National Institute for Health and Care Excellence

6-year surveillance (2016) – Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings (2011) NICE guideline CG120

Appendix A: Summary of new evidence from surveillance

Experience of care

120 – 01	**For people with psychosis and coexisting substance misuse, what are their experiences of having problems with psychosis and coexisting substance misuse, of access to services and of treatment?**
120 – 02	**For families, carers or significant others of people who have psychosis and coexisting substance misuse, what are their experiences of caring for people with psychosis and coexisting substance misuse, and what support is available for families, carers or significant others?**

Recommendations derived from this question

Principles of care

Working with adults and young people with psychosis and coexisting substance misuse

1.1.1 When working with adults and young people with known or suspected psychosis and coexisting substance misuse, take time to engage the person from the start, and build a respectful, trusting, non-judgemental relationship in an atmosphere of hope and optimism. Be direct in your communications, use a flexible and motivational approach, and take into account that:

- stigma and discrimination are associated with both psychosis and substance misuse
- some people will try to conceal either one or both of their conditions
- many people with psychosis and coexisting substance misuse fear being detained or imprisoned, being given psychiatric medication forcibly or having their children taken into care, and some fear that they may be 'mad'.

1.1.2 When working with adults and young people with known or suspected psychosis and coexisting substance misuse:

- ensure that discussions take place in settings in which confidentiality, privacy and dignity can be maintained
- avoid clinical language without adequate explanation
- provide independent interpreters (who are not related to the person) if needed
- aim to preserve continuity of care and minimise changes of key workers in order to foster a therapeutic relationship.

Race and culture

1.1.3 Healthcare professionals working with adults and young people with psychosis and coexisting substance misuse should ensure that they are competent to engage, assess, and negotiate

with service users from diverse cultural and ethnic backgrounds and their families, carers or significant others*.

1.1.4 Work with local black and minority ethnic organisations and groups to help support and engage adults and young people with psychosis and coexisting substance misuse. Offer organisations and groups information and training about how to recognise psychosis with coexisting substance misuse and access treatment and care locally.

Providing information

1.1.5 Offer written and verbal information to adults and young people appropriate to their level of understanding about the nature and treatment of both their psychosis and substance misuse. Written information should:

- include the Information for the public, which contains a list of organisations that can provide more information (see section 5.3)
- be available in the appropriate language or, for those who cannot use written text, in an alternative format (audio or video).

1.1.6 All healthcare professionals in primary, secondary or specialist substance misuse services working with adults and young people with psychosis should offer information and advice about the risks associated with substance misuse and the negative impact that it can have on the experience and management of psychosis.

Working with and supporting families, carers and significant others*

1.1.7 Encourage families, carers or significant others* to be involved in the treatment of adults and young people with psychosis and coexisting substance misuse to help support treatment and care and promote recovery.

1.1.8 When families, carers or significant others* live or are in close contact with the person with psychosis and coexisting substance misuse, offer family intervention as recommended in Schizophrenia: core interventions in the treatment and management of schizophrenia in adults in primary and secondary care (NICE clinical guideline 82).

1.1.9 When families, carers or significant others* are involved in supporting the person with psychosis and coexisting substance misuse, discuss with them any concerns about the impact of these conditions on them and on other family members.

1.1.10 Offer families, carers or significant others* a carer's assessment of their caring, physical, social, and mental health needs. Where needs are identified, develop a care plan for the family member or carer.

1.1.11 Offer written and verbal information to families, carers or significant others* appropriate to their level of understanding about the nature and treatment of psychosis and substance misuse, including how they can help to support the person. Written information should be available in the appropriate language or, for those who cannot use written text, in an accessible format (audio or video).

1.1.12 Offer information to families, carers or significant others* about local family or carer support groups and voluntary organisations, including those for psychosis and for substance misuse, and help families, carers or significant others* to access these.

1.1.13 Negotiate confidentiality and sharing of information between the person with psychosis and coexisting substance misuse and their family, carer or a significant other*.

1.1.14 Ensure the needs of young carers or dependent adults of the person with psychosis and coexisting substance misuse are assessed. Initiate safeguarding procedures where appropriate (see recommendations 1.1.16–1.1.20).

Support for healthcare professionals

1.1.15 Working with people with psychosis and coexisting substance misuse can be challenging and healthcare professionals should seek effective support – for example, through professional supervision or staff support groups.

Consent, capacity and treatment decisions

1.1.21 Before undertaking any investigations for substance misuse, and before each treatment decision is taken:

- provide service users with full information appropriate to their needs about psychosis and substance misuse and the management of both conditions, to ensure informed consent
- understand and apply the principles underpinning the Mental Capacity Act (2005), and be aware that mental capacity is decision-specific (that is, if there is doubt about mental capacity, assessment of mental capacity should be made in relation to each decision)
- be able to assess mental capacity using the test set out in the Mental Capacity Act (2005).

  These principles should apply whether or not people are being detained or treated under the Mental Health Act (1983; amended 1995 and 2007).

Advance decisions and statements

1.1.22 Develop advance decisions and advance statements in collaboration with adults with psychosis and coexisting substance misuse, especially if their condition is severe and they have been treated under the Mental Health Act (1983; amended 1995 and 2007). Record the decisions and statements and include copies in the care plan in primary and secondary care. Give copies to the person, their care coordinator, and their family, carer or a significant other* if the person agrees.

1.1.23 Take advance decisions and advance statements into account in accordance with the Mental Capacity Act (2005). Although advance decisions and advance statements can be overridden using the Mental Health Act (1983; amended 1995 and 2007), try to honour them wherever possible.

* 'Significant other' refers not just to a partner but also to friends and any person the service user considers to be important to them.

Surveillance decision

This review question should not be updated.

Experiences of access to services and treatment

2-year evidence update

No relevant evidence was identified.

4-year surveillance summary

A secondary analysis[1] of an RCT aimed to validate a three factor model of perceived empowerment in patients with and schizophrenia with coexisting drug and alcohol misuse. The findings showed some evidence of associations between empowerment and both symptoms and global functioning, suggesting that empowerment should be assessed in treatments in addition to traditional outcome measures.

6-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

No topic expert feedback was relevant to this question.

Impact statement

The 4-year evidence on perceived empowerment is unlikely to impact on CG120. Further evidence and a standardised definition of empowerment are required before it can be incorporated into CG120.

No further evidence identified at the 6-year surveillance review to impact recommendations.

New evidence is unlikely to change guideline recommendations.

Assessment and care pathways

120 – 03	**In people with psychosis and coexisting substance misuse, what are the key elements for a comprehensive assessment (of needs and risks)?**
120 – 04	**In people with psychosis and coexisting substance misuse, what is the most appropriate care pathway (involving all NHS and non-NHS providers) and referral guidance at each transition?**

Subquestions

Should the assessment be the same in primary and secondary care?

Should the assessment be modified for subgroups of people (for example, young people, women, people from BME groups, homeless people, offenders, type of psychosis, type of substance misuse)?

What factors should trigger a reassessment?

Recommendations derived from this question

Principles of care

Safeguarding issues

1.1.16 If people with psychosis and coexisting substance misuse are parents or carers of children or young people, ensure that the child's or young person's needs are assessed according to local safeguarding procedures**.

1.1.17 If children or young people being cared for by people with psychosis and coexisting substance misuse are referred to CAMHS under local safeguarding procedures:

- use a multi-agency approach, including social care and education, to ensure that various perspectives on the child's life are considered
- consider using the Common Assessment Framework†; advice on this can be sought from the local named lead for safeguarding.

1.1.18 If serious concerns are identified, health or social care professionals working with the child or young person (see recommendation 1.1.17) should develop a child protection plan.

1.1.19 When working with people with psychosis and coexisting substance misuse who are responsible for vulnerable adults, ensure that the home situation is risk assessed and that safeguarding procedures are in place for the vulnerable adult. Advice on safeguarding vulnerable adults can be sought from the local named lead for safeguarding.

1.1.20 Consider adults with psychosis and coexisting substance misuse for assessment according to local safeguarding procedures for vulnerable adults if there are concerns regarding exploitation or self-care, or if they have been in contact with the criminal justice system.

