National Institute for Health and Clinical Excellence

Psychosis with substance misuse
Guideline Consultation Comments Table
10 August – 5 October 2010

No.	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
1	Alder Hey Children's NHS Foundation Trust	27.01	Full	2.2.1	19	It would be very appropriate for a separate listing of the proportion of patients in any sample that are parents living with their children or in regular contact with their children. Otherwise this dimension of the social problem of dual diagnosis will remain hidden and nnot acknowledged.	Thank you for your comment, the GDG were not aware of any reliable data on what proportion of people with psychosis and coexisting substance misuse are parents living with their children, or in regular contact. We did consider looking at this data in trials (e.g. the recent MIDAS trial) but its unlikely this will reflect the population of all people with psychosis and coexisting substance misuse. We do agree a number of social problems for children and parents in this context will remain hidden. This is particularly so for the large number of people with psychosis and coexisting substance misuse who are homeless.
2	Alder Hey Children's NHS Foundation Trust	27.02	FULL	2.2.2	21	Course and prognosis of patients who are parents in clinical experience are significantly influenced by how their status as parents is managed in relation to the care of their children.	Thank you for your comment. Our literature search did not find an evidence base for this.
3	Alder Hey Children's NHS Foundation Trust	27.03	Full	2.5.2	32	Psychological treatment (environmental) should make reference to the special conditions/skill requirements when small children are part of a family that is receiving a family intervention.	Thank you for your comment, the Introduction is not intended to give advice on how to deliver interventions. Instead it is intended to introduce the reader to the issues around psychosis and coexisting substance misuse, so that the reader will understand the context for the later presentation of evidence.
4	Alder Hey Children's NHS Foundation Trust	27.04	Full	General	General	There is a universal absence or absolutely minimalist presence/consideration of young carers and children, and services for families with dual diagnosis parents and children. Therefore no further detailed specific comments to any particular parts. In general:	Thank you for your comments. We agree these issues are important and therefore make recommendations regarding safeguarding (see section on safeguarding in NICE version of guideline), and refer specifically to the situation in which parents with psychosis and coexisting

						1) There might be an opportunity to evaluate health economics of family focussed treatment of Dual Diagnosis (DD) patients separately as it will not always be similar or equivalent to the data for individual patients. 2) The CPA guidance should be specifically referred to re parental mental health. 3) Residential treatment might offer an opportunity for joint residential treatment for whole families. 4) There should be at least one account of a young carer or children in the guidance. 5) Research proposals should include at least on recommendation for this client group.	substance misuse need support as well as assessment, and sometimes monitoring. Specific issues regarding carers (including young carers) are outside the scope of this guideline.
5	British Association for Psychopharmacology	22.01	Full	5.8.1	135 -141	We welcome the recommendations about the need for competency across health systems to recognise and assess for substance misuse.	Thank you for your comment.
6	British Association for Psychopharmacology	22.02	Full	5.8.1.7	136	We welcome the recommendation for the role of substance misuse services in training of healthcare professionals. a.) However recent commissioning decisions have meant that nationally many 'specialist' services now do not have any specialist addiction psychiatry leadership, and are commissioned from non-statutory services with minimal metal health (or clinical) training. b.) The focus of many local DAT commissioners is on the performance management of 'process targets such as number of people in and retained in (or more recently moved through) treatment. Consequently, the more complex management of patients with psychosis results in 'poor performance' and any time spent by clinicians delivering training, increases the reference costs of those services that do such work (primarily those based within NHS mental health trusts). This makes them more expensive than competing non-statutory organisations who do not see it as their remit to do	Thank you for your comment, we accept that there is variation in the way substance misuse services are delivered and emphasis placed on training and supervision such that in some areas substance misuse services may be less able to provide input to mental health services. This makes it more important that the guideline sets a standard which the GDG believe to be both aspirational and implementable. There are bound to be services which can not deliver care in line with the guideline – the guideline is there to help them improve. It is important commissioners read these guidelines for the same reasons.

						this training. It is important that the guideline does not assume that 'specialist' services are being delivered by NHS Trusts who see training as part of their ethos and 'non statutory services' as support services only. Guidance for commissioners on the role of 'specialists' in training is needed if this recommendation is to be anything other than an aspiration	
7	British Association for Psychopharmacology	22.03	All	General	General	These guidelines are very welcome and clearly written.	Thank you for your comment.
8	British Association for Psychopharmacology	22.04	Full	General	General	Please can consistency be checked between this and alcohol guideline also recently out for consultation.	Thank you for your suggestion, we will ensure consistency across guidelines.
9	British Association for Psychopharmacology	22.05	Full	2.5.1	30	Line 33 "There are a wide range of pharmacological treatments for substance problems which are almost invariably prescribed if service users are dependent on one or more substances." This may be the case for nicotine or opioid, but is much less common for alcohol and not common for stimulants where there is an absence of effective pharmacotherapy.	Thank you for pointing this out, this has been amended in the text to read: "*There are a number of pharmacological treatments for substance problems, including replacement treatments (nicotine, opiates etc.) and others. These are commonly delivered within the context of psychosocial interventions, and the overall framework of a primary care setting and/or the specialist multidisciplinary team."*
10	British Association for Psychopharmacology	22.06	Full	2.5.1	31	Line 2 "Additional treatment for vitamin deficiency syndromes" - nutritional deficiencies may also be common rather than specific vitamin deficiencies.	Thank you, , this has been amended from "vitamin deficiency syndromes" to "nutritional deficiencies"
11	British Association for Psychopharmacology	22.07	Full	8.1	205	Line 9 Sentence starting The pharmacological treatments of .... does not read well, particularly from 'shows greater overlap with lithium salts....	Thank you, this section has been amended in line with your comments.
12	British Association for Psychopharmacology	22.08	Full	8.1	205	Line 28 I am not sure Petrakis et al have concluded this. She has authored more studies on this topic eg the trial in Biol Psychiatry, 2005 has not been described, nor the paper where psychotic vs non-psychotic analysis was done. Whilst I acknowledge the limitations of secondary analyses, not to mention these studies at all or why there were	Thank you for your comment. We have revised the introduction, replacing this paragraph with text about the purpose of the chapter (this was done because we felt the introduction should not review the evidence as this was covered in the rest of the chapter).

						excluded is an omission. Those that have been suggested, such as the specific use of 28 disulfiram and naltrexone in service users with these coexisting diagnoses, 29 have not been supported by the evidence (Petrakis et al., 2006).	
13	British Association for Psychopharmacology	22.09	Full	8.1	205	Line 30 My reading of the literature is that there is not a specific theory about clozapine being 'anti-craving' as such but the case reports, surveys etc cite reduce substance misuse. Anti-craving is not the same.	Thank you, please see response to comment #12
14	British Association for Psychopharmacology	22.10	Full	8.2.7	220	Line 14 Brown et al - not all indices of drinking were worse in the naltrexone group, and % reduction was used rather than absolute levels.	Thank you for your comment. We have amended the last two sentences of the paragraph to read "*The authors report that although the decline in alcohol consumption was numerically greater in the naltrexone group, there was no significant difference between groups on the primary outcome (percentage of drinking days) or any secondary outcome."*
15	British Association for Psychopharmacology	22.11	Full	8.2.7	220	Line 23 Re Kemp et al study - please reconsider wording of 'suggestion' since paper does not cite significant benefit and number which completed study was very small.	Thank you, we have changed the last sentence to read "*The authors report no statistically significant advantage in using combination therapy in terms of the primary outcome measure (time to relapse; defined as treatment for a mood disorder), or secondary outcomes (time to discontinuation, psychiatric symptoms, and substance misuse)."* We have also changed the clinical summary to reflect these changes.
16	British Association for Psychopharmacology	22.12	Full	8.2.8	221	Line 23 I realise that nicotine is outside scope but nicotine can have profound effects on antipsychotic levels and is a drug of abuse.	Thank you for your comment. There was some discussion of this issue at one of the GDG meetings, but there was little evidence regarding interactions from existing systematic reviews.
17	British Association for Psychopharmacology	22.13	Full	8.3.2.1	229	Line 3 Research recommendation. Reduction in craving as a primary outcome should be reconsidered - wouldn't reduction in use be better? The two do not necessarily correlate.	We agree, there may not be a correlation between craving and drug usage and have updated our research recommendation to reflect both end points.
18	British Psychological Society	12.01	Full	General	General	This area is often of great concern to families of those with dual diagnosis and so a review of the evidence underlying treatment is important.	Thank you for your comments. Most healthcare professionals will find the Quick Reference Guide that will be based on the NICE version of the

				2.4	26	Whilst it is always helpful to have the evidence reviewed and collected together in one place, the outcome in this instance promotes the question of who should read this very long Guideline? One might expect the answer to be anyone who treats patients presenting with a psychotic disorder, whilst concurrently inclined to substance abuse. But the conclusions presented here would be consistent with the practice of any experienced and specialist clinician. This comment is by no means intended to be read as a criticism of the authors, for they have pointed out directly and helpfully where the problems lie. For example, understanding the concept of "dual diagnosis" is problematic and traditionally services are constructed to suit the traditional single diagnosis model. One result is to limit the evidence base which the authors could present. Another problem inherent in the evidence and in most of the putative treatments is that they are short-term ---- the treatment is usually brief as is the follow-up. This probably biases the economic modelling from both ends.	guideline (just the recommendations) to be the most appropriate document to read. As you point out, the full guideline will be a useful resource for anyone wanting further information about the evidence underpinning the recommendations.
19	Central and North West London NHS Trust	26.01	NICE	general	general	We note the factors mentioned in the draft guidelines known to influence change in clients (with substance and psychosis) environment and community integration. Occupational Therapists with a specialism in substance misuse focus on lifestyle redesign and using evidence based occupational assessments are able to assess and work in detail with the above mentioned factors We would recommend that any service working with this client group would include occupational therapists in their team skill mix.	Thank you for your comments. The standard term that we use is healthcare professional unless there are very good reasons to be specific – for example, prescribing of controlled drugs, some particular role within the NHS (e.g. the coordinating role and gatekeeping role of GPs), or some other statutory duty which rests with a particular professional group (e.g. social work roles). The GDG does not usually focus on professional roles per se, but rather with interventions and care being delivered by healthcare professionals with the relevant competencies and experience.
20	College of Mental Health Pharmacy	14.01	Full	8.2.1	207	[Table 29] We are surprised to see clonidine in this list as it was not routinely recommended by NICE in	Thank you for your comment. Table 29 is a list of drug treatments that have been reviewed by NICE

						CG52.	guidelines (Table 32 provides information about whether the drug is recommended).
21	College of Mental Health Pharmacy	14.02	Full	8.2.1	208	[Table 29] Antipsychotics first generation e.g. haloperidol. Why have you given haloperidol as an example over the other first generation antipsychotics? We suggest you add chlorpromazine and trifluperazine.	Thank you, we've added chlorpromazine.
22	College of Mental Health Pharmacy	14.03	Full	8.2.1	208	[Table 29] Antipsychotics second generation e.g. Olanzapine and clozapine. We suggest you add risperidone here as it is currently the second generation antipsychotic with the lowest acquisition cost.	Thank you, we've added risperidone.
23	College of Mental Health Pharmacy	14.04	Full	8.2.9	224	[Table 32] Carbamazepine entry. We feel it is also important to mention that carbamazepine is a potent enzyme inducer of CYP 3A4. This may reduce the levels and effectiveness of other drugs metabolised by this enzyme for example methadone, benzodiazepines, digoxin, oestrogens/ progesterones etc. see the SPC for details	Thank you for your comment. We have updated table 33 to include reference to carbamazepine as a potent enzyme inducer of CYP3A4.
24	College of Mental Health Pharmacy	14.05	All	General	General	The College would like to congratulate NICE on a useful and pragmatic guideline in light of little robust evidence to guide treatment.	Thank you for your comment.
25	Department of Health	5.01	All	General	General	The Department of Health responded with no substantive comments to make.	Thank you.
26	Faculty of Forensic and Legal Medicine	10.01	Full	4.1.2	254	It is noted that people with drug-induced mental illness will not be covered in the guideline. However, it is important to recognise that it is very difficult to determine whether the mental illness is caused by the substance misuse or not, particularly if the person is seen for the first time in the police custodial setting.	Thank you for your comment. The guideline does cover people with drug-induced psychosis, however it was the view of the GDG the focus should not be on whether substance use precipitated the mental health problem, or made it worse, but rather more important to focus on how to manage psychosis with coexisting substance misuse, as discussed in the introduction, see section 2.3.
27	Faculty of Forensic and Legal Medicine	10.02	Full	4.2a	255	Many people who are seen in police custody do not have a GP and consulting a Forensic Physician may be their first contact with a health care professional.	Thank you for your comments, this guideline has not reviewed the evidence for prison populations, although the recommendations may be relevant to those working within prison/forensic services, and is unfortunately outside the scope of this guideline.
28	Faculty of Forensic and Legal Medicine	10.03	Full	4.3.1a	255	Some people, particularly adolescents, may present acutely as apparently straight forward substance misusers in the criminal justice system. Whilst legal	Thank you for your comments, this guideline has not reviewed the evidence for prison populations, although the recommendations may be relevant to

						processing in this context may take precedence in the short term, the long term importance of getting these people to engage with health services may be a better way of preventing future problems.	those working within prison/forensic services, and is unfortunately outside the scope of this guideline.
29	Faculty of Forensic and Legal Medicine	10.04	All	General	General	I looked at both the NICE document and the full version - briefly. I could see no mention of contact with affected individuals in police custody - primary contacts were mentioned GP, A & E and then prison medical services and there did not appear to be any representative from clinical forensic medicine on the group producing the paper. I accept that contact with ill DPs at police stations is likely to be brief but early consideration of undiagnosed disorders or the continuing management of them is likely to be of assistance both to the DP and the police. I found the individual accounts helpful.	Thank you for your comments. Recommendations relating to people with psychosis and coexisting substance misuse in police custody were outside the scope. However, we did have a Consultant Forensic Psychiatrist on the GDG (please see front of full guideline).
30	Faculty of Forensic and Legal Medicine	10.05	All	General	General	My only comment is that, with the exception of the odd chronic methamphetamine with psychosis and demyelinating disease, the most common problem forensic physicians face (i.e. DEATH) is in chronic stimulant abuser who suffer from delirium which is not at all the same thing as psychosis. I am not even aware of a specifically identified opiate-induced psychosis. Is there such a thing? As such, I don't think this document really addresses your problem	Thank you for your comments. The guideline addresses the problems faced by, and the treatments for, people with coexisting (functional) psychosis and substance misuse. The scope does not cover delirium or the organic psychoses. The guideline makes no assumptions about whether drugs may lead to psychosis or trigger a psychosis, or whether people with psychosis take drugs in an attempt to self-medicate. Rather, the guideline focuses on how to help people with both conditions at the same time, since the use of drugs leads to a worse prognosis for people with psychosis and tends to complicate the treatment of the psychosis, and the presence of psychosis tends to make it more difficult to treat the substance misuse problem. There is no psychosis associated with the use of opiates. Indeed, it has been suggested that opiates may have some antipsychotic effect.
31	Faculty of Forensic and Legal Medicine	10.06	NICE	1.1.1	11	**Principles of care**: As forensic physicians, we may have no previous information about the detainee who may present with a psychosis: enquiries into their past medical/psychiatric histories may be unhelpful: in other words we have no idea if their psychosis is acutely related in anyway to their acute	Thank you for your comments, this guideline has not reviewed the evidence for prison populations, although the recommendations may be relevant to those working within prison/forensic services, and is unfortunately outside the scope of this guideline.

						or chronic substance misuse: the only way we can identify the possibility of drug induced psychosis is to place the detainee on careful (occasionally constant observations) and wait for the effects of the drugs to wear off then reassess the detainee	
32	Faculty of Forensic and Legal Medicine	10.07	NICE	1.1.6	12	We agree that any contact with these detainees is a valuable opportunity for all forensic Health Care Professionals (HCP) to discuss health promotion and discuss the risks of substance misuse on the detainees general and psychiatric help	Thank you.
33	Faculty of Forensic and Legal Medicine	10.08	NICE	1.1.9	13	We agree that the forensic HCP in custody should, (with the consent of the detainee using the Mental Capacity Act 2005 criteria: section 1.1.18), try to obtain information from the family and carers and encourage the primary and secondary care psychiatric services that the detainee will hopefully be referred to, to inform and support those affected	Thank you.
34	Faculty of Forensic and Legal Medicine	10.09	NICE	1.3.1 & 1.3.2	17	The forensic HCP should, if necessary inform and involve the Criminal Justice Mental Health Liaison Team (or similar body depending upon the age of the detainee, the Child & Adolescent Mental Health Services) in the subsequent care of the detainee, and if necessary, seek a psychiatric opinion whilst the detainee is in custody for a formal mental health assessment and possible section under the Mental Health Act 1983	Thank you for your comments, this guideline has not reviewed the evidence for prison populations, although the recommendations may be relevant to those working within prison/forensic services, and is unfortunately outside the scope of this guideline.
35	Faculty of Forensic and Legal Medicine	10.10	NICE	1.6.5	25	**Discharge** from secondary mental healthcare services: we would value any information pertaining to a detainee with a known or coexisting drug induced psychosis being stored on the police national computer (PNC) that should be updated so that information is immediately available as to the diagnosis for future reference	Thank you for your comments, this guideline has not reviewed the evidence for prison populations, although the recommendations may be relevant to those working within prison/forensic services, and is unfortunately outside the scope of this guideline.
36	Faculty of Forensic and Legal Medicine	10.11	Full	1.2.2	15	There is no mention of 'forensic' healthcare professionals in the guidance	Thank you for your comments. The standard term that we use is healthcare professional unless there are very good reasons to be specific – for example, prescribing of controlled drugs, some particular role within the NHS (e.g. the coordinating role and gatekeeping role of GPs), or some other statutory duty which rests with a particular professional group

