NICE National Institute for Health and Care Excellence

Coexisting severe mental illness and substance misuse - community health and social care services

Consultation on draft guideline
Stakeholder comments table

12 May 2016 - 23 June 2016

NOTE

ID	Type	Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
1	SH	Addaction	Full	3	5	Question 1 Biggest impact and a challenge will be in terms of allocating sufficient resource to deliver/develop training for healthcare staff. Ensuring ALL staff working in health understand the principles and practice/actions to meet the needs of people with Dual Diagnosis (DD) incl health and wellbeing needs will be challenging. This is particularly pertinent when considering attitudinal barriers (1.4.10).This will facilitate a shared understanding and consistent approach to support partnership working to address a range of needs regardless of the health setting where the service user engages.	Thank you for your comment. We appreciate that this is a difficult issue, however it is beyond the remit of this guideline to make recommendations on how or where local resources could be spent. Your comments will be also be considered by NICE where relevant support activity is being planned.
2	SH	Addaction	Full	1	7	Biggest challenge to implement: The guidance is very difficult to implement for 14-18 year olds. Mental Health diagnoses are often delayed to see what emerges (psychiatrists understandably reluctant to label a young person with a severe Mental Health diagnosis) and substance misuse services for Young People are often not equipped to deal with severe mental health. There are NO facilities in the country for under 18s to access detoxification and rehabilitation (although there is one due to open in November 2016). There should be separate NICE guidance for under 18s.	Thank you for your comment. Your comments will be considered by NICE where relevant support activity is being planned. The guideline covers age groups 14 years and older. The committee acknowledged in their discussions that there may be limited existing capacity for services to address the needs of this specific group. This was based on expert testimony on early intervention services and their experience.
3	SH	Addaction	Full	4	3	General comment: This section of health conditions could usefully make mention of cigarette smoking, those with a dual diagnosis are more likely to be smokers than the general population.	Thank you for your comment. The aim of recommendation 1.1.3 of the final guideline is to highlight health conditions and not health behaviours. Health behaviours such as smoking are covered in recommendation 1.3.3. (recommendation 1.2.11 in the consultation version)
4	SH	Addaction	Full	4	13	General comment: It would be helpful to spell out here what kind of support could be offered to those in a caring role – for example	Thank you for your comment. The committee agreed with the suggestion and examples

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						respite, recreational activities, support groups etc.	have been added to recommendation 1.2.8 of the final guideline.
5	SH	Addaction	Full	6	14-24	General comment: would be good to include support for carers as another primary method of retaining engagement of those with dual diagnosis	Thank you for your comment. While the committee agreed with the sentiment they did not agree to include this suggestion within this specific recommendation
6	SH	Addaction	Full	7	7	General comment: would be good to change the sentence to 'work with relevant primary care staff to meet the physical health needs of people with dual diagnosis; **essential to** involve staff from substance misuse services	Thank you for your comment. This recommendation has been amended to indicate it care coordinators should collaborate with a range of agencies (please see revised recommendation 1.3.1 of the final guideline).
7	SH	Addaction	Full	8	10	General comment: would be helpful to mention possible adverse affects of medication for physical and mental health and whether this affects their access to services – eg side effects of medication.	Thank you for your comment. The committee has recommended in 1.3.9 (recommendation 1.2.18 in the consultation version) monitoring for any adverse effects from medications. Adverse effects from medications and their impact on access to services in identified as a barrier in recommendation 1.6.2 of the final guideline.
8	SH	Addaction	Full	10	4	Question 1. Biggest Impact. Making sure people with dual diagnosis are part of local needs assessment strategy – so that they don't get 'lost. One way to achieve this would be by ensuring that local substance misuse services are routinely included in local needs assessment processes. Would also be beneficial to talk about Information Sharing Agreements here.	Thank you for your comment. It is not within our remit to make recommendations about needs assessment. Please refer to the Putting this guideline into practice section of the guideline. Recommendations on Information sharing are included in section 1.4 of the final guideline. Your comments will also be considered by NICE where relevant support activity is being planned.
9	SH	Addaction	Full	3	15	Question 1. Biggest Impact. Clear guidance on best practice to assess substance problems in mental health services (and assessing mental health problems in substance misuse services) to give some consistency in principles and 'common language'. This is something Addaction is working on for use within our own mental health and substance misuse provision and also for use with our external partners. At present, this is in the development phase, but we would be happy to share our work so far if appropriate.	Thank you for your comment. The committee shared your concern that a lack of 'common language' is often a barrier. It therefore recommended in section 1.5 that as part of support for staff, it is important to recognise the different knowledge levels of mental health and drug-or alcohol-related problems which may exist.

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							We will pass this information to our local practice collection team. More information on local practice can be found here.
10	SH	Addaction	Full	9	20	Question1. Biggest Impact. Partnership working at a strategic and commissioning level- good relationships and regular communication, joint responsibility. At Addaction we have an example of this via a multiagency DD steering group within one of our services	Thank you for your comment. Your comments will be considered by NICE where relevant support activity is being planned. We will pass this information to our local practice collection team. More information on local practice can be found here.
11	SH	Addaction	Full	9	20	Question 1. Challenges for service delivery. A difficulty in assessing whether a person has SMI whilst actively using/ under the influence of substances (in a crisis situation or in routine assessment) can mean a delay due to establishing who is optimal 'first response' service. It could be made clearer that a first response is the responsibility of the organisation where the person first presents until such time as a fuller picture can be identified.	Thank you for your comment. Recommendation 1.1 has been amended to clarify that help is provided to the person wherever they present.
12	SH	Addaction	Full	13	19	Question 1 and 2. Challenges for commissioners, service performance managers, service managers. Taking a long term view of outcomes ie having the capacity to take time to build relationship and sustained engagement is important within service that people with DUAL DIAGNOSIS use. This can be challenging for those involved in data capture and performance standards that 'reward' high rates of (successful) discharges/treatment completion. A time / resource cost may be incurred for longer term engagement – for example, in areas with payment by results type contractual arrangements.	Thank you for your comment. The committee acknowledged the importance of staff and services taking a long term view. This was in relation to both taking the time to build and sustain relationships with people who have a coexisting severe mental illness and substance misuse as well as recognising that even small improvements may take a long time . This is included in recommendation 1.6 of the final guideline. In addition, the committee made a research recommendation on barriers and facilitators for young people and adults with coexisting severe mental illness and substance misuse to obtain an optimal service to meet their needs and enable their recovery. Part of the rationale for this recommendation is that the committee felt it is important to understand the experience of people who are at different stages of recovery, how their progress and success have been maintained. This will help towards designing a more effective service and planning that will enable interventions to be delivered at the right

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							time. Your comments will also be considered by NICE where relevant support activity is being planned.
13	SH	Addaction	Full	9	20	Question 3. Overcoming challenges. The approach to any difficulty in assessing whether a person has SMI whilst actively using/ under the influence of substances (in a crisis situation or in routine assessment) should be part of local services planning and an agreement of responsibilities for these scenarios made which is widely shared with key stakeholders.	Thank you for your comment. The guideline makes recommendations on partnership working between specialist services, health, social care and other support services and commissioners. This set of recommendations highlight working together to using an agreed set of local policies and procedures, sharing the response to risk management and ensuring that data sharing protocols are in place. Your comments will also be considered by NICE where relevant support activity is being planned.
14	SH	Addaction	Full	11	12	Question 3. Overcoming Challenges. Include drug use and risky practice in relation to Substance Misuse (not just confined to needle and syringe risks) and highlight the dynamic nature of risk depending on changes in the stability of one or both substance use and /or mental health – this may further be impacted by side effects of medication for mental health issues. This is important in Dual Diagnosis guidance and can be enhanced by effective training and supervision.	Thank you for your comment. Recommendation 1.3.3 includes drug use and consequences of drug or alcohol misuse practices. The guideline makes recommendations on reviewing the person's care plan with practitioners from a range of disciplines to ensure changes to the person's circumstances and any needs (including any arising from adverse effects from medications) are taken into account.
15	SH	Addaction	Full	9	24	Question 3. Overcoming challenges. Utilising local champions for Dual Diagnosis from a range of backgrounds (employees having an additional Dual Diagnosis interest, service user, carer, practitioner, commissioner, etc,) at different tiers of organisations that span a range of health, social care and community settings. It will be important for champions receive appropriate training and supervision alongside their role.	Thank you for your comment. The committee considered the suggestion but there was no evidence for the use of local champions. The committee however did recognise that there may be a role for peer support for service users and therefore made a research recommendation on evaluating peer support as part of a service delivery intervention. Your comments will also be considered by NICE where relevant support activity is being planned.
16	SH	Addaction	Full	9	16	Question 3. Overcoming challenges. Local area Dual Diagnosis Steering groups (comprised, at least of those champions mentioned	Thank you for your comment. The guideline makes recommendations that multi-agency

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						in above point) to meet at intervals and be a portal for reporting where local pathways/agreements are falling down for individuals or working well for individuals so that pathways /agreements can be reviewed and adjusted to be more effective, efficient and safe. One of our local services has developed an example of a steering group which is also monitoring the operation of a jointly compiled DUAL DIAGNOSIS working agreement. This may also take on an operational remit, reviewing joint cases and sharing pertinent case information.	and multidisciplinary meetings are held annually (or more frequently if needed) to review a person's care plan. Recommendations on partnership working between specialist services, health, social care and other support services and commissioners emphasise the importance of working together. This includes using an agreed set of local policies, joint working arrangements, sharing response to risk management and ensuring data sharing protocols are in place. Your comments will also be considered by NICE where relevant support activity is being planned.
17	SH	Addaction	Full	General	General	The Care Planning section refers to multi disciplinary working but insufficient emphasis is placed on liaising with Substance Misuse services and agencies.	Thank you for your comment. The committee shared your concern and have noted in sections 1.2 and 1.3 where wider health, social or support services as well as substance misuse services have a role and the recommendations have been amended accordingly.
18	SH	Addaction	Full	General	General	The guidance seems to comes from the perspective of the mental health worker involving substance misuse workers but doesn't appear to address the issue of getting cooperation from mental health workers to work with substance misuse use services when the service user has accessed substances misuse services first. To add in this perspective would be very valuable for substance misuse servies, where there are sometimes difficulties in gaining access to local mental health service provision.	Thank you for your comment. The committee shared your concern and took this into account in the revised recommendations in sections 1.2 and 1.3.
19	SH	Addaction	Full	General	General	Cost implications: Training of staff would have the biggest cost implications. Due to mental health and substance misuse services sitting within different funding streams, there may be some problems establishing joint training ventures. An alternative methodology would be to site teams together or to second staff from one team into the other.	Thank you for your comment. We have passed your comment to the NICE resource impact assessment team to inform their support activities for this guideline
20	SH	Addaction	Full	General	General	Overcoming challenges: Having Dual Diagnosis Lead Practitioners in each Mental Health Trust and each Substance Misuse Service – meeting regularly to discuss service users in treatment and also those at risk.	Thank you for your comment. Your comments will be considered by NICE where relevant support activity is being planned.

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						Encouraging staff to attend local Mental Health Network events. Mandatory training for all staff involved in mental health and Substance misuse.	
21	SH	Addaction	Full	General	General	Question 3. Overcoming challenges. Develop clearer guidance on best practice for what people can actually do to support people with Dual Diagnosis. e.g. accessible guidance/illustrations/live examples of best practice interventions for mental health and substance misuse and how they may need adaptation to take into account the needs of people with a Dual Diagnosis e.g. substance use interactions with mental health (and concomitant medication) and adapting a standard substance misuse relapse prevention approach.	Thank you for your comment. Your comments will be considered by NICE where relevant support activity is being planned.
22	SH	Addaction	Full	General	General	Example of good practice: Many mental health Trusts have a Dual Diagnosis Lead practitioner. How they interact with local Substance Misuse services is variable. In St Helens we have a Dual Diagnosis CPN who comes into the Addaction service once a month to discuss cases. Keyworkers from Addaction attend CPA meetings. The medical staff from Addaction work closely with the psychiatrists to communicate regarding e.g. Opioid substitution treatment (OST). However, still some service users 'fall through the net' as not all staff are fully aware of the need for good communication between the two services. This refers back to our earlier point about training needs of staff.	Thank you for your comment. We will pass this information to our local practice collection team. More information on local practice can be found here.
23	SH	Addaction	Full	General	General	Example of good practice Addaction and a local NHS Mental Health Trust formed a Dual Diagnosis Steering Group to review existing working relationships, to develop and enhance the approach in order to improve service user care and to support staff in best practice. The Steering Group representing both Addaction and Trust, meet at intervals and face to face and comprises service managers, clinical psychology, medical lead, commissioners, practitioners and partnership services such as IAPT. To date work has included: - Review of case examples to identify what works well and what does not - Discussion of values and beliefs of the relevant services for alignment - Development of a local Dual Diagnosis Joint Working Protocol - Joint Dual Diagnosis training	Thank you for your comment. We will pass this information to our local practice collection team. More information on local practice can be found here.