Working with the voluntary sector

1.1.24 Healthcare professionals in primary care and secondary care mental health services, and in specialist substance misuse services, should work collaboratively with voluntary sector organisations that provide help and support for adults and young people with psychosis and coexisting substance misuse. Ensure that advocates from such organisations are included in the care planning and care programming process wherever this is possible and agreed by the person with psychosis and coexisting substance misuse.

1.1.25 Healthcare professionals in primary care and secondary care mental health services, and in specialist substance misuse services, should work collaboratively with voluntary sector organisations providing services for adults and young people with psychosis and coexisting substance misuse to develop agreed protocols for routine and crisis care.

Recognition of psychosis with coexisting substance misuse

1.2.1 Healthcare professionals in all settings, including primary care, secondary care mental health services, CAMHS and accident and emergency departments, and those in prisons and criminal justice mental health liaison schemes, should routinely ask adults and young people with known or suspected psychosis about their use of alcohol and/or prescribed and non-prescribed (including illicit) drugs. If the person has used substances ask them about all of the following:

- particular substance(s) used
- quantity, frequency and pattern of use
- route of administration
- duration of current level of use.

In addition, 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 115]) and also seek corroborative evidence from families, carers or significant others*, where this is possible and permission is given.

1.2.2 Healthcare professionals in all settings, including primary care, secondary care mental health services, CAMHS and accident and emergency departments, and those in prisons and criminal justice mental health liaison schemes, should routinely assess adults and young people with known or suspected substance misuse for possible psychosis. Seek corroborative evidence from families, carers or significant others*, where this is possible and permission is given.

Primary care

Referral from primary care

1.3.1 Refer all adults and young people with psychosis or suspected psychosis, including those who are suspected of coexisting substance misuse, to either secondary care mental health services or CAMHS for assessment and further management.

1.3.2 Refer all adults and young people with substance misuse or suspected substance misuse who are suspected of having coexisting psychosis to secondary care mental health services or CAMHS for assessment and further management.

Physical healthcare

1.3.3 Monitor the physical health of adults and young people with psychosis and coexisting substance misuse, as described in the guideline on schizophrenia (NICE clinical guideline 82). Pay particular attention to the impact of alcohol and drugs (prescribed and non-prescribed) on physical health. Monitoring should be conducted at least once a year or more frequently if the person has a significant physical illness or there is a risk of physical illness because of substance misuse.

Secondary care mental health services

Competence

1.4.1 Healthcare professionals working within secondary care mental health services should ensure they are competent in the recognition, treatment and care of adults and young people with psychosis and coexisting substance misuse.

1.4.2 Healthcare professionals working within secondary care mental health services with adults and young people with psychosis and coexisting substance misuse should consider having supervision, advice, consultation and/or training from specialists in substance misuse services. This is to aid in the development and implementation of treatment plans for substance misuse within CAMHS or adult community mental health services.

Pathways into care

1.4.3 Do not exclude adults and young people with psychosis and coexisting substance misuse from age-appropriate mental healthcare because of their substance misuse.

1.4.4 Do not exclude adults and young people with psychosis and coexisting substance misuse from age-appropriate substance misuse services because of a diagnosis of psychosis.

Assessment

1.4.10 Adults and young people with psychosis and coexisting substance misuse attending secondary care mental health services should be offered a comprehensive, multidisciplinary assessment, including assessment of all of the following:

- personal history
- mental, physical and sexual health
- social, family and economic situation
- accommodation, including history of homelessness and stability of current living arrangements
- current and past substance misuse and its impact upon their life, health and response to treatment
- criminal justice history and current status
- personal strengths and weaknesses and readiness to change their substance use and other aspects of their lives.

The assessment may need to take place over several meetings to gain a full understanding of the person and the range of problems they experience, and to promote engagement.

1.4.11 When assessing adults and young people with psychosis and coexisting substance misuse, seek corroborative evidence from families, carers or significant others* where this is possible and permission is given. Summarise the findings, share this with the person and record it in their care plan.

1.4.12 Review any changes in the person's use of substances. This should include changes in:

- the way the use of substances affects the person over time
- patterns of use
- mental and physical state
- circumstances and treatment.

Share the summary with the person and record it in their care plan.

1.4.13 When assessing adults and young people with psychosis and coexisting substance misuse, be aware that low levels of substance use that would not usually be considered harmful or problematic in people without psychosis, can have a significant impact on the mental health of people with psychosis.

1.4.14 Regularly assess and monitor risk of harm to self and/or others and develop and implement a risk management plan to be reviewed when the service users' circumstances or levels of risk change. Specifically consider additional risks associated with substance misuse, including:

- physical health risks (for example, withdrawal seizures, delirium tremens, blood-borne viruses, accidental overdose, and interactions with prescribed medication) and
- the impact that substance use may have on other risks such as self-harm, suicide, self-neglect, violence, abuse of or by others, exploitation, accidental injury and offending behaviour.

Biological/physical testing

1.4.15 Biological or physical tests for substance use (such as blood and urine tests or hair analysis) may be useful in the assessment, treatment and management of substance misuse for adults and young people with psychosis. However, this should be agreed with the person first as part of their care plan. Do not use biological or physical tests in routine screening for substance misuse in adults and young people with psychosis.

Treatment

1.4.17 When developing a care plan for an adult or young person with psychosis and coexisting substance misuse, take account of the complex and individual relationships between

substance misuse, psychotic symptoms, emotional state, behaviour and the person's social context.

Substance misuse services

Competence

1.5.1 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.

Assessment

1.5.2 Adults and young people with psychosis and coexisting substance misuse attending substance misuse services should be offered a comprehensive, multidisciplinary mental health assessment in addition to an assessment of their substance misuse.

Joint working

1.5.3 Healthcare professionals in substance misuse services should be present at Care Programme Approach meetings for adults and young people with psychosis and coexisting substance misuse within their service who are also receiving treatment and support in other health services.

1.5.4 Specialist substance misuse services should provide advice, consultation, and training for healthcare professionals in adult mental health services and CAMHS regarding the assessment and treatment of substance misuse, and of substance misuse with coexisting psychosis.

1.5.5 Specialist substance misuse services should work closely with secondary care mental health services to develop local protocols derived from this guideline for adults and young people with psychosis and coexisting substance misuse. The agreed local protocols should set out responsibilities and processes for assessment, referral, treatment and shared care across the whole care pathway.

Inpatient mental health services

Substance misuse

1.6.3 Biological or physical tests for substance use should only be considered in inpatient services as part of the assessment and treatment planning for adults and young people with psychosis and coexisting substance misuse. Obtain consent for these tests and inform the person of the results as part of an agreed treatment plan. Where mental capacity is lacking, refer to the Mental Capacity Act (2005).

* 'Significant other' refers not just to a partner but also to friends and any person the service user considers to be important to them.

** Safeguarding Children

† Common Assessment Framework

Surveillance decision

This review question should not be updated.

Elements for a comprehensive assessment

2-year evidence update

No relevant evidence was identified.

4-year surveillance summary

A systematic review[2] (29 studies) examined risk factors for relapse in first episode psychosis. Persistent substance use disorder was found to increase the risk of relapse 3-fold in this sub population. Clinical variables and

general demographic variables were found to have little impact on relapse rates.

Self-Rated Assessment

A secondary analysis[3] of a RCT (n=1042) sought to examine the degree to which individuals with schizophrenia disclose their use of drugs on self-rated assessments. The findings showed high rates of under-reported drug use among individuals with schizophrenia when compared to laboratory assays, and indicated that self-rated assessments alone should be used with caution.

Self-Harm

A meta-analysis[4] (222 studies, n=31,294) showed that comorbid bipolar disorder and substance misuse was significantly associated with suicide attempts and that this population should be targeted for suicide prevention efforts.

A systematic review and meta-analysis[5] (18 studies) examined risk factors for deliberate self-harm before and after treatment for first episode psychosis. Alcohol and other substance misuse were associated with an increased risk of deliberate self-harm in addition to duration of untreated psychosis.

Cognitive Function

A systematic review and meta-analysis[6] examined the effect of substance misuse on cognitive function in psychosis. Results showed that substance users performed significantly better than nonusers in the cognitive domains of attention and psychomotor speed and verbal memory, but were limited by methodological limitations.

A systematic review and meta-analysis[7] (22 studies) compared the symptoms and social function of patients with psychosis and current substance use to those with psychosis and no history of substance use. Current substance users were found to have more severe positive symptoms than patients who had never used substances, but the findings were limited by demographic differences.