							(e.g. social work roles). The GDG does not usually focus on professional roles per se, but rather with interventions and care being delivered by healthcare professionals with the relevant competencies and experience.
37	Faculty of Forensic and Legal Medicine	10.12	Full	2.3.1	24	The full guideline DRAFT alludes to 'substance misuse precipitating the onset of or is a direct cause of psychosis': the forensic HCP should be fully aware of the possible slight difference in presentation of those with drug induced psychosis from those with schizophrenia: i.e. predominating agitation and confusion in psychosis following drug use	Thank you for your comments. The guideline addresses the problems faced by, and the treatments for, people with coexisting (functional) psychosis and substance misuse. . The guideline makes no assumptions about whether drugs may lead to psychosis or trigger a psychosis. Rather, the guideline focuses on how to help people with both conditions at the same time, since the use of drugs leads to a worse prognosis for people with psychosis and tends to complicate the treatment of the psychosis, and the presence of psychosis tends to make it more difficult to treat the substance misuse problem.
38	Faculty of Forensic and Legal Medicine	10.13	Full	2.5.4	34	Guidance for forensic healthcare professionals dealing with a substance misusing detainee with psychosis would be most valuable: the custody suite is as mentioned previously a frequent place for the presentation of this condition	Thank you for your comments, this guideline has not reviewed the evidence for prison populations, although the recommendations may be relevant to those working within prison/forensic services, and is unfortunately outside the scope of this guideline.
39	Huntercombe Group	15.01	Full	General	General	There do not appear to be any representatives on the GDG from either non statutory Tier 4 (specialist inpatient) drug and alcohol services or from primary care GPs. Both have significant interest in and input into people with substance misuse and psychosis. This seems to be a major weakness in the GDG.	As far as possible the GDG has to have the expertise to be able to address the scope, although sometimes individual members may bring expertise across different areas to complement the other GDG members. So, we did have representative from specialist tier 4 CAMHs services, and also in adolescent drug misuse but in the later they also had expertise in adult drug misuse, and in the former they dealt with a number of clients routinely with coexisting psychosis and substance misuse. It is also worth pointing out that GDGs can get very large if you have experts in all parts of services that the guideline addresses, especially when a guideline is dealing with all age groups (children, young people, adults and older adults), primary care, secondary care (community) secondary care

							(inpatient), specialist drug misuse services (adults and young people) and CAHMS services, including tier 4.
40	Huntercombe Group	15.02	NICE	1.4.3	9	Good to see encouragement for both psychiatric and substance misuse services to keep patients with both problems in their services and not to try and shift responsibility.	Thank you for your comment.
41	Huntercombe Group	15.03	NICE	1.4.4	9	As above for 1.4.3.	Thank you for your comment.
42	Huntercombe Group	15.04	NICE	1.4.6	9	This section should include stimulants and hallucinogens as they are more likely to induce psychotic symptoms then the others. How about heavy cannabis use?	Thank you for this comment, we agree that substance misuse services are able to offer advice on a wide range of substances. However, the GDG felt it important to highlight that advice should be sought for these particular substances as mental health services may not be experienced in providing the treatments for them e.g. prescribing methadone.
43	Huntercombe Group	15.05	NICE	1.4.15	20	It states "consider use of biological testing in the assessment treatment and management of substance misuse." I would strongly say that unless tests are done, you cannot provide evidence based treatment or even have done a proper assessment. This should state "Use biological testing…" – it should be recommended not "considered". Testing is integral to all substance misuse work and is not optional.	Thank you for your comment, it was the view of the GDG that biological testing should be agreed with the service user first as part of their care plan, and not as a routine measure.
44	Huntercombe Group	15.06	NICE	1.4.16	20	Ditto the above for 1.4.15. Proper inpatient care for people with substance misuse cannot be done without testing for abused substances.	Please see the response to comment 43.
45	ISPS[1]	23.01	Full	2.3	25	**The influence of early life experiences should be more clearly recognised.** The section discussing '*a common cause for both disorders'* seems very inadequate, in particular as it makes no reference at all to the literature on the increased frequency of childhood adversity (attachment insecurity, trauma, loss etc) which occurs both in individuals with psychosis and in individuals with substance misuse. (This may of course relate to the changes in frontal lobes and	Thank you for your comment, the Introduction is not intended to be an exhaustive or definitive examination of the evidence. Instead it is intended to introduce the reader to the issues around psychosis and coexisting substance misuse, so that the reader will understand the context for the later presentation of evidence.

[1] International Society for the Psychological Treatment of the Schizophrenias and Other Psychoses

						hippocampus in both conditions, which are referred to in the relevant paragraph). The associated relevance of personality dysfunction also seems inadequately treated. Clinical experience strongly supports the view that psychosis with substance misuse is frequently also associated with difficulties related to personality development and functioning, including all forms of Cluster B personality disorders, not just antisocial personality disorder as mentioned here.	
46	ISPS	23.02	Full	2.5.1 2.5.2	30 -31	**Pharmacological and Psychological Treatments** RE two papers, soon to be published in **Medical Hypotheses and Addictive Disorders and Their Treatment:** 1. *Melatonin, Agomelatine and Alcoholism: Relevance to Alcohol Related Brain Damage and Comorbid Psychosis.* George Anderson 2. *Melatonin: Its Inhibition of Anti-Psychotic Side-Effects, and an Overlooked Developmental and Maintenance Factor in Psychosis.* George Anderson Both papers detail some of the intra- and inter-cellular mechanisms associated with Bipolar disorder (BD) and schizophrenia, and suggest a powerful role for variations in the levels of melatonin in the etiology and course of psychosis. This is most evident in BD, where some data suggests a genetic decrease in the levels of melatonin in BD, maybe especially in rapid cyclers. The co-administration of melatonin with anti-psychotics is likely to prevent many of metabolic side-effects caused by such medication. Melatonin is also proposed to prevent much of the brain damage that is associated with alcohol intake. My experience of work within the addiction service suggests that the problem of comorbidity has no coherent approach, nor any obvious evidence based direction, resulting in many local solutions to how this should be approached. In the context of such a scenario, a coherent theoretical perspective may be the most	Thank you for your comment. Given that these papers are not yet available, we will not be able to review them for this edition of the guideline. Furthermore, our search did not identify relevant evidence for SRT.

						fruitful approach. BD is conceptualized as both a circadian disorder and metabolica disorder, and it seems likely that the application of melatonin will tackle both of these aspects. Much of this is also applicable to schizophrenia. In terms of a co-ordinated psychological approach, then "social rhythm therapy" (SRT) would seem the most obvious, allowing for some medical and psychological coherence to treatment. Recent data suggest that SRT is useful in off-setting the time to the occurence of another mood disorder episode, although more data is needed in the context of both BD and schizophrenia.	
47	ISPS	23.03	Full	2.5.2	31	**Psychological Treatments** Re: Phil Jones' **Drama as Therapy Theory, Practice and Research,** Routledge 2007, which discusses the therapeutic core processes which dramatherapy can offer. In dramatherapy the body as well as the mind are the focus. Jennings S. 1990 uses the EPR developmental model of dramatherapy which enables non-verbal engagement with clients who are in chaotic states. With reference to 'non-judgemental attitude' (2.5.2), the individual's appreciation of their illness can be looked at within a dramatherapy session, through the interactive audience and witnessing (Jones p.82). The patient's substance addiction can be 'put out there' and observed from a distance; it can be thought about. Using metaphor enables difficult feelings to be worked with sometimes more indirectly. Dramatherapy enables patients to begin to symbolise. This can change how the patient views his difficulties.	Thank you for your reflections on drama therapies and their possible place within the treatment of people with psychosis and coexisting substance misuse, unfortunately the GDG found no evidence to support dramatherapy specifically for people with both disorders.
48	ISPS	23.04	Full	2.5.3	33	[Lines 1-2] **Service Level and Other Interventions** The structure of the consultation militates against a service delivery model of earlier intervention of	Thank you for your comment. We found no evidence to support integrated service models. The guideline scope is about the recognition and

						integrated services. The Draft guidance requires an established diagnosis of either schizophrenia or of bipolar disorder. This is not consistent with person-centred care and does not take into account the high level of substance abuse and its additive and in some cases, multiplicative, effects on functioning and subjective well-being. To set a diagnostic barrier does not prevent coercive treatment, but makes it more likely by failing to have a pro-active approach to milder forms of morbidity.	management of coexisting psychosis and substance misuse. Although this is important, it is outside the scope to consider substance misuse coexisting with 'milder' forms of illness (such as depression).
49	ISPS	23.05	Full	4.8.1.1	112	**Recommendations should consider what may help staff develop the desired attitudes and behaviours** The draft recommends that staff should build respectful, trusting and non-judgmental relationships in an atmosphere of hope and enthusiasm. It is clear that anyone with experience of this client group that this is not always easy despite the best of intentions. This client group presents many challenges for staff, for example through their risk profile, the difficulties in engagement, and the increased anxiety and workload generated. The summary of online accounts (p. 107) identifies discontinuity of care, feeling discriminated against because of their diagnosis, and problems in therapeutic relationships as important issues for service users. Such experiences can be a consequence of the difficulties that staff have in relating to the client group. These difficulties for staff can in turn result from their feelings of anxiety, powerlessness, hopelessness, inadequacy or even anger and conscious or unconscious efforts to manage them, eg through avoidance or blaming. Factors likely to help staff interact with clients in the desired ways include (1) having longitudinal formulation of the service user's difficulties and difficult behaviours, so that their current choices are seen as arising out of a complex set of circumstances rather than simply a perverse choice.	Thank you for your comment, we agree that healthcare professionals do need support when working with this group and have added a recommendation (1.1.15) to reflect this.

						(2) having a good understanding of the relapsing and remitting nature of many substance misuse problems and of appropriate expectations of timescales for consolidating change. (3) feeling supported themselves eg through supervision, team discussions etc.	
50	ISPS	23.06	Full	5.4.3	124	**Assessment needs to lead to develop of a formulation** The section on components of assessment alludes to the purpose of assessment being to inform diagnosis and also obtain a picture of the reasons for the substance misuse. It would be helpful for this to be expanded to recognise that assessment is also important in developing longitudinal formulation, ie an understanding of why the person may have developed the problems that they have - both the substance misuse and the psychosis. In relation to this, the section in table 9 on personal and family history could usefully be expanded to clarify that what is most useful is some kind of timeline, where life experiences are related to feelings, substance use and development of symptoms.	Thank you for your comment, these are indeed important. However, the GDG decided that there was sufficient detail in table 9 and any further would risk the guideline becoming a treatment manual.
51	ISPS	23.07	Full	5.8.1.10	137	**A detailed personal history is a key component of assessment** See comments above. Could another bullet point be added to reflect this?	Thank you for your comment, we have added an extra bullet point to the recommendation in line with your suggestion.
52	ISPS	23.08	Full	7.1	169	**The influence of early life experiences should be more clearly recognised** In discussion here (as in the earlier background section) no consideration is given to the fact that early environmental factors (attachment insecurity, trauma etc) are associated both with the development of psychosis and with the development of substance misuse. This is of direct relevance to the development of psychological treatment approaches. For example (1) the effects of early life experiences on interpersonal functioning, may (in addition to the psychosis and substance misuse) generate needs for specific approaches and skills in	Thank you, we agree this issue is very important across the whole of psychiatry/mental health and will be important for people with psychosis, people with substance misuse problems, for people with both psychosis and substance misuse problems and for people with personality disorders. As such, it wouldn't be manageable to include specific treatment recommendations of such a broadly applicable nature in a disorder specific guideline.

						establishing engagement and in effective therapeutic alliance and (2) the low self esteem and self-stigmatisation common in individuals with psychosis and substance misuse, may sometimes be directly addressed by helping the client develop an understanding of the longitudinal development of their problems and the influence of external circumstances on this.	
53	ISPS	23.09	NICE	Contents	7	**Person-Centred Care** Response to needs should be focused around the individual, not around the clinician, for example three are concerns around linking to diagnosis the requirement to identify a lead clinician.	Thank you for your comment, but we believe this is covered in the section on person-centred care.
54	ISPS	23.10	NICE	1.1.15 1.1.16 1.1.17	14 -15	**Safe-guarding issues** SCIE guidance on parental mental health and child welfare has pointed out the lack of the reference to the special needs of patients who are parents in NICE guidance, and this lack remains. While there might be little or no evidence on this aspect of provision of care to dual diagnosis patients, there will inevitably be a number of parents among them with dependent children. These are some of the most difficult to manage patients and the children are at reasonably high risk in a number of respects. The guidance makes some reference to the social role of patients and of those who care, but 'parent' as a social role is only considered for the parents of the patient in this guidance. Policies like 'Think Family' do not seem to make any difference at all to guideline development. And as long as there is no evidence in the literature that is of sufficient solidity, issues are not taken forward. That is a recipe for continuing systemic blind spots by design, i.e. because there is no evidence an issue cannot be considered for a guideline, therefore it is not part of the NICE guidance therefore it does not become a priority in research, therefore there is no evidence and so on. The guidance on this particular topic should mention at least three aspects of care and how to manage it:	The recommendations 1.1.17 and 1.1.18 are aimed at addressing this issue. Whilst this an extremely important concern, in the absence of evidence for specific interventions we have highlighted the need for a multiagency approach so appropriate support and help can be provided on an individual needs basis. Regarding your specific points about topics to include. Guidelines can not cover all aspects of the care pathway, and the GDG covered those areas identified as a priority (e.g., safeguarding).

						1) If a patient is pregnant and the pregnancy is continued to delivery. How should this be managed? The guidance simply and only refers to the need for advice on the safety of medicines. 2) Safeguarding needs of the children of parents with dual diagnosis illness. 3) Kinship care especially if the patient continues to live in the (grand)parental home with her own children but the children are looked after by other family members. This is a constellation I have come across a number of times and invariably the parenting dimension, the intergenerational conflict over the care of the child(ren), and the complexity of the grandparent-parent relationship are variables that crucially contribute to management/treatment needs and outcome. Kinship care has massively increased over recent decades to a largish part because of parental drug addiction. Guidance should explicitly acknowledge the lack of evidence for this particular aspect. For a summary of available evidence on parents with dual diagnosis see http://www.copmi.net.au/gems/files/copmi_gems_4_march_09.pdf. There is also a copmi gem on kinship care.	
55	ISPS	23.11	NICE	1.4	18	**Secondary Mental Health Care: Competence** Suggest refer to*: The Competences required to deliver effective Systemic therapies* by Pilling, P., Roth, A.D. & Stratton, P. which includes recommended couple and family therapies. www.ucl.ac.uk/CORE	Thank you for your comment. This is an implementation issue for healthcare trust, professional managers and professional colleges and is outside the scope of this guideline.
56	ISPS	23.12	NICE	1.5	23	**Substance Misuse Services: Competencies** Suggest refer to*: The Competences required to deliver effective Systemic therapies* by Pilling, P., Roth, A.D. & Stratton, P. which includes recommended couple and family therapies. www.ucl.ac.uk/CORE	Thank you for your comment. We don't think it's appropriate to refer to an external document in this case, but we have clarified the wording of recommendation 1.5.1 on competencies.
57	ISPS	23.13	NICE	Gener	Gener	There is no provision for assertive but voluntary	Thank you for highlighting the issue of exploitation

				al	al	realistic bargaining about the individual's financing and budgeting as a way of protecting them from drug dealers. These hang around service users, and exploit the source of money that particularly inpatient services provide, sometimes recruiting patients who get into debt to be sub-procurers of further sources of finance. Readmissions may often arise from unmanageable friction in this process in which the vulnerable patient's grooming breaks down, even though they may be recorded formally as having an exacerbation of their psychotic diagnosis. This misses the precipitating pathway. The guidance completely fails to take into account the changeable and multiple patterns of substance misuse in the illicit market that exists. Only by putting the individual at the centre of the care plan can this be addressed.	of vulnerable service users by drug dealers. We have included an additional recommendation about the importance of people with psychosis and substance misuse themselves being considered for safeguarding vulnerable adult procedures. We agree that it is important for the individual to be at the centre of care, as explained in Chapter 2 of the guideline.
58	Lancashire Care NHS Foundation Trust	8.01	Full	General	General	No mention of legal highs in the document.	The scope of this guideline does not specifically identify legal highs and it is therefore outside the scope to do a detailed analysis of individual legal highs, however, the introduction of the NICE guideline classifies 'substance misuse' as *'a broad term encompassing, in this guideline, the hazardous or harmful use of any psychotropic substance, including alcohol and either legal or illicit drugs.'*
59	Lancashire Care NHS Foundation Trust	8.02	Full	General	general	"substance misuse"- does this include alcohol as if so needs to be stated. Also would it be better to refer to substance use rather than misuse as this is quite subjective and would differ from individual to individual as to the quantities required to affect mental health and the diagnostic criteria refers to use rather than misuse. As most of the drugs used are illicit there are no agreed safe amounts so what is considered misuse? With alcohol one could say that drinking over the govt guidelines is misuse but again might be better to refer to this as harmful use.	Thank you for your comments. This guideline does include alcohol as is outlined in section 2.1 of the full guideline and the introduction of the NICE guideline classifies 'substance misuse' as *'a broad term encompassing, in this guideline, the hazardous or harmful use of any psychotropic substance, including alcohol and either legal or illicit drugs.'*
60	Lancashire Care NHS Foundation Trust	8.03	Full	1.2.3	15	[Line 30] This refers to service users but earlier in the document refers to patients- need to decide which term to use. Also need apostrophes on the end of families/carers	Thank you for pointing this out, the document has been amended to refer to service users throughout.