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24	SH	Addaction	Full	11	17	Question 3. Overcoming challenges. Review of need at every contact is important especially if contact is intermittent. Care plans and those contributing to them need to be able to flex to respond to rapid changing needs and crisis management. Partly for this reason phone appointments (1.4.3) need to be supplemented with face to face contact to safeguard wellbeing.	Thank you for your comment. Recommendation 1.5.8 (recommendation1.4.3 in the consultation version) states phone and face to face contact for people with a dual diagnosis and phone sessions only to family/carers. This is based on the evidence identified.
25	SH	Addaction	Full	General	General	Question 4. Definition of Dual Diagnosis. The focus of the guidance is on those with severe mental illness. There is as much potential for a lack of co ordinated service provision for those on the continuum of mental health severity as there is for those with severe mental health problems. Guidance dealing with the full quadrant of Low/high severity mental health and low/high severity substance misuse is required. For substance misuse and mental health services the potential for blurring of service responsibilities means guidance for the full range of severity of both substance misuse and mental health would be useful.	Thank you for your comment. The definition of 'dual diagnosis' for the purpose of the guideline was agreed at the scoping stage of the development. Please note, following stakeholder feedback at the consultation the committee agreed to amend the title of the guideline to Coexisting severe mental illness and substance misuse.
26	SH	Addaction	Full	General	General	Question 4. Definition of Dual Diagnosis. Forthcoming Public Health England guidance using the term Co-existing alcohol and drug misuse with mental health issues would give a clearer indication of the specific domains of focus unlike e.g. 'complex need'. The PHE term also suggests there is scope to focus on the full range of complexity for both domains (see point above)	Thank you for your comment. The committee agreed to amend the title of the guideline to Coexisting severe mental illness and substance misuse. Please note: the NICE guideline covers only severe mental illness whereas the PHE guidance also covers common mental health problems. Substance misuse in the NICE guideline drugs, alcohol and medicine but not tobacco use (which is included in the PHE guidance).
27	SH	Avon and Wiltshire Mental Health Partnership (NHS) Trust	Full	7	20	Impact on mental health mentioned here?	Thank you for your comment. Impact on both mental and physical health is now included in recommendation 1.3.3 of the final guideline.
28	SH	Avon and Wiltshire Mental Health Partnership	Full	11	10	Rather than adapting services you might wish to evaluate a pilot merger of mental health community services and alcohol and drug services to provide a complex care service, which would have an integrated approach.	Thank you for your comment. The committee reviewed the evidence for service delivery models evaluating integrated treatment approach interventions. Although there was

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		(NHS) Trust					moderate evidence, there were small improvements noted for some outcomes and for some outcomes it was debatable whether the intervention showed any evidence of benefit.
29	SH	Avon and Wiltshire Mental Health Partnership (NHS) Trust	Full	12	12	Making services integrated. The policy documentation is often in place, there needs to be robust assurance processes to ensure they are consistently delivered.	Thank you for your comment. The committee recognised that ensuring an integrated approach to how services are delivered is often a challenge and noted this in the committee's discussion section. Therefore the committee made recommendations on partnership working between specialist services, health, social care and other support services and commissioners (section 1.4) and improving service delivery (section 1.5) to ensure there is an integration of services. In this context integration involves joint working and coordinated care.
30	SH	Avon and Wiltshire Mental Health Partnership (NHS) Trust	Full	12	23	I would suggest a more assertive approach to help families access support. Just providing information and signposting has limited take up (See Keith Humphries work). Important to help make initial contact.	Thank you for your comment. The committee agreed with the suggestion and recommendation 1.5.4 (recommendation 1.4.8 in the consultation version) has been amended to reflect that help should be given to make initial contact.
31	SH	Avon and Wiltshire Mental Health Partnership (NHS) Trust	Full	13	12	This might not be possible with capacity pressures. Staff may need to consider, harm reduction and contingency packages of care as part of discharge planning.	Thank you for your comment. The committee acknowledge in their discussions the pressures in relation to capacity and the aim of recommendation 1.5.12 (1.4.11 in the consultation version) was to highlight that needs of staff are taken into account . Recommendation 1.5.7 outlines the interventions can be offered as part of a service delivery model and recommendation 1.5.9 in the final guideline highlights the importance of discharge planning.
32	SH	Avon and Wiltshire Mental Health Partnership (NHS) Trust	Full	15	27	The lead role is pivotal. They need the necessary training, and experience and need to have support of senior management.	Thank you for your comment. This relates to a sentence in the Putting this guideline into practice section. This is standard text.

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33	SH	Cambridgeshire Drug & Alcohol Trust, Cambridgeshire & Peterborough Foundation Trust, Anna Freud Centre	Full	General	General	I would like to see a greater emphasis on the DEVELOPMENTAL impacts of substance use in young people, and a clearer statement of impact that differentiates this population from the adult population. Workers should accept a lower threshold of concern for children using substances than for adults (i.e. equal concern for lower amounts used, or "lower risk" drugs, in children, because of the disproportionate impact that these have on the complex developmental pathways that are active (social, psychological, biological, educational...)) I would like to see a clearer statement that dual diagnosis or complexity is the NORM in childhood substance use, rather than a rare additional burden (very few children with significant substance use difficulties are not ALSO vulnerable to exploitation, traumatised, failing educationally, and suffering from mental health problems that all warrant treatment, and that all undermine progress in other domains. So that identification of a child using drugs should automatically trigger a rich multi-domain assessment. Adults tend to present with much more differentiated problems, whereas children are (almost by definition!) more undifferentiated. Examples of good practice & existing resources I don't have access to the evidence that thy drew upon (as far as I can see) but [please consider] "What works for Whom? A Critical review of treatments... " by Bevington, Fonagy, Cottrell, Phillips and Glaser (2nd edition, Guilford, 2014) - this was a review of every treatment trial in the field for the last 20 or so years, and includes at the end recommendations, etc. I hope they will have already seen this, but I'd hate to think that all that work would not get used for something as important as this! The book provides all the references. I am also linking to a set of guidelines for substance use in young people from the RCPsych and other bodies that I co-authored in 2012, which was a collaboration between a group of experts in the field. http://www.rcpsych.ac.uk/pdf/Practice%20standards%20for%20young%20people%20with%20substance%20misuse%20problems.pdf	Thank you for your comment. The committee shared your concern and noted in the discussion section that the point at which a person is diagnosed would have an effect on development (including for example educational attainment). The committee noted that the reference (Fonagy et al 2014) the stakeholder refers to in their response is a book that focuses on psychosocial and pharmacological interventions for mental health for children and adolescents. This does not appear to be to for a dual diagnosis population and if the interventions are stand-alone pharmacotherapy or psychosocial interventions it is outside of scope for this guideline. The RCPsych guideline is specific to substance misuse not dual diagnosis. We're afraid the Fuggle et al (2015) does not appear to be relevant to this guideline and is considered to be outside of our scope.

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						I'd also point to the work I have done on AMBIT, as this is a model of practice specifically designed as an approach to these kinds of high risk, multi-problem, low help-seeking (or at least not in "conventional" terms) groups. It has demonstrated high levels of acceptability to a wide range of teams (more than 160 across the UK and internationally, many of which address comorbidity. The manual is freely available at http://ambit.tiddyspace.com but I also enclose a collection of papers that describe the method. The CASUS team in CPFT is one of the places where this method has been developed, and their locally-adapted version of the AMBIT manual is here http://ambit-casus.tiddlyspace.com (AMBIT supports multiple local adaptations of its core principles and practices, so that local teams document in detail the actual practice that they are engaged in.) "The Adolescent Mentalization-based Integrative Treatment (AMBIT) approach to outcome evaluation and manualization: adopting a learning organization approach, by Peter Fuggle, Dickon Bevington, Liz Cracknell, James Hanley, Suzanne Hare, John Lincoln, Garry Richardson, Nina Stevens, Heather Tovey and Sally Zlotowitz" , Clin Child Psychol Psychiatry published online 3 March 2014, DOI: 10.1177/1359104514521640. The online version of this article can be found at http://ccp.sagepub.com/content/early/2014/03/03/1359104514521640	
34	SH	Cambridgeshire Drug & Alcohol Trust, Cambridgeshire & Peterborough Foundation Trust, Anna Freud Centre	Full	4	1-7	In terms of more specific feedback I was slightly surprised by the list of physical health conditions featuring under 1.1.3 both in terms of the conditions identified and why have them here. What evidence is there that people with dual diagnosis have more cancer or problems with blood glucose management? I think it would be more appropriate in this section to expand on how people may be using substances to manage their mental health and how they may be passed around services with each service not quite meeting their needs.	Thank you for your comment. The evidence for the physical health conditions are based on expert testimony, the committee's expertise and existing NICE guidelines on common physical health conditions of people with a severe mental illness.
35	SH	Cambridgeshire Drug &	Full	4	14	Does admission to secondary care mental health services mean inpatient admission or simply acceptance into specialist /Psychiatry	Thank you for your comment. The term 'admission' was used to indicate

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		Alcohol Trust, Cambridgeshire & Peterborough Foundation Trust, Anna Freud Centre				caseload?	acceptance into secondary care mental health service teams such as community mental health teams. The heading (for recommendations 1.2.2-1.2.3) has been changed to 'on acceptance to secondary care mental health services'.
36	SH	Cambridgeshire Drug & Alcohol Trust, Cambridgeshire & Peterborough Foundation Trust, Anna Freud Centre	Full	General	General	There is no mention of the challenges in getting people clearly diagnosed/labelled with dual diagnosis. I perceive the barriers to be: 1) patients not attending appointments (designing services that are non stigmatising & accessible is recommended in guidelines). The most severely ill chaotic patients are simply not assessed until they attend hospital or are picked up by police. 2) patients not assessed by mental health services. In many health economies, patients who are heavily misusing substances, without a previous diagnosis of SMI will not be accepted for assessment by mental health services .	Thank you for your comment. Diagnosis is an area excluded from the scope for this guideline. However the committee made a recommendation (1.2.1) cross-referring to the existing NICE guideline coexisting severe mental illness (psychosis) and substance misuse: assessment and management in health care settings which provides best practice advice on the assessment and management of people with psychosis with coexisting substance misuse.
37	SH	Cambridgeshire Drug & Alcohol Trust, Cambridgeshire & Peterborough Foundation Trust, Anna Freud Centre	Full	General	General	There must be significant cost implications to providing a quality service. Particularly;	Thank you for your comment. The committee acknowledged in their discussions the implications of benefits versus the costs of providing a quality service. The NICE resource impact assessment report which will be available at the time of publication of this guideline will provide an assessment of the cost implications.
38	SH	Cambridgeshire Drug & Alcohol Trust, Cambridgeshire & Peterborough Foundation Trust, Anna Freud Centre	Full	6	16	One-to-one support	Thank you for your comment. The committee noted in their discussions that providing one-to-one support is based on their experience but acknowledged that practice may vary. The word 'consider' has been used in this recommendation to reflect the evidence of benefit is less certain.