Disengagement

A systematic review[8] (10 studies) examined rates and definitions of disengagement among services for first-episode psychosis (FEP) and identified the most relevant demographic and clinical predictors of disengagement. Substance misuse and dependence was found to be a risk factor for disengagement, indicating that approaches to reduce risk of service disengagement in this population could increase service effectiveness.

A secondary analysis[9] (n=198) of a RCT explored factors predictive of incarceration among people with coexisting severe mental illness and substance use disorder. Positive social relationships and substance use treatment engagement were associated with a reduced likelihood of incarceration.

6-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

4-year feedback

No topic expert feedback was relevant to this question.

6-year feedback

Topic expert highlights the changes to the guidance on lower risk drinking. This would primarily impact on the Alcohol Use Disorders guidance, which the CG120 guidance draws upon/cross references. There has been some discussion about whether AUDIT should be modified to reflect the reduced number of units for men.

Topic experts highlighted the use and effects of new psychoactive substances 'legal highs' which are not covered in CG120.

Impact statement

The 4-year evidence on risk factors for relapse is consistent with CG120, which recommends (1.2.1) assessment of substance usage frequency and duration within a comprehensive assessment.

The evidence on self-rated assessment is consistent with CG120, which states that supplementing self-report with observation is important in the assessment, especially when people are reluctant to reveal their experience or details of their substance use or financial status.

It reinforces recommendation 1.2.1, which states that when conducting an assessment of dependency, corroborative evidence should be sought from families, carers or significant others, where this is possible and permission is given.

The evidence on self-harm is consistent with CG120 1.4.14 which recommends regular assessment and monitoring of risk of harm to self and development of a risk management plan to be reviewed when service users' circumstances or levels of risk change.

The evidence partially addresses research recommendation 1 for patients with first episode psychosis and alcohol or other substance misuse, although further research is required on specific sub-populations.

The systematic review evidence on cognitive and social function is consistent with recommendation 1.2.1 to assess dependency and duration of current level of use.

The evidence on service disengagement is consistent with CG120 1.4.10 which recommends promoting engagement through a comprehensive multidisciplinary assessment.

The 6-year topic expert feedback highlighted the changes to guidance on lower risk drinking. These changes apply to the alcohol use disorder guidelines (CG100 and CG115) which CG120 makes general cross-referrals to and are unlikely to impact on recommendations in CG120.

The 6-year topic expert feedback also highlighted the increased use of 'legal highs' however there is currently a paucity of evidence to impact on recommendations. NICE guideline CG120 does not refer to specific substances in the recommendations, apart from when discussing coordinating care (1.4.6). The scope already includes the misuse of both legal and illegal substances.

New evidence is unlikely to change guideline recommendations.

Prevalence

2-year evidence update

No relevant evidence was identified.

4-year surveillance summary

A systematic review[10] assessed comorbidity rates of alcohol use disorders (AUDs) in bipolar disorder and found that AUDs are highly prevalent in bipolar disorder, indicating that patients with bipolar disorder should be assessed for current and previous AUDs.

A secondary analysis[11] (n=61) of a RCT of adults with co-occurring alcohol use disorders and severe mental illness found a 54% prevalence of cannabis use during the study, some of which was obtained via medical prescription. Among those who used cannabis, most used it frequently. Cannabis use prevalence was considerably higher than in non-severely mentally ill adults with alcohol use disorders.

6-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

4-year feedback

No topic expert feedback was relevant to this question.

6-year feedback

There are informative studies on the presentation of psychosis and substance misuse including clinical features, socio-demographic correlates:

A sub-analysis[12] of an RCT (n=114) found that in patients with first episode psychosis, men were significantly more likely to use substances overall than women. Amongst men, those who used multiple substances had an earlier onset of psychosis than single substance users.

Impact statement

The 4-year systematic review evidence showed alcohol use disorders to be highly prevalent in bipolar disorder, indicating that patients with bipolar disorder should be assessed for current and previous alcohol use disorders.

The 4-year primary research evidence indicated a high prevalence of cannabis use among patients with co-occurring alcohol use disorders and severe mental illness.

The topic expert highlighted study indicates a higher prevalence of substance use in men than women.

The current evidence supports the recommendations in CG120 to conduct a comprehensive assessment to understand the history of substance use.

New evidence is unlikely to impact on the guideline.

Risk and protective factors

2-year evidence update

No relevant evidence was identified.

4-year surveillance summary

A systematic review and meta-analysis[13] (9 studies) investigated the potential impact of cannabis use on duration of untreated psychosis (DUP). Although in most studies DUP was shorter in cannabis using patients, meta-analysis did not detect a significant relationship between DUP and cannabis use.

A systematic review[14] (20 studies) found no significant differences between former substance users with psychosis and non-substance users with psychosis in ratings of positive symptoms, negative symptoms, depression or global function. The findings indicated that a history of substance use is not a poor prognostic indicator for patients who are able to stop using substances.

A systematic review[15] found some evidence that chronic cannabis abuse could alter brain morphology in schizophrenia in patients continuing their cannabis consumption, but that there is no convincing evidence that this alteration takes place before the onset of schizophrenia when looking at first-episode patients.

A systematic review[16] investigated the distinction between pro-psychotic and anti-psychotic substances and found opiates to be the only sedative drugs that possess an anti-psychotic effect, despite possessing a similar addictive process.

6-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

4-year feedback

No topic expert feedback was relevant to this question.

6-year feedback

Topic expert highlights the increased focus on the physical health of people with severe mental illness, particularly in light of this group dying 10-20 years younger than the general population, and the fact that substance misuse, effects of medication and poorer access to healthcare are likely to be factors, perhaps a/some recommendations on physical health care/monitoring would be beneficial.

Topic experts highlighted the following studies:

A longitudinal cohort study[17] (n=6217) found the strongest predictors for psychosis were polydrug use, cannabis use, previous psychiatric hospitalisation, and non-drug related hallucinations.

An association study[18] (n=800) found no association between GABA system genes and amphetamine-induced psychotic disorder.

Impact statement

Systematic review evidence suggested that chronic cannabis abuse could alter brain morphology in schizophrenia.

The systematic review evidence of cannabis impact on duration of untreated psychosis was inconclusive.

Systematic review evidence indicated that opiates are the only sedative drugs that possess an anti-psychotic effect, despite possessing a similar addictive process. Further research is warranted on the value of opiate agonism in psychosis treatment.

The topic expert evidence supports the recommendation (1.4.10) in CG120 to conduct a comprehensive assessment to understand the risks and protective factors in the life of a person with psychosis and coexisting substance misuse.

New evidence is unlikely to impact on the guideline.

Course of illness

2-year evidence update

No relevant evidence was identified.

4-year surveillance summary

No relevant evidence was identified.

6-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

4-year feedback

No topic expert feedback was relevant to this question.

6-year feedback

Topic experts highlighted the following studies:

A study[19] (n=642) investigated the association between cannabis use disorders and the course of bipolar disorder in tobacco smoking patients. When analyses accounted for confounding variables, an earlier onset of bipolar disorder, higher frequency of manic episodes, and increased hospitalisations were significantly associated with cannabis use disorder.

An investigation[20] of psychiatric inpatients with methamphetamine-induced psychosis found violence, delusions, hallucinations, suicidal thoughts and attempts, and homicidal thoughts and attempts as the most frequent symptoms.

Impact statement

The topic expert evidence supports the recommendations (1.4.10 – 1.4.14) in CG120 to conduct a comprehensive assessment to understand the history of substance use and monitor the course of illness in people with psychosis and coexisting substance misuse.

New evidence is unlikely to change guideline recommendations.

Subgroups according to type of substance misuse

2-year evidence update

No relevant evidence was identified.

4-year surveillance summary

A post hoc analysis[21] of a RCT (n=323) investigated the effects of comorbid substance abuse in first-episode schizophrenia on cognition and psychopathology. Substance use and non-substance use disorder patients showed similar psychopathology and neuropsychological performances at baseline and during the first 6 months of antipsychotic treatment. A correlation between longer duration of cannabis use and higher cognitive performance as well as reduced symptom improvement and more extrapyramidal motor symptoms in patients with higher frequency of cannabis consumption.