61	Lancashire Care NHS Foundation Trust	8.04	Full	1.2.4	16	[Line 19] Need to add “to” after used	Thank you for pointing this out, it has been amended in the document.
62	Lancashire Care NHS Foundation Trust	8.05	Full	2.1	18	[Line 38] Refers to service users & patients in the same sentence	Thank you for pointing this out, the document has been amended to refer to service users throughout.
63	Lancashire Care NHS Foundation Trust	8.06	Full	2.2.3	22	[Line 40] ‘especially stimulants and cannabis.’ Is this a repetition of the role of cannabis or does this relate to the effect of the substances in combination?	Thank you for your comment, this sentence has been amended in the document.
64	Lancashire Care NHS Foundation Trust	8.07	Full	2.3	25	[Line 19] dopaminergic reward systems in the brain give example of how this will impact on service user	Thank you for your comment, we feel a sufficient example is given is section 2.3. where it states: *These medications work by blocking dopamine receptors in the brain, including dopaminergic reward systems in the brain. Individuals may attempt to counteract this effect by using substances.*
65	Lancashire Care NHS Foundation Trust	8.08	Full	2.3	26	[Line 9] and cannabis cause dopaminergic stress - is this correct as it doesn’t read right.	Thank you for your comment, this has been amended to read: *“cannabis promotes the release of dopamine and this stimulation of dopamine pathways can precipitate the onset of disease.”*
66	Lancashire Care NHS Foundation Trust	8.09	Full	2.3	26	[Line 17] consumption of the strongest forms of cannabis, particularly ‘skunk’, are more prone to psychosis (Verdoux *et al.,* 2005; Murray *et al.,* 2007).- would sound better if first part of sentence was changed to “individuals who consume “	Thank you for pointing this out, this has been amended.
67	Lancashire Care NHS Foundation Trust	8.10	Full	2.4	26	[Line 35] (rather than two as implied by ‘dual’- bracket mark missing from end of this section	Thank you for pointing this out, this has been amended.
68	Lancashire Care NHS Foundation Trust	8.11	Full	2.5.2	31	[Line 29] Such “integrated care” combines- need to add “which” after care.	Thank you for pointing this out, it has been amended in the document.
69	Lancashire Care NHS Foundation Trust	8.12	Full	2.5.3	34	[Line 15] If this guidance does not cover all providers how can sign up by individual independent providers by secured?	Thank you for your comment. NICE guidance is produced for the NHS, and sometimes for social care. It is always relevant to other agencies, even though it is not specifically for them. For us to generate evidence based recommendations for settings other than health (and sometimes social care) would involve interrogating a much broader

							range of research databases than we currently are able. I should say that we have done this by special agreement (dementia included social care; ADHD included education and social care; antisocial personality disorder included the penal system).
70	Lancashire Care NHS Foundation Trust	8.13	Full	2.5.4	35	[Line 12] a treatment programmes- need to remove the s from programmes.	Thank you for pointing this out, it has been amended in the document.
71	Lancashire Care NHS Foundation Trust	8.14	Full	2.5.4	35	[Line 24] have remained abstinent whilst using significant- change “using” to “utilising “	Thank you for pointing this out, it has been amended in the document.
72	Lancashire Care NHS Foundation Trust	8.15	Full	2.5.4	35	[Line 27] there is no good research evaluation of the- change “the” to this	Thank you for pointing this out, it has been amended in the document.
73	Lancashire Care NHS Foundation Trust	8.16	Full	4.2.2	63	[Line 41] I tool olanzapine- should read “took”	Thank you for pointing this out, it has been amended in the document.
74	Lancashire Care NHS Foundation Trust	8.17	Full	4.4.1	80	[Line 20] A systematic search for qualitative studies, observational studies and reviews of qualitative studies of people with psychosis and coexisting substance misuse.- This sentence does not make sense.	Thank you for pointing this out, it has been amended.
75	Lancashire Care NHS Foundation Trust	8.18	Full	4.4.5 4.4.8 4.5.4 4.5.6 6.3.5	84	[Line 23 – also: 86 line 19; 88 line 6; 91 line 32; 96 line 41; 100 line 19; 161 line 18; 162 line 16. Refers to dual diagnosis but previously document has advised against this term	Thank you for pointing this out, the document has been amended throughout the guideline.
76	Lancashire Care NHS Foundation Trust	8.19	Full	4.4.5	85	[Line 20] SES)- assume this refers to socio economic status but this is not clear	Thank you for your comment. SES does refer to socioeconomic status, and has now been spelt out.
77	Lancashire Care NHS Foundation Trust	8.20	Full	4.4.7	89	[Line 16] there not enough- need to include a verb after there, “was” would suffice.	Thank you for pointing this out, it has been amended in the document.
78	Lancashire Care NHS Foundation Trust	8.21	Full	4.4.7	89	[Line 25] “both of the person’s diagnoses” this might read better as “all of the person’s identified needs”	Thank you for the suggestion, this has been amended.
79	Lancashire Care NHS Foundation Trust	8.22	Full	4.4.7	89	[Line 30] some participants were positive views about services, need to either take out views or replace “were” with “had”	Thank you for pointing this out, it has been amended in the document.

80	Lancashire Care NHS Foundation Trust	8.23	Full	4.4.7	90	[Line 7] Should this be medication not meditation.	Thank you this has been amended.
81	Lancashire Care NHS Foundation Trust	8.24	Full	4.4.7	90	[Line 17] Relapse was also associated with discontinuing drug treatment- this sentence a little confusing as it could be interpreted as treatment for drug use- might be better to say discontinuing psychotropic medication	Thank you this has been amended.
82	Lancashire Care NHS Foundation Trust	8.25	Full	4.4.7	91	[Line 6] with a with psychosis- need to delete with	Thank you this has been amended.
83	Lancashire Care NHS Foundation Trust	8.26	Full	4.4.7	91	[Line 14] “was the benefits and marked differences due to person taking the medication”- might be better if added “their prescribed” before medication	Thank you this has been amended.
84	Lancashire Care NHS Foundation Trust	8.27	Full	4.4.7	93	[Line 37] A thorough assessment not assesments	Thank you this has been amended.
85	Lancashire Care NHS Foundation Trust	8.28	Full	4.4.9	93	[Line 37] a thorough assessments- need to remove “a”	Thank you this has been amended.
86	Lancashire Care NHS Foundation Trust	8.29	Full	4.5.1	94	[Line 13] include personal narratives from- need to change include to included as the tense has changed from past to present in tis sentence	Thank you for pointing this out, it has been amended in the document.
87	Lancashire Care NHS Foundation Trust	8.30	Full	4.5.8	105	[Line 10] Many carers’- need to remove apostrophe	Thank you for pointing this out, it has been amended in the document.
88	Lancashire Care NHS Foundation Trust	8.31	Full	4.5.9	107	[Line 3] could have increased awareness about mental health, and promote more coordination and integration between services.- would read better as “could increase awareness”	Thank you for pointing this out, it has been amended in the document.
89	Lancashire Care NHS Foundation Trust	8.32	Full	4.5.9	107	[Line 38] diagnosis psychosis- need to add “of” after diagnosis	Thank you, this has been amended.
90	Lancashire Care NHS Foundation Trust	8.33	Full	4.5.9	107	[Line 42] express optimism- needs to say “expressed”	Thank you, this has been amended.
91	Lancashire Care NHS Foundation Trust	8.34	Full	4.6	109	[Line 2] continuity care. Need to add “of” after continuity	Thank you, this has been amended.

92	Lancashire Care NHS Foundation Trust	8.35	Full	4.6	110	[Line 9] be particular- need to add “a” after be	Thank you, this has been amended.
93	Lancashire Care NHS Foundation Trust	8.36	Full	4.6	110	[Line 12] as prominent theme-need to add “a” after as	Thank you, this has been amended.
94	Lancashire Care NHS Foundation Trust	8.37	Full	4.6	111	[Line 14] than ran- should say “than”	Thank you for your comment, this sentence has been reworded.
95	Lancashire Care NHS Foundation Trust	8.38	Full	4.7	111	[Line 44] information could about- need to remove “could”	Thank you, this has been amended.
96	Lancashire Care NHS Foundation Trust	8.39	Full	5.3.1	120	[Line 25] drug misuse- this should say substance rather than drug	Thank you, this has been amended.
97	Lancashire Care NHS Foundation Trust	8.40	Full	5.3.1	121	[Line 6] GP’s- need to remove apostrophe	Thank you, this has been amended.
98	Lancashire Care NHS Foundation Trust	8.41	Full	5.3.1	121	[Line 8] liaise closely- this would read better as “close liaison”	Thank you, this has been amended.
99	Lancashire Care NHS Foundation Trust	8.42	Full		127	[Table row 7] “With a peers” need to remove “a”	Thank you, this has been amended.
100	Lancashire Care NHS Foundation Trust	8.43	Full	5.5.1	128	Needs to include cannabis and legal highs as other examples	Thank you for your comment, however this list is indicative and not exhaustive. The scope of this guideline does not specifically identify legal highs and it is therefore outside the scope to do a detailed analysis of individual legal highs, however, the introduction of the NICE guideline classifies ‘substance misuse’ as *‘a broad term encompassing, in this guideline, the hazardous or harmful use of any psychotropic substance, including alcohol and either legal or illicit drugs.’*
101	Lancashire Care NHS Foundation Trust	8.44	Full	5.4.5	128	[Line 27] “The care co-ordinator” might be worth adding keyworker or people will interpret as the CC for CPA & the individual may not meet criteria for CPA.	Thank you, we have amended this in line with your comment.
102	Lancashire Care	8.45	Full	5.5.1	129	[Line 4] Needs to include a much wider range of	Thank you for your comment, this list is illustrative

	NHS Foundation Trust					substances used.	rather than exhaustive and it is not possible to list all substances that may be used.
103	Lancashire Care NHS Foundation Trust	8.46	Full	5.5.1	129	[Line 17] Guidance needs to cover how to promote and enhance a clients readiness for change	Thank you for your comment. Motivational interviewing techniques may be used to this effect, see section 7.2.2.
104	Lancashire Care NHS Foundation Trust	8.47	Full	5.5.1 6.2.10 .2	129 156	[129: Row 4] Criteria for referral to SMS may differ in areas as in Lancashire services will take referrals for all substances e.g. cannabis, legal highs, mephedrone etc. Need to include this in the document	Thank you for your comment, we appreciate this and have added to the text: *"(although there will be variation between services)".*
105	Lancashire Care NHS Foundation Trust	8.48	Full	5.5.2	129	[Line 44] "but it also aim" might be better to add "should" before "aim"	Thank you, this has been amended.
106	Lancashire Care NHS Foundation Trust	8.49	Full	5.5.1	130	[Line 31] Not only pharmacies offer needle exchange and this needs to be mentioned	Thank you for pointing this out, we have amended to the text to reflect this.
107	Lancashire Care NHS Foundation Trust	8.50	Full	5.5.1	130	[Line 35] The liaison model where staff from mental health and substance misuse services are nominated to represent their own service and meet up to engage in ensuring robust networks of communication are in place has been proved to be useful.	Thank you for your comment, whilst we are sure this works well locally we are unable to recommend as a national model as organisational structures vary.
108	Lancashire Care NHS Foundation Trust	8.51	Full	5.5.4	131	[Line 4] Remove may and replace with will	Thank you for pointing this out, it has been amended in the document.
109	Lancashire Care NHS Foundation Trust	8.52	Full	5.6.1	132	[Line 6] "inpatient psychiatric" change psychiatric to "mental health"	Thank you for pointing this out, it has been amended in the document.
110	Lancashire Care NHS Foundation Trust	8.53	Full	5.6.1	132	[Line 26} "general adult inpatient" add "mental health" after "adult" as it's a bit misleading	Thank you for pointing this out, it has been amended in the document.
111	Lancashire Care NHS Foundation Trust	8.54	Full	5.8.1. 19 5.8.1. 20	139	[Lines 3 & 10] Healthcare professionals are not the only group of staff undertaking client assessments in substance misuse services. Teams are now comprised of a number of non healthcare staff.	Thank you for your comment, we agree and have amended this to 'healthcare and other professionals'.
112	Lancashire Care NHS Foundation	8.55	Full	5.8.1. 24	140	[Lines 2 & 11]"Local named nurse" – is this always a nurse, might be better to say "local named lead"	Thank you for your comment, we agree with your suggestion and have amended the text.

	Trust						
113	Lancashire Care NHS Foundation Trust	8.56	Full	6	142	[Line 17] Give full name to RCTs in first use of abbreviation.	Thank you for your comment but this abbreviation has been used a number of times in this document and is first spelt out in full in the first chapter of the guideline.
114	Lancashire Care NHS Foundation Trust	8.57	Full	6.2.3	145	[Line 18] ACT,- does this refer to assertive community treatment as there is no explanation	Thank you for pointing this out, we are referring to assertive community treatment and this has been amended in the document.
115	Lancashire Care NHS Foundation Trust	8.58	Full	6.2.7	153	[Line 16] DDT- need to explain what this stands for	Thank you for pointing this out, we are referring to Dual Disorders Treatment and this has been amended in the document.
116	Lancashire Care NHS Foundation Trust	8.59	Full	6.2.8	154	[Line 43] although the authors argue that this limited statistical power rather than internal validity of the study findings. – sentence doesn't make sense.	Thank you. We've amended the sentence to read: "*Sample attrition may have biased the results of the cost analysis, although Morse and colleagues argue that attrition resulted in low statistical power, but did not affect internal validity."*
117	Lancashire Care NHS Foundation Trust	8.60	Full	6.2.9	155	[Line 41] parallel model in which both substance misuse services and mental health services work with the patient in the overall context of the Care Programme Approach.- might be better if "is recommended or advocated" is added at the end of this sentence as at present it does not make sense.	Thank you, the text has been changed to read: **"***For reasons of safety in prescribing and the expertise required in monitoring the service user's requirements of substitute opiates**, the GDG concluded that it would be appropriate to recommend** a parallel model in which both substance misuse services and mental health services work with the **s**ervice user in the overall context of the Care Programme Approach.**"***
118	Lancashire Care NHS Foundation Trust	8.61	Full	6.2.10 .3	156	Local substance misuse services are keen to offer advice to cmht staff in cases where clients are using at a wider range of use and not just at the dependant level. They will also offer advice in relation to a wider range of substances than listed e.g stimulants and legal highs , cannabis.	Thank you for this comment, we agree that substance misuse services are able to offer advice on a wide range of substances. However, the GDG felt this was the appropriate level to set the recommendation at to ensure services are not overwhelmed.
119	Lancashire Care NHS Foundation Trust	8.62	Full	6.5.3	166	[Line 14] RCTs- need to remove the "s"	Thank you, this has been amended.
120	Lancashire Care NHS Foundation Trust	8.63	Full	7.1.1	169	[Line 18] Many people with psychosis experience negative affective = should this say symptoms after affective	Thank you, we agree and have amended the text as you suggested.
121	Lancashire Care NHS Foundation Trust	8.64	Full	7.2.2	174	[Line 37] intervention are designed- needs to say "is" instead of "are"	Thank you, this has been amended.

122	Lancashire Care NHS Foundation Trust	8.65	Full	7.2.2	176	[Line 4] “Service users are taught to set limits for drinking, self-monitor drinking episodes, refusal skills training and training for coping behaviours 5 in high-risk relapse situations” this would read better written as “Service users are taught to set limits for drinking and self-monitor drinking episodes and are offered refusal skills training and training for coping behaviours in high-risk relapse situations”	Thank you for pointing this out, it has been amended in the document.
123	Lancashire Care NHS Foundation Trust	8.66	Full	7.2.2	176	[Line 10] (NCCMH, 2008b,- need to replace comma with bracket	Thank you, this has been amended.
124	Lancashire Care NHS Foundation Trust	8.67	Full		177	[Line 9] sstandard CBT-	Thank you, this has been amended.
125	Lancashire Care NHS Foundation Trust	8.68	Full	6.6.1.3	168	[Line 27] Needs NICE guidance reference	Thank you, this has been amended.
126	Lancashire Care NHS Foundation Trust	8.69	Full	7.3.2.2	204	[Line 34] cost-effectiven	Thank you, this has been amended.
127	Lancashire Care NHS Foundation Trust	8.70	Full	9.5.2	238	[Line 44] EIP- should this be EIS?	Thank you for pointing this out, it has been amended in the document.
128	Lancashire Care NHS Foundation Trust	8.71	Full	9.5.2	239	[Line 32] young persons’- should be ‘s	Thank you, this has been amended.
129	Lancashire Care NHS Foundation Trust	8.72	Full	9.7	241	[Line 28] help is not isolated,- should say “are” not “is” as the subject of the verb is plural i.e “interventions”	Thank you, this has been amended.
130	Lancashire Care NHS Foundation Trust	8.73	Full	9.7	241	[Line 36] substance issue- would read better as substance use.	Thank you, this has been amended.
131	Manchester Mental Health and Social Care Trust	17.01	NICE	Intro	5	MMHSCT supports the emphasis placed upon the ‘self medication hypothesis’ expressed within the introduction. Local research by this commentator supports the view.	Thank you.
132	Manchester Mental Health and Social Care Trust	17.02	NICE	General	General	The document does not appear to promote the concept of ‘mainstreaming’ of substance misuse interventions (DH DD PIG 2002) in the same	Thank you for your comment, we have avoided using the term ‘mainstreaming’ in this document as it can mean different things to different people and

						manner as did the 2002 DD PIG. For consistencies sake it may be preferable to see the same language and philosophy promoted. That said the detail of the NICE guide does possess the mechanisms for 'mainstreaming' to take place.	did not want to create any confusion. However, the guideline does share many principles of 'mainstreaming', see recommendation 1.4.5.
133	Manchester Mental Health and Social Care Trust	17.03	NICE	General	General	The term dual diagnosis has been categorically avoided in the guidance. Since the term is now functional for training and development purposes and is accepted across substance misuse and mental health services widely to refer to the client group for which the guidance pertains, the term could be employed, with good effect. For instance when referring to the concept of co-morbidity. Dual diagnosis as a term remains valuable in gaining a shared understanding of the issues associated with mental illness and substance misuse.	Thank you for your comments, however the GDG decided not to use this term as it can be confusing to some people and can apply to other coexisting problems. Given that the term used "psychosis and coexisting substance misuse" is easily understood and much less open to misunderstanding, we do not think there should be a change back to 'dual diagnosis'.
134	Manchester Mental Health and Social Care Trust	17.04	NICE	1.4.1	9	The emphasis placed upon training is highly valued and useful. Essential skills for mainstream clinicians can be promoted with greater urgency and focus as a result.	Thank you for your comments.
135	Manchester Mental Health and Social Care Trust	17.05	NICE	1.4.3	9	The emphasis placed on care pathways is supported	Thank you.
136	Manchester Mental Health and Social Care Trust	17.06	NICE	1.4.6 & 1.5.1	9	The emphasis placed on joint working in the specialist high risk fields of opiate, alcohol and benzodiazepine dependency is supported by MMHSCT	Thank you.
137	Manchester Mental Health and Social Care Trust	17.07	NICE	1.1.1	11	A flexible and motivational approach, whilst failing to be demonstrated through RCT, remains the preferred approach among opinion leaders in the field. It is also consistent with assertive outreach and motivational work with pre/contemplators therefore we welcome its inclusion within the guidance.	Thank you.
138	Manchester Mental Health and Social Care Trust	17.08	NICE	1.2.1	16	MMHSCT supports the emphasis placed on A&E, CAMHS and Primary Care services in relation to their pre-requisite skills and knowledge for detection, assessment and onward referral.	Thank you.
139	Manchester Mental Health and Social	17.09	NICE	1.4.3	18	The emphasis given to developing and employing care pathways is essential.	Thank you.