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39	SH	Cambridgeshire Drug & Alcohol Trust, Cambridgeshire & Peterborough Foundation Trust, Anna Freud Centre	Full	6	19	Providing help with transport & advocacy	Thank you for your comment. The committee noted in their discussions that providing help with transport is based on their experience but acknowledged that practice may vary. However, the committee did note that providing advocacy is part of the Care Act (2014). The word 'consider' has been used in this recommendation to reflect the evidence of benefit is less certain
40	SH	Cambridgeshire Drug & Alcohol Trust, Cambridgeshire & Peterborough Foundation Trust, Anna Freud Centre	Full	6	25	Liaising with other organisations	Thank you for your comment. The committee acknowledged in their discussions (based on their experience and the evidence) that a lack of liaison between organisations can have a far reaching impact on a person with coexisting severe mental illness and substance misuse. The committee considered the trade-off between the benefits and costs of recommending working with other organisations.
41	SH	Cambridgeshire Drug & Alcohol Trust, Cambridgeshire & Peterborough Foundation Trust, Anna Freud Centre	Full	8	13	Multidisciplinary case review meetings. These are very costly in time /opportunity costs to hard pressed professionals in health and social care	Thank you for your comment. The committee acknowledged this concern in their discussions and this has been considered in the NICE resource impact assessment document. This will be published alongside the guideline.
42	SH	Cambridgeshire Drug & Alcohol Trust, Cambridgeshire &	Full	12	21	Flexible opening times drop-in sessions or meeting people in their preferred location.	Thank you for your comment. The word 'consider' has been used in this recommendation to reflect that the evidence of benefit is less certain. However, committee's experience has also been used to develop this

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		Peterborough Foundation Trust, Anna Freud Centre					recommendation.
43	SH	Cambridgeshire Drug & Alcohol Trust, Cambridgeshire & Peterborough Foundation Trust, Anna Freud Centre	Full	13	12	Promoting resilience and tolerance in practitioners	Thank you for your comment. The committee reflected on their experience and evidence and considered the far reaching impact that early discharge can have on the lives of people with coexisting severe mental illness and their family or carers. They felt the potential harms of this on people, the impact on their family or carers as well as the impact on staff or services is potentially outweighed by the resource needed to promote resilience and tolerance.
44	SH	Cambridgeshire Drug & Alcohol Trust, Cambridgeshire & Peterborough Foundation Trust, Anna Freud Centre	Full	14	23	Keeping same member of staff as point of contact	Thank you for your comment. It is unclear how this comment relates to recommendation 1.5.4 of the consultation version of the guideline. Recommendation 1.6.1 of the final guideline does recommend that where possible to keep the same member as point of contact.
45	SH	Cambridgeshire Drug & Alcohol Trust, Cambridgeshire & Peterborough Foundation Trust, Anna Freud Centre	Full	9 12	14-19 14-18	The section on partnership working 1.3 the language is quite passive e.g. language like "support services need to collaborate with each other" and "services could consider working together to positively encourage people with dual diagnosis to engage with services" – I think NICE should be more directive expecting a higher standard of care, they should say services must work together and should highlight that without a clear pathway clients will not get the services they need. This is less about positively encouraging to engage and more about identifying and removing local barriers to care. To find out about the barriers which exist local leads should consult with a broad range of service users and partners especially in homelessness services where lots of people with dual diagnosis	Thank you for your comment. The wording in the section on partnership working (now section 1.4) has been amended but where there is weak evidence 'consider' has been used to reflect a recommendation for which the evidence of benefit is less certain.

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						who don't get the help they need may end up.	
46	SH	Cambridgeshire Drug & Alcohol Trust, Cambridgeshire & Peterborough Foundation Trust, Anna Freud Centre	Full	11	9	I can see the point about adapting local services rather than creating specialist services but where is the evidence that adapting local services has worked, this needs to come through more in the guidance. The danger is by having a general approach the interventions get weakened as you have to try and get buy in across services.	Thank you for your comment. The committee's discussion outlines the rationale for proposing adapting existing services (section 1.5 of the final guideline).
47	SH	Cambridgeshire Drug & Alcohol Trust, Cambridgeshire & Peterborough Foundation Trust, Anna Freud Centre	Full	General	General	Two useful existing resources on designing service models that are responsive to chaotic itinerant people with dual diagnosis are described in 1)"Standards for Commissioners and Service Providers" by the Faculty for Homeless Health, version 1.0, 2011. The relevant chapter is "Standards for Commissioning Mental Health Services". Link http://www.pathway.org.uk/wp-content/uploads/2013/02/Homeless-Health-Standards.pdf 2) The Queens National Institute describes the challenges in existing services http://www.qni.org.uk/docs/Dual%20DiagnosisNEW.pdf	Thank you for your comment. The committee considered these and noted that the 'Standards for Commissioners and Service Providers' reference provided by the stakeholder doesn't appear to be specific to the dual diagnosis population. The QNI reference provided by the stakeholder outlines a holistic service designed for homeless people with dual diagnosis. We will pass this information to our local practice collection team. More information on local practice can be found here.
48	SH	Cambridgeshire Drug & Alcohol Trust, Cambridgeshire & Peterborough Foundation Trust, Anna Freud Centre	Full	17	18	People with personality disorder + substance misuse are excluded from this guidelines. I am concerned this will exclude a significant proportion of people who suffer severely and are costly to services and society in general.	Thank you for your comment. In this guideline severe mental illness includes personality disorder.
49	SH	Cambridgeshire Drug & Alcohol Trust, Cambridgeshi	Full	28	24—30	Overall I have found it hard to comment on this guidance because of the way NICE works which is to summarise evidence. If that evidence is not available they may call for more, or say it is weak. Taking such an approach means the guidance kind of reflects	Thank you for your comment. We are sorry to hear that you found it difficult to comment on the guideline due to the nature of the report. This is not our intention.

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		re & Peterborough Foundation Trust, Anna Freud Centre				research which is out there rather than setting out a template for exactly how services could/should look.	The aim of NICE guidelines is to provide readers with key actions. These are the recommendations (1.1 to 1.6 of the final guideline) which aim to set how services could/ should look and what services and staff could/ should aim towards. The process and methods for the development of NICE guidelines require that the recommendations are evidence-based. The committee arrives at these recommendations based on available evidence, expert testimony and committee expertise. Please see the Developing NICE guidelines: the manual for further information.
50	SH	Cambridgeshire Drug & Alcohol Trust, Cambridgeshire & Peterborough Foundation Trust, Anna Freud Centre	Full	33	22-30	The guidance noted a lack of evidence for staff training and did not make a recommendation for this area, this is worrying because surely there is a need for training? Could they say there was not enough evidence to say that training was effective but services should ensure professionals in both mental health and substance misuse services have a basic understanding of their respective areas and understand the impact of dual diagnosis and the agreed local systems, strategies, protocols and pathways.	Thank you for your comment. The recommendation (1.5.11 of the final guideline) has now been amended to reflect that practitioners within mental health services and substance misuse services may have different knowledge of their respective areas and that this may be a barrier to delivering service.
51	SH	Central and North West London NHS Foundation Trust	Full	General	General	Implicit throughout the document is that staff will know how to recognise dual diagnosis but many staff lack any training in substance misuse. Increasing knowledge and confidence in staff in this area would have an immense impact. The current commissioning model of addiction services has had a significant impact on training for medical, nursing, psychology such that people do not get the opportunity for such placement during their training. Currently the majority have no substance misuse training and this will only get worse. This then impacts on all other professions working to support individuals with dual diagnosis.	Thank you for your comment. Recommendation 1.2.1 in the guideline cross-refers to the NICE guideline coexisting severe mental illness (psychosis) and substance misuse: assessment and management in health care settings (CG120). This guideline provides best practice advice on the recognition, assessment and management of people with psychosis with coexisting substance misuse.
52	SH	Central and North West London NHS Foundation Trust	Full	General	General	Dual implies 2 and most individuals have more than 2 diagnoses so it should not be the preferred term. Co-existing or comorbid is better.	Thank you for your comment. The committee agreed to amend the title of the guideline to Coexisting severe mental illness and substance misuse.

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53	SH	Central and North West London NHS Foundation Trust	Full	4	14	Regarding "on admission to secondary care services" presupposes that secondary care will 'admit' the individual to their service; it is unlikely they will not for psychotic illness but may happen for those who are depressed. Could be proposed that such secondary care should / must have these individuals on their caseload? The document also presupposes that an assessment and diagnosis has been made. I suggest that mental health services have a responsibility to assess mental health issues in any individual with alcohol/drug problems given the lack of mental health expertise in many addictions services now. At the very least, they should assist with assessment and diagnosis however hard this may be due to ongoing alcohol/drug misuse. It is appropriate that mental health services should provide a care coordinator. (line 28)	Thank you for your comment. The committee shared your concern. Recommendations 1.2.1 outlines actions that should take place within secondary care mental health services once a person with coexisting severe mental illness and substance misuse has been referred to this service. Recommendation 1.2.1 also refers to existing NICE guideline coexisting severe mental illness (psychosis) and substance misuse: assessment and management in health care settings (CG120) which provides best practice advice on the recognition, assessment and management of people with psychosis with coexisting substance misuse.
54	SH	Central and North West London NHS Foundation Trust	Full	4	26	The "alcohol dependence" guidelines (CG1; 2011) do discuss comorbidity with depression and anxiety and other disorders and should also be signposted here. I appreciate this guidance applies to SMI but would be helpful to signpost other sources of information.	Thank you for your comment. Recommendation 1.3.3 (recommendation 1.2.11 in the consultation version) cross-refers to the NICE pathway on alcohol-use disorders (which includes alcohol dependence guidelines CG100 and CG115).
55	SH	Central and North West London NHS Foundation Trust	Full	7	6	Re 'consider involving staff in substance misuse services" – this is not clear. Surely if the patient is misusing substances, a substance misuse service will be involved given their expertise which is not generally / rarely present in the rest of psychiatric or other services such individuals are in contact with? This expertise is necessary and so 'consider' is in appropriate. In addition where a substance misuse service is involved, they should be consulted about care plan and involved in CPAs. If this recommendation is only referring to physical health of individual it should be made clearer – but substance service should be involved though will not primary service meeting the patient's needs. .	Thank you for your comment. This was in reference to managing physical health conditions. The recommendations in this section have been reorganised and the recommendation (1.3.1 of the final guideline) has been reworded to clarify that the care coordinator in secondary mental health services should collaborate with other services (including substance misuse services) when developing or reviewing the person's care plan.
56	SH	Community		3	1.12	In over 18 s Dual diagnosis service patients are already in	Thank you for your comment.

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		Addiction Service, St Luke's Hospital, Armagh				secondary care services and referrals come from secondary care not primary to Dual diagnosis service.	The committee considered your comment and noted that even if over 18s are in secondary community addiction services they will have to be referred to the secondary care mental health services. The committee felt that that the recommendation should place onus on the mental health team to take the lead.
57	SH	Community Addiction Service, St Luke's Hospital, Armagh		4	1.21	This representative of an English care programme approach is not in existence in NI. However support and recovery services would adapt the coordination/keyworker role- dual diagnosis service is a co working service.	Thank you for your comment.
58	SH	Community Addiction Service, St Luke's Hospital, Armagh		5	1.21	Carer's assessments are offered and provided. Carers signposted to relevant supporting agencies. 14-18 years can access support through referral to Family Support Hubs. On some occasions service users have noted not following completion of carer's assessment as limited support has been offered following completion of assessments.	Thank you for your comment. Assessment of and support for carer's needs (including young carers) are in recommendation 1.2.7 and 1.2.8 (recommendation1.2.5 in the consultation version) of the guideline
59	SH	Community Addiction Service, St Luke's Hospital, Armagh		5	1.26	Implementation of mental health care core pathway incorporates a tailored package to meet needs of both service user and carer. Services currently adapting and implementing recovery care plans and wellness plans. While it is important to highlight the need for personal responsibility in terms of the patient taking personal responsibility for their recovery; we need to be mindful of the patient groups' complex needs and the important place that assertive outreach, harm reduction strategies and cognisance of the limitations of having a severe mental illness and a co-morbid substance misuse problem can play in a patients ability to make their stated recovery goals	Thank you for your comment. The committee shared your concern on this issue and the intention of the guideline is that practitioners meet the person where they are in their personal journey towards recovery. Recommendation 1.2 .5 of the final guideline highlights the need to reconcile goals.
60	SH	Community Addiction Service, St Luke's Hospital, Armagh		6	1.28 – 1.2.12	Identifies the complex needs that individuals present with and importance of liaising with Primary Care and other services and linkages of other NICE pathways regarding to physical health needs.	Thank you for your comment.