6-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

4-year feedback

No topic expert feedback was relevant to this question.

6-year feedback

Topic expert highlighted the following study:

A secondary analysis[22] of the CapOpus trial (n=60) assessed the association between levels of cannabis use at baseline and severity of psychotic symptoms at 6-month and 10-month following treatment. Four levels of cannabis use were compared (minor, moderate, high and severe). Positive and general symptoms were significantly higher for the severe use group compared with the minor use group. Negative symptoms were significantly higher in the severe use group compared with the moderate use group.

Impact statement

The new evidence reinforces CG120 recommendation 1.4.10 to offer a comprehensive multidisciplinary assessment to include an assessment of current and past substance misuse and its impact upon their life, health and response to treatment.

New evidence is unlikely to change guideline recommendations.

Care pathways

2-year evidence update

An 8-week study[23] of 102 veterans in the USA comparing a time-limited care coordination intervention (n=55) compared with a matched attention control (n=47) to evaluate the effects on engagement with outpatient treatment following discharge from a psychiatric unit. Participants had a schizophrenia spectrum or bipolar I disorder and a substance misuse or dependence disorder and had used drugs or alcohol within the past 3 months. The study began in an inpatient facility and continued in

the community after the patient's discharge from hospital.

The results of this study provide limited evidence that an intervention with a specific focus on promoting engagement across the transition from inpatient to community care that includes assertive outreach and peer support components may increase engagement with outpatient treatment in people with psychosis with coexisting substance misuse who are discharged from inpatient psychiatric care. However, the Evidence Update concluded that this study was unlikely to impact on CG120 due to the limitations of the evidence.

4-year surveillance summary

No relevant evidence was identified.

6-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

4-year feedback

Clinical feedback advocated a review of current inpatient discharge policy, in order to reduce the length of inpatient stays. The current national practice is to retain patients in inpatient care for testing with the use of gradual exposure into the community. This was stated as incurring a high cost to the NHS, and having no evidence base. However, no new evidence was cited and no further evidence was identified in the surveillance review.

6-year feedback

Topic experts commented on the changes to care pathways with services now being provided by the voluntary sector. Concerns were raised around the ability of the workforce to deal with this population and the lack of professional training in some services. As several recommendations in CG120 are for healthcare professionals, these may now be limited in relevance if the workforce is not trained in health or social care. Further concerns around the reduction in funding to substance misuse services were highlighted. Topic expert suggests this result in reduction of individual interventions, pressure on staff time due to increased caseloads and the closure of NHS addiction inpatient units. Topic expert comments that these changes may exclude people from treatment who are unable to attend group therapy due to their symptoms, the workforce is less able to work with complex presentations and key aspects of mental health work such as assessments are not conducted.

Impact statement

The limitations of the evidence identified in the Evidence Update mean it is unlikely to impact on CG120 recommendation 1.6.6. This recommends that when adults and young people are discharged from an inpatient health service, they should have an identified care coordinator and a care plan considering their needs associated with both their psychosis and their substance misuse.

Topic experts raised concerns regarding the availability and quality of services for this population. However, no further evidence was provided to impact current recommendations.

New evidence is unlikely to change guideline recommendations.

Service delivery models

120 – 05 **In people with psychosis and coexisting substance misuse, does an integrated service model (usually involving the model of assertive community treatment) when compared with an alternative management strategy lead to improved outcomes?**

120 – 06 **In people with psychosis and coexisting substance misuse, does staffed accommodation when compared with an alternative management strategy lead to improved outcomes?**

120 – 07 **When a person with psychosis and coexisting substance misuse is admitted to an inpatient mental health setting (including forensic**

settings), should treatment follow the same principles as interventions delivered in a community setting?

Subquestions

What are the elements in an integrated service model that are most likely to be associated with better outcomes?

Are there any subgroups of people (for example, young people, BME groups) that benefit from some elements of the service model more than others?

Are there subgroups of people (for example, based on severity of substance misuse and severity of psychosis; young people, BME groups) who may benefit from alternatives strategies (non-integrated service models, serial treatment, for example)?

Are there subgroups of people for whom we would alter our approach to treatment?

Recommendations derived from this question

Secondary care mental health services

Pathways into care

1.4.5 For most adults with psychosis and coexisting substance misuse, treatment for both conditions should be provided by healthcare professionals in secondary care mental health services such as community-based mental health teams.

Coordinating care

1.4.6 Consider seeking specialist advice and initiating joint working arrangements with specialist substance misuse services for adults and young people with psychosis being treated by community mental health teams, and known to be:

- severely dependent on alcohol or
- dependent on both alcohol and benzodiazepines or
- dependent on opioids and/or cocaine or crack cocaine.

Adult community mental health services or CAMHS should continue to provide care coordination and treatment for the psychosis within joint working arrangements.

1.4.7 Consider seeking specialist advice and initiate joint working arrangements with specialist substance misuse services if the person's substance misuse:

- is difficult to control and/or
- leads to significant impairment of functioning, family breakdown or significant social disruption such as homelessness.

1.4.8 If a person with psychosis and coexisting substance misuse requires planned detoxification from either drugs or alcohol, this should take place in an inpatient setting (see section 1.6).

1.4.9 Delivery of care and transfer between services for adults and young people with psychosis and coexisting substance misuse should include a care coordinator and use the Care Programme Approach.

Inpatient mental health services

Substance misuse

1.6.1 All inpatient mental health services should ensure that they have policies and procedures for promoting a therapeutic environment free from drugs and alcohol that have been developed together with service users and their families, carers or significant others*. These should include: search procedures, visiting arrangements, planning and reviewing leave, drug and alcohol testing, disposal of legal and illicit substances, and other security measures. Soon after admission, provide all service users, and their families, carers or significant others*, with information about the policies and procedures.

1.6.2 When carrying out a comprehensive assessment for all adults and young people admitted to inpatient mental health services, ensure that they are assessed for current substance misuse and evidence of withdrawal symptoms at the point of admission.

1.6.4 Ensure that planned detoxification from either drugs or alcohol is undertaken only:

- with the involvement and advice of substance misuse services
- in an inpatient setting, preferably in specialist detoxification units, or designated detoxification beds within inpatient mental health services and
- as part of an overall treatment plan.

For the further management of opioid detoxification see the guideline on opioid detoxification (NICE clinical guideline 52). For the further management of assisted alcohol withdrawal see the guideline on alcohol dependence and harmful alcohol use (NICE clinical guideline 115).

Discharge

1.6.5 Do not discharge adults and young people with psychosis and coexisting substance misuse from an inpatient mental health service solely because of their substance misuse.

1.6.6 When adults and young people with psychosis and coexisting substance misuse are discharged from an inpatient mental health service, ensure that they have:

- an identified care coordinator and
- a care plan that includes a consideration of needs associated with both their psychosis and their substance misuse and
- been informed of the risks of overdose if they start reusing substances, especially opioids, that have been reduced or discontinued during the inpatient stay.

Staffed accommodation

Exclusion from services

1.7.1 Do not exclude people with psychosis and coexisting substance misuse from staffed accommodation (such as supported or residential care) solely because of their substance misuse

1.7.2 Do not exclude people with psychosis and coexisting substance misuse from staffed accommodation aimed at addressing substance misuse solely because of their diagnosis of psychosis.

Aims of treatment

1.7.3 Ensure that people with psychosis and coexisting substance misuse who live in staffed accommodation receive treatment for both their psychosis and their substance misuse with the explicit aim of helping the person remain in stable accommodation.

* 'Significant other' refers not just to a partner but also to friends and any person the service user considers to be important to them.

Surveillance decision

This review question should not be updated.

Integrated service model outcomes

2-year evidence update

No relevant evidence was identified.

4-year surveillance summary

A systematic review[24] (66 studies) found that community-based strategies for integrated treatment from the first outbreak of schizophrenia significantly reduced negative and psychotic symptoms, days of

hospitalization, and comorbidity with substance abuse and improved global functioning and adherence to treatment.

A meta-analysis[25] (13 studies n=2824) found that integrated treatment of co-occurring substance use and mental health disorders resulted in modest, non-statistically significant improvements in psychiatric outcomes and alcohol use when compared to treatment as usual. Further examination of the effectiveness of integrated treatment in outpatient versus residential treatment settings revealed that the effectiveness of integrated care varies by setting. The impact of the evidence is weakened by the inclusion of small heterogeneous studies and geographical specificity to the USA.