	Care Trust						
140	Manchester Mental Health and Social Care Trust	17.10	NICE	1.4.9	19	The emphasis placed upon 'longitudinal assessment' of the client is fitting. The client group is often chaotic, difficult to engage and variable in presentation therefore their assessment in a number of environments and the collection of corroborative information is essential. By promoting the longitudinal nature of assessment of this client group Trusts can support, and practitioners can justify, conducting assessment over a period of time. This will reduce the likelihood of inaccurate and often value laden conclusions being reached that lead to exclusion or rejection of the client on the grounds that they are possibly unmotivated to change or that their psychiatric presentation is due to substance misuse.	Thank you, we agree.
141	Manchester Mental Health and Social Care Trust	17.11	NICE	1.4.14	20	Biological testing is well contextualised in this section and will help clarify its use as a therapeutic measure rather than an automatic / assumed sanction supporting strategy.	Thank you, we agree.
142	Manchester Mental Health and Social Care Trust	17.12	NICE	1.4.24	22	Within this section more could be added about harm reduction and substance / medication interactions. The MMHSCT research in this field demonstrates powerfully (albeit a qualitative study) that psychosis and substance misuse clients are not as reckless as they are perceived by many to be. Many service users appear to utilise the same biochemical model of addressing psychological / emotional distress as that underpinned by pharmacology. They seek information that will enable them to use their substances and medication in combination and avoid detrimental side effects or interactions.	Thank you. This is an important issue in the management of drug misuse, and we do recommend that the NICE drug misuse guidelines are used for this group of people. The qualitative evidence you cite is interesting and may well be relevant for some individuals. However, we can only use fairly robust quantitative research (which can include qualitative work) to underpin treatment recommendations.
143	Manchester Mental Health and Social Care Trust	17.13	NICE	1.5	23	It may be unrealistic to expect all substance misuse service staff to be able to conduct a full mental health needs assessment. SM services need to possess practitioners that can conduct such full assessments though.	Thank you for your comment, we agree that substance misuse service staff should not have to give a full assessment, but should know when to refer to mental health services. There we have amended this recommendation to read: *Healthcare professionals in substance misuse services should be competent to:*

							• *recognise the signs and symptoms of psychosis* • *undertake a mental health needs and risk assessment sufficient to know how and when to refer to secondary care mental health services*.
144	Manchester Mental Health and Social Care Trust	17.14	NICE	1.5.4	23	MMHSCT support the development of formal joint working protocols	Thank you.
145	Manchester Mental Health and Social Care Trust	17.15	NICE	1.6.4	25	The statement 'Patients should not be discharged from mental health units solely due to substance use' is encouraging and places an emphasis on wider assessment and treatment provision. This statement could be strengthened by a section on contingency planning in such circumstances.	Thank you.
146	Manchester Mental Health and Social Care Trust	17.16	NICE	4.3	31	Whilst there are insufficient studies showing the effectiveness of psychosocial interventions in this client group PSI remains a clinically intuitive approach that opinion leaders and experts promote. Underpinning PSI in this client group are flexible, tenacious and motivationally styled approaches which NICE refers to earlier in the guide. This could be cross referenced.	Thank you. The NICE guideline on schizophrenia is recommended for this group of people if the psychosis is schizophrenia. This guideline includes the use of family interventions and CBT for psychosis, both being key component of "PSI".
147	Manchester Mental Health and Social Care Trust	17.17	NICE	4.4	32	There is sufficient evidence to support environmental interventions. People with a psychosis and substance misuse problem residing in mental health care settings should be targeted optimistically. Staff working in such settings should be better trained and made aware of the valuable potential intervention their environment can provide. Subsequently there is room for greater therapeutic optimism among inpatient staff. In its self a valuable commodity predictive of better outcomes.	Thank you for your comment; however, you provide no actual evidence to support the use of environmental interventions. We agree that staff should work with service users in a atmosphere of optimism – please see recommendation 1.1.1
148	Mental Health Nurses Association	9.01	NICE	General	General	The guidance gives pointers to good practical strategies for services who care for this client group (we assume that 'adults and young people' refers to all over 14, particularly given the rise of alcohol problems in older people).	Thank you. The guideline refers to adults and young people over the age of 14, as specified in the scope of the guideline.
149	Mental Health Nurses Association	9.02	NICE	General	General	Given that the guidance is aimed at Northern Ireland (NI) and Wales as well as England, we are concerned that NI and Wales do not appear to be represented on the development group. This is	Thank you for your comments, we welcome relevant experts from Wales and Northern Ireland to apply for positions on the GDG, however there were no applications forthcoming from Northern Ireland or

						particularly problematic in the case of NI where legislation, policy and service design is quite different from the other countries. We will refer to this below with regard to specific matters.	Wales. Vacancies for GDG positions are posted on the NICE website. They may also appear on the website of the NCC and/or the Royal College or professional body that hosts the NCC, and in other appropriate places identified by the NCC.
150	Mental Health Nurses Association	9.03	NICE	General	General	It may be inevitable with this type of ongoing work stream but NICE guidance is becoming very formulaic. This runs the risk of its users skimming over sections which are very familiar but actually very important in contextualising the care environment. The frequent direction to other NICE guidance whilst understandable may not be that useful for busy practitioners.	Thank you for your comment. We would hope that all NICE guidance is read fully. In a guideline looking at the relationship between two conditions it is inevitable that guidelines focusing on the evidence for the 'pure' condition will have to be referred to, otherwise this guideline would be repeating the evidence base/recommendations of the guidelines for schizophrenia, bipolar, drug misuse, etc. The GDG considered this issue fully and came to the conclusion that the approach taken is the most suitable.
151	Mental Health Nurses Association	9.04	NICE	General	General	Many practitioners working in this field use the term 'dual diagnosis' and many have that phrase in their job title. Is NICE suggesting that this is now out of vogue? It can be confusing because of its use in other service contexts (e.g. to refer to those with learning disability and mental health problems).	Thank you for your comment, as you suggest it can be confusing to use the term dual diagnosis and for that reason it has been avoided in this guideline.
152	Mental Health Nurses Association	9.05	NICE	General	General	In many ways the guidance appears like a rehash of the earlier good practice guidance (2002). It seems disappointing that there is not much new to say!	Thank you for your comment, we agree it is disappointing there is not a more substantial evidence base.
153	Mental Health Nurses Association	9.06	NICE	N/A	6	There is no similar legislation or policy in NI regarding capacity and consent.	Thank you for your comment. We understand the implementation of NICE guidance can be complex, however the onus is on the Department of Health, Social Services and Public Safety in Northern Ireland to make the links and highlight any aspects of the guideline that would be inconsistent or needs special thought in their policy context. For further details please see: http://www.dhsspsni.gov.uk/nice_guidance_01-06.pdf
154	Mental Health Nurses Association	9.07	NICE	N/A	6	Advice regarding the involvement of families and carers glosses over the complex dilemmas that may be involved – could readers be pointed elsewhere for advice?	Thank you for your comment. As well as the NICE guideline we also produce a document called 'Understanding NICE guidance' for each guideline which is specifically targeted at service users and

							carers, and includes a list of relevant organisations. This is referenced in the NICE guideline.
155	Mental Health Nurses Association	9.08	NICE	1.1.11 & 1.6.1	13	It seems wasteful and very expensive that each and every organisation has to set out to generate this kind of information (including DVDs already prepared for carers). Could NICE recommend a national 'bank' of health information that services can use as templates for adding specific local detail? What about written information for patients?	Thank you for your comment. As well as the NICE guideline we also produce a document called 'Understanding NICE guidance' for each guideline which is specifically targeted at service users and carers. These are all available on the NICE website: www.nice.org
156	Mental Health Nurses Association	9.09	NICE	1.1.16	14	It would be useful to refer here to the policy document 'Unmet needs of children in Northern Ireland'.	Thank you for your comment. The Department of Health, Social Services and Public Safety in Northern Ireland have responsibility for highlighting any aspects of the guideline that would be inconsistent or needs special thought in their policy context. It might be more appropriate that policy documents are reviewed by them before specific reference. For further details please see: http://www.dhsspsni.gov.uk/nice_guidance_01-06.pdf
157	Mental Health Nurses Association	9.10	NICE	1.1.18	15	Mental Health Act 2007 does not relate to NI.	Thank you for your comment. As described in response to your earlier comment, the Department of Health, Social Services and Public Safety in Northern Ireland will highlight any aspects of the guideline that would be inconsistent or needs special thought in their policy context.
158	Mental Health Nurses Association	9.11	NICE	1.2.1	16	Many staff working in these areas will lack skills in assessing drug use and dependency. Could written guidance be recommended? Will this be based on the ICD-10 dependency criteria?	Thank you. The guideline states that all people working in mental health services should be competent to work with this group of people and therefore competent to recognize and work with the coexisting substance misuse. The guideline cannot repeat the substance misuse guidelines. Therefore, we have amended the recommendation to read: *"conduct an assessment of dependency (see drug misuse: opioid detoxification (NICE clinical guideline 52). and alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE clinical guideline, forthcoming)"*
159	Mental Health	9.12	NICE	1.3.3	17	This seems rather non-specific, for example, just	Thank you for your comment; we have specified

	Nurses Association					how regularly should physical health be monitored?	that this should be at least once a year (as in the Schizophrenia guideline to which this recommendation refers) but that it should be more frequently if the person has a significant physical illness or is at high risk of physical illness because of their substance misuse.
160	Mental Health Nurses Association	9.13	NICE	1.4.1	17	How is competence to be measured? Should the new e-learning modules produced by the CH and Coventry University be recommended?	Thank you for your comment. Measuring competence is an important issue for healthcare trust, professional managers and professional colleges, as well as being important to patients, however this is an implementation issues and outside the scope of this guideline.
161	Mental Health Nurses Association	9.14	NICE	1.4.2	17	We would prefer this recommendation to be strengthened from 'should consider' to 'should'.	Thank you for your comment. Unfortunately there is not enough evidence to use the word 'should' without consider.
162	Mental Health Nurses Association	9.15	NICE	1.4.3 & 1.4.4	18	It would be helpful to address the question of how services manage people who are intoxicated and unfit to engage in treatment.	Thank you for your comment, we would expect clinicians to exercise their clinical judgement when dealing with individual case and refer to the NICE guidelines *Drug misuse: opoid detoxification (NICE, 2007)* and the forthcoming *Alcohol Use Disorders (NICE, 2011*).
163	Mental Health Nurses Association	9.16	NICE	1.4.5	18	What about those employed in specific 'dual-diagnosis' posts?	Thank you. Unfortunately, there was no good quality evidence about the role or value of dual diagnosis nurses or posts.
164	Mental Health Nurses Association	9.17	NICE	1.4.6	18	Clarity will be required if and when welfare benefit changes occur in relation to engagement in treatment.	Thank you for your comment, however we are only able to comment on the current situation and not on possible changes to government policy.
165	Mental Health Nurses Association	9.18	NICE	Assessment	19 -20	Should the Care Programme Approach and its NI equivalent be referred to?	The CPA is referred to in recommendation 1.4.8. Given that it is used to co-ordinate delivery where the service user is in receipt of more than one service, it is more appropriate here than in the assessment section as you suggest.
166	Mental Health Nurses Association	9.19	NICE	1.4.13	20	Should this include assessment of weight change and liver function?	Thank you, the list in the first bullet are illustrative and not a full list and do not feel it necessary to list all physical health risks.
167	Mental Health Nurses Association	9.20	NICE	Treatment	21 -22	Could advice be included regarding the management and treatment of acute ill-health in cases of, for example, drug induced acute psychosis?	Thank you. Although the physical health of people with coexisting psychosis and substance misuse is an important issue to which we refer at a number of points in the guideline (e.g. 1.4.9), the specific issue of so-called drug induced psychosis has not been

							addressed in this guideline, in particular, we did not look at people with a drug induced organic psychosis. This is outside the scope of the guideline.
168	Mental Health Nurses Association	9.21	NICE	1.4.16	20	Some patients have experienced drug testing as stigmatising. Should it be routine for all people admitted?	Thank you for your comment. The guideline is recommending that biological tests should not be routine, but be agreed with the person first as part of their care plan. The original wording of this recommendation may have been unclear and we have redrafted to make this more understandable.
169	Mental Health Nurses Association	9.22	NICE	1.4.17	21	Could advice be included regarding the complexity and challenges of making a correct diagnosis?	Thank you. This is a complex issue. Rather than specifying the specific details of how to come to a diagnosis for this group of people, we decided to recommend that healthcare workers in both mental health and substance misuse services should be competent to assess both of these conditions. There will need to be considerable effort invested in making this a reality.
170	Mental Health Nurses Association	9.23	NICE	1.5.1	23	This raises issues concerning the professional backgrounds of those working in substance misuse services – not all are qualified mental health practitioners.	Thank you for your comment. The extent of professional involvement of healthcare workers will be determined by their qualifications and experience. The GDG felt all workers should have an understanding of the influence of substance misuse on those with psychosis, and the increased likelihood of this group of service users of taking substances.
171	Mental Health Nurses Association	9.24	NICE	1.6.3	24	Given the enormous pressures in inpatient psychiatry 'designated detoxification beds' seem rather idealistic! If substance misuse services are unavailable this may delay detoxification treatment.	Thank you for your comment, designated detoxification beds are the optimal arrangement as if appropriate services are not available this may delay treatment which could be dangerous.
172	Mental Health Nurses Association	9.25	NICE	1.7	26	Has this been considered in relation to rehabilitation services which often have a complete ban on alcohol and illegal drugs?	Thank you. We have not specified different types of inpatient unit – we have included ALL (1.6.1). This includes rehabilitation words
173	Mental Health Nurses Association	9.26	NICE	1.8.1	26	This seems aspirational rather than feasible.	We recognize that, when a guideline is produced, there is a gap between what can be provided immediately and what the guideline aims for. Otherwise the guideline would just reflect what is already in place – which would make the guideline redundant. Guidelines are, in their conception,

							aspirational.
174	Mental Health Nurses Association	9.27	NICE	General	General	We hoped to see clear direction with regard to the 'dual diagnosis' role given the tensions between clinical work, practice and policy development and practice leadership within these posts.	Thank you. We are sorry that the guideline has been unable to do this. There was no good quality evidence about the role or value of dual diagnosis nurses.
175	MIDAS Therapists	25.01	Full	General	General	***Strengths of the guidelines*** The emphasis of the guidelines in a number of key areas is welcome. This includes: The consistent recognition of the complex interaction between biological, social and psychological factors. Noting that in their (reasons for) substance use, people with psychosis are the same as people without psychosis who use substances Adapting evidence based interventions (including MI) for people with psychosis *and* Noting that there should be no obstacles to people with psychosis accessing mainstream substance misuse treatment	Thank you for your comments.
176	MIDAS Therapists	25.02	Full	General	General	We benefited tremendously from initial and ongoing training opportunities aimed at delivering adherent Motivational Interviewing and CBT. We have all maintained training and professional development since leaving the trial and believe our skills have improved accordingly. Motivational Interviewing was shown to be effective with these clients who were more motivated and more ready to change. Clients with alcohol problems made the biggest changes. We hypothesised that they have more social capital, experience less discrimination or are less marginalised and, as a consequence, are more able to effect change when motivated. A very high proportion of clients stayed in therapy which seemed to reflect something of the integrated and flexible nature of our therapy: Engagement is a challenge for many secondary services. The value of an engaging and flexible style of intervention seems to be supported by the accounts of service	Thank you for all your comments. I am sure that the experience you have all gained in undertaking the most comprehensive study of the treatment of people with coexisting psychosis and substance misuse with motivational interviewing/CBT is considerable if not unique. Unfortunately, at the time of receiving your comments the GDG had not been allowed to see the full results of the MIDAS trial. We will, however, explore with NICE whether we are in a position, at this late stage, to be able to incorporate an analysis of the MIDAS trial into the guideline. However, we can't use your very rich experiences having undertaken all the therapy for this trial, even though I am sure in another (clinical practice) forum your observations, reflections and insights will be of considerable value.

						users. We believe that the therapy is effective in engaging people who are ambivalent about service use *and* in strengthening commitment to change in people who are engaged in treatment. However too short a period of time for both tasks. Therapy provision should helpfully be sensitive to windows of opportunity, a position which does not fit with traditional models of therapy provision and waiting lists. Routine feedback delivered in the context of a motivational Interview is seen to be effective in reducing substance use; perhaps we need to look at this more.	
177	MIDAS Therapists	25.03	Full	General	General	***Implications for practice/service delivery*** Our reflections seem to cover three main areas. In no order of priority (25.04-25.07):	Thank you for your comment, please our response to comment 176.
178	MIDAS Therapists	25.04	Full	6.2.5	151	• **Practice and skills development** Whilst guidelines stress the need for Mental Health and Substance Use practitioners to be skilled up, our experience is that this process is often patchy and characterised by a failure to attend to different levels of need, little thought given to sustaining skills development (e.g. managers and supervisors not involved in training), a lack of attention to integrating training with existing approaches and finally some recognition of the complexity of learning new skills - and maintaining them. Motivational Interviewing training especially, needs to be integrated alongside emerging and existing areas of work (e.g. CBT, Recovery Model). Further some benefits of the wider application -and effectiveness of MI- both in engagement and other health behaviours could be used to integrate it more widely.	Thank you for your comment, please our response to comment 176.
179	MIDAS Therapists	25.05	Full	4.2.2 /4.2.3	63 -71	• **Service user feedback** This is a hallmark of collaborative psychological therapy. Listening to the experiences of service users and using these to in form the development of effective services should be central to all aspects of service delivery.	Thank you for your comment, please our response to comment 176.

				4.4.7	88	Our experience was that clients were often surprised at worst and very positive at best at the novelty of working in a collaborative, person centred way that took clear account of their experiences. We believe that this is an important factor in maintaining engagement and developing motivation for change.	
180	MIDAS Therapists	25.06	Full	5.2.3 6.2.5	119 151	• **Service models** There is not a unified strong view about service models and this seems to reflect the variety of services within which we found ourselves working. However there are several key elements that link our thoughts about this: • Building capacity to develop a generation of trainers who promote sustainable learning both through promoting continual cycles of training and practice development within teams and linked to clinical practice. Training people to work across approaches takes additional time. • Promoting integrated approaches both within and between services and agencies so that interventions take place with a wider context of care.	Thank you for your comments. We agree that training and building capacity are important, and so developed a number of recommendations that specifically addressed this issue. For example, see NICE guideline recommendation 1.4.2.
181	MIDAS Therapists	25.07	Full	4.8.1.7	114	The MIDAS Therapy was a psychological intervention which we believe would work most effectively alongside social interventions including Family Support, SBNT and CRAFT. The guidelines are by definition targeted at healthcare providers where our experience and the guidelines highlight the importance of housing and social care providers in this area. This suggests – at least- a wider circulation for the guidelines or some supplementary information to social care providers.	Thank you for your comment, please our response to comment 176.
182	MIDAS Therapists	25.08	Full	General	General	The focus on 'change' (and to some extent engagement) should not solely be on the client but it as the heart of work related to people with psychosis who use alcohol and drugs. Changing attitudes, changing perceptions and changing relationships are central to the successful support of	Thank you for your comment, please our response to comment 176.

						these service users and staff in our view. Feedback from a recent conference presentation (BABCP, Manchester 2010) suggested that this was a very complex and heterogeneous study group which defies any straightforward explanation in terms of change. We think the results of the MIDAS study and our experiences have begum to unpick some of these issues. In their own right, but also to match what we know about demographic changes, older adult mental health services should be included in training, information and consultation networks routinely and substance misuse services should show demonstrable commitment to adapting services to the needs of older adults.	
183	National Mental Health Development Unit	16.01	NICE	1.4.14 1.4.15	20	On biological testing - The language needs to be clearer to avoid confusion and potential conflict with UK clinical guidelines for substance misuse treatment. biological testing should be used as part of a consensual agreement and care planned activity and never as an imposed, routine screening without consent"	Thank you for your comment; we have redrafted this section.
184	National Mental Health Development Unit	16.02	NICE	1.2.1 1.4.3 1.4.4	16 18 18	These points are very good	Thank you.
185	National Mental Health Development Unit	16.03	NICE	1.6.4 1.4.9	25 19	Welcome these statement	Thank you.
186	National Mental Health Development Unit	16.04	NICE	1.4.6 1.5.1	18 23	But only in the presence of acute Mental ill health	Thank you, we feel this is reflected in the recommendations.
187	National Mental Health Development Unit	16.05	All	general	general	there are many variables across the country with regard to crisis or planned detox for individuals with psychosis If an inpatient (acutely unwell) patient would get a detoxification programme but if in community and needing detox to prevent deterioration of psychotic	Thank you for this comment – we agree the implications of planned detox will need to be carefully considered by service managers and commissioners.