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61	SH	Community Addiction Service, St Luke's Hospital, Armagh		8	1.2.13	Limited budget to access community resources. Limited support to assist service users with accessing community services. Clear need for individuals to be supported.	Thank you for your comment.
62	SH	Community Addiction Service, St Luke's Hospital, Armagh		8	1.2.16	Case strategy meetings do not be offered routinely and have difficulty in arranging in adult services unless in crisis.	Thank you for your comment. The committee recommended (recommendation 1.3.9) that case review meetings are held annually as this is a point of good practice and is in line with the Care Programme Approach.
63	SH	Community Addiction Service, St Luke's Hospital, Armagh		9	1.20	Discharge planning arrangements in place. Importance of good communication between agencies – continue to develop communication between community and inpatient facilities, and interface protocols to support same.	Thank you for your comment.
64	SH	Community Addiction Service, St Luke's Hospital, Armagh			1.3	On-going development of communication interface policies. Ensure joint working arrangements in place. (Currently enhanced by co-working model).	Thank you for your comment.
65	SH	Community Addiction Service, St Luke's Hospital, Armagh		9	1.36	Current developments of PARIS IT system should ensure clearer information shared between agencies within trust. Current system has limitations and further development. Importance. Importance of information being shared too and with community and voluntary sector if involved and role of carer.	Thank you for your comment.
66	SH	Community Addiction Service, St Luke's Hospital,		11	1.4	If Dual diagnosis model is to sit within teams as opposed to specialist practitioners this highlight a need for training and a competence base for existing staff. Currently our service provides tiered training programme on dual diagnosis awareness with Clinical education centre and also developed and teach on the post-	Thank you for your comment. The committee's recommendations on support for staff and the related committee's discussion section acknowledge there may different levels of knowledge. The intention of

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		Armagh				graduation certificate within QUB certificate on Dual diagnosis. Current Dual Diagnosis and under 18s service has limitations given the limited resources i.e. staffing levels.	recommendations on 'Adapting existing secondary care mental health services' (1.5.6 to 1.5.9) is that the expertise from these specialist services would be utilised within the secondary care mental health services (instead of creating a specialist dual diagnosis service).
67	SH	Community Addiction Service, St Luke's Hospital, Armagh		12	1.45	Dual Diagnosis population often excluded from services, supported accommodations due to on-going substance use. Accessing services is limited due to service delivery restrictions ie 9-5 working. Accessing services generally requires referral into services which in itself leads to a time delay to access services.	Thank you for your comment. Recommendations 1.1 and 1.2 highlight that there should not be restriction criteria for access to services. Recommendation 1.5.3 highlights the importance of flexibility within services.
68	SH	Community Addiction Service, St Luke's Hospital, Armagh		13	1.4.10	Stigma continues to exist towards this population group – however with development of recovery focused work this will allow for attitudes to be challenged. It would be beneficial for services to consider the delivery of group supervision or consultation with practitioners to discuss Dual Diagnosis issues, cases and allow signposting and suggestions regarding treatment and management of individual cases.	Thank you for your comment. Recommendation 1.5.10 of the final guideline highlights the importance of supervision. However there was insufficient evidence to specify how supervision should be delivered.
69	SH	Community Addiction Service, St Luke's Hospital, Armagh		13	1.5	Engaging this client group remains challenging; consider pre-engagement assessments and tailing a person centred approach to intervention. Outreaching work may be appropriate for this client group and flexibility in appointments etc.	Thank you for your comment. The committee shared your concern and therefore have made recommendations in section 1.2 and 1.6 that are based on a person-centred approach. The recommendations include strategies to engage the person with their care and to help people who may find it difficult to engage with services to get into and stay connected with services.
70	SH	Community Addiction Service, St Luke's Hospital, Armagh		14	1.5.5	Non-attendance - Currently services comply with IEAP guidance. Discretion needs to apply to this population group, giving their high risk and complex needs, with good communication protocols with agencies involved being adopted and implemented.	Thank you for your comment. The committee shared your concern that good communication is key to ensure people are not discharged because of non-attendance. This is reflected in recommendation 1.3.8 of the final guideline.
71	SH	Community Addiction Service, St		15	General	Putting Guidance into practice We find that there is a differentiation within trust areas regarding definition of Dual Diagnosis and this applies between supporting	Thank you for your comment.

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		Luke's Hospital, Armagh				recovery and the Addiction Services who currently provide Dual Diagnosis input.	
72	SH	Community Addiction Service, St Luke's Hospital, Armagh		11	1.4	Improving service delivery Appropriate rehab intervention for Dual Diagnosis inpatient ie Pabrinex, diet, lifestyle, length/duration of groups, and mental health and physical health checks. Cautionary role whilst the evidence is not available from the popular as quoted within consultation document – there needs to be a review of local, regional and national levels of the outcomes using specific validated evidenced base of impact necessary tools, which are not of a generic foundation background. Also a need for specialist training appropriate for population and existing services.	Thank you for your comment
73	SH	Community Addiction Service, St Luke's Hospital, Armagh		8	1.2.16	Under 18's need further commentary exploring assessment, diagnosis and intervention.	Thank you for your comment. Diagnosis and assessment is outside the scope of this guideline. However, the committee shared your concern and therefore added a cross-reference (recommendation 1.2.1 of the final guideline) to the NICE guideline on coexisting severe mental illness (psychosis) and substance misuse: assessment and management in health care settings which covers these areas..
74	SH	Department of Health	Full	3	5-6	As this guideline covers young people from the age of 14, there should be mention of staff in children's social care and education who come into contact with these young people.	Thank you for your comment. Recommendation 1.1 is for all general services, in addition to urgent care and criminal justice system. The settings listed in recommendation 1.1.1 of the guideline are not exhaustive.
75	SH	Department of Health	Full	17	13-17	It might be an idea for this text to say that although the cut off has been set at 14, people should remain aware that a small number of under 14s will experience severe mental illness and substance misuse, and that this group should not be ignored.	Thank you for your comment. The committee acknowledged your concern however did not wish to make the suggested addition. This is because the evidence review had not reviewed the prevalence of coexisting severe mental illness and substance misuse in under 14s or their health and social care needs.
76	SH	Department of Health	Full	18	8	This could also include that they might have poor educational outcomes.	Thank you for your comment. The committee acknowledged in their discussions that

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							educational attainment may be another area where there maybe disparity. However, it noted that there was inconsistent evidence for educational outcomes and the point at which a person is diagnosed would have an effect on their overall education attainment.
77	SH	Department of Health	Full	23	11-12	This should also include consideration of children's social care needs, including looked after children and care leavers.	Thank you for your comment. The committee agreed that the needs of looked after children should be considered in Discharge or transition recommendations in section 1.3 (recommendation 1.3.12).
78	SH	Department of Health	Full	31	7	The JSNA process could be referred to here, i.e. the message could be that services to meet severe mental illness and substance misuse should correspond to the needs identified in the JSNA process.	Thank you for your comment and helpful suggestion. The committee discussion has been amended accordingly.
79	SH	Department of Health	Full	General	General	The document needs to make reference to CAMHS as this will be the lead mental health provider for young people aged 18 and under. This could do with referencing throughout the document but in particular sections 1.1.2, 1.2.1, 1.2.16 and pages 18-19.	Thank you for your comment. CAMHS is included as part of secondary care mental health services. A specific reference to this has been added to recommendation 1.3.12.
80	SH	Hampshire Drug & Alcohol Action Team	Full	General	General	Guidance appears to be primarily targeted at mental health providers. Focus needs to be broadened to encompass substance misuse providers and commissioners.	Thank you for your comment. The role of commissioners and substance misuse services has been clarified in the guideline.
81	SH	Hampshire Drug & Alcohol Action Team	Full	General	General	Guidance should make express reference to the PHE guidance, 'Co-existing alcohol and drug misuse with mental health issues: guidance to support local commissioning and delivery of care' (currently draft) and should reflect its the 5 key principles: 1. Commissioners and providers of alcohol and drug misuse and mental health services have a joint responsibility to meet the needs of individuals with co-existing alcohol and drug misuse and mental health issues. 2. Commissioning enables services to respond effectively and flexibly to presenting needs and prevent exclusion 3. Providers in alcohol and drug, mental health and other services should have an open door policy for individuals with co-existing alcohol and drug misuse and mental health issues, and should make every contact count.	Thank you for your comment. The committee was aware of this guidance and the NICE guideline refers to the Public Health England guidance in the committee's discussion section 1.4 of the final guideline (section 1.3 of the draft guideline).

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						4. Vulnerable children and young people are able to access the support they need, when and where they need it. 5. People can and do recover from alcohol and drug misuse and mental ill health	
82	SH	Hampshire Drug & Alcohol Action Team	Full	3	5	The following bullet point should be added to paragraph 1.1.1: • *are competent to recognise and respond to presenting alcohol, drug and mental health needs; including being competent in the use of appropriate effective screening tools and the delivery of substance misuse focussed advice and brief interventions.*	Thank you for your comment. Recommendation 1.1 is aimed at all general services and other services such as urgent care and criminal justice system. The points suggested here are for specialist services. Recommendation 1.2.1 of the final guideline cross-refers to NICE's guideline coexisting severe mental illness (psychosis) and substance misuse: assessment and management in health care settings which outlines competencies in assessment of mental health and substance misuse.
83	SH	Hampshire Drug & Alcohol Action Team	Full	3	16	The following bullet point should be added to paragraph 1.1.2: *Ensure that clear and effective referral pathways are in place and that these prioritise prompt access to appropriate care.*	Thank you for your comment. Recommendations relating to referral processes and pathways are in section 1.4 of the guideline.
84	SH	Hampshire Drug & Alcohol Action Team	Full	4	11	The following principles and service standards should be stated within Paragraph 1.2: *Service users:* • *should never turned away from services based on levels of alcohol and drug use or degree of mental ill health.* • *should be supported to access the care they need in the service(s) most appropriate to their needs, but services should adopt a "no wrong door" approach* • *have their alcohol and drug needs recognised, prioritised and responded to by mental health practitioners, and their mental health needs recognised, prioritised and responded to by alcohol and drug practitioners* • *regardless of their entry point to the care pathway, report that the care they receive is timely, compassionate and responsive to their needs* *Clinicians and frontline staff:*	Thank you for your comment. Service Users: • Bullet points 1 and 2 are covered in sections 1.1 and 1.2 of the guideline • Bullet point 3, is in recommendation 1.2.1 of the guideline [cross-referral to coexisting severe mental illness (psychosis) and substance misuse: assessment and management in health care settings] • Bullet point 4 – recommendations in sections 1.1,1.2, 1.5 and 1.6 address this concern. Clinicians and frontline staff: • Bullet points 1 and 2 are in

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						• *Are competent to recognise and respond to presenting alcohol, drug and mental health needs* • *Use effective screening, assessment, and (where appropriate) diagnosis information to inform development of comprehensive care planning, never to exclude people from services* • *ensure where people are assessed as having co-existing issues that the provider addresses both initially and refers on when needed, rather than only addressing one area of need* • *Work flexibly across organisational boundaries to enable service users to access the care that they need for alcohol, drug and mental health issues,* This section also needs to consider prescribing issues and should include a requirement for mental health, primary care and substance misuse services to share information on all pharmacological interventions being accessed by client. (Consider making specific reference to prescribing of pregabalin and benzodiazepines.)	recommendation 1.2.1 [cross-refers to recommendations 1.2 and 1.4.10 of the coexisting severe mental illness (psychosis) and substance misuse: assessment and management in health care settings guideline] • Bullet point 3- The NICE coexisting severe mental illness (psychosis) and substance misuse: assessment and management in health care settings guideline covers referral processes for suspected and diagnosed 'dual diagnosis' . This guideline makes recommendations on onward referral and treatment for both conditions in secondary care mental health services (recommendation 1.4.5) • Bullet point 4 is addressed in section 1.4 of the final guideline Prescribing issues • Recommending specific pharmacological interventions is outside of the scope of the guideline • Sharing information, including on pharmacological interventions is covered under care planning. .
85	SH	Hampshire Drug & Alcohol Action Team	Full	5	24	Paragraph 1.2.6 should include requirement for care planning to be undertaken jointly with specialist substance misuse services.	Thank you for your comment. In recommendation 1.3.1, the committee acknowledged that the care plan needs to be taken jointly with a range of organisations, including substance misuse services.
86	SH	Hampshire Drug & Alcohol Action Team	Full	6	1	Bullet point should make reference to phrase 'Recovery Capital' to ensure consistency with National Drug Strategy	Thank you for your comment. The committee considered your comment and noted that there may not be 'Recovery Services'. However, it noted that this is all part of the 'Recovery Agenda' that mental health services are expected to implement.