A secondary analysis[26] (n=383) of an RCT examined quality of life among patients with bipolar disorder in primary care versus community mental health settings**.** The effect of treatment setting on quality of life was adjusted for hazardous drinking and substance abuse. Participants reported similar impairments in mental and physical health related quality of life across both treatment settings, indicating the need for integrated care regardless of the setting they present at. The limitations of the study, including reliance on self report without formal diagnostic interview, weaken its impact on CG120.

6-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

4-year feedback

Clinical feedback indicated that people over the age of 60 were incorrectly excluded from the scope of CG120. This might have greater relevance in services which are not age stratified i.e. old age services that are not separated from adult services. No evidence was cited or retrieved in the surveillance review to support this feedback.

The scope of CG120 incorporated a cut-off age of 60 because people with very late onset psychosis were considered to have different needs and a different evidence base for treatment. Their treatment and management should be covered separately, and were considered beyond the resources available for CG120.

Clinical feedback indicated that there are emerging novel psychoactive substances (NPS) that may have relevance for people who may be susceptible because of serious mental illnesses. Feedback also indicated that the variability and unpredictability of these substances adds an extra level of concern for this sub-group of patients and creates a need for enhanced competence.

No evidence was cited or retrieved in the surveillance review on this sub-topic.

6-year feedback

No topic expert feedback was relevant to this question.

Impact statement

The systematic review evidence on community based strategies for integrated treatment is consistent with CG120 recommendation 1.4.5 which states that for most adults with psychosis and coexisting substance misuse, treatment for both conditions should be provided by healthcare professionals in secondary care mental health services such as community-based mental health teams.

The evidence on outpatient versus residential care setting for integrated care is unlikely to impact on CG120 recommendations for staffed accommodation and reinforces the recommendation for further research to decide if staffed accommodation is more cost effective than a combination of hospital and home treatment.

No further evidence was identified at the 6-year surveillance review to impact decisions.

New evidence is unlikely to change guideline recommendations.

Elements in an integrated service model

2-year evidence update

No relevant evidence was identified.

4-year surveillance summary

A systematic review[27] (280 studies) and consensus building technique identified essential evidence based components of first episode psychosis services. 32 components were established, including acceptance of

referrals with potential comorbid psychosis and substance misuse, a comprehensive assessment upon admission, and integrated mental health and addictions treatment.

A systematic review[28] (14 studies) assessed the evidence of component interventions in effective outpatient integrated treatment for patients with comorbid schizophrenia and substance use disorders. The findings suggested that behavioural treatment and specific interventions (e.g. motivational interviewing, family interventions) were effective. Programs integrating multiple interventions were also found to be more effective. The impact of the review is weakened by the heterogeneous study designs, and further research is needed to corroborate the findings.

Service delivery

A systematic review[29] (8 studies) of evidence supporting the efficacy of mental health apps for mobile devices found significant reductions in substance use. However, it should be noted that although trials on psychotic disorders were included, coexisting substance misuse was not reported in the abstract. The evidence was of low quality and is unlikely to impact on CG120.

6-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

4-year feedback

Clinical feedback indicated that psychiatric and addiction services have changed greatly in the last 5 years and this group of patients is likely to be affected by the changes e.g. in commissioning for substance misuse services. However, no evidence was cited that may impact on CG120.

Clinical feedback stated that there are some advances in online computer aided substance misuse programmes not considered in the original guideline and not tested in those with a dual diagnosis of psychosis and substance misuse, but only in depression and anxiety. This was stated as an area for future research, with two references cited that were outside the scope of the surveillance review.

6-year feedback

No topic expert feedback was relevant to this question.

Impact statement

The new evidence on components of first episode psychosis services is consistent with CG120 recommendation 1.5.2 for patients with psychosis and coexisting substance misuse attending substance misuse services to be offered a comprehensive, multidisciplinary mental health assessment in addition to an assessment of their substance misuse.

No further evidence was identified at the 6-year surveillance review to impact decisions.

New evidence is unlikely to change guideline recommendations.

Psychological and psychosocial interventions

120 – 08 **In people with psychosis and coexisting substance misuse, do psychological/psychosocial interventions when compared with an alternative management strategy lead to improved outcomes?**

120 – 09 **For people with psychosis and coexisting substance misuse, should the psychological and psychosocial treatment (family intervention, CBT, arts therapies) of their psychosis be modified as a result of the substance misuse and the treatment provided (for example, methadone, buprenorphine, psychological treatment)? (a) During the acute phase (b) During the non-acute phase. If so, how should treatment be modified?**

120 – 10 **For people with psychosis and coexisting substance misuse, should psychological and psychosocial treatment for substance misuse be**

modified as a result of the presence of psychosis and the treatment provided? (a) During the acute phase (b) During non-acute phase. If so, how should treatment be modified?

Subquestions

Are there sub-groups of people (for example, young people, people with a particular type of psychosis, or BME groups) who may benefit from alternative strategies?

Should interventions be matched to stages of the treatment process (that is, engagement, persuasion, active treatment, relapse prevention)?

Recommendations derived from this question

Secondary care mental health services

Treatment

1.4.16 Before starting treatment for adults and young people with psychosis and coexisting substance misuse, review:

- the diagnosis of psychosis and of the coexisting substance misuse, especially if either diagnosis has been made during a crisis or emergency presentation and
- the effectiveness of previous and current treatments and their acceptability to the person; discontinue ineffective treatments.

1.4.18 Ensure that adults and young people with psychosis and coexisting substance misuse are offered evidence-based treatments for both conditions (see recommendations 1.4.19 and 1.4.20).

1.4.19 For the treatment of psychosis, see Bipolar disorder: the management of bipolar disorder in adults, children and adolescents, in primary and secondary care (NICE clinical guideline 38) or the guideline on schizophrenia (NICE clinical guideline 82).

1.4.20 For the treatment of substance misuse, see:

- Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications and the guideline on alcohol dependence and harmful alcohol use (NICE clinical guidelines 100 and CG115) and/or
- Drug misuse: psychosocial interventions and the guideline on opioid detoxification (NICE clinical guidelines 51 and 52).

1.4.21 When developing a treatment plan for a person with psychosis and coexisting substance misuse, tailor the plan and the sequencing of treatments to the person and take account of:

- the relative severity of both the psychosis and the substance misuse at different times and
- the person's social and treatment context and
- the person's readiness for change.

1.4.22 Do not exclude adults and young people with psychosis and coexisting substance misuse from contingency management programmes because of their psychosis.

Surveillance decision

This review question should not be updated.

Psychological/psychosocial interventions compared with alternative management

2-year evidence summary

A single-centre RCT[30] studied a motivational intervention to reduce cannabis use compared with treatment as usual over 12 months (n= 62) for psychosis and coexisting cannabis use. Participants were aged 18–35 years and smoked at least 3 cannabis joints per week in the month before joining the study.

This evidence suggests that a specifically designed motivational intervention may reduce cannabis use in people with psychosis to a greater extent than usual care in the 6 months in which the intervention is delivered, but this difference may not be sustained at 12 months. The intervention is more time-intensive and resource-intensive than the general brief motivational intervention recommended in CG51, so is not likely to affect current recommendations.

4-year surveillance summary

Psychological or psychosocial treatments

An updated systematic review[31] (32 studies) of psychosocial interventions for people with both severe mental illness and substance misuse found no compelling evidence to support any one psychosocial treatment over another for people to remain in treatment or to reduce substance use or improve mental state.

A systematic review[32] (8 trials) investigated specific psychological treatments, antipsychotics and cannabinoids for cannabis reduction in people with schizophrenia. Results were inconclusive due to the small number and size of trials and indicated that further research is required.

A secondary analysis[33] (n=121) of a RCT of adult inpatients with a psychiatric disorder or dual diagnosis found that gender, dual diagnosis status, age and education may be important predictors of aftercare treatment adherence and that gender may be a moderator of motivational interviewing.

A systematic review of meta-analyses[34] (61 meta-analyses) showed that effect sizes of psychotherapies vs placebo for major psychiatric disorders tended to be higher than those of medication, but direct comparisons did not reveal consistent differences. It should be noted that the number of meta-analyses covering psychosis with coexisting substance misuse was not specified in the abstract, which weakens the impact on CG120.