						symptoms a detox would be unlikely due to pressures on beds etc.	
188	National Mental Health Development Unit	16.06	All	general	general	Welcome the inclusion of CAMHS, OA, Forensic MH however would welcome some focus on Learning Dissability, asbergers, ADHD also as increasing presentations.	Thank you for your comment, however these conditions fall outside the scope and we are therefore unable to address them in this guideline.
189	National Mental Health Development Unit	16.07	All	general	general	IAPT services generally exclude Drugs & Alcohol which is a missed opportunity. should this guidance cross reference with the nice guidelines on psychological therapy to address this?	Thank you for your comments. We hope this guideline will address the exclusion of individuals with psychosis and substance misuse from such services.
190	National Mental Health Development Unit	16.08	NICE	4.3 1.4.2.4	30 22	Welcome the fact this guidance recognises the self medication hypothesis and use of PS.I despite the evidence strongly welcome this however self medication hypothesis to be used with caution as can sometimes be seen as pejorative – this could however be supported by point 1.4.2.4	Thank you for your comment, we are not sure we fully understand the point you are making but it appears you are happy with the guideline's current orientation.
191	National Mental Health Development Unit	16.09	All	General	general	2002 DH guidance concentrated on mainstreaming however there is little comment on this within the guidance. Should this be mentioned within the guidance? Integrated services recommendation provided a significant amount of role legitimacy and supported an integrated treatment approach within MH services and the absence of any direction within the guidance could weaken this important point.	Thank you for your comment, we have avoided using the term 'mainstreaming' in this document as it can mean different things to different people and did not want to create any confusion. However, the guideline does share many principles of 'mainstreaming', see recommendation 1.4.5.
192	National Mental Health Development Unit	16.10	All	General	general	Offender health contribution welcomed but needs to reinforce the pathways from prison to community.	Thank you for your comments, this guideline has not reviewed the evidence for prison populations, although the recommendations may be relevant to those working within prison/forensic services, and is unfortunately outside the scope of this guideline.
193	National Mental Health Development Unit	16.11	All	General	general	The guidance focuses greatly on psychosis and substance misuse in mental health services but misses an opportunity to address how substance misuse services can in put into this process with appropriate support and training.	Thank you for your comments. We agree it is extremely important for healthcare professionals working in substance misuse services to support the process. We've included further recommendations for substance misuse services to address these issues.
194	National Mental Health Development Unit	16.12	Full	General	General	We were struck by the fact that almost all of the important questions are 'don't know - there isn't sufficient evidence to say'.	Thank you for your comments. We agree there is currently a paucity of evidence, and little to suggest that treatment should be different for service users with both psychosis and substance misuse

						As a consequence, the long version shows an extremely robust and industrious approach, with excellent analysis of the issues, but the short version (conclusions and recommendations) comes over as a more bland document suggesting that we do pretty-much everything recommended in the two separate sets of Guidelines - for Schizophrenia and Substance Misuse - with little extra added.	problems. However, the GDG feel that there are important recommendations for management that are not covered by the existing guidelines. In addition, the research recommendations have been expanded.
195	National Mental Health Development Unit	16.13	Full	General	General	We felt there was limited consideration of how Early Intervention in Psychosis Services and Dual Diagnosis posts contributed to care - the former being the primary treatment service in the early stages for all those with these co-morbid difficulties; the latter representing the pool of expert knowledge in the marriage of these dual difficulties. We recognise, however, that the GDG may have positioned this deliberately to espouse an integrated approach rather than a specific service configuration or worker role.	Thank you for your comment, it was the GDG view that the primary place for treating people with psychosis and substance misuse would be community mental health teams, which includes Early Intervention services, CMHTs, ACTs and others. There is no evidence regarding dual diagnosis workers, and in general we refer to health care professionals, rather than specific job titles.
196	National Treatment Agency for Substance Misuse	21.01	NICE	Intro	4	The broad definition of substance use, including alcohol use is welcomed.	Thank you.
197	National Treatment Agency for Substance Misuse	21.02	NICE	Intro	5	Suggest rewording: “partly because the substances used “may” exacerbate the psychosis and partly because substances “may” interfere with pharmacological or psychological treatment.	We have changed to ‘may exacerbate’ but have not changed ‘may’ to often in the second instance because this will weaken the message.
198	National Treatment Agency for Substance Misuse	21.03	NICE	Intro	5	Suggest adding the words: “or stop” to the last sentence so that it reads “to reduce or stop substance misuse”.	Thank you, we have changed the introduction as you have suggested.
199	National Treatment Agency for Substance Misuse	21.04	NICE	3	8	In addition to (or instead of) describing what healthcare professionals should ask about in relation to substance use, it would be helpful to recommend healthcare professionals find out about and use locally-agreed screening tools.	Thank you for your comment. The specific management of substance misuse is dealt with in the *Drug misuse: opoid detoxification* (NICE, 2007) guideline.
200	National Treatment Agency for Substance Misuse	21.05	NICE	3	9	There is a recommendation to “conduct an assessment of dependency” but no indication of how this might be done.	Thank you. The guideline states that all people working in mental health services should be competent to work with this group of people and therefore competent to recognize and work with the coexisting substance misuse. The guideline cannot repeat the substance misuse guidelines. Therefore,

							we have amended the recommendation to read: *"conduct an assessment of dependency (see drug misuse: opioid detoxification (NICE clinical guideline 52). and alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE clinical guideline, forthcoming)"*
201	National Treatment Agency for Substance Misuse	21.06	NICE	3	9	Co-ordinating Care: (crack) cocaine use is not included here.	Thank you for your comment; we have added (crack) cocaine to the recommendation.
202	National Treatment Agency for Substance Misuse	21.07	NICE	3	9	Substance misuse services are advised to be competent to "recognise the signs and symptoms of psychosis" and undertake full mental health needs and risk assessment but there is no indication of how they might do this. We suggest references to clinical competences and ensuring access to comprehensive mental health assessment including risk assessment by professionals with relevant qualifications. We cannot expect the vast bulk of addictions workers to assess significant psychiatric risk.	Thank you for your comments. The guideline can not give the level of detail suggested without becoming a treatment manual. The GDG were quite sure that healthcare workers working with people with psychosis should ensure that they are competent to identify and assess substance misuse; and that healthcare professionals working in substance misuse services should be able to recognise, assess and know when to refer people in the substance misuse service with possible psychosis. Both of these are necessary for us to collectively improve the rate of recognition and treatment of these conditions in people where they simultaneously co-exist.
203	National Treatment Agency for Substance Misuse	21.08	NICE	1.1.2	11	The competences of interpreters to neutrally convey information around both substance use and mental health is important here.	Thank you, it is important that all professionals referred to in the guideline are competent. Whilst we do raise this issue for health care professionals working in secondary mental health are and specialist substance misuse services, to raise the competence issue for all others, including interpreters would make the guideline very long and wordy.
204	National Treatment Agency for Substance Misuse	21.09	NICE	1.1.5	12	Re word: "written information" can't be made available in "an accessible format (audio or video)". We suggest this is changed to 'alternative format'.	Thank you. We have changed the recommendation as you have suggested.
205	National Treatment Agency for Substance Misuse	21.10	NICE	1.1.15	14	Agreed safeguarding procedures between the young people's specialist substance misuse agency and the local safeguarding children's board should already be in place so that the child's or young person's needs can be assessed according to local	Thank you for this comment, we agree. We hope that 1.1.17 makes this explicit.

						safeguarding procedures.	
206	National Treatment Agency for Substance Misuse	21.11	NICE	1.1.16	14	CAF should be carried out by the lead professional. The second bullet point seems confusing. It should read "ensure that joint working takes place between the specialist agency and the lead professional."	Thank you for your comment; we have made some changes to the recommendation that cites the CAF. However we do not agree that that the second bullet point should read as you have suggested. Your wording seems to be about a different recommendation, but without the correct number we are not sure which one.
207	National Treatment Agency for Substance Misuse	21.12	NICE	1.1.18	15	This section needs to consider wider legislation in terms of young people consenting to treatment and parental involvement, for example the Gillick Competence.	Thank you for your comment. Issues of consent are covered in section 2 on patient-centred care.
208	National Treatment Agency for Substance Misuse	21.13	NICE	1.2.1	16	Healthcare professionals are advised to conduct an assessment of dependency. We again suggest references to clinical competences which may be described in Drug and alcohol national occupational standards (DANOS).	Thank you. The guideline states that all people working in mental health services should be competent to work with this group of people and therefore competent to recognize and work with the coexisting substance misuse. The guideline cannot repeat the substance misuse guidelines. Therefore, we have amended the recommendation to read: *"conduct an assessment of dependency (see drug misuse: opioid detoxification (NICE clinical guideline 52). and alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE clinical guideline, forthcoming)"*
209	National Treatment Agency for Substance Misuse	21.14	NICE	1.2.2	16	We know that many healthcare professionals do not have the competencies to accurately assess mental health problems. Can we suggest an overarching comment about the competences of two staff groups to assess and refer.	Thank you for your comment, we agree that substance misuse service staff should not have to give a full assessment, but should know when to refer to mental health services. There we have amended this recommendation to read: *Healthcare professionals in substance misuse services should be competent to:* • *recognise the signs and symptoms of psychosis* • *undertake a mental health needs and risk assessment sufficient to know how and when to refer to secondary care mental health services*.
210	National Treatment Agency for Substance Misuse	21.15	NICE	1.4.1	17	More information about these competences may be useful.	Thank you for your comment. This is an implementation issue for healthcare trust, professional managers and professional colleges

							and is outside the scope of this guideline.
211	National Treatment Agency for Substance Misuse	21.16	NICE	1.4.3	18	We support this recommendation; often young people are excluded from CAMHS provision because of their substance misuse.	Thank you.
212	National Treatment Agency for Substance Misuse	21.17	NICE	1.4.6	18	Include (crack) cocaine	Thank you, we have added (crack) cocaine to the recommendation.
213	National Treatment Agency for Substance Misuse	21.18	NICE	1.4.9	19	The recommendation to assess "personal strengths and weaknesses and readiness for change" perhaps needs to be expanded to assess other recovery resources that may be available to someone in their family, friends or community?	Thank you for your comment, we feel this is covered by the bullet point "social, family and economic situation", as well as recommendations 1.1.8 – 1.1.14
214	National Treatment Agency for Substance Misuse	21.19	NICE	1.4.9	19	Perhaps clarification on what a patient might be ready to change – presumably their substance misuse rather than their mental health.	Thank you for your comment, this has been amended in the document.
215	National Treatment Agency for Substance Misuse	21.20	NICE	1.4.19	21	There is no mention of NICE Technology Appraisal on opioid substitution therapy (Technology Assessment Report , 2007)	Thank you for your comment. We agree that achievement of stability in opiate use e.g. by the use of OST, should be beneficial for the patient who is experiencing psychosis. The Technology Appraisal is included in the NICE guideline *Drug misuse: opoid detoxification* (NICE, 2007) and therefore will not be covered in this guideline.
216	National Treatment Agency for Substance Misuse	21.21	NICE	1.4.24	22	Consider the interaction between methadone and buprenorphine and psychiatric medications?	Thank you for your comment. We agree that consideration of potential drug interactions are important. These issues are covered in more detail in section 8.2.8 of the full guideline.
217	National Treatment Agency for Substance Misuse	21.22	NICE	1.4.20	22	Readiness to change point as in example 14.	Thank you for your comment, however we are unsure what you are referring to in 'example 14'?
218	National Treatment Agency for Substance Misuse	21.23	NICE	1.4.21	22	We are not aware of any evidence base for under-16s with contingency management.	Thank you for your comment. Given the paucity of evidence for the treatment of young people, the GDG extrapolated from the evidence for adults.
219	National Treatment Agency for Substance Misuse	21.24	NICE	1.5.1	23	There is a wide range of "substance misuse services" and it perhaps needs to be clarified which should be expected to "undertake a full mental health needs and risk assessment". Not all services have specialist professionals such as psychologist and psychiatrists.	Thank you for your comment. The GDG were convinced that these basic competencies for people working in substance misuse services were essential to be able to recognise assess and refer people with psychosis.
220	National Treatment	21.25	NICE	1.5.3	23	This recommendation would have resource	Thank you for this comment – we agree the

	Agency for Substance Misuse					implications for substance misuse services especially in terms of training.	implications of training will need to be carefully considered by service managers and commissioners.
221	National Treatment Agency for Substance Misuse	21.26	NICE	1.6.3	24	There is no mention of opioid substitution therapy (OST). OST has antipsychotic effects to stop or reduce methadone may well lead to a worsening of symptoms – as well as placing the client at the well known risk of overdose death following enforced detoxification.	Thank you for your comment. We agree that achievement of stability in opiate use e.g. by the use of OST, should be beneficial for the patient who is experiencing psychosis. The Technology Appraisal is included in the NICE guideline *Drug misuse: opoid detoxification* (NICE, 2007) and therefore will not be covered in this guideline.
222	National Treatment Agency for Substance Misuse	21.27	NICE	1.6.5	25	Include planning and advice to service users on discharge from environments such as inpatient wards on risks of overdose for relevant substances such as opioids. Suggest specifing that the care coordinator needs to be in a community CMHT.	Thank you. Thank you for your comment, we have added an extra bullet point to 1.6.5 to incorporate your concerns regarding overdose. We do recommend that the mainstay of treatment and care for this group should be the CMHT including the care coordinator (see 1.4.8).
223	National Treatment Agency for Substance Misuse	21.28	NICE	1.8.8	27	This document needs to make clear that within every local authority area there are specialist substance misuse services for young people under 18 and these services should all be working with CAMHS.	Thank you for your comment, recommendation 1.8.8 (now 1.8.9) specifies that there should be age appropriate MH services for all young people. These could be provided within CAMHS or EIS with support from specialist substance misuse workers either from within or from other services. There is no evidence to suggest which configuration is best.
224	NETSCC – Referee 1	6.01	Full	general	general	**1.1 Are there any important ways in which the work has not fulfilled the declared intentions of the NICE guideline (compared to its scope – attached)**No, obviously major problem with lack of evidence but good design and structure for the guidance. I particularly welcome the qualitative reviews and narratives. Carer section useful but see below in terms of lack of consideration in NICE economic evaluation guidance and how that may impact on future evaluations.	Thank you for your comments.
225	NETSCC – Referee 1	6.02	Full	general	general	**2.1 Please comment on the validity of the work i.e. the quality of the methods and their application (the methods should comply with NICE's Guidelines Manual available at http://www.nice.org.uk/page.aspx?o=guidelines manual).**These were good and well explained	Thank you for your comment.
226	NETSCC –	6.03	Full	1.1.2	13	**2.2 Please comment on the health economics**	Thank you for your comments. Anyone with

	Referee 1					**and/or statistical issues depending on your area of expertise.** The guidance correctly identifies the need to support care and interventions to engage and retain the client group. The importance of key workers was also a feature of the narrative reviews. It is important to note that such case monitoring and key working could add expense to many of the recommendations in the guidance while being a major factor in ensuring better care. Clearly there was no evidence on effectiveness or cost-effectiveness of this part of integrated care – I did not see this worked up in a research recommendation either and it seems important	psychosis will have a key worker as this is standard practice within mental health services. Indeed, most people with psychosis will have a care co-ordinator as well as a key worker, who may be the same person.
227	NETSCC – Referee 1	6.04	Full	general	114	The needs of carers are mentioned in this section but generally the costs and effects on carers would not be included in NICE economic modeling. Does this need some comment?	Thank you. A comment on the economic burden to carers has been added to the relevant evidence to recommendations section.
228	NETSCC – Referee 1	6.05	Full	6.2.2 & 7.2.8 for example	145	The outcomes of interest for the effectiveness review include a number which would be excluded from an economic modeling exercise if such data had been available. This may be an issue if the guidance is revised. The economic evidence reviewed while limited had taken a wider social perspective and included economic values for many of these items. However, in the review no attempt was made to look at the results as they would have been from a Health and personal social services – NICE perspective. These points do not alter any of the conclusions but I feel some comment should be made on this coverage in the economic review sections in the document	Thank you. Further discussion of the societal perspective adopted in the studies considered in the health economics literature has been added to sections 6.2.7 and 7.2.8.
229	NETSCC – Referee 1	6.06	Full	General	General	**3.1 How far are the recommendations based on the findings? Are they a) justified i.e. not overstated or understated given the evidence? b) Complete? i.e. are all the important aspects of the evidence reflected?** Yes very clear	Thank you for your comment.
230	NETSCC – Referee 1	6.07	Full	General	General	**3.2 Are any important limitations of the evidence clearly described and discussed?** Yes	Thank you for your comment.
231	NETSCC –	6.08	Full	Gener	Gener	**4.1 Is the whole report readable and well**	Thank you for your comment.

