and meditation can constitute a range of activities, including artistic activities (such as colouring in) and music (chanting), we would like to see a more precise definition of what mindfulness/meditation activities can include, or at least acknowledge the range of forms such activities might take. Again, this supports the core idea of patient choice, by offering sub-choices of specific activities within each broader choice as listed on the visual summary documents. |
| **6** | Guideline | General | General | **Economics**. The suggestions around group exercise and mindfulness potentially encompassing various creative and arts-based therapies, and the accompanying peer support benefits, are important. Broadening the range of choices may also have an economic benefit depending on the availability or proximity of such resources in the community. |
| **7** | Guideline | 62 | 3 | **Recommendations for research – peer support.** Citing a lack of evidence (p.67, li.7), the guidelines recommend establishing if peer support is effective and cost-effective. We suggest extending this to recommend research into the efficacy/cost-effectiveness of peer support *across clinical and non-clinical interventions*.  Most non-clinical creative approaches, such as singing or art classes, are conducted in groups, so have a strong peer support element (aligning with other NICE recommended activities including exercise and mindfulness). This would provide further opportunities for research into peer support. |
| **8** | Guideline | 11 | 3-12 | **Patient choice - communication.** Among the recommended therapeutic approaches, some, such as psychodynamic psychotherapy, can be adapted to accommodate alternative forms of communication such as music or art, if appropriate. Initial discussions with the patient around selecting a therapeutic approach should acknowledge this – although it would be at the therapist’s discretion. |
| **9** | Guideline | 49 | 15-16 | **ECT** for severe depression if other treatments have been unsuccessful. While there is some evidence in support of ECT, we find it worrying that so much space is devoted to this ‘esoteric’ (Naqvi, 2007) therapeutic approach, yet none is devoted to any arts or cultural approaches. ECT is likely to be *less* preferable to patients compared with the broad range of non-clinical interventions that could be offered but are not mentioned in these guidelines.  ECT is often prescribed for patients who have lost all motivation and who are unresponsive to other therapies. If creative arts-based interventions are not available, this restricts choice, has human rights implications and costs a lot of money. The continued use of ECT, even as a last resort, has been described as ‘a stark example of a system failing people’ (Clarke, 2021). |
| **10** | Guideline | 71-72 | 31-3 | **ECT – patient choice.** “Based on their knowledge and experience, and to ensure better patient experience, the committee reinforced the recommendations about taking into account patient preferences when considering ECT as a treatment option, in line with their recommendations for other treatment options”.  For this to be realistic, a wider range of therapeutic alternatives must be available, including arts and creative interventions, and other activities which, as we have noted, are not mentioned anywhere in this document. |
| **11** | Guideline | 50 | 15-16 | **ECT – informed consent.** The guidelines rightly discuss informed consent. However, we have serious concerns that while a person with severe depression may be deemed to have cognitive capacity to understand, they might not have the motivational capacity to decline ECT as an option.  **Advance Treatment Decisions.** “If a person with depression cannot give informed consent, only give ECT if it does not conflict with an advance treatment decision the person made”.  In making Advance Treatment Decisions, the patient is likely to opt for less intrusive options. These options must include non-clinical approaches if available. In line with our previous suggestions, we would like to see a wider range of alternatives (including creative arts-based approaches) offered ahead of ECT, including in Advance Treatment Decisions. |
| **12** | Guideline | General | General | **Patient choice.** Given NICE’s commitment to patient choice we suggest that moving forward, better use could be made of qualitative evidence, as well as organisations such as the LENs (lived experience network), which exists to ensure that lived experience is central to the development of policy and practice in relation to culture, creativity and health. The LENs has champions in each English region, all with lived experience of mental health needs. Members’ testimonials refer to the impacts of creativity on mental health:  “Art making can enable us to listen to our inner thoughts and feelings, which we can quite often choose to hide away or ignore. Developing a sense of focus and understanding of these processes are as much challenges of understanding our true nature and questions of psychological wellbeing as they are of art making […] In addition to finding solutions, art can also help us to tell our stories, and this process can often provide us with a much needed healing. Perhaps some things that we experience just cannot put into words and are better told through drawing, painting, dancing or music?” <https://www.culturehealthandwellbeing.org.uk/news/blog/sue-flowers-creative-perspective> |
| **13** | Guideline | 52 | 20-26 | **Social interventions**. “…as well as community services (for example social care, education and housing). This should include: […] social interventions”.  ‘Social interventions’ needs more attention throughout. While such interventions rely on a broader range of evidence types compared with more clinical interventions, which more often rely on RCT-type evidence, the fact that these are acknowledged here is positive and noteworthy.  Social interventions may include community-based creative, cultural, nature- or heritage-related activities. An infrastructure is being developed to enable **social prescribing** to signpost these types of resource and this option should have more prominence in the guidelines. |

Insert extra rows as needed

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