An RCT[35] (n=121) of individuals with serious mental illness and alcohol or drug dependence found that a 12-session 12-step facilitation therapy resulted in greater participation but not did not demonstrate greater improvement in alcohol and drug use.

Behavioural and Contingency Management

A secondary analysis[36] (n=96) of an RCT investigated predictors of treatment response of individuals receiving contingency management treatments for addictions who suffer from co-occurring severe mental illness. The findings suggested that individuals with low levels of stimulant use and psychiatric severity, as well as those actively engaged in services are most likely to succeed in a typical contingency management intervention. For other sub-groups, modifications to contingency management may be required.

A systematic review[28] (14 studies) assessed the evidence of component interventions in effective outpatient integrated treatment for patients with comorbid schizophrenia and substance use disorders. The findings suggested that behavioural treatment and specific interventions (e.g. motivational interviewing, family interventions) were effective. Programs integrating multiple interventions were also found to be more effective. The impact of the review is weakened by the heterogeneous study designs, and further research is needed to corroborate the findings.

A RCT[37] (n=110) of phase-specific psychological therapy for people with problematic cannabis use following a first episode of psychosis. Results showed that neither extended nor brief psychological therapy (motivational interviewing and with CBT) conferred benefit over standard care in terms of reductions in frequency or amount of cannabis use.

A RCT[38] (n=176) found that contingency management plus treatment as usual was associated with increased abstinence from stimulant drug use in stimulant-dependent patients with serious mental illness. It should be noted that the serious mental illnesses were not specified in the abstract, which weakens the impact on CG120.

A RCT[39] of patients with psychosis and comorbid cannabis dependence found that a group psychological intervention based on cognitive behavioural therapy and motivational

interviewing improved quality of life but did not improve cannabis use, symptoms, global functioning insight or attitude to treatment.

Family Intervention

An RCT[40] (n=108) found that both brief (2-3 months) and longer term (9-18 months) family education programs for co-occurring severe mental illness and substance misuse led to improved psychiatric, substance abuse and functional outcomes. The longer term program, which also incorporated communication and problem solving training, had significantly less severe overall psychiatric and psychotic symptoms and improved more in functioning. Substance abuse severity and family burden were not significantly different.

6-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

4-year feedback

No topic expert feedback was relevant to this question.

6-year feedback

Topic expert highlighted the following study:

A pilot randomised controlled trial[41] (n=59) in people with schizophrenia or bipolar disorder and comorbid substance misuse found that a brief integrated motivational intervention combined with treatment as usual (TAU) was associated with a significant increase in treatment engagement compared with TAU alone.

Impact statement

The totality of the 4-year evidence on psychological and psychosocial treatments is inconclusive and is unlikely to affect CG120, which defers to the related NICE guidelines for the treatment of specific psychosis or substance misuse conditions.

The behavioural and contingency management evidence from the 4 year surveillance review was insufficiently robust to impact on CG120, which does not recommend any specific psychological or psychosocial intervention or combination of interventions to people with psychosis and coexisting substance misuse. Recommendations 1.4.18-1.4.20 make general cross referrals to related guidelines CG38, CG82, CG100, CG115, CG51 and CG52 to ensure that evidence-based treatments are offered for both conditions.

Recommendation 1.4.22 states that adults and young people with psychosis and coexisting substance misuse should not be excluded from contingency management programmes because of their psychosis, based on weak evidence in favour of this intervention. The new evidence is consistent with this recommendation.

The family intervention evidence supports the utility of family intervention for the CG120 population, but also indicates the need to modify programs to retain more families in treatment.

This evidence is consistent with CG120 recommendation 1.1.8 which cross refers to CG82 schizophrenia recommendation 1.3.7 on family intervention. This recommends a specific supportive, educational or treatment function and inclusion of negotiated problem solving or crisis management work. Further evidence is required on the specific longer term program (FIDD) to justify incorporating it in the recommendations.

Evidence from topic experts is unlikely to impact recommendations which do not specify the psychological or psychosocial interventions to be used.

New evidence is unlikely to change guideline recommendations.

Modified interventions

2-year evidence update

No relevant evidence was identified.

4-year surveillance summary

A RCT[42] (n=103) of patients with cannabis use disorder and psychosis found that specialised psychosocial treatment plus treatment as usual did not reduce the frequency of cannabis use, but produced a non-significant reduction in the amount of cannabis used.

A secondary analysis[43] (n=103) of a RCT of patients with cannabis use disorder and psychosis found that specialised psychosocial treatment (motivational interviewing and cognitive behaviour therapy) plus treatment as usual resulted in a higher risk of psychiatric

emergency room contact and admission, but fewer days admitted to psychiatric hospitals.

6-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

No topic expert feedback was relevant to this question.

Impact statement

The 4-year evidence is inconclusive with regards to modifying treatments for psychosis and cannabis use disorder.

No further evidence was identified at the 6-year surveillance review to impact decisions.

New evidence is unlikely to change guideline recommendations.

Pharmacological and physical interventions

120 – 11	**For people with psychosis and coexisting substance misuse, should the medical treatment of their psychosis be modified as a result of substance misuse and the treatment provided (for example, methadone, buprenorphine, and so on)? (a) During the acute phase (b) During the non-acute phase. If so, how should treatment be modified?**
120 – 12	**For people with psychosis and coexisting substance misuse, should the medical/physical treatment of substance misuse be modified as a result of the presence of psychosis and the treatment provided (for example, antipsychotics, lithium)? (a) During the acute phase? (b) During non-acute phase? If so, how should treatment be modified?**
120 – 13	**In people with psychosis and coexisting substance misuse, is there any evidence that the management of drug interactions or adverse effects from pharmacological treatments should be different from those people without coexisting disorders? If so, how should management of drug interactions be modified?**

Subquestion

Are there subgroups of people (for example, young people, people with a particular type of psychosis, people from BME groups) who may benefit from alternative strategies than those recommended for people with a single disorder?

Recommendations derived from this question

Secondary care mental health services

Treatment

1.4.16 Before starting treatment for adults and young people with psychosis and coexisting substance misuse, review:

- the diagnosis of psychosis and of the coexisting substance misuse, especially if either diagnosis has been made during a crisis or emergency presentation and
- the effectiveness of previous and current treatments and their acceptability to the person; discontinue ineffective treatments.

1.4.18 Ensure that adults and young people with psychosis and coexisting substance misuse are offered evidence-based treatments for both conditions (see recommendations 1.4.19 and 1.4.20).

1.4.19 For the treatment of psychosis, see Bipolar disorder: the management of bipolar disorder in adults, children and adolescents, in primary and secondary care (NICE clinical guideline 38) or the guideline on schizophrenia (NICE clinical guideline 82).

1.4.20 For the treatment of substance misuse, see:

- complications and the guideline on alcohol dependence and harmful alcohol use (NICE clinical guidelines 100 and CG115) and/or
- Drug misuse: psychosocial interventions and the guideline on opioid detoxification (NICE clinical guidelines 51 and 52).

1.4.23 Use antipsychotics according to the guideline on schizophrenia (NICE clinical guideline 82) or bipolar disorder (NICE clinical guideline 38) because there is no evidence for any differential benefit for one antipsychotic over another for people with psychosis and coexisting substance misuse.

1.4.24 Use depot/long-acting injectable antipsychotics according to the guideline on schizophrenia (NICE clinical guideline 82) in managing covert non-adherence with treatment for psychosis and not as a specific treatment for psychosis and coexisting substance misuse.

1.4.25 When prescribing medication for adults and young people with psychosis and coexisting substance misuse:

- take into account the level and type of substance misuse, especially of alcohol, as this may alter the metabolism of prescribed medication, decrease its effectiveness and/or increase the risk of side effects
- warn the person about potential interactions between substances of misuse and prescribed medication
- discuss the problems and potential dangers of using non-prescribed substances and alcohol to counteract the effects or side effects of prescribed medication.

Surveillance decision

This review question should not be updated.

Pharmacological interventions

2-year evidence update

A study[44] of a subset (n=141) sample taken from a larger cohort study examined patients who were taking a single antipsychotic drug (risperidone, olanzapine or clozapine) and who had a diagnosis of cannabis dependence.