	Referee 1			al	al	**presented? Please comment on the overall style and whether, for example, it is easy to understand how the recommendations have been reached from the evidence.** No this was clear	
232	NETSCC – Referee 1	6.09	Full	8.3.2	229	**4.2 Please comment on whether the research recommendations, if included, are clear and justified.** Did there need to be a research recommendation on interactions of different pharmacotherapies?	Thank you for your comment. The GDG feel that due to the large number of variables, together with the findings from general reviews that drug interactions did not appear to be significant for the majority of cases, we are unable to consider this as a priority recommendation.
233	NETSCC – Referee 1	6.10	Full	9.9.2	250	The research question posed is a bit general – risk factors and potentially there should be more specific recommendations on care research	Thank you, all research recommendations have been amended to provide better justifications, however risk factors are notoriously difficult to research effectively and we would need to take a fairly broad approach to begin with.
234	NETSCC – Referee 1	6.11	Full	gener al	gener al	Some other general research questions could include how to include researching lower levels of substance misuse for intervention within this patient group and which interventions work – this links to the qualitative sections. Does there also need to be some research recommendations around how different professionals could work with each other and provide some of the systems research lacking for guidance of this sort.? Perhaps also more research on the outcomes for this clinical group and whether EQ-5D could capture impacts on patients and their carers/families.	Thank you for your comment. Although these are important questions, they are not central to the guideline. This question is difficult to research and the design is unlikely to give definitive answers, and although it is an important one about the value of EQ-5D in mental health but it is too broad for this guideline.
235	NETSCC – Referee 1	6.12	Full	7.2.2	177	**Please make any additional comments you want the NICE Guideline Development Group to see, feel free to use as much or as little space as you wish.** Small typing mistake line 9 sstandard	Thank you, this has been amended.
236	NETSCC – Referee 1	6.13	Full	7.2.2	178	[Lines 12-19] This is an odd definition of a family interventions – it seems to suggest some sessions with families rather than being either a family support intervention or more directed at client and families in supporting the families	Thank you for your comment. As there is no evidence of effectiveness for family interventions it is not fully explored in this guideline. For further information on family interventions please see NICE clinical guideline 82, *Schizophrenia Update,* pg 23.
237	NETSCC – Referee 1	6.14	Full	7.2.2	178	Clinical colleagues who I work with in evaluating MET would suggest that feedback is an essential	Thank you for your comment. The guideline is not a textbook on all aspects of care and cannot provide

						part of MET differentiated the intervention for motivational interviewing as a style of therapy.	specific details of MI and MET techniques. For further information please be referred to references which elaborate on the elements of the approaches in considerable detail.
238	NETSCC – Referee 2	7.01	Full	general	general	**1.1 Are there any important ways in which the work has not fulfilled the declared intentions of the NICE guideline (compared to its scope – attached)** As far as I can tell, each element of the scope is addressed to some degree	Thank you for your comment.
239	NETSCC – Referee 2	7.02	Full	general	general	**2.1 Please comment on the validity of the work i.e. the quality of the methods and their application (the methods should comply with NICE's Guidelines Manual available at http://www.nice.org.uk/page.aspx?o=guidelines manual).** In my opinion, the guideline is presented in a clear and logical manner, and the methods used appear to be appropriate throughout, subject to the statistical comments below	Thank you for your comment.
240	NETSCC – Referee 2	7.03	Full	3.5.4	47	**2.2 Please comment on the health economics and/or statistical issues depending on your area of expertise.** In general, the meta-analysis methods used are appropriate	Thank you for your comment.
241	NETSCC – Referee 2	7.04	Full	3.5.4	48	Lines 12-13. The description of a confidence interval is not correct. Better descriptions would be "The CI shows a range of values within which we are 95% confident that the true effect will lie" or "The CI shows a range of possible effect sizes that are consistent with the available data at a 5% level of statistical significance; if the "line of no effect" is not within the CI, then the data are not consistent with there being no effect"	Thank you for your comment. Part of this description comes from the Cochrane Handbook, although the handbook acknowledges that "This statement is a loose interpretation, but is useful as a rough guide." We are happy to use your suggestion "*The CI shows a range of values within which we are 95% confident that the true effect will lie",* but believe the description of statistical significance is open to misinterpretation. We have amended the text to read "*If the effect size has a CI that does not cross the 'line of no effect', then the effect is commonly interpreted as being statistically significant."*
242	NETSCC – Referee 2	7.05	Full	3.5.4	49	Line 6 should read ">50%"; line 8 should read "<30%", or possibly ">=" and "<="	Thank you, the text has been amended.
243	NETSCC –	7.06	Full	3.5.4	49	The section on publication bias discusses funnel	Thank you, we have amended the text to read

	Referee 2					plots, but I did not see any in the guideline or the appendices	*"Where there was sufficient data, we intended to use funnel plots to explore the possibility of publication bias. Asymmetry of the plot would be taken to indicate possible publication bias and investigated further. However, due to a paucity of data, funnel plots could not be used."*
244	NETSCC – Referee 2	7.07	Full	6.2.4	149	Table 13: I found this and other similar tables to be difficult to digest: o -The outcome descriptions are repetitive – if the table were split into 3 parts, one for each outcome, then the outcome description could be included in the table heading, and the first column of the table could be simply the time point. o Splitting the CI for the effect size over two lines is not good presentation o footnote 1 – the meaning of "optimal information size not met" is not clear o footnote 2 – there is no definition of "appreciable benefit or appreciable harm" o "MD" is defined, but "SMD" is not o "RR" is defined, but no RRs are reported	Thank you. The GRADE software produces these tables. Manually editing the tables is possible in this guideline, but would be difficult in a guideline with a large number of GRADE profiles. We have improved the footnote description, and defined SMD (and removed RR).
245	NETSCC – Referee 2	7.08	Full	6.2.4	150	The rows: "Service use: 1. Days in stable community residences (not in hospital) – by 36 months", and "Functioning: 1. Average general score (GAS, low=poor) – by 6 months" are repeated lower down the table	Thank you, we have amended that table.
246	NETSCC – Referee 2	7.09	Full	6.2.5	38 -39	If mean total 18 month costs are £26,449 and £23,266, then the difference is not £1,033, unless this is an adjusted estimate of the mean difference	Thank you. The figures of £26,449 and £23,266 have been incorrectly quoted from the article. The correct mean total 18 month costs (£18,672 and £17,639) have been inserted in the guideline text.
247	NETSCC – Referee 2	7.10	Full	6.2.6	39	Lines 16-19: prevalences are reported as ranges – are these confidence intervals, or something else?	Thank you, the two numbers represent the proportion in each group. Given that the paper reports no significant difference between groups, we've amended the text to give the overall proportion. "Of the total sample, 21% had a principal diagnosis of schizophrenia, 20% bipolar, 11% alcohol or substance use disorder."
248	NETSCC –	7.11	Full	6.2.6	40	Lines 6-7: as above, now using the term "range"	Thank you, the text has been amended to be

	Referee 2						consistent with Mangrum.
249	NETSCC – Referee 2	7.12	Full	6.2.6	39 -40	Why are the prevalence figures from Mangrum reported as integers, but for Drake they are reported to 1 decimal place?	Thank you, the text has been amended to be consistent with Mangrum. “The entire sample met criteria for alcohol or drug dependence, and most had a diagnosis of schizophrenia (50%) or bipolar disorder (17%).”
250	NETSCC – Referee 2	7.13	Full	7.2.5	191	We are told that a negative MD favours the intervention, but only RRs and SMD are reported	Thank you, the text “MD” should have been “SMD” and, where appropriate, has been amended in the text.
251	NETSCC – Referee 2	7.14	Full	7.2.5	192	Functioning 1 at 9 months and Functioning 2 at 12 months are referenced to footnote 2, but neither CI includes zero	Thank you, the wrong footnote was referenced – this has been amended.
252	NETSCC – Referee 2	7.15	Full	7.2.5	193	The rows from Substance use 1 at 12 months, to Functioning 1 at 12 months all have CIs that include zero, but are not referenced to footnote 2	Thank you for your comment. However, each outcome is only downgraded on the basis of footnote 2 if the CI includes BOTH no effect and appreciable benefit or harm. In these cases, the GDG did not consider these criteria to be met (for example, a MD of between -3.35 and 1.77 on the C-DIS-R was not thought to be clinically important, therefore, the outcome was not downgraded on the basis of imprecision).
253	NETSCC – Referee 2	7.16	Full	7.2.5	194	Table 27: none of the effect estimates include zero, but all are referenced to footnote 2	Thank you, we agree these outcomes should not have been downgraded on this basis.
254	NETSCC – Referee 2	7.17	Full	7.2.5	194	Table 27: the footnote includes definitions of MD and RR, but all effects are reported as SMD, which is not defined	Thank you, we’ve updated the footnote.
255	NETSCC – Referee 2	7.18	Full	9.2.1	232	Line 31, in brackets: should read “…12949 in 25 to 34 age group”	Thank you, this has been amended.
256	NETSCC – Referee 2	7.19	App 14	General	General	Many of the forest plots are of single studies. For figure 1.1, fo example, each pair of effect estimates is a single study and te “subtotal” which is the same estimate. Some report the estimate from one study, a subtotal, and a total effect estimate, all of which are the same (2.2 on page 16, and 5.1 and 5.3 on page 23). One (3.6 on page 18) shows a forest plot of one study, with nothing to report. Whilst not technically incorrect, these figures give the impression that a meta analysis is being carried out when it is not.	Thank you, we agree that it may be misleading to include subtotal and total summaries when there is only a single study, and so have recreated the graphs without these. We believe that forest plots are useful for displaying data from even a single study (and this is what the GDG were presented with), and so we do not propose to change this.

						Some discretion should be used to decide which results to report in tables (single studies) and which to show in forest plots (where there are two or more studies being combined)	
257	NETSCC – Referee 2	7.20	Full	general	general	**3.1 How far are the recommendations based on the findings? Are they a) justified i.e. not overstated or understated given the evidence? b) Complete? i.e. are all the important aspects of the evidence reflected?** In general, there is little room to make recommendations based on the quantitative evidence, since there tend to be few studies on any particular topic, often providing little or no evidence of treatment effect differences. Where such evidence is found, the recommendations reflect this.	Thank you for your comment.
258	NETSCC – Referee 2	7.21	Full	General	general	**3.2 Are any important limitations of the evidence clearly described and discussed?** I think this is handled quite well, throughout	Thank you for your comment.
259	NETSCC – Referee 2	7.22	Full	general	general	**4.1 Is the whole report readable and well presented? Please comment on the overall style and whether, for example, it is easy to understand how the recommendations have been reached from the evidence.** Some of my statistical comments could be seen as matters of presentation	Thank you for your comment.
260	NETSCC – Referee 2	7.23	Full	general	general	**4.2 Please comment on whether the research recommendations, if included, are clear and justified.** I cannot give any specific suggestions, but my impression was that there were quite few research recommendations, given that the evidence from existing studies is generally so weak	Thank you for your comment, we have expanded the research recommendations.
261	NETSCC – Referee 2	7.24	Full	general	general	One recommendation that could be made (though it may already exist) would be the setting up of a register of patients in this category, which could support epidemiological research	Thank you for this comment, however we would need a specific question, and if answered it could improve the next guideline.
262	NHS Direct	19.01	All	General	General	NHS Direct welcome the guideline and have no comment on its content.	Thank you.
263	Nottinghamshire Healthcare NHS Trust	20.01	NICE	1.4.14 1.4.15	20	Biological screening – the paragraph is somewhat contradictory. The language is confusing and conflicts with UK clinical guidelines for substance	Thank you for your comment; we have redrafted this section.

						misuse treatment.	
264	Nottinghamshire Healthcare NHS Trust	20.02	NICE	1.2.1 1.4.3 1.4.4	16 18 18	The Trust welcomes these very clear directives.	Thank you.
265	Nottinghamshire Healthcare NHS Trust	20.03	NICE	1.5	23	There is potential conflict between the content of the NICE guidelines and commissioning of services. DAAT and CDP commissioners have clearly stated in Nottinghamshire that mainstream Substance misuse services are not commissioned to perform this function.	Thank you for your comment. The GDG were convinced that these basic competencies for people working in substance misuse services were essential to be able to recognise assess and refer people with psychosis. We would hope commissioners would take note of these recommendations.
266	Nottinghamshire Healthcare NHS Trust	20.04	NICE	1.6.4 1.4.9	25 19	The Trust welcomes these very clear statements.	Thank you.
267	Nottinghamshire Healthcare NHS Trust	20.05	NICE	general	general	The NICE guidance could be more explicit on the use of Community Treatment Orders for this client group.	Thank you for your comment. Whilst we agree this is an important issue, it is outside the scope of this document and would be inappropriate for NICE guidelines to interpret the amended Mental Health Act, or related guidance.
268	Nottinghamshire Healthcare NHS Trust	20.06	NICE	general	general	There are significant inequalities resulting from variability in commissioning practices with regard to crisis or planned detox for individuals with psychosis. People who are inpatients on acute psychiatric wards are often appropriately detoxified but the situation is far more varied for people in the community who need detoxification. There is still considerable challenges in getting Psychiatrists to take on responsibility for detoxification and liaison with their addiction colleagues. It would be helpful if the NICE guidance could highlight these inequalities and we would refer them to the concept of mainstreaming or integration outlined in the 2002 DH Good Practice Guidance.	Thank you for your comment, the more complex issues regarding detox arrangements are covered in the NICE guideline *Drug misuse: opoid detoxification (NICE, 2007)* and the forthcoming *Alcohol Use Disorders (NICE, 2011)* and are not in the remit for this guideline. We have avoided using the term 'mainstreaming' in this document as it can mean different things to different people and did not want to create any confusion. However, the guideline does share many principles of 'mainstreaming', see recommendation 1.4.5.
269	Nottinghamshire Healthcare NHS	20.07	NICE	general	general	Clearly this guidance is aimed at those individuals with Psychosis. However, we would welcome some	Thank you for your comment, however these conditions fall outside the scope and we are

	Trust					future focus on Learning Disabilities particularly Aspergers and ADHD where there are growing problems associated with Alcohol and drug use co-morbid to the primary diagnosis. The reference to other services such as CAMHS, Old Age psychiatry and Forensic Mental Health is welcome.	therefore unable to address them in this guideline.
270	Nottinghamshire Healthcare NHS Trust	20.08	NICE	4.3 1.4.2. 4	30 22	Recognition the self medication hypothesis is most welcome. However, the guidance might urge caution when referring to the self medication hypothesis as can sometimes be used pejoratively by practitioners to suggest that the client/service user has control over their substance misuse. Use of PSI despite the lack of conclusive evidence is strongly welcomed.	Please see the response to comment 190.
271	Nottinghamshire Healthcare NHS Trust	20.09	NICE	general	general	The guidance states it is MDT in it's makeup of the group however it must be noted that psychiatrist formed the majority of the group	Thank you. Individuals are selected for their expertise and to ensure that the GDG can properly address the scope of the guideline.
272	Nottinghamshire Healthcare NHS Trust	20.10	NICE	general	general	2002 DH guidance concentrated on mainstreaming however there is little comment on this within the guidance. Integrated service approach which was a recommendation in DH 2002 provided role legitimacy and supported an integrated treatment approach within MH services.	Thank you for your comment, we have avoided using the term 'mainstreaming' in this document as it can mean different things to different people and did not want to create any confusion. However, the guideline does share many principles of 'mainstreaming', see recommendation 1.4.5.
273	Nottinghamshire Healthcare NHS Trust	20.11	NICE	general	general	The issue of Offender Health is welcomed. The guidance could offer a stronger steer in accentuating the opportunity for integration between offender health care and community services	Thank you for your comments, this guideline has not reviewed the evidence for prison populations, although the recommendations may be relevant to those working within prison/forensic services, and is unfortunately outside the scope of this guideline.
274	Nottinghamshire Healthcare NHS Trust	20.12	NICE	general	general	The focus of this guidance appears to be on substance misuse in mental health services which is clearly where the significant proportion of issues arise. However, this may be seen as an overemphasis and the panel may wish to explore how to rebalance the document so that there is equal focus and emphasis on the need for substance misuse services to identify, assess and treat those people within their services who do not have contact with secondary mental health services.	Thank you for your comment, the GDG felt overall this is a balanced document with information about identification and assessment in substance misuse services (section 5.5), and we also address assessment for psychosis within substance misuse services in recommendation 1.2.2, but did agree that a further recommendation was needed and this has been added as 1.5.2.

275	Nottinghamshire Healthcare NHS Trust	20.13	NICE	1.1.11 & 1.6.1	13	There may be significant cost implications for the generation of data in this manner. What about written information for service users?	Thank you for your comment. As well as the NICE guideline we also produce a document called 'Understanding NICE guidance' for each guideline which is specifically targeted at service users and carers. These are all available on the NICE website: www.nice.org
276	Nottinghamshire Healthcare NHS Trust	20.14	NICE	1.2.1	16	Many staff working in these areas lack skills in assessing drug use and dependency.	Thank you. The guideline states that all people working in mental health services should be competent to work with this group of people and therefore competent to recognize and work with the coexisting substance misuse. The guideline cannot repeat the substance misuse guidelines. Therefore, we have amended the recommendation to read: *"conduct an assessment of dependency (see drug misuse: opioid detoxification (NICE clinical guideline 52). and alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE clinical guideline, forthcoming)"*
277	Nottinghamshire Healthcare NHS Trust	20.15	NICE	1.4.1	17	How are competencies benchmarked and measured?	Thank you for your comment. Measuring competence is an important issue for healthcare trust, professional managers and professional colleges, as well as being important to patients, however this is an implementation issues and outside the scope of this guideline.
278	Nottinghamshire Healthcare NHS Trust	20.16	NICE	1.4.16	20	Some patients experience drug testing as stigmatising.	Thank you for your comment. The guideline is recommending that biological tests should not be routine, but be agreed with the person first as part of their care plan. The original wording of this recommendation may have been unclear and we have redrafted to make this more understandable.
279	PROGRESS[2]	18.01	NICE	1.4.14 1.4.15	20	On biological testing - appears to be contradictory. The language needs to be clearer to avoid confusion and potential conflict with UK clinical guidelines for substance misuse treatment. Something like "objective biological testing of clients substance misuse can be important in establishing drug and alcohol use and appropriate treatment	Thank you for your comment; we have redrafted this section.

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						options. However, biological testing should be used as part of a consensual agreement and care planned activity and never as an imposed, routine screening without consent"	
280	PROGRESS	18.02	NICE	1.2.1 1.4.3 1.4.4	16 18 18	Welcome these very clear directives	Thank you.
281	PROGRESS	18.03	NICE	1.5	23	Conflict between Nice guidelines and commissioners	Thank you for your comment. The GDG were convinced that these basic competencies for people working in substance misuse services were essential to be able to recognise assess and refer people with psychosis. We would hope commissioners would take note of these recommendations.
282	PROGRESS	18.04	NICE	1.6.4 1.4.9	25 19	Welcome these statement	Thank you.
283	PROGRESS	18.05	NICE	gener al	gener al	Need guidance on use of CTO	Thank you for your comment. Whilst we agree this is an important issue, it is outside the scope of this document and would be inappropriate for NICE guidelines to interpret the amended Mental Health Act, or related guidance.
284	PROGRESS	18.06	NICE	1.4.6 1.5.1	18 23	But only in the presence of acute Mental illhealth	Thank you, we feel this is reflected in the recommendations.
285	PROGRESS	18.07	NICE	gener al	gener al	In practice there is currently inequalities (due to commissioning practices) with regard to crisis or planned detox for individuals with psychosis If an inpatient (acutely unwell) they would get detoxed but if in community and needing detox to prevent deterioration of psychotic symptoms their changes of this happening are greatly reduced We feel these inequalities need ironing out within such guidance. If someone has primary psychosis and need a detox then MH service should provide this even if their MH is stable	Thank you for this comment – we agree the implications of detox services will need to be carefully considered by service managers and commissioners. The GDG spent some time discussing these issues and believe they have offered the right guidance to secondary care services.
286	PROGRESS	18.08	NICE	gener al	gener al	Welcome breath encompassing CAMHS, OA, Forensic MH however would welcome some focus	Thank you for your comment, however these conditions fall outside the scope and we are

						on LD asbergers, ADHD – those who fall between MH and LD but also Although this guidance is not remitted to do so we would ask NICE to consider this issue	therefore unable to address them in this guideline.
287	PROGRESS	18.09	NICE	General	general	IAPT – exclude D&A even if in stage of recovery where they could access systems – should this guidance cross reference with the nice guidelines on psychological therapy to address this?	Thank you for your comment. The IAPT programme aims to support Primary Care Trusts in implementing NICE guidelines for people suffering from depression and anxiety disorders.
288	PROGRESS	18.10	NICE	4.3 1.4.2.4	30 22	Recognises the self medication hypothesis and use of PSI despite the evidence we strongly welcome this however self med hypothesis to be used with caution as can sometimes be seen as pejorative – this could however be supported by point 1.4.2.4	Please see the response to comment 190.
289	PROGRESS	18.11	NICE	General	General	The guidance states it is MDT in it's makeup of the group however it must be noted that psychiatrist formed the majority of the group	Thank you. Individuals are selected for their expertise and to ensure that the GDG can properly address the scope of the guideline.
290	PROGRESS	18.12	NICE	General	General	2002 DH guidance concentrated on mainstreaming however there is little comment on this within the guidance. We feel it is important to not lose this point. Integrated services recommendation provided a significant amount of role legitimacy and supported an integrated treatment approach within MH services and the absence of any direction within the guidance could weakness that impetuous	Thank you for your comment, we have avoided using the term 'mainstreaming' in this document as it can mean different things to different people and did not want to create any confusion. However, the guideline does share many principles of 'mainstreaming', see recommendation 1.4.5. The GDG reviewed the evidence around service provision and found no evidence to strongly support integrated services.
291	PROGRESS	18.13	NICE	General	General	Offender health contribution welcomed but misses the opportunity to pick up on the need for integration between offender health care and community services	Thank you for your comments, this guideline has not reviewed the evidence for prison populations, although the recommendations may be relevant to those working within prison/forensic services, and is unfortunately outside the scope of this guideline.
292	PROGRESS	18.14	NICE	General	General	The guidance focuses greatly on psychosis and substance misuse in mental health services and neglects to address how substance misuse services can identify, assess and treat accordingly for those within their services and no contact with secondary mental health service	Thank you for your comment, the GDG felt overall this is a balanced document with information about identification and assessment in substance misuse services (section 5.5), and we also address assessment for psychosis within substance misuse services in recommendation 1.2.2, but did agree that a further recommendation was needed and this has been added as 1.5.2.