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87	SH	Hampshire Drug & Alcohol Action Team	Full	6	25	Section should include express requirement for care planning to be undertaken jointly with other agencies and for care plan to be held jointly.	Thank you for your comment. The revised recommendations on the care plan (now in section 1.3 of the final guideline) highlight the multi-agency approach in care planning.
88	SH	Hampshire Drug & Alcohol Action Team	Full	7	7	"consider involving" should be deleted and replaced with "*involve*"	Thank you for your comment. The recommendations in this section have been reorganised and the recommendation (1.3.1) reworded to clarify that the care coordinator (in secondary mental health services) should collaborate with other services (including substance misuse services).
89	SH	Hampshire Drug & Alcohol Action Team	Full	7	20	Requirement needs to be strengthened. Should say: *"The following health behaviours must be considered in the care plan"*	Thank you for your comment. The term '*consider*' has been used to reflect the strength of the evidence.
90	SH	Hampshire Drug & Alcohol Action Team	Full	7	21-27	List must include drug misuse and make reference to hepatitis B.	Thank you for your comment. The committee agreed with the suggestions and these have been added to recommendation 1.3.3 of the final guideline.
91	SH	Hampshire Drug & Alcohol Action Team	Full	8	3	Paragraph should make explicit reference to mutual aid and/or peer-led recovery communities.	Thank you for your comment. There was no evidence specific to mutual aid or peer led recovery communities in the evidence reviews. However, the committee were aware of mutual aid and agreed to include this as a type of peer support in a research recommendation.
92	SH	Hampshire Drug & Alcohol Action Team	Full	8	9	Guidance needs to state that decisions on detox and rehab should only be made in conjunction with substance misuse services.	Thank you for your comment. Recommendation 1.3.7 has been worded to reflect that these decisions on what type and level of support is made in collaboration with relevant providers.
93	SH	Hampshire Drug & Alcohol Action Team	Full	8	12	Safeguarding is a separate issue to housing and should be subject to a distinct requirement which includes liaison with local authority safeguarding provision where appropriate.	Thank you for your comment. The reference to safeguarding has been removed from this section.
94	SH	Hampshire	Full	8	14	Annual multi-disciplinary case reviews are too infrequent. Clients in	Thank you for your comment.

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		Drug & Alcohol Action Team				receipt of pharmacological substance misuse interventions should be being reviewed *at least* 3-monthly by substance misuse services. This could be undertaken jointly with mental health team.	Annual meetings were recommended to be in line with the Care Programme Approach. The recommendation does note that meetings may be more frequent, as determined by the person's circumstances.
95	SH	Hampshire Drug & Alcohol Action Team	Full	9	2	Requirement should state that discharge or transfer should not occur without prior consultation with substance misuse services, primary care and (where relevant) other support agencies.	Thank you for your comment. The wording in recommendation 1.3.11 (recommendation 1.2.20 in the consultation version) has been amended to note that all practitioners who have been, or who will be, involved are invited to the multi-agency case review meetings.
96	SH	Hampshire Drug & Alcohol Action Team	Full	9	20	Requirement needs to be strengthened. Should state that: *"Services should work together to proactively…"*	Thank you for your comment. The wording in recommendation 1.4.1 (recommendation 1.3.2 in the consultation version) has been amended.
97	SH	Leicestershire Partnership NHS Trust	Full	9	20	Multidisciplinary working will not happen without funded teams, good will when services are busy and pushed to capacity does not happen because it is not commissioned.	Thank you for your comment. The committee recognised in their discussions the challenges in relation to funding and other pressures facing services. However, it felt that multidisciplinary working was essential to the implementation of the care plan and to keep people with coexisting severe mental illness and substance misuse engaged with services.
98	SH	Leicestershire Partnership NHS Trust	full	11	10	We know that without dual diagnosis services service users are thrust between pillar to post because of lack of training and understaffing. Substances become drug services issue and mental remain entrenched in mental health. Actually commissioning teams with the clinical skills would improve access and care.	Thank you for your comment. The committee shared your concern that people with coexisting severe mental illness and substance misuse are often moved between services. Therefore the committee recommended partnership working between the different types of services and commissioners (section 1.4).
99	SH	Leicestershire Partnership NHS Trust	full	14	27	Non attendance nhs services are funded on patients seen not cancelled or non attended appointments. Dual diagnosis clients tend to fail more appointments this needs to be built into commissioning and funding to ensure staff can take time to chase up failed appointments and not discharge.	Thank you for your comment. The intention of recommendations 1.3.8 and 1.6.5 in the final guideline is that staff and services proactively address the issue of loss of contact or non-attendance. The resource impact document

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							(published separately) recognises that when a provider follows up missed appointments, there will be a resource impact of making these telephone calls and making home visits.
100	SH	Leicestershire Partnership NHS Trust	full	7	20	Why are drugs not included in this	Thank you for your comment. Drug misuse and the consequences of these on a person's physical health are now covered in recommendation 1.3.3 of the final guideline.
101	SH	Leicestershire Partnership NHS Trust	full	39	15	Dual diagnosis clients need mutual aid groups that are specific to them they are often excluded from mutual aid or hear discriminatory language in groups about themselves and mental health their vulnerabilities are better protected in groups designed for dual diagnosis	Thank you for your comment. There was no evidence specific to mutual aid or peer led recovery in the evidence reviews. However the committee were aware of this area and added this to research recommendation 2.
102	SH	Making Every Adult Matter coalition (Clinks, Homeless Link and Mind)	Full	General	General	MEAM was pleased to present evidence to NICE as part of the development of these guidelines. Below we provide some additional brief comments on the draft document. We have not sought to duplicate the points made in our original submission.	Thank you for your comment.
103	SH	Making Every Adult Matter coalition (Clinks, Homeless Link and Mind)	Full	1	1	As described in 1.1.1, this guidance will also be relevant to staff working in wider services. **We suggest adding a bullet point under "It is also relevant to:" that uses the same language, for instance: "Staff working in health (including urgent care), social care, voluntary and community sectors, and the criminal justice system who may come into contact with young people and adults with severe mental illness who misuse substances (dual diagnosis)."**	Thank you for your comment. The overview text of the guideline has been amended. However, the aim is not repeat sections of recommendations.
104	SH	Making Every Adult Matter coalition (Clinks, Homeless Link and Mind)	Full	3	15 – 16	In practice, secondary mental health services are often not prepared to work with people who have a dual diagnosis, either because their mental health problem is not judged severe enough to meet a defined threshold, or because they are actively using drugs or alcohol. This regularly leads to people being excluded from mental health services and is one of the most regular issues we hear about from locations across the country.	Thank you for your comment. The committee shared your concern about people with substance misuse who are often excluded in mental health services and have taken this into account in recommendation 1.2.1 of the final guideline. The wording for recommendation 1.1.6

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						We think the guidance should state that secondary mental health services have a responsibility to accept all people with dual diagnosis and to develop and deliver a care plan as set out in the guidance. **We suggest that line 15 is changed from "Ensure the person is referred to secondary care mental health services" to "Ensure the person is referred to and accepted by secondary care mental health services"**.	(recommendation 1.1.2 in the consultation version) on the responsibility of secondary care mental health services has been extended beyond referral.
105	SH	Making Every Adult Matter coalition (Clinks, Homeless Link and Mind)	Full	7	19	We have had reports of instances where people on probation have had care plans that might lead them to break the conditions of their license, for instance by travelling to certain prohibited locations. We suggest adding a bullet point under 1.2.10 that reads **"work with probation staff where relevant to ensure the care plan is consistent with any license conditions"**.	Thank you for your comment. NICE is currently developing a guideline on the mental health of adults in contact with the criminal justice system, which includes recommendations on care planning for this population.
106	SH	Making Every Adult Matter coalition (Clinks, Homeless Link and Mind)	Full	8	14-21	It would be useful to reference housing and criminal justice services too.	Thank you for your comment. Housing has been added to the list of practitioners who should be included in review meetings in recommendation 1.3.9 of the final guideline. The committee acknowledged that people with coexisting severe mental illness and substance misuse are likely to transition between the criminal justice services and community. However, this area is out of scope of the guideline and the evidence reviews did not specifically search for studies on the transition between criminal justice systems and healthcare services.
107	SH	Making Every Adult Matter coalition (Clinks, Homeless Link and Mind)	Full	9	16-17	It would be useful to reference housing and criminal justice services too.	Thank you for your comment. The recommendation (1.3.1 in the consultation version) has been removed
108	SH	Making Every Adult Matter	Full	10	21-23	It would be useful to reference housing and criminal justice services too.	Thank you for your comment. Suggested addition in relation to housing has been made

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		coalition (Clinks, Homeless Link and Mind)					to recommendation 1.4.6 (recommendation 1.3.6 in the consultation version). Please note criminal justice system setting is out of scope of the guideline.
109	SH	Making Every Adult Matter coalition (Clinks, Homeless Link and Mind)	Full	12	19 – 22	In the evidence we provided to the committee, we pointed to the specific challenges experienced by women with multiple needs in accessing services. We welcome the reference to providing services that are "easily accessible, safe and discreet", but think this should be **extended to specifically recognise the needs of women who have experienced trauma due to violence or abuse, who may require gender-specific or trauma-informed services**.	Thank you for your comment. The committee considered this comment and noted that the services reported in the expert testimony appears to be for women with mental health needs only not for those with coexisting severe mental illness and substance misuse. The committee also noted that review on current configuration of health and social care community services [review 1] did not identify any such services. In line with the recommendation on 'do not create a specialist service', the committee did not view that creating a gender specific service is the way forward. Recommendation 1.5.5 of the final guideline highlights the importance of being aware that this group may have experienced trauma. The committee's discussion recognises that all people with coexisting severe mental illness and substance misuse are vulnerable; therefore services need to be aware of trauma-informed practices.
110	SH	Making Every Adult Matter coalition (Clinks, Homeless Link and Mind)	Full	General	General	The guidance only makes one reference to suicide and no reference to unintentional death through overdose. These are both significant risks for people with a dual diagnosis, and we recommend that the committee **seeks further advice on how to incorporate these risks and their management into the guidance**. Public Health England may be able to provide helpful input from its recent work on drug-related deaths.	Thank you for your comment. The committee acknowledged your concern and made additional reference to these issues in recommendation 1.3.11. There are NICE guidelines which recommend risk assessment or coordinating care in relation to suicide (for people with coexisting severe mental illness (psychosis) and substance misuse: assessment and management in health care settings; depression; bipolar disorder; borderline

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							personality disorder; people who self-harm). There is also a NICE guideline in development on Preventing suicide in community and custodial settings.
111	SH	Manchester Mental Health and Social Care Trust	Full	5	27	Whilst the NICE guideline 'Behaviour Change: Individual Approaches' is cross referenced here it would be useful to also cross reference Psychosis and Substance Misuse Guideline that describes employing a motivational interviewing intervention in greater depth.	Thank you for your comment. Reference to the interventions recommended in NICE's coexisting severe mental illness (psychosis) and substance misuse: assessment and management in health care settings guideline is in recommendation 1.5.7 of the final guideline. This cross-refers to the interventions recommended within the guideline and other NICE guidelines.
112	SH	Manchester Mental Health and Social Care Trust	Full	8	1-12	This section should emphasise recovery services delivered by integrated drug and alcohol services. They mirror the strengths led philosophy of this guide, their inclusion would be (i) a prompt to practitioners and (ii) a standard worthy of audit (joint working)	Thank you for your comment. We did not find any publications relating to recovery services in the searches carried out for this guideline.
113	SH	Manchester Mental Health and Social Care Trust	Full	11	17-19	Due to the relatively new evidence base for telephone delivered intervention / therapy We would suggest a clearer framework and rationale for phone intervention could be delivered.	Thank you for your comment. The evidence base for telephone delivered intervention is from a US study included in the economic analysis.
114	SH	Manchester Mental Health and Social Care Trust	Full	13	1-16	Clinical supervision and case advice should be available to staff for (i) managing vicarious trauma and other burn out factors and (ii) developing case formulation for clearer intervention	Thank you for your comment. The committee agreed with the suggestion and supervision has now been included in recommendation 1.5.10.
115	SH	Manchester Mental Health and Social Care Trust	Full	15	27	We feel 'identifying a lead with an interest in the topic' conveys insufficiently the expertise a 'lead' should possess. The 'lead' should be suitably qualified in the field of co-morbidity and have seniority commensurate with the task and the authority required therein.	Thank you for your comment. This comment relates to a sentence in the Putting this guideline into practice section. This is standard text.
116	SH	Manchester Mental Health and Social Care Trust	Full	17	18-21	The definition here is too narrow. Severer presentations of personality disorder combined with substance misuse seen on our inpatient wards and community mental health teams often warrant Care Programme Approach. This guideline should be applicable to a more widely defined group of patients to avoid unequal standards of	Thank you for your comment. The definition of dual diagnosis was agreed at the scoping stage of the guideline development which included an external stakeholder consultation. Due to mixed