People with cannabis dependence were more likely than those in a comparator group on risperidone, olanzapine and clozapine who did not have cannabis dependence (n=363) to have used nicotine, alcohol or other illicit drugs in the past year. The group taking clozapine had significantly lower nicotine use in the previous 12 months compared with those taking risperidone or olanzapine.

People taking risperidone had significantly higher scores than those on clozapine or olanzapine for OCDUS total score, thoughts subscale and craving subscale. No significant differences were seen between clozapine and olanzapine.

Nicotine use was significantly lower in the clozapine group, which could have been a factor contributing to the lower craving for cannabis in this group.

A secondary analysis[45] of a RCT (n=120) compared risperidone and olanzapine in people with first-episode schizophrenia. This new analysis looked at data only for the first 16 weeks of treatment in 49 people meeting (DSM) - IV criteria for a lifetime history of cannabis misuse or dependence.

No significant differences were seen between the rates of treatment completion or treatment response for either drug. Rates of cannabis use at the end of the study were also not significantly different between people on olanzapine and people on risperidone.

The new evidence shows conflicting results for comparisons or olanzapine and risperidone, and the small sample size for clozapine (n=23) may prevent any firm conclusions about its effects. Therefore, these studies reinforce the need for an adequately powered randomised controlled trial to determine whether differences in the effects of antipsychotic drugs exist in this population. The current evidence is unlikely to affect NICE CG120.

A RCT[46] compared quetiapine with placebo as an add-on treatment to lithium (n=185) or valproate semisodium (n=177) in people with DSM-IV diagnosed bipolar I disorder and alcohol dependence assessed by the Structured Clinical Interview for DSM. The results of this study provide limited evidence that quetiapine has no effect on alcohol use in people with bipolar I disorder who drink heavily, and may not have additive effects on mania, depression or anxiety in people taking lithium or valproate semisodium. This evidence is unlikely to affect NICE CG120, which recommends that people should have treatment according to the underlying psychotic disorder.

4-year surveillance summary

A systematic review[47] investigated the evidence base for the different treatment options in residual insomnia in schizophrenia that may be secondary to coexisting substance misuse. No conclusive evidence was found for specific interventions.

A secondary analysis[48] of a RCT of lithium- or quetiapine-treated patients with bipolar disorder found that there was no significant effect of adjunctive benzodiazepine use on any outcome measure in patients with comorbid substance use disorders.

A RCT[49] (n=60) of patients with bipolar depression or major depressive disorder and methamphetamine dependence treated with the food supplement citicoline found that there was a significant improvement in depressive symptoms but no significant differences in memory or methamphetamine use.

A RCT[50] (n=45) of patients with amphetamine-induced psychotic disorder found that both aripiprazole and risperidone were effective in reducing positive and negative symptoms. Risperidone had a statistically significantly greater effect on positive psychotic symptoms while aripiprazole had a non-significantly greater effect on negative symptoms.

A systematic review[32] (8 trials) investigated specific psychological treatments, antipsychotics and cannabinoids for cannabis reduction in people with schizophrenia. Results were inconclusive due to the small number and size of trials and indicated that further research is required.

A systematic review[51] on aripiprazole for bipolar disorder in adults found that data does not support its use as a first choice maintenance monotherapy but it may be useful as a combination therapy for bipolar disorder patients with comorbidities such as drug abuse.

A systematic review[52] (11 studies) examined the cost effectiveness of interventions to promote the physical health of people with mental health problems. Although most studies suggested that that value for money actions in specific contexts and settings are available, none were reported for psychosis and coexisting substance misuse which weakens the impact on CG120.

A systematic review[53] investigated the effectiveness of antipsychotic treatments for cocaine dependence in schizophrenic patients. The results were inconclusive and reinforced the CG120 research recommendation for further research.

A RCT[54] (n=90) of quetiapine in patients with bipolar disorder and alcohol dependence found no significant between-group differences on the primary outcome measure of drinks per day or other alcohol-related or mood measures.

A RCT[55] (N=37) of methamphetamine dependent patients with a history of psychosis found that aripiprazole significantly decreased psychotic symptoms without serious adverse events. No statistically significance was found between the two groups in maintaining abstinence.

A pilot RCT[56] (n=30) of dually diagnosed (DD) patients with schizophrenia and cannabis use disorders found that both clozapine and ziprasidone reduced cannabis use. Clozapine treatment was associated with less positive symptoms of schizophrenia, more side effects and poorer compliance with treatment.

6-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

No topic expert feedback was relevant to this question.

Impact statement

The 2-year evidence update and 4-year surveillance review found no conclusive evidence, due to small sample sizes or inconclusive results for the following interventions:

Residual insomnia in schizophrenia secondary to substance misuse

Adjunctive benzodiazepine for bipolar disorder with comorbid substance misuse

Olanzapine and risperidone for schizophrenia and coexisting cannabis use

Specific treatments for reducing cannabis use in people with schizophrenia

Citicoline for methamphetamine dependence in bipolar disorder

Aripiprazole or risperidone for amphetamine-induced psychotic disorder

Quetiapine as monotherapy or adjunctive treatment to lithium or valproate semisodium in people bipolar I disorder and alcohol dependence.

For other interventions, the research recommendation remains ongoing for the specific CG120 comorbid population.

The totality of the evidence is unlikely to affect CG120, which defers to the related NICE guidelines for the treatment of specific psychosis and substance misuse conditions.

No further evidence was identified at the 6-year surveillance review to impact decisions.

New evidence is unlikely to change guideline recommendations.

Medical treatment for BME groups

2-year evidence update

No relevant evidence was identified.

4-year surveillance summary

A subgroup analysis[57] of a RCT of unstable patients with schizophrenia showed no superiority of long acting injectable risperidone to psychiatrist's choice of oral antipsychotic in most clinically defined subgroups, although the white patients benefited more than the other groups on substance abuse outcomes.

6-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

No topic expert feedback was relevant to this question.

Impact statement

Further evidence is required on long acting injectable risperidone in the subgroup of white patients and other subgroups before it can be incorporated into CG120.

No further evidence was identified at the 6-year surveillance review to impact decisions.

New evidence is unlikely to change guideline recommendations.

Modified interventions

2-year evidence update

No relevant evidence was identified.

4-year surveillance summary

A pilot RCT[58] (n=55) found that varenicline treatment of concurrent alcohol and nicotine dependence in schizophrenia may be problematic because of safety concerns limiting recruitment and poor tolerability. Although there were no serious neuropsychiatric adverse events in the varenicline group, gastrointestinal adverse effects limited study completion.

6-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

4-year feedback

No topic expert feedback was relevant to this question.

6-year feedback

Topic experts suggest that there have been some new antipsychotic drugs/depots licensed since the last time pharmacological treatment for psychosis was reviewed for the 2009 update of the psychosis guideline. This includes the 3-monthly paliperidone depot trevicta which may have a role in maintenance treatment of more chaotic service users.

Impact statement

The 4-year evidence is unlikely to impact on CG120.

CG120 cross refers to CG100 and CG115 for alcohol misuse treatment, which do not recommend varenicline for off label use. Varenicline is covered by TA123 and is licensed for smoking cessation but not alcohol dependence.

Further research on off label use of varenicline is required before it could be considered for the CG120 population.

CG120 also cross refers to CG178 Schizophrenia, which states that there is reasonable evidence of a benefit of varenicline for smoking cessation for people with schizophrenia. However, there are concerns about possible neuropsychiatric adverse effects as stated in the Summary of Product Characteristics, and found in the evidence review. The GDG considered that varenicline should be prescribed cautiously for smoking cessation for an adult with psychosis and schizophrenia. The evidence is consistent with this recommendation.

Topic experts highlighted the newly licensed antipsychotic drugs and depot paliperidone. However, no further evidence or supporting studies identified to impact on recommendations at this time. Also, the use of depot and long-acting injectable antipsychotics are already covered by recommendation 1.4.24 in CG120 which cross-refers to NICE guideline CG82.

New evidence is unlikely to change guideline recommendations.

Young people with psychosis and coexisting substance misuse

The review questions relating to young people with psychosis and coexisting substance misuse were sub-questions of those for adults as described in sections above. These relevant subquestions are listed below.