293	PROGRESS	18.15	NICE	1.1.11 & 1.6.1	13 23	very expensive that each organisation has to generate this kind of information Could the guidance recommend a national resource for Dual Diagnosis related information What about written information for patients?	Thank you for your comment. As well as the NICE guideline we also produce a document called 'Understanding NICE guidance' for each guideline which is specifically targeted at service users and carers. These are all available on the NICE website: www.nice.org
294	PROGRESS	18.16	NICE	1.2.1	16	Many staff working in these areas lack skills in assessing drug use and dependency. Could written guidance be included?	Thank you. The guideline states that all people working in mental health services should be competent to work with this group of people and therefore competent to recognize and work with the coexisting substance misuse. The guideline cannot repeat the substance misuse guidelines. Therefore, we have amended the recommendation to read: *"conduct an assessment of dependency (see drug misuse: opioid detoxification (NICE clinical guideline 52). and alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE clinical guideline, forthcoming)"*
295	PROGRESS	18.17	NICE	1.4.1	17	How is competence to be measured?	Thank you for your comment. Measuring competence is an important issue for healthcare trust, professional managers and professional colleges, as well as being important to patients, however this is an implementation issues and outside the scope of this guideline.
296	PROGRESS	18.18	NICE	1.4.3 & 1.4.4	18	We would welcome guidance on how services manage people who are intoxicated and unfit to engage in treatment.	Thank you for your comment, we would expect clinicians to exercise their clinical judgement when dealing with individual case, and refer to the NICE guidelines *Drug misuse: opoid detoxification (NICE, 2007)* and the forthcoming *Alcohol Use Disorders (NICE, 2011*)..
297	PROGRESS	18.19	NICE	Treat ment	21 -22	Could advice be included regarding the management and treatment of acute ill-health in cases of, for example, drug induced acute psychosis?	Thank you. Although the physical health of people with coexisting psychosis and substance misuse is an important issue to which we refer at a number of points in the guideline (eg 1.4.9), the specific issue of so-called drug induced psychosis has not been addressed in this guideline, in particular, we did not look at people with a drug induced organic psychosis. This is outside the scope of the guideline.

298	PROGRESS	18.20	NICE	1.4.16	20	Some patients have experienced drug testing as stigmatising. Should it be routine for all people admitted?	Thank you for your comment. The guideline is recommending that biological tests should not be routine, but be agreed with the person first as part of their care plan. The original wording of this recommendation may have been unclear and we have redrafted to make this more understandable.
299	PROGRESS	18.21	NICE	1.4.17	21	Could advice be included regarding the complexity and challenges of making a correct diagnosis?	Thank you. This is a complex issue. Rather than specifying the specific details of how to come to a diagnosis for this group of people, we decided to recommend that healthcare workers in both mental health and substance misuse services should be competent to assess both of these conditions. There will need to be considerable effort invested in making this a reality.
300	Royal College of Nursing	4.01	All	General	General	The Royal College of Nursing welcomes this draft guideline. There are no further comments to add at this stage.	Thank you.
301	Royal College of Paediatrics and Child Health	11.01	All	General	General	In clinical practice, the services available to deal with under-18s with this combination of problems include a random combination of three main types of service: CAMHS, Early Intervention for Psychosis and Substance Misuse. The reason the combination is random is because it depends on local policies for acceptance of referrals, such as lower age limit. For instance, an Early Intervention for Psychosis team may not accept referrals of young people below the age of 16 years, or with autistic spectrum disorder. A substance misuse service may be embedded within adult mental health, meaning that the practitioners feel de-skilled with those much younger than 18 years; or specific to under-18s, in which case it may have to cover a large population to make itself viable. So the role that each of these three services may have with a particular individual can vary tremendously, making it difficult to generalise. This also makes it difficult to choose from which of these three services the young person's key worker should be chosen, and can make **engagement** and	We recognise that the configuration of services for people with psychosis and coexisting substance misuse will vary considerably from one geographical area to another, and one service to another. Part of the role of a guideline is aimed at helping to standardise services. We specifically make recommendations about engagement, a very important issue for this group, right from the outset in recommendations 1.1.1 and 1.1.2; for collaborative working, whatever the precise local configuration of services, in recommendations 1.1.24 and 1.1.25 and to promote access in 1.4.3 - 1.4.5 and 1.5.3 to 1.5.5. In terms of the integration and coordinated working for early intervention services and CAMHS services for psychosis, this will be addressed in the forthcoming NICE guideline on schizophrenia in children and young people.

						continuity problematic. The young person and his carers (and involved professionals) may become confused by the bewildering array of well-meaning people involved, particularly as professionals from other services may also have a crucial role: for example Connexions with young people who are not in education, employment or training (NEET). These issues could more helpfully be addressed specifically in both the full guideline and the brief version.	
302	Royal College of Paediatrics and Child Health	11.02	NICE	Person-centred care	7	[Also Full version: 11: 1.1.2; 71 (line 34): 4.3.1; 109 (line 30): 4.6; 112 (Lines 37-38): 4.8.1.2] Both NICE and full guidelines justly emphasise the need to "preserve **continuity** of care and minimise changes of key workers in order to foster a therapeutic relationship".	Thank you.
303	Royal College of Paediatrics and Child Health	11.03	NICE guideline	KPIs	8	[Also: 11: 1.1.1; 12: 1.1.3 & 1.1.4; 19: 1.4.9; 31: 4.3] The guideline justly emphasises the importance of **engagement** with the young person as a priority, and the need to allow time for an adequate assessment, to understand the potentially complex relationship between substances and psychotic symptoms.	Thank you.
304	Royal College of Paediatrics and Child Health	11.04	Full	2.2.2 & 2.3	21-22 & 23-26	These sections are particularly helpful in understanding complex relationship between substances and psychotic symptoms.	Thank you for your comment.
305	Royal College of Paediatrics and Child Health	11.05	Full	4.5.8 9.7.1	105 243	[Also NICE version: 1.8.8 – pages 7, 10 & 27] **Transition** is justly highlighted as an important issue; unfortunately, the guidance given is too vague to be helpful. A government guidance document referred to as relevant, 'Transition: getting it right for young people' specifically states on 6: "The guide specifically does not seek to describe the approach or approaches for improving transition for young people that are users of Child and Adolescent Mental Health (CAMH) services". A later document available from the same website, 'Transition: moving on well', *does* address mental	Thank you for your comment, the GDG feel they have covered this complex issue as fully as possible in this type of guidance, acknowledging the difficulties, but making practical suggestions. It is not in the scope of this guideline to cover all the issues you have listed.

						health needs – in the context of a disability model – but is not very helpful in relation to under-18s with substance misuse and psychotic symptoms. An Early Intervention for Psychosis team can function as a transition team covering the age range 14-25. The team may be able to provide a conduit into adult services, but problems with transition may remain. CAMHS teams may have to cease their involvement around their cut-off age (usually 18th birthday, but sometimes 17th or 16th). Substance misuse teams specific to under-18s may also have to cease their involvement, leaving the Early Intervention for Psychosis team rather isolated. Some Early Intervention for Psychosis teams remain involved only for the first episode of psychosis, and will not re-accept a young person, even though still under 25, if they have a second episode, so that they have to present to a completely new team on the second occasion (the adult mental health team). The above are only examples. More generally, transition from the care of CAMHS to adult mental health is fraught with a variety of difficulties relating to clashing perspectives, funding issues and different views of clinical priorities. A young person with psychotic symptoms and substance misuse may not qualify for follow-up by adult mental health services, and perhaps not even by an Early Intervention for Psychosis team, because the psychotic symptoms are not seen to be due to an enduring mental illness, but instead 'only' to the substance misuse, an autistic spectrum disorder or learning difficulties. Most child and adult psychiatrists would agree that it is difficult to make a firm diagnosis of psychotic illness at an early stage of psychotic symptoms. Such practical issues should be dealt with more explicitly in the full and brief guidelines.	

306	Royal College of Paediatrics and Child Health	11.06	Full	9.5 9.6 9.7	235 -243	This helpfully covers the variety of service configurations that may cater for young people.	Thank you for your comment.
450	Royal College of Psychiatrists	33.01	All	General	General	Thank you for giving the College the opportunity to comment on these draft guidelines. The College's Addictions Faculty is content with the guidelines as drafted.	Thank you.
307	Royal College of Psychiatrists (Wales)	24.01	Full	General	General	The guideline recognises and acknowledges some important key areas in management of Psychosis with Substance Misuse. It lays emphasis on the patterns of psychosis and substance misuse seen in clinical settings. The various models discussed in the document are well known and experience of these models in countries within and outside UK have generally highlighted the efficiency of an Integrated Model with the mental Health Services being the lead organisation in managing patients with Psychosis and Substance Misuse. The biggest challenge from a Welsh perspective and from the British perspective in implementing these lies in the change of the fundamental approach towards this clinical area. The current services are by and large following a 'sequential' model and as the document has rightly identified, the patients are bounced between the acute or mental health services and substance misuse services with little communication between the two. The implementation of the guideline requires an appropriate strategy at a national level where the existing frameworks can be adapted to incorporate a fundamental change in culture, a culture that can foster equality of service provision for people with these problems, a culture that can destigmatise mental health and particularly substance misuse	Thank you for these comments and suggestions – we agree the implications of effectively treating these individuals will need to be carefully considered by service managers and commissioners.

						within generic mental health services. Basic training in assessments and interventions for this group of patients is important for both mental health services and substance misuse services along with the primary care and prison services. It is important to emphasise the significant morbidity, mortality and cost implications of having separate services and one can argue the importance of joint working with all agencies involved in managing this populations' needs. From a Welsh perspective, the structure of the NHS has changed recently and in the current financial climate, there is a refocus on community based services and a move away from inpatient services. This clinical population has important and often complex clinical needs which would require appropriate allocation of resources either in inpatient or strengthening the existing community services. The guideline has rightly highlighted several key issues including the models of delivery, expected requirements from various services, lead organisations and the importance of other agencies involved in the management of this clinical population. More suggestions:- 1. Inclusion of current evidence based treatments for managing stimulant use in this population 2. Emphasise the importance of a 'Whole Person Approach' in managing co-morbidities. It is difficult to compartmentalise a patient into different boxes of diagnoses. The continuation of a	1. The approach taken for this guideline was to look for evidence that people with psychosis and coexisting substance misuse should be managed differently from that recommended in existing NICE guidelines for the single disorders. It was not possible to conduct new reviews as you suggest. 2. As described in the Chapter 6, there is currently insufficient evidence to make recommendations

						'sequential model' in UK will result in a lack of improvement in clinical management. If evidence from various research projects and experience of use of 'Integrated Model' consistently demonstrates its efficiency, then perhaps the guideline can mention the other models but ONLY recommend one model. 3. Statutory services other than NHS, eg Drug Intervention Programme, have not been mentioned in the guideline and these agencies should be included to allow the standardisation of clinical management, from a clinical governance perspective. 4. The recommendations have implications- both clinical and for resource allocation. The implementation would require a fundamental change of culture in secondary care- mental health leading with appropriate assessments and basic awareness of management of substance misuse and for the substance misuse services to strengthen management of patients with psychosis. 5. Specialist dedicated workforce may be one option but this would not be resource neutral. The current provisions will need to be tapped into and the knowledge of management of this clinically significant problem will have to increase by virtue of training. The strengthening of Early intervention services, Crisis Resolution Home Treatment Teams and Assertive Outreach teams would become absolutely essential. 6. The role of specialists in Substance Misuse (as per the Royal College expectations) would be more realized by being involved in training and fulfilling a specialist advisory role to other agencies.	about service delivery models, and given the resource implications, the GDG felt it was appropriate to wait for further evidence. 3. We have amended recommendation 1.1.23 and added recommendation 1.1.24 regarding working with the voluntary sector. 4. We agree there will be implications for implementation, and therefore NICE provide implementation support. 5. These teams are specifically dealt with in the schizophrenia guideline (NICE, CG 82) and to which readers of this guideline are referred. We would hope that people working in mental health services and substance misuse services would read all guidelines relevant to this group of people. 6. Although we regard the Royal College expectations of specialists in substance misuse important and worthy of note, it would be inappropriate to develop recommendations based on this in an evidence based guideline. 7. We agree. However, please see 1.2 of the NICE guideline which specifically addresses recognition of these coexisting disorders and 1.3 which requires referral when the coexisting disorders are suspected. Again, this guideline should be read along side the NICE guidelines *Schizophrenia Update (NICE, 2010*) and *Drug misuse: opoid detoxification (NICE, 2007)*, the former in particular emphasises early referral and intervention. 8. Please see above for the response to your point 7.

						7. More emphasise can be laid on the prognostic implications of this clinical condition and that an early intervention approach needs to be the principle of primacy. This would entail early screening within primary care services. 8. Prognostic implications of this condition also stress the importance of adequate and appropriate treatment of both conditions. Initiating appropriate and timely clinical interventions should be encouraged and any delay due to presence of substance misuse should be discouraged.	
308	Royal Pharmaceutical Society	30.01	All	General	General	The Royal Pharmaceutical Society welcomes these guidelines and has nor further comments to make	Thank you.
309	SCAN[3]	28.01	NICE	General	General	SCAN welcomes the NICE guideline on psychosis and substance misuse. It is a timely and useful piece of work which rightly draws attention to the high level of coexistence of both substance misuse and psychosis and the higher levels of unmet need, length of inpatients admissions and poorer outcomes for such individuals. As consultant psychiatrists in the addictions field, our ambition would be for patients with psychosis and substance misuse to have a clinically excellent service for their substance misuse as well as for their psychosis. Consultant psychiatrists in the addictions are well placed to lead in implementing clinical guidelines within teams and across services in local areas.	Thank you for your comments.
310	SCAN	28.02	NICE	1.1.1	11	We welcome the emphasis on skilled engagement for patients with psychosis and coexisting substance misuse. The skills described are those that are an inherent part of the training and skills of consultant psychiatrists in substance misuse and other clinicians in the specialist substance misuse field. Consultant psychiatrists are also well placed to train others in these skills and to provide high quality	Thank you.

[3] Specialist Clinical Addiction Network

						supervision to clinicians working with this patient group.	
311	SCAN	28.03	NICE	1.1.15	14	We are pleased to see that child safeguarding issues are given due prominence. Consultant psychiatrists in addictions are expected to be up to date in safeguarding training and to be competent in initiating and following up referrals.	Thank you.
312	SCAN	28.04	NICE	1.1.17	15	We are pleased to see that child safeguarding issues are given due prominence. Consultant psychiatrists in addictions are expected to be up to date in safeguarding training and to be competent in initiating and following up referrals.	Thank you.
313	SCAN	28.05	NICE	1.1.18	15	We welcome the guidelines on consent, capacity, and treatment decisions. Addiction psychiatrists are well placed to assess these issues and offer advice to other professionals in the substance misuse field where necessary.	Thank you.
314	SCAN	28.06	NICE	1.1.21	16	We are pleased that the guideline recommends close working with the voluntary sector with regard to patients with substance misuse and psychosis. Whilst such patients should have a care plan co-ordinated by NHS mental health and substance misuse services, the voluntary sector provides many valuable services such as rehabilitation and housing services. Such services value the support and advice given by addiction psychiatrists and their teams and such ways of working are to be encouraged. Supporting patients in treatments and placements in the voluntary sector can help engagement with these services and enable better longer-term treatment outcomes.	Thank you, we agree.
315	SCAN	28.07	NICE	1.2.1	16	We welcome the explicit recommendation that staff in all settings should be equipped with the skills to routinely take a brief substance misuse screening history in patients with suspected or known psychotic illness. In the guideline it is stated that healthcare professionals in all settings including primary care, secondary mental health services, CAMHS, Accident & Emergency, and prisons and crime justice liaison services should routinely ask	Thank you.

						adults and young people with known or suspected psychosis about their use of alcohol and non-prescribed and illicit drugs. We very much welcome this emphasis on ensuring competency in this area across a range of medical and related specialities. Addiction psychiatrists are well paced to offer training, liaison, second opinions and supervision of such staff.	
316	SCAN	28.08	NICE	1.2.2	16	The guideline states that healthcare professionals working within mental health services should ensure they are competent in the treatment and care of adults and young people with psychosis and coexisting substance misuse. Consultant psychiatrists in the Addictions and other clinicians in the specialist substance misuse services have a key role to play in ensuring that staff in the mental health services are competent with regard to the treatment and care of substance misuse, by means of teaching, supervision, consultancy and offering joint care for such patients.	Thank you, we agree.
317	SCAN	28.09	NICE	1.3.3	17	Addictions consultants welcome the explicit guideline to attend to the physical healthcare needs of patients with psychosis and substance misuse. Addiction psychiatrists have been concerned about the levels of physical harm caused by substances (for example alcohol-related brain damage, hepatitis, overdoses) and many services have now instituted relevant programmes (for example community-based vitamin supplementation, vaccination and naloxone). It is vitally important that patients with co-morbid psychosis are not excluded from these physical healthcare initiatives. Sexual health aspects need to be included as does risk of pregnancy, especially as health improves during treatment leading to increased fertility	Thank you, we agree.
318	SCAN	28.10	NICE	1.4.2	17	Addiction psychiatrists welcome the guideline that staff in mental health services should consider having supervision, advice, consultation and/or training from specialists in substance misuse services. Addiction psychiatrists are well placed to	Thank you.