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						service delivery.	responses at this stage on listing personality disorder this term was removed. However, the definition aims to cover personality disorder as it is noted 'severe mental illness includes…' and the evidence review included studies with people with personality disorder although this term was not specifically included in the search strategy.
117	SH	Manchester Mental Health and Social Care Trust	Full	21	11-22	The issue about preserving and promoting engagement from both practitioner and client perspectives is described clearly however we feel that access to specialist clinical supervision for staff should be emphasised.	Thank you for your comment. The committee agreed with the suggestion and recommendation 1.5.10 (recommendation 1.4.9 in the consultation version) has been amended to include supervision.
118	SH	Manchester Mental Health and Social Care Trust	Full	25	1-6	We have experience of informative and risk ameliorating medicines reconciliation reports. Medicines reconciliation should be included as a specific element of intervention. It is consistent with a harm reduction evidence base and incorporated into brief advice	Thank you for your comment. The committee acknowledge this is an important issue but did not wish to add a specific point to a recommendation.
119	SH	Manchester Mental Health and Social Care Trust	Full	33	22-30	We feel that staff competencies in dual diagnosis improve through training. This was reinforced by a local study (unpublished). We also have experience of Coroners rulings (43 and regulation 28) based on enhancing skills and improving safety. Thus we feel the guide fails to promote training as an essential component to its implementation.	Thank you for your comment. Although the committee did not make recommendations on how to provide training, the recommendations in 'support for staff' (1.5.10-1.5.12) aims to provide the skills and competencies that services should aim for.
120	SH	Manchester Mental Health and Social Care Trust	Full	36	27-28	Service attendance policies often lead to discharge. Attendance performance targets are often crude and fail to appreciate the complexity of this client group and also lead to premature discharge. These factors should be explained and incorporated into the guide especially since the National Confidential Inquiry into Suicides and Homicides cites 'engagement' is vital in reducing both homicide and suicide rates.	Thank you for your comment. This issue of loss of contact or non attendance leading to premature discharge is addressed in recommendations 1.3.8 and 1.6.5.
121	SH	Manchester Mental Health and Social Care Trust	Full	General	General	The guideline is helpful and promotes the importance of multi-agency working with a client group that often moves from pillar to post, sometimes by their choosing, sometimes because of the way services operate. The reliance on expert opinion from the Committee was too great	Thank you for your comment. The guideline is based on the available evidence in this area, on topic expert and expert testimony.

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						and the reference to a lack of high quality research both combined to reduce the sense of validity of the guide to the reader. We feel that a pre-amble and rationale explaining that the evidence base is growing and that a collective of opinion leaders and experts support the recommendations would increase the guide's likelihood of successful implementation. Finally we feel that there are insufficient recommendations related to addressing stigma (both mental health and substance related). Stigma that exists within the public and within provider organisations which inadvertently leads to poor engagement.	Recommendations in sections 1.1,1.5 and 1.6 aim to address how services can address stigma people with coexisting severe mental illness and substance misuse often face.
122	SH	NHS England	Short	general	general	Purpose of the guideline and reasons for not including treatment options and clinical evidence needs to be more strongly outlined. Currently the recommendations cover existing strategies or policy (eg CPA) that coexisting serious mental illness and substance misuse services are already trying to implement.	Thank you for your comment. Additional text has been added to clarify that this guideline should be read in conjunction with NICE coexisting severe mental illness (psychosis) and substance misuse: assessment and management in health care settings guideline. The committee acknowledges that some of the recommendations cover existing strategies and policies. This is because it was aware there is a lack of good practice in implementing a person's care plan.
123	SH	NHS England	Short	general	general	The title should reflect the clinical conditions it relates too. Dual diagnosis could relate to the diagnosis of any condition. The title could be - Coexisting Serious Mental Illness and Substance Misuse.	Thank you for your comment. The committee agreed to amend the title of the guideline to Coexisting severe mental illness and substance misuse.
124	SH	NHS England	Short	general	general	Previous clinical guidance on this co-existing serious mental illness and substance misuse found limited evidence of any benefit for treatments designed to treat the combined problem (like the MIDAS trial).	Thank you for your comment.
125	SH	NHS England	Short	general	general	The guideline could be strengthened by referring and including evidence found through development of the psychosis with coexisting substance misuse NICE guidance.	Thank you for your comment. The remit of this guideline is on organisation and delivery of services. The coexisting severe mental illness (psychosis) and substance misuse: assessment and management in health care settings (CG120) guideline is cross-referred to throughout the guideline, particularly in relation

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							to diagnosis and assessment (recommendation 1.2.1) and interventions that should be offered (recommendation 1.5.7) as part of adapting existing services. Additional text has been added to advise readers that the CG120 guideline should be read in conjunction with this guideline.
126	SH	NHS England	Short	general	general	The guideline could be strengthened by outlining treatment options - treat each condition just as you would if the person had just that condition, and give priority for treatment to the one that is most serious at the time. There is limited evidence of benefit of treatments designed to treat the combined problem.	Thank you for your comment. The aim of this guideline is to provide recommendations on optimal configuration of wider health and social care services. The committee recognised there was limited evidence in relation to effective service models to address wider health and social care needs. Therefore, as part of a recommendation on improving service delivery, the committee recommended in 1.5.7 (recommendation 1.4.2 in the consultation version) that interventions that have shown to be effective for either severe mental illness or substance misuse (based on existing NICE guidelines) should be included as part of adapting secondary care mental health services.
127	SH	NHS England	Short	general	general	As there is limited mention of the treatment options – the guideline does not address how differing levels of substance misuse may impact on people and their mental health and whether services need to provide varying treatment options. For example brief interventions for substance misuse are delivered by services very differently to people with complex addiction problems.	Thank you for your comment. Treatment options are covered in the NICE coexisting severe mental illness (psychosis) and substance misuse: assessment and management in health care settings guideline.
128	SH	NHS England	Short	general	general	The guideline could be strengthened by including more public health interventions that can support and treat people with co-existing serious mental illness and substance misuse.	Thank you for your comment. The interventions considered within the guideline are based on those identified in the evidence review (which were based on a systematic search of the literature from 2000-2015 for effectiveness reviews and 1990-2015 for the cost-effectiveness review), call for evidence, expert testimony and the committee's expertise.

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129	SH	NHS England	Short		1.1.1	Include 'public health staff' in list of staff	Thank you for your comment and helpful suggestion. This has been added to section 1.1.
130	SH	NHS England	Short	general	general	The guidelines do not address the lack of workforce and competencies needed for staff and its impact on services. The committee's discussion does cover lack of evidence for training interventions but does not address wider issue of lack of staff and reduction of services due to funding cuts.	Thank you for your comment. The committee acknowledged in their discussion that there is variation in services related to funding and staffing.
131	SH	NHS England	Short	general	general	The guidance is largely focused on community services and does not address models whereby integrated teams work in acute hospitals such as addictions psychiatrists and alcohol/drug workers in liaison psychiatry teams, or psychology or psychiatry input into alcohol care teams.	Thank you for your comment. The guideline focused on service delivery models in 'community services' as the remit of the scope from the Department of Health was for 'people living in the community'. The type of service models identified were based on a systematic search of the literature from 2000-2015 for effectiveness reviews and 1990-2015 for the cost-effectiveness review, call for evidence, expert testimony and the committee's expertise.
132	SH	NHS Greater Glasgow & Clyde Area Psychology Committee	Full	General	General	Question 1: The biggest impact on practice is likely to be on Community Mental Health Teams – there would be recommendations that everyone with a severe mental illness has a care manager in a community mental health team; support should be offered to attend appointments; families and carers should be offered phone sessions. Community Mental Health Teams may not have the capacity to meet this. Also advocates should attend appointments and this might have an impact on advocacy services.	Thank you for your comment. Your comments will be considered by NICE where relevant support activity is being planned.
133	SH	NHS Greater Glasgow & Clyde Area Psychology Committee	Full	General	General	Question 2: There would be significant cost implications if extra staff were needed to meet these recommendations or staff were removed from other duties.	Thank you for your comment. We have passed it to the NICE resource impact assessment team to inform their support activities for this guideline. A resource impact assessment document will be published separately.
134	SH	NHS Greater Glasgow & Clyde Area	Full	General	General	Question 3: Practical help like help with transport and support to attend appointments; text reminders of appointments; good	Thank you for your comment.

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		Psychology Committee				communication with other services such as Alcohol and Drug Services, General Practitioners, Housing, Voluntary Sector.	
135	SH	NHS Greater Glasgow & Clyde Area Psychology Committee	Full	General	General	Question 4: The term 'co-existing alcohol and drug misuse' is preferable.	Thank you for your comment. The committee agreed to amend the title of the guideline to Coexisting severe mental illness and substance misuse.
136	SH	Opportunity Nottingham	Full	General	General	Service User feedback….It looks really good and comprehensive, I guess I like the part about service's adapting working together and no need for a new service 1.4.1, line 10. But as an afterthought, maybe a service that works like Opportunity Nottingham, could serve a purpose, in helping them to join and work together ? If not who ? Or maybe a job for commissioners	Thank you for your comment. The committee acknowledges (in Putting this guideline into practice section of the guideline) that leadership from commissioners is essential for the implementation of the guideline.
137	SH	Opportunity Nottingham	Full	General	General	There seems to be an assumption that having dual diagnosis means mental health services are being received – whereas it may be accessing MH services in the first place is the biggest issue as MH series are reluctant work with people with substance misuse issues.	Thank you for your comment. The committee shared your concern and therefore developed a new set of recommendation on the actions that should take place upon referral to secondary care mental health services (recommendation 1.2.1).
138	SH	Opportunity Nottingham	Full	3	9	understanding that it is important to meet the needs of people with dual diagnosis is not enough. This would not ensure that the needs are met. The guidance should give clear indications that services should be geared up to meet these needs and deliver services that are accessible and relevant. The guidance should state that services should actively take steps to combat the issues that exclude people with dual diagnosis or multiple complex needs and make their services inclusive by overcoming these barriers.	Thank you for your comment. Recognition that people with coexisting severe mental illness and substance misuse are often excluded, making service inclusive, barriers to accessing services and ways to overcome barrier are in recommendations 1.1, 1.5, 1.2 and 1.6.
139	SH	Opportunity Nottingham	Full	3	12	directing people to other services runs the risk of reinforcing the systemic problems that often lead to drop out and lack of engagement. We know from the people that use our service that frequently being redirected to another service to again tell your story is a major barrier to engagement. Services should preferably, where possible gear themselves up to be suitable to see people with dual diagnosis.	Thank you for your comment. The committee shared your concern and have outlined in sections 1.2, 1.5 and 1.6 strategies to increase engagement.

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140	SH	Opportunity Nottingham	Full	8	14	The list outlining who should be involved in joint working & care planning has too narrow a health focus. Too often, health care providers work in isolation, ignoring the input of voluntary sector workers or other services that may have a different but equally valuable perspective. It should be expanded to include all relevant agencies	Thank you for your comment. The list of practitioners identified in recommendation 1.3.9 (recommendation 1.2.16 in the consultation version) is not exhaustive but has been amended to include the voluntary sector.
141	SH	Opportunity Nottingham	Full	10	21	More robust guidance should be given about information sharing as agreements are often delayed and complicated by legal guidance. It would be helpful if guidance could state that information sharing agreements should be simple and action taken in order to help implement them where ever possible.	Thank you for your comment. The committee shared your concern and felt the recommendations and committee discussion addresses these issues.
142	SH	Opportunity Nottingham	Full	11	17	should be expanded to acknowledge that people with dual diagnosis will need flexibility around all aspects of their service provision, including appointments, DNA's, location of where they are seen etc.	Thank you for your comment. Flexibility around location is considered in recommendation 1.5.3 (recommendation 1.4.7 in consultation version). Section 1.6 (section 1.5 in the consultation version) provides practical strategies and flexible approaches to ensure people with coexisting severe mental illness and substance misuse maintain contact with services. This includes strategies to deal with loss of contact or non-attendance in recommendation 1.6.5 (recommendaiton1.5.5 in the consultation version).
143	SH	Opportunity Nottingham	Full	12	19	Providers should consider Psychologically Informed Environments (see www.PIElink.net) in underpinning this guidance	Thank you for your comment. The committee agreed and noted in recommendation 1.5.5 of the final guideline the importance of recognising people with coexisting severe mental illness and substance misuse may be traumatised and in the committee discussion's section highlighted the importance of adopting a 'trauma-informed' approach.
144	SH	Opportunity Nottingham	Full	13	12	staff resilience and tolerance – Opportunity Nottingham has produced a research report that could be shared as evidence of the effects working with this client group has on staff, and which outlined measures taken in order to support staff. We are also setting up a Practice development Unit to encourage best practice, effective working and resilience and should stand as an example of good practice for commissioners.	Thank you for your comment. We will pass this information to our local practice collection team. More information on local practice can be found here.