Subquestions

Assessment and care pathways

Should the assessment be modified for subgroups of people (for example, young people, women, people from BME groups, homeless people, offenders, type of psychosis, type of substance misuse)?

Service delivery models

Are there any subgroups of people (for example, young people, BME groups) that benefit from some elements of the service model more than others?

Are there subgroups of people (for example, based on severity of substance misuse and severity of psychosis; young people, BME groups) who may benefit from alternatives strategies (non-integrated service models, serial treatment, for example)?

Are there subgroups of people for whom we would alter our approach to treatment?

Psychological and psychosocial interventions

Are there sub-groups of people (for example, young people, people with a particular type of psychosis, or BME groups) who may benefit from alternative strategies?

Pharmacological and physical interventions

Are there subgroups of people (for example, young people, people with a particular type of psychosis, people from BME groups) who may benefit from alternative strategies than those recommended for people with a single disorder?

Recommendations derived from this question

Specific issues for young people with psychosis and coexisting substance misuse

Competence

1.8.1 Professionals in Tier 1 (primary care and educational settings) should be competent to recognise early signs of psychosis and substance misuse in young people.

1.8.2 Healthcare professionals in Tier 3 (community mental health teams) and Tier 4 (specialist inpatient and regional services) CAMHS, and in early intervention in psychosis services, should be competent in the management of psychosis and substance misuse in young people.

Identification and referral

1.8.3 Professionals in Tier 1 (primary care and educational settings) should seek advice or consultation from Tier 2 CAMHS (primary care) when signs of psychosis are detected in young people. If healthcare professionals in Tier 2 CAMHS detect signs of psychosis in young people, a referral to Tier 3 CAMHS or early intervention in psychosis services for young people should be made according to local protocols.

1.8.4 Ask all young people seen in Tier 3 and Tier 4 CAMHS and in early intervention in psychosis services who have psychosis or suspected psychosis about substance misuse (see recommendation 1.2.1).

1.8.5 Children and young people who, after comprehensive assessment, are considered to be at high risk of harm to themselves or others, should be referred directly to Tier 4 CAMHS including inpatient services where necessary.

Assessment and treatment

1.8.6 Healthcare professionals working with young people with psychosis and coexisting substance misuse should ensure they are familiar with the legal framework that applies to young people including the Mental Health Act (1983; amended 1995 and 2007), the Mental Capacity Act (2005), and the Children Act (2004).

1.8.7 For psychological, psychosocial, family and medical interventions for young people, follow the recommendations for adults in this guideline; they may need to be adapted according to the young person's circumstances and age. In addition, other agencies, including children's services, should be involved to ensure that the young person's educational, employment, family and housing needs are met.

1.8.8 When prescribing medication, take into account the young person's age and weight when determining the dose. If it is appropriate to prescribe unlicensed medication, explain to the young person and/or their parents or carers the reasons for doing this.

1.8.9 Those providing and commissioning services should ensure that:

- age-appropriate mental health services are available for young people with psychosis and coexisting substance misuse and
- transition arrangements to adult mental health services are in place where appropriate.

Surveillance decision

This review question should not be updated.

Assessment

2-year evidence update

No relevant evidence was identified.

4-year surveillance summary

No relevant evidence was identified.

6-year surveillance summary

A systematic review and meta-analysis[59] consisting of 30 studies for people with bipolar disorder found significantly increased rates of substance and alcohol misuse disorders in people with a history of childhood maltreatment.

Topic expert feedback

No topic expert feedback was relevant to this question.

Impact statement

Evidence from the 6-year surveillance review study indicates an increased risk of substance and alcohol misuse in people with a history of childhood maltreatment and bipolar disorder. However, further evidence is required on the effect of childhood maltreatment to impact recommendations at this time.

New evidence is unlikely to impact on the guideline.

Psychological and psychosocial interventions

2-year evidence update

No relevant evidence was identified.

4-year surveillance summary

A secondary analysis[60] (n=506) of a RCT of middle aged versus younger adults receiving web-delivered psychosocial treatment for substance use disorders identified unique features of middle aged substance abusers to inform age-specific substance abuse treatment planning.

6-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

No topic expert feedback was relevant to this question.

Impact statement

The new evidence identifying unique features of middle aged substance abusers to inform age-specific substance abuse treatment planning is insufficient to impact on CG120. CG120 only makes recommendations for adapting adult recommendations for young people (1.8.7) but does not differentiate between adult age groups. Further evidence is required before adult age sub group treatment planning can be incorporated into CG120.

No further evidence was identified at the 6-year surveillance review to impact decisions.

New evidence is unlikely to change guideline recommendations.

Research recommendations

Prioritised research recommendations

At 4-year and 8-year surveillance reviews of guidelines published after 2011, we assess progress made against prioritised research recommendations. We may then propose to remove research recommendations from the NICE version of the guideline and the NICE database for research recommendations. The research recommendations will remain in the full versions of the guideline. See NICE's research recommendations process and methods guide 2015 for more information.

These research recommendations were deemed priority areas for research by the Guideline Committee; therefore, at this 6-year surveillance review time point a decision **will not** be taken on whether to retain the research recommendations or stand them down.

RR – 01 What are the prevalence, risk and protective factors, and course of illness for different combinations of psychosis and coexisting substance misuse (for example, schizophrenia and cannabis misuse or bipolar disorder and alcohol misuse)?

New evidence relevant to the research recommendation was found but an update of the related review question is not planned because evidence supports current recommendations.

See 120-03 to 120-04 for evidence relating to this research recommendation.

Surveillance decision

This research recommendation will be considered again at the next surveillance point.

RR – 02 What risk factors predict the onset of substance misuse in young people with psychosis?

New evidence relevant to the research recommendation was found but an update of the related review question is not planned because the new evidence is insufficient to trigger an update.

See young people with psychosis and coexisting substance misuse for evidence relating to this research recommendation.

Surveillance decision

This research recommendation will be considered again at the next surveillance point.

RR – 03 Are psychosocial interventions clinically and cost effective when compared with standard care for people with psychosis and coexisting substance misuse?

New evidence relevant to the research recommendation was found but an update of the related review question is not planned because evidence supports current recommendations.

See 120-08 to 120-10 for evidence relating to this research recommendation.

Surveillance decision

This research recommendation will be considered again at the next surveillance point.

RR – 04 Are environmental interventions clinically and cost effective when compared with standard care for people with psychosis and coexisting substance misuse?

No new evidence relevant to the research recommendation was found and no ongoing studies were identified.

Surveillance decision

This research recommendation will be considered again at the next surveillance point.

RR – 05 Is clozapine clinically and cost effective when compared with other pharmacological interventions for people with psychosis and coexisting substance misuse?

New evidence relevant to the research recommendation was found but an update of the related review question is not planned because the new evidence is insufficient to trigger an update.

See 120-11 to 120-13 for evidence relating to this research recommendation.

Surveillance decision

This research recommendation will be considered again at the next surveillance point.

Other research recommendations

The following research recommendations were not deemed as priority areas for research by the guideline committee.

RR – 06 What and how should training be provided to healthcare professionals working with people with psychosis and substance misuse?

No new evidence relevant to the research recommendation was found and no ongoing studies were identified.

Surveillance decision

This research recommendation will be considered again at the next surveillance point.

RR – 07 Is providing treatment for psychosis and substance misuse services within staffed accommodation more cost effective than a combination of hospital and home treatment?

New evidence relevant to the research recommendation was found but an update of the related review question is not planned because evidence supports current recommendations.

See 120-05 to 120-07 for evidence relating to this research recommendation.

Surveillance decision

This research recommendation will be considered again at the next surveillance point.

RR – 08 What service delivery models allow people with psychosis and coexisting substance misuse to remain living outside hospital?

New evidence relevant to the research recommendation was found but an update of the related review question is not planned because evidence supports current recommendations.

See 120-05 to 120-07 for evidence relating to this research recommendation.

Surveillance decision

This research recommendation will be considered again at the next surveillance point.

RR – 09 Are interventions for psychosis or substance misuse clinically and cost effective when compared with standard care for people with psychosis and coexisting substance misuse?

New evidence relevant to the research recommendation was found but an update of the related review question is not planned because evidence supports current recommendations.

See 120-08 to 120-13 for evidence relating to this research recommendation.

Surveillance decision

This research recommendation will be considered again at the next surveillance point.

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