						offer this.	
319	SCAN	28.11	NICE	1.4.3 & 1.4.4	18	The guideline states that patients should not be excluded from either service due to the presence of either diagnosis. This is an important issue and experience suggests that the support of a consultant psychiatrist in addictions and a specialist substance team working closely with their counterparts in a mental health team can lead to greater understanding of substance misuse issues and care and treatment for such.	Thank you.
320	SCAN	28.12	NICE	1.4.6	18	Consultant psychiatrists in the addictions agree that joint working arrangements for patients with psychosis and substance misuse are the most effective means of providing a coordinated care plan for such patients.	Thank you, we agree.
321	SCAN	28.13	NICE	1.4.9	19	Consultant psychiatrists in the addictions are expert in assessment and ongoing assessment as outlined in this part of the guideline. We can provide detailed assessments on patients referred to our services and supervise and train others in these skills.	Thank you for your comments.
322	SCAN	28.14	NICE	1.4.13	20	Consultant psychiatrists in the addictions are expert in the assessment of risks as outlined here and can provide detailed risk assessment of individual patients and training to others in how to accomplish such assessments.	Thank you.
323	SCAN	28.15	NICE	1.4.19	21	Consultant psychiatrists in the addictions are well placed to implement and deliver evidence-based treatment for the addictions.	Thank you for your comment.
324	SCAN	28.16	NICE	1.4.24	22	We think this rightly acknowledges the risks of interactions between prescribed and unprescribed drugs and alcohol and the need to warn patients and discuss the potential dangers. This needs highly skilled clinicians such as consultant psychiatrists in the addictions who have been trained in pharmacology of medications for psychosis and medication for addiction and who also have a knowledge of the pharmacology of illicit and unprescribed medications.	Thank you, we agree.
325	SCAN	28.17	NICE	1.5.1	23	Healthcare professionals should be competent to recognise the signs and symptoms of psychosis and	Thank you, we agree.

						undertake a full mental health needs and risk assessment and know how and when to refer to secondary mental health services. We very much welcome this outlining of the necessary competencies required in substance misuse services given the high co-morbidity of substance misuse and psychosis. Many geographical areas have a number of providers involved in the provision of substance misuse services, usually (but not always) including a provision from the NHS of a specialist substance misuse team lead by a consultant psychiatrist in addictions with mental health nurses specialising in addictions. Such health professionals are clearly able to identify psychotic illnesses, but more importantly they can offer support, advice and liaison to workers in other agencies who have not had such mental health training and experience.	
326	SCAN	28.18	NICE	1.5.2	23	Addiction psychiatrists agree that attending joint care programme meetings is an important part of providing effective joint care.	Thank you.
327	SCAN	28.19	NICE	1.5.3	23	Addiction psychiatrists welcome the guideline that substance misuse services should provide advice consultation and training to adult mental health services and CAMHS regarding the assessment and treatment of substance misuse and of substance misuse with coexisting mental illness.	Thank you.
328	SCAN	28.20	NICE	1.5.4	23	Consultant psychiatrists in the addictions welcome the guidelines to develop local protocols and will be key personnel from the substance misuse services in drawing up such protocols in collaboration with other key personnel from the relevant services such as the mental health services, CAMHS etc.	Thank you.
329	SCAN	28.21	NICE	1.6.3	24	We agree that detoxification should only occur under the advice of specialist substance misuse services. If there are significant risks (such as significant psychosis or severe withdrawal symptoms such as seizures or lack of community support or accommodation) this should preferably be in a specialist substance misuse inpatient unit	Thank you for your comment. We agree that young people may require intensive management by specialist team(s). We agree that if young patients require to be admitted on clinical grounds every effort should be made to persuade them to do this perhaps with support of families if this is appropriate and if parental consent is appropriate and if there

						where possible. However, there is experience that younger patients may refuse inpatient admission or there may be a lack of age appropriate facilities. Some addiction psychiatrists have developed particular experience and expertise in slow community detoxification of younger patients. Such patients should be intensively managed during detoxification by specialist substance misuse services and specialist services such as an early psychosis team. Detoxification should be part of an overall treatment plan as is stated and it is important that the risks and benefits of detoxification are fully discussed with the patient and that informed consent is given. There is a particular risk of overdose after opioid detoxification and care should be taken that such risks are understood and minimised where possible, for example by provision of overdose training and naloxone for patients and carers.	are age appropriate units or age appropriate facilities can be specially organised.
330	SCAN	28.22	NICE	1.6.5	25	We agree that careful aftercare planning is necessary and that specialist substance misuse teams are involved in the care plan.	Thank you.
331	SCAN	28.23	NICE	1.7	26	We agree that patients should not be excluded from staffed accommodation because of a diagnosis of substance misuse or psychosis. In the case of provision for patients with psychosis, support to the staff from the specialist substance misuse team may help to support the placement. In the case of substance misuse provision such as rehabilitation placements, the support of mental health nurses and a consultant from the substance misuse team and the mental health team may support the placements.	Thank you, we agree.
332	SCAN	28.24	NICE	1.8	26	We fully agree that services need to be age appropriate and that adequate competencies are required when working with young people with substance misuse and psychosis. In some areas, consultant psychiatrists in addictions have formed good working relations with CAMHS and other services such as the early psychosis teams and	Thank you, we agree.

						developed joint working arrangements that have proved very helpful.	
333	SCAN	28.25	NICE	4	28	We agree that further research is needed and agree with the areas outlined, Research into models of service delivery for this group of patients would be particularly valuable.	Thank you.
334	SCAN	28.26	NICE	4.5	32	The use of clozapine in particular needs further investigation because of complications of immunosuppression due to HIV and because clozapine requires venous access which can be a problem for injecting drug users	Thank you for your comment, we agree, the role of clozapine in reducing drug usage in this population should be addressed in line with the GDG research recommendation 4.6, *Is clozapine clinically effective and cost-effective at reducing drug usage in people with psychosis and coexisting substance misuse?*
335	Welsh Assembly Government	13.01	Full	1	3 General	No visible input from social work profession to the m-d team	Thank you for your comment. We were not sure whether you are referring to the composition of the GDG or local multidisciplinary groups who will be responsible for translating the implementation plan into local protocols (discussed in section 1.1.5), therefore, we considered both issues. With regard to the GDG, Theresa Renwick is Social Care Lead for Mental Health (Royal Borough of Kensington and Chelsea) and brought a social care perspective to the group. With regard to section 1.1.5, we have amended the text to read 'specialist mental health and other relevant healthcare professionals'.
336	Welsh Assembly Government	13.02	Full	2	17	Issues around the social context are most important. Is there any more evidence which can be added here?	Thank you for your comment, we have referred to two pieces of work regarding this issue in the Introduction, which is not intended to be an exhaustive or definitive examination of the evidence. Instead it is intended to introduce the reader to the issues around psychosis and coexisting substance misuse, so that the reader will understand the context for the later presentation of evidence.
337	Welsh Assembly Government	13.03	NICE	General	general	Reference to health care professionals could be supplemented with "and other involved professionals" as the guidance "is relevant to the work of OT, Social services and the Independent sector"	Thank you for your comment. We've checked the use of this term and added clarification if needed.
338	Welsh Assembly	13.04	NICE	1.1	11	Principles of care helpful. Makes issue of including	Thank you.

	Government				-14	usefulness to professionals other than healthcare particularly pertinent.	
339	Welsh Assembly Government	13.05	NICE	1.1.19	15	Accuracy: Mental Health Act 1983, amended in 2007	Thank you for your comment; we have changed the way we cite various Acts in order to avoid the inaccuracies you have identified.
458	Welsh Assembly Government	13.06	All	General	General	I attach the Welsh Assembly Government "A Service Framework to Meet the Needs of People with a Co-occurring Substance Misuse and Mental health Problem" published in 2007. You will see from this the approach taken in Wales.	Thank you for your comments and for this document.
341	West London Mental Health NHS Trust	29.01	NICE	General	General	While it is acknowledged that further research is required to validate the most effective interventions for Psychosis and Substance Misuse versus other diagnoses, it still feels quite limiting that the NICE Guidance does not cover other, non-psychotic illnesses, such as depression and personality disorder, which often feature highly in dual diagnosis work.	Thank you for your comment, the remit from the Department of Health for a guideline on psychosis and substance misuse and therefore other conditions are outside the scope of this document. Future topics can be suggested using the NICE website: http://www.nice.org.uk/getinvolved/
342	West London Mental Health NHS Trust	29.02	NICE	1.2.1	16	Suggested that in addition to collection of quantitative information on assessment about; a persons substance of use; quantity, frequency and pattern of use; route of administration; and duration of current level of use. An additional 5th piece of more qualitative information could be gathered by asking the Client how they feel about their substance use, in order to assess where they are in the Cycle of Change so that appropriate interventions can be delivered in accordance with Staged Approach to Treatment, as detailed in the draft guidance. Felt very positive that it continues to be reinforced that all professionals at each stage of the care pathway should be routinely asking about substance use, as this is still often overlooked.	Thank you, this is an important issue and one which we have emphasised a little more in assessing a person's readiness to change both substance misuse patterns and levels, and other aspects of their lives (see recommendation 1.4.9).
343	West London Mental Health NHS Trust	29.03	NICE	1.4.14	20	"Do not use biological or physical tests for substance use (…) in routine screening for drug and alcohol use" Within In-patient Mental Health Services, undertaking a Urine Drug Screen on admission helps to identify substance use which might be	Thank you for your comment, it was the view of the GDG that biological testing should be agreed with the service user first as part of their care plan, and not as a routine measure.

						impacting on mental state, identifies risk of withdrawals, and further informs appropriate and safe prescription of medication.	
344	West London Mental Health NHS Trust	29.04	NICE	1.4.9 1.5.1	19 23	Felt very positive that both MH and SM Services were required to continue up-skilling their Staff to a high level of competence within their counter-parts area of expertise.	Thank you.
345	West London Mental Health NHS Trust	29.05	NICE	1.1	11	Considered important positive focus on the principles of engaging Client's within a non-judgemental relationship etc. while acknowledging the stigma and potential reluctance to engage in services, described in clear and simple terminology.	Thank you for your comment.
346	West London Mental Health NHS Trust	29.06	NICE	1.2.1	16	Suggested that in addition to collection of quantitative information on assessment about; a persons substance of use; quantity, frequency and pattern of use; route of administration; and duration of current level of use. An additional 5th piece of more qualitative information could be gathered by asking the Client how they feel about their substance use, in order to assess where they are in the Cycle of Change so that appropriate interventions can be delivered in accordance with Staged Approach to Treatment, as detailed in the draft guidance. Felt very positive that it continues to be reinforced that all professionals at each stage of the care pathway should be routinely asking about substance use, as this is still often overlooked. We find it important however that this should not be asked in isolation. An unfortunate consequence of this is 'care plans' that read along the lines of "don't take substances, they are bad for you". This issue needs to be taken in context and in combination with motivational interviewing techniques.	Thank you for your comment, the GDG in large part agree, but this is dealt with in the guideline *Drug misuse: opoid detoxification* (NICE, 2007) to which readers are referred.
347	Yorkshire and the Humber LSA	32.02	All	General	General	The general comment that I would like to make refers to Psychosis with Substance Misuse in childbearing women and guidance for management with alternative medication, no medication and/or alternative treatments in pregnancy. There is a need for specialist care as women may return to	Thank you for your comment. The scope of this guideline does not specifically include reviewing evidence for pregnant women, but please refer to the NICE guideline 'Pregnancy and complex social factors' (NICE, 2010) available on the NICE website: www.nice.org.uk

						substance misuse if unable to cope without the medication they were given prior to the pregnancy.	
348	Dr Carol Caton	31.01	NICE	1.4.9	19	Assess homeless history, adequacy of current living situation	Thank you for your comment, we have added an extra bullet point to recommendation 1.4.9 in line with your suggestion.
349	Dr Carol Caton	31.02	All	General	General	The Guideline is excellent-thorough and comprehensive. The methodology for guideline development is state-of-the-art. Research recommendations are highly relevant. Given its length and degree of detail, it may be useful to consider using educational workshops or in-service programming to inform clinicians of the recommendations in the Guideline.	Thank you for your comments and suggestion.

These stakeholder organisations were approached but did not respond

Adfam
Adverse Psychiatric Reactions Information Link (APRIL)
Afiya Trust, The
Ambulance Service Association
Association For Family Therapy and Systemic Practice in the UK (AFT)
Association of Dance Movement Therapy UK
Association of Nurses in Substance Abuse
Association of Professional Music Therapists
Association of Psychoanalytic Psychotherapy in the NHS
Association of the British Pharmaceuticals Industry (ABPI)
BALANCE North East
Barnet, Enfield and Haringey Mental Health Trust
Barnsley PCT
Bedfordshire & Luton Partnership NHS Trust
Berkshire Healthcare NHS Foundation Trust
Birmingham and Solihull Mental Health Foundation Trust
Birmingham City Council
Birmingham Early Intervention Service
BMJ
Bolton Council
Brent Teaching PCT
Brighton and Sussex University Hospitals Trust
British Acupuncture Council
British Association for Counselling and Psychotherapy
British Association of Art Therapists
British Association of Drama Therapists
British Association of Psychodrama and Sociodrama (BPA)
British National Formulary (BNF)
British Paediatric Mental Health Group
British Pain Society
British Paramedic Association
British Psychoanalytic Council
British Psychodrama Association
Bro-Morgannwg NHS Trust
BUPA
Care and Social Services Inspectorate Wales
Care Quality Commission (CQC)
Cheshire & Wirral Partnership NHS Trust
CIS'ters

Citizens Commission on Human Rights
College of Emergency Medicine
College of Occupational Therapists
Commission for Social Care Inspection
Connecting for Health
Cornwall & Isles of Scilly PCT
County Durham PCT
Coventry and Warwickshire Partnership Trust
CRI
Critical Psychiatry Network
Department for Communities and Local Government
Department for Education
Department for Work and Pensions
Department of Health Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI)
Department of Health, Social Services & Public Safety, Northern Ireland (DHSSPSNI)
Derbyshire County PCT
Derbyshire Mental Health Services NHS Trust
Doncaster PCT
Drinksense
DrugScope
Dual Diagnosis National Programme
Eastern Health & Social Services Board
EMDR UK and Ireland Association
Faculty of Occupational Medicine
Fasawareuk
Gloucestershire Partnership NHS Foundation Trust
Greater Manchester West Mental Health NHS Foundation Trust
HAGAM
Hammersmith and Fulham PCT
Hampshire Partnership NHS Foundation Trust
Haven Project, The
Hertfordshire Partnership NHS Trust
Humber Mental Health Teaching NHS Trust
Inclusive Health
Infermed Ltd
Institute of Alcohol Studies
Institute of Liver Studies
Intapsych Ltd
Janssen-Cilag Ltd
Kent & Medway NHS and Social Care Partnership Trust

Leeds Irish Health and Homes
Leeds Partnerships NHS Foundation Trust
Leeds PCT
Lifeline
Lighthouse Project
Lilly UK
Liverpool Women's NHS Foundation Trust
Liverpool Community Health
Lundbeck Ltd
Manchester Community Health
MBB Connections Healthcare
Medicines and Healthcare Products Regulatory Agency (MHRA)
Mental Health Act Commission
Mental Health and Substance Use: dual diagnosis
Mental Health Foundation
Mental Health Providers Forum
Mersey Care NHS Trust
MIND
Ministry of Defence (MoD)
MK ADHD
National Institute for Mental Health in England
National Offender Management Service
National Patient Safety Agency (NPSA)
National Public Health Service for Wales
National Self Harm Network
NeuroDiversity International (NDI)/NeuroDiversity Self-Advocacy Network (NESAN)
Newcastle Upon Tyne Hospitals NHS Foundation Trust
NHS Bath and North East Somerset
NHS Bedfordshire
NHS Clinical Knowledge Summaries Service (SCHIN)
NHS Improvement
NHS Isle of Wight
NHS Kirklees
NHS Knowsley
NHS Plus
NHS Quality Improvement Scotland
NHS Sefton
NHS Sheffield
NHS Western Cheshire
NIMHE (CSIP)

North East London Mental Health Trust
North Essex Mental Health Partnership Trust
North Shrewsbury CMHT
North Staffordshire Combined Healthcare NHS Trust
North Yorkshire and York PCT
Northumberland Tyne & Wear Trust
OCD-UK
Offender Health - Department of Health
Oxfordshire & Buckinghamshire Mental Health Partnership NHS Trust
Oxfordshire and Buckinghamshire NHS Trust
Oxleas NHS Foundation Trust
PAPYRUS (Prevention of Suicides)
Partnerships for Children, Families, Women and Maternity
Patients Council
PERIGON Healthcare Ltd
Poole and Bournemouth PCT
Rethink
Retreat, The
Royal College of General Practitioners
Royal College of General Practitioners Wales
Royal College of Midwives
Royal College of Pathologists
Royal College of Psychiatrists
Royal College of Speech and Language Therapists
Royal Society of Medicine
Sandwell & West Birmingham Hospital NHS Trust
Sandwell PCT
SANE
Sanofi-Aventis
Schering-Plough Ltd
School of Health and Social Science
Scottish Intercollegiate Guidelines Network (SIGN)
Sheffield Care Mental Health Trust
Sheffield Health and Social Care Foundation Trust
Sheffield PCT
Sheffield Teaching Hospitals NHS Foundation Trust
Social Care Institute for Excellence (SCIE)
Social Perspectives Network
Society for Acute Medicine
Society of Occupational Medicine

South East Development Centre (CSIP)
South Essex Partnership NHS Foundation Trust
South London and Maudsley NHS Foundation Trust
South Staffordshire & Shropshire NHS Foundation Trust
South West Autistic Rights Movement
South West London and St Georges Mental Health NHS Trust
St Andrew's Healthcare
St Ann's Hospital
St James Priory Project
St Mungos
St. Anne's Community Services
State Hospitals Board For Scotland, The
Sussex Partnership NHS Foundation Trust
Swansea University
Tavistock & Portman NHS Foundation Trust
Tees Esk & Wear Valleys NHS Trust
Teva UK Limited
The Princess Royal Trust for Carers
The Royal College of Psychiatrists
Trident Care and Support
Turning Point
UCLH NHS Foundation Trust
Unite / Mental Health Nurses Association
United Lincolnshire Hospitals NHS Trust
University of Coventry
University of Nottingham
University of York
Welsh Scientific Advisory Committee (WSAC)
West Hertfordshire PCT & East and North Hertfordshire PCT
Western Cheshire Primary Care Trust
Western Health and Social Care Trust
Wiltshire PCT
York NHS Foundation Trust
Yorkshire and the Humber Specialised Commissioning Group