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145	SH	Opportunity Nottingham	Full	13	16	The principles in this section broadly echo the whole ethos of Opportunity Nottingham and the wider Fulfilling Lives Multiple Needs programme (Big Lottery funded). As such we are well placed to inform this guidance by sharing our project aims, learning and evaluation and evidence based practice. NICE could reference this.	Thank you for your comment. We will pass this information to our local practice collection team. More information on local practice can be found here.
146	SH	Pathway	Full version and EIA	18, and general	1.5.4 and general	We note that people who are homeless are referenced in the main document and also the EIA. This is welcome and positive, as homeless people are often ignored and homelessness is a 'state not a trait'. We also note the comprehensive responses from St Mungo's regarding service responses and good practice with vulnerable adults in hostels, and Dr Mary Hickey's evidence regarding high levels of ill-health and multiple needs in the homeless population, including an estimated 40% with dual diagnosis. A gap in the document and evidence is the difficulties of enabling people who are homeless to access assessment and treatment when they refuse to engage; this is often the case with entrenched rough sleepers who have been on the streets for many years. Homelessness is both a result of and a cause of severe mental illness, and many entrenched rough sleepers have a severe mental illness and substance misuse problem. It is likely that some will not have the mental capacity to make decisions regarding medical and other care & support. Professionals may well dismiss the rough sleeping and failure to engage as a "lifestyle choice" rather than the result of severe mental illness, and those with dual diagnosis may be dismissed as 'only' having a substance misuse problem. Pathway develops and supports guidance and screening tools for street outreach workers and other professionals working with rough sleepers, which are located in the services section of the Pathway website and can also be found here: http://www.pathway.org.uk/services/mental-health-guidance-advice/ The guidance provides advice regarding mental capacity and mental health and simple screening tools to determine whether mental capacity is in doubt, or the likely presence of a mental illness,	Thank you for your comment. The committee shared your concerns. It is the aim of recommendations in section 1.1 that wherever a person with coexisting severe mental illness and substance misuse present, whatever their personal situation, services should ensure that the person is given the immediate help they need, and are referred to secondary care mental health services so that they can be assessed for their needs. The committee recognised that there is an inequity in how this group are treated within services and the recommendations in this guideline also aim to address at removing the stigma and barriers of working with this vulnerable group. Thank you for the useful resource. We will pass this information to our local practice collection team. More information on local practice can be found here.

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						providing evidence that the rough sleeper in question requires admission for assessment and treatment. The guidance has been in operation now for almost 3 years, and have enabled entrenched rough sleepers to be admitted to psychiatric or medical wards for assessment. Frequently, the patients have dual diagnosis. A recent example is the patient admitted to hospital with physical health problems and Deprivation of Liberty safeguards were applied to enable continued admission and treatment. After treatment and detoxification, he was diagnosed for the first time with a severe psychotic disorder, whereas previously he had been regarded as 'only' having an alcohol problem. There are many other examples where the tools and guidance have been used to enable rough sleepers with dual diagnosis to access appropriate assessment, care and treatment. The patient can then be discharged to appropriate accommodation where community treatment can continue.	
147	SH	Pathway	Full	General	General	Both the document and the evidence by Dr Mary Hickey reference the difficulties of keeping homeless people and people who are insecurely housed engaged in treatment. However, the high thresholds for access to CMHT care, particularly in inner city areas, must be acknowledged. Therefore, many homeless people who access first stage hostels and other short term accommodation may well have difficulties with referrals to community mental health care; again, their symptoms may be disregarded as solely attributable to substance misuse. A term that Pathway has adopted to reflect the mental health, substance misuse and physical health care needs is tri-morbidity. The extent of severe physical and mental health problems and substance issue issues occur in the homeless population is well documented in Dr Hickey's submission. This is where specialist substance misuse services and GP clinics provided on site to the hostels may assist, by providing a rapid and robust assessment for the CMHT to consider if dual diagnosis is identified. Treatment for the substance misuse problem may also uncover a masked severe mental illness. The medical input ensures	Thank you for your comment and helpful suggestions. The committee agreed to amend the title of the guideline to Coexisting severe mental illness and substance misuse. Recommendations in section 1.1 aim to address the difficulties this group often faces particularly in relation to further referral.

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						physical health needs are also addressed, and assists the care and support workers to work with the patient and ensure continued engagement. There are many examples of this good practice, such as the clinics provided the SLAM and a local GP practice at the Lambeth Assessment Centre and Graham House high needs hostel (provided by ThamesReach), as well as the hostel-based clinical services outlined by St Mungo's submission. A recommendation in the guidance for good practice in this area – providing clinical GP services on site working in partnership with substance misuse services - in first stage and high need hostels would therefore be welcomed.	
148	SH	Public Health England (PHE)	Full	General	General	Safeguarding is only briefly referred to in one place. It would be helpful to see references to both adult and child safeguarding included at points (see comments 12 and 14 below for examples). Ref: 'Working together to safeguard children' (HM Government 2015) statutory guidance to the 1989 and 2004 Children Acts. Ref: 'What about the children?' (Ofsted 2013) a report of a thematic inspection on child safeguarding and joint working between adult services and children's services identifies a need for improved joint working between mental health services and children's services.	Thank you for your comment. The committee amended the recommendation (1.1.5 in final guideline) to cover the safeguarding needs for people with coexisting severe mental illness and substance misuse, their family or carers (including young children). The committee acknowledged the statutory guidance in relation to children's safeguarding needs in the committee's discussion section of the guideline.
149	SH	Public Health England (PHE)	Full	General	General	It is worth noting that flexible opportunities to engage clients who are less able to attend structured appointments, or who need immediate support, can be achieved through direct access drop-in appointments. However, this would have a high cost as it is staffing intensive.	Thank you for your comment. We have passed it to the NICE resource impact assessment team to inform their support activities for this guideline.
150	SH	Public Health England (PHE)	Full	General	General	Dual diagnosis is often not understood as a term. Recommend the PHE terminology 'co-occurring mental health and alcohol/drug misuse conditions' which is broad enough to include transient/episodic use/states of intoxication.	Thank you for your comment. The committee agreed to amend the title of the guideline to Coexisting severe mental illness and substance misuse.
151	SH	Public Health England (PHE)	Full	General	General	Crisis response to people with a dual diagnosis is consistently inadequate to their acute needs. There is a particular difficulty if the client is intoxicated, even if they are still coherent and are co-operating with the assessment process. We recommend there is a specific reference to crisis response and crisis care and this specifies that clients with dual diagnosis are not excluded from crisis	Thank you for your comment. The committee were aware of poor crisis care and the Crisis Care Concordant. This resource is referred to in section 1.5 of the committee's discussion section of the guideline.

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						support even if it is not possible to conduct a formal mental health assessment at that point. See the CQC thematic review 'Right here, right now', the crisis care concordat national action plan, 'The five year forward view for mental health' and section 1.5 of the NICE guidelines 'Service user experience in adult mental health', available at the following: https://www.cqc.org.uk/sites/default/files/20150630_righthere_mhcrisiscare_full.pdf http://www.crisiscareconcordat.org.uk/wp-content/uploads/2014/04/36353_Mental_Health_Crisis_accessible.pdf https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf https://www.nice.org.uk/guidance/cg136 Crisis response to suicidal ideation and attempts should acknowledge the strong association between substance misuse and suicide. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (Healthcare Quality Improvement Partnership, The University of Manchester 2015) reviewed suicides among the patient population during that period 2003 – 2013. Results showed 45% of those in England had a history of alcohol misuse and 32% had a history of drug misuse.	Recommendation 1.2.1 of the final guideline links to the NICE guideline on Service user experience in adult mental health. Recommendations 1.3.11 and 1.5.9 of the final guideline highlight the importance of crisis response so that a person with coexisting severe mental illness and substance misuse is able to receive help and access services seamlessly.
152	SH	Public Health England (PHE)	Full	General	General	We are concerned that there is only one mention of suicide in the document, which is in relation to the non-attendance of patients (1.5.5). We know that people in the care of mental health services with histories of drug and/or alcohol use conditions are at particularly high risk of suicide. We also know that non-attendance isn't the only risk factor that should be considered for this group in relation to suicide – relationship breakdown, social isolation, and other disruptions in life appear to be highly correlated with suicide.	Thank you for your comment. It was not the intention of the recommendation to imply non-attendance is the only risk factor in relation to suicide. Risk of suicide has also now been reflected in recommendation 1.3.11 of the final guideline.
153	SH	Public Health England (PHE)	Full	General	General	Associated with the above is the lack of focus on suicide risk among this cohort and what service providers could do to mitigate against it. We are concerned that there is no explicit mention of the importance of service providers linking in with local safeguarding arrangements for children and adults and ensuring the need to safeguard is writ large throughout the care planning process.	Thank you for your comment. Recommendation 1.1.5 links to the NICE coexisting severe mental illness (psychosis) and substance misuse: assessment and management in health care settings guideline (CG120) which has detailed recommendations on safeguarding issues.

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154	SH	Public Health England (PHE)	Full	General	General	There is no mention of the risk of unintentional overdose death for this group – something that needs highlighting given the issues around discharge and transition that the document does draw out.	Thank you for your comment and helpful suggestion. This suggestion has been added to recommendation 1.3.11.
155	SH	Public Health England (PHE)	Full	1	7	It would be good to state that this guidance would support commissioners as well as organisations working directly with people who have co-existing substance misuse and mental health. Recommendation 1 on page 3 is specifically aimed at commissioners and promotes the need to incorporate the good practice outlined throughout the document in service specifications.	Thank you for your comment. The text for the guideline overview has been amended. The role of commissioners has also been highlighted in the heading for recommendations in section 1.4.
156	SH	Public Health England (PHE)	Full	3	3 onwards	Within the 'First Contact' section, all service providers are advised to be mindful of co-existing substance misuse and mental health need, to refer individuals into wider social care services or to ensure that referrals are made to secondary care mental health services. However, there is no explicit reference made to the importance of routine screening to identify alcohol-related need and to ascertain the need for brief intervention or onward referral into substance misuse treatment of those presenting in mental health services. Routine consideration of alcohol consumption and its potential impact on presenting mental health need would assist the care planning process.	Thank you for your comment. Recommendation 1.2.1 of the guideline refers to the assessment of substance misuse needs following referral to secondary care mental health services. The pathways into care (including onward referral to substance misuse treatment) for those presenting in mental health services is reported in NICE's guideline on coexisting severe mental illness (psychosis) and substance misuse: assessment and management in health care settings. This is cross-referred in bullet point 4 of recommendation 1.2.1.
157	SH	Public Health England (PHE)	Full	4	8	Recent research by the Lankelly Chase Foundation suggests that there are approximately 58,000 people in England who are in touch with substance misuse services, homelessness services and the criminal justice system. There are a further 34,000 in touch with homelessness and substance misuse services (but not criminal justice services). The definition of homelessness used in the report includes not those only rough sleeping, but also other forms of highly insecure and inappropriate accommodation. This seems significantly different to recognising that people with co-morbid conditions might experience 'poor housing' in the draft guidelines. Ref: 'Hard Edges: Mapping severe and multiple disadvantage' (Lankelly Chase 2015)	Thank you for your comment. The committee shared your concern and recommendation 1.1.1 reflects different housing situations that people with coexisting severe mental illness and substance misuse may encounter.
158	SH	Public Health	Full	4	20	Line 18 specifies the need to assess individuals to identify social	Thank you for your comment.

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		England (PHE)				care, physical and mental health need and substance misuse need but then line 20 omits any direct reference to the involvement of specialist substance misuse service providers in the care planning process (this is later addressed explicitly in 1.2.10).	The involvement of substance misuse services is now included in recommendation 1.2.4 of the final guideline (recommendation 1.2.1 of the consultation version).
159	SH	Public Health England (PHE)	Full	4	20 – 22	We recommend adding 'identifies any adult or child safeguarding needs'.	Thank you for your comment. The committee considered the suggestion but felt that safeguarding needs should be addressed under a recommendation for all services. Recommendation 1.1.5 now addresses both child and adult safeguarding needs.
160	SH	Public Health England (PHE)	Full	7	4	It is not clear whether the reference to employment would also include those administering social security benefits. If not, this list should include Job Centre Plus. Recent research on conditionality suggests people with multiple needs are more likely to be sanctioned than others in receipt of benefits, often because they do not understand the conditions being required of them.	Thank you for your comment. The committee agreed a clarification was needed. Recommendation 1.3.2 (was recommendaiton1.2.10 in the consultation version) has been amended to reflect this.
161	SH	Public Health England (PHE)	Full	7	9 – 16	We recommend including 'adult or child safeguarding needs'.	Thank you for your comment. There is a recommendation on safeguarding needs for adult and children in section 1.1 of the final guideline.
162	SH	Public Health England (PHE)	Full	8	8	We recommend highlighting the need for explicit recognition of the additional support people with multiple needs may have around the administration of their benefit claims.	Thank you for your comment. The committee considered your comment but noted that while support with benefit claims is important, a care coordinator cannot administer a person's finances if the person is considered to have capacity.
163	SH	Public Health England (PHE)	Full	8	21	We recommend specifying 'adult social care and children's social care' here and elsewhere where potential partner services are listed. Ref: 'Working together to safeguard children' (HM Government 2015) Ref: 'What about the children?' (Ofsted 2013)	Thank you for your comment. The committee agreed and a variation of the suggested term has been included in the recommendation 1.3.9 of the final guideline.
164	SH	Public Health England (PHE)	Full	9	15	Need to highlight the responsibility of commissioners here. There are limits to the extent to which providers 'can collaborate… to provide a broad range of flexible services' if the service specification or funding limits their activity. We need a strong and joint lead from mental health (CCG/NHSE) and substance misuse (LA) commissioners and incorporation of actions to improve services to this client group into key local strategic plans. Improvements in crisis assessment and care would be a major challenge requiring joint strategic planning. Improvements in this area would have a major	Thank you for your comment. Commissioners are now included in the heading for the recommendations in section 1.4 and the role of the commissioners has been expanded in the 'Recommendations' text box.

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						impact (see references above at comment 4).	
165	SH	Public Health England (PHE)	Full	11	26	We recommend adding 'support for children, family, carers or providers'. Ref: "What about the children?' (Ofsted 2013)	Thank you for your comment. The committee agreed and the suggested addition has been incorporated in recommendation 1.5.8 (recommendation 1.4.3 in the consultation version)
166	SH	Public Health England (PHE)	Full	12	11	A reference to the need for crisis response (see comment 6 above) could be included under this section.	Thank you for your comment. Recommendation 1.5.9 in this section of the final guideline highlights the importance of crisis response so that a person with coexisting severe mental illness and substance misuse is able to receive help and access services seamlessly.
167	SH	Public Health England (PHE)	Full	13	5	This section (1.4.10) usefully recognises the different attitudes to mental health and substance misuse-related problems between different agencies and mentions ways to overcome this. However, there is no explicit focus on the importance of a coherent and well-resourced workforce development strategy with access to multi-agency training to promote a more consistent response from service providers. Joint training would possibly have the biggest impact on practice and the experience of this cohort.	Thank you for your comment. The committee shared your concern and the issue of joint training has been noted in the Putting this guideline into practice section of the guideline. Your comments will be considered by NICE where relevant support activity is being planned.
168	SH	Public Health England (PHE)	Full	14	27	Good to see that this section (1.5.5) recognises the importance of following up non-attendance as a matter of concern given the vulnerability of this client group.	Thank you for your comment.
169	SH	Public Health England (PHE)	Full	25	12	Discharge or transfer – it would be worth pointing out that there is significant evidence that the 4 weeks after discharge or transfer appear to be a particularly high risk period for people with co-morbidities (particularly around deaths – suicide and unintentional overdose).	Thank you for your comment. The committee acknowledged in their discussion that discharge or transfer are key points where a person may be at higher risk but noted that they are not aware of evidence in relation to time period to make this a specific point in the recommendation.
170	SH	Public Health England (PHE)	Full	26	31/32	It would be good to see a reference to the forthcoming PHE guidance for commissioners and providers working with people who have co-existing alcohol, drug and mental health issues. Related to this point, consistency in language would be useful so we would recommend replacing the term dual diagnosis and aligning the language used in this NICE publication with that used by PHE in the forthcoming guidance and referring to co-existing need (see comment 3 above).	Thank you for your comment. A reference to the forthcoming Public Health England publication is in the committee's discussion section 1.4 of the final guideline (section 1.3 in the consultation version).

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171	SH	RCGP	Short	General	General	A thoughtful, useful and sensible approach and attention to the problem of inadequate epidemiology to define the problem, the needs and the resource implications. However there are huge challenges for its implementation. (PS) (JS) This group is vulnerable and difficult to help often estranged from family and support network and where drug use can worsen or even precipitate psychotic illness. (PS) Perhaps some discussion on managing the addiction/misuse by selective dose reduction or longer term maintenance therapy would be helpful. (PS) The guideline does not address pregnancy or the postnatal period, although there is no evidence that this was excluded. This is an area that was not covered in NICE 192 nor NICE guideline CG110: Pregnancy and complex social factors (National Institute for Health and Care Excellence 2010) and it is an area highlighted by the Confidential Enquiry into Maternal deaths, 2015 "There is a need for practical national guidance for the management of women with multiple morbidities and social factors prior to pregnancy, and during and after pregnancy". The costs in these cases fall on the infant as well and there is a "window of opportunity", so this is a very different case. (JS)	Thank you for your comment. Recommendations on dose reduction are outside the scope of this guideline. The committee shared your concern that women who are pregnant or have recently given birth may be a particular vulnerable group. This group is now included in recommendation 1.6.4.
172	SH	RCGP	Short	27	12	The change in commissioning responsibility to local authorities since 2002 has meant a significant deterioration in services for substance misuse, but the guideline says "has changed considerably". It would be important to raise this problem and mention it in this guideline. (JS)	Thank you for your comment. The sentence in the committee's discussion section has been amended.
173	SH	Rethink Mental Illness	Short	General	General	Rethink Mental Illness welcomes the development of these guidelines. We are particularly pleased to see the focus on person-centred and holistic care, including physical healthcare, social care and housing. Our members tell us that they often do not feel supported in their wider needs by mental health services and it is encouraging to see these guidelines trying to address this.	Thank you for your comment.

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174	SH	Rethink Mental Illness	Short	4	15	It would be helpful to more explicitly mention involving people in the development of their care plan here – although it is covered in recommendation 1.2.6, it could be emphasised here too.	Thank you for your comment. Recommendation 1.2.1 now explicitly mentions developing a care plan with the person and there are a set of recommendations under the heading 'involving people with coexisting severe mental illness and substance misuse in care planning' (similar to the consultation version).
175	SH	Rethink Mental Illness	Short	5	7	Where permission has explicitly been given, it would be helpful to share the care plan with a carer too.	Thank you for your comment. Your suggested amendment has been added in recommendation 1.2.6 (recommendation 1.2.4 in the consultation version).
176	SH	Rethink Mental Illness	Short	6	5	We welcome the explicit recognition that people's goals might be different to those of professionals and services.	Thank you for your comment.
177	SH	Rethink Mental Illness	Short	8	22-25	It might be useful here to signpost best practice around physical health checks for people taking antipsychotic medication in NICE CG178 and others.	Thank you for your comment. The committee considered your comment, however an explicit reference to antipsychotic medication has not been made as recommendation 1.2.18 in the consultation version was referring to adverse effects from any medications.
178	SH	Rethink Mental Illness	Short	11 12	10 11	Something that is often raised by our members is that drug or alcohol use can be a criterion for exclusion from mental health services and vice versa – this can result in people feeling like they are being bounced between services and not get the right support. It would be helpful to explicitly address this as part of both the section on adapting existing services and on making services more inclusive.	Thank you for your comment. The committee shared your concern and addressed this point in recommendation 1.2.1 of the final guideline.
179	SH	Rethink Mental Illness	Short	12	19-22	We welcome this focus on flexibility of services – feedback from our members suggests there is no one model that works for everyone. For some a drop-in service offered greater flexibility, which was positive, but for others this model created a lot of uncertainty and anxiety.	Thank you for your comment. The committee shared your concern as this is a particularly vulnerable group and noted in their discussion that direct access to service may be more beneficial, as this would give the person a sense of continuity of care. In turn, this may also enhance feelings of trust.
180	SH	Revolving Doors	Short version	1 (and general)	2 (and general)	The term 'dual diagnosis' is seen by some as being a little outdated, although it is still widely understood. It may be worth acknowledging that other terms are often used (e.g. co-occurring mental ill-health and substance misuse)	Thank you for your comment. The committee agreed to amend the title of the guideline to Coexisting severe mental illness and substance misuse.

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181	SH	Revolving Doors		3	6	Voluntary and community sectors can be types of service providers, not settings. Suggest changing to 'health, social care, community groups and the criminal justice system'	Thank you for your comment. The committee discussed this suggestion but concluded that there may be a variation across the country on what encompasses voluntary or community groups and did not agree with the suggested amendment.
182	SH	Revolving Doors		3	15	While current guidance suggests that in the absence of integrated services, MH services take the lead, where there are problems relating to substance misuse a referral to meet those needs should also be considered.	Thank you for your comment. Recommendation 1.2.1 of the final guideline recommends assessment of substance misuse needs and cross-refers to NICE's coexisting severe mental illness (psychosis) and substance misuse: assessment and management in health care settings guideline. This guideline has recommendations on pathways for further referral.
183	SH	Revolving Doors		4	8	Not social care, but people may also need support to achieve and maintain a stable income through the welfare benefits system.	Thank you for your comment and helpful suggestion. Recommendations 1.1.3 (1.1.4 in the consultation version) has been amended accordingly.
184	SH	Revolving Doors		6	18	Suggest including housing plus education, training and employment as examples.	Thank you for your comment. The committee agreed with the suggested examples and these have been incorporated in the first bullet in recommendation1.3.6 (recommendation 1.2.7 in the consultation version).
185	SH	Revolving Doors		7	7	Suggest putting it more strongly than suggesting staff consider involving substance misuse service staff.	Thank you for your comment. The recommendations in this section have been reorganised and the recommendation 1.3.1 in the final guideline (1.2.10 in the consultation version) reworded to clarify that care coordinators (in secondary mental health services) should adopt a collaborative approach with other organisations (including substance misuse services).
186	SH	Revolving Doors		7	9	Consider adding Jobcentre Plus and/or other employment support providers.	Thank you for your comment. The committee did not wish to specify a provider but did note in recommendation 1.3.2 that it could include 'those administering social security benefits'.
187	SH	Revolving		7	28	Consider an approach such as five ways to mental wellbeing	Thank you for your comment. We did not

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		Doors					identify any evidence in relation to this in the evidence reviews or expert testimony so a specific reference to this approach was not included in recommendation 1.3.5 (1.2.12 of the consultation version)
188	SH	Revolving Doors		7	6	Amend to 'learning new skills to aid future employment'.	Thank you for your comment. The committee took on board this suggestion and the wording has been incorporated in recommendation 1.3.2 of the final guideline
189	SH	Revolving Doors		7	14	It may be appropriate to invite the housing provider, particularly if the client is in specialist accommodation.	Thank you for your comment. Housing services has been added to recommendation 1.3.1 of the final guideline.
190	SH	Revolving Doors		9	10	Consider amending to 'move to adult health or social care services at an appropriate time'	Thank you for your comment. The setting has been added to the bullet point in recommendation 1.3.12 of the final guideline.
191	SH	Revolving Doors		9	18	Consider deleting 'voluntary sector' (as above, some of the other services mentioned may be VCS providers, so the distinction may confuse.	Thank you for your comment. The committee considered the suggestion but it did not agree it is appropriate to delete 'voluntary sector' from the recommendation.
192	SH	Revolving Doors		9	23	Consider adding 'such as a service level agreement (SLA)'.	Thank you for your comment. The committee considered the suggestion but did not wish to add this to the bullet point.
193	SH	Revolving Doors		10	15	Would be helpful to clarify whether 'housing' means housing, housing support, or both.	Thank you for your comment. 'Housing' refers to both 'housing' and 'housing support' and this has been clarified in recommendation 1.4.4 (recommendation 1.3.4 in the consultation version).
194	SH	Revolving Doors		11	10	This could benefit from being reframed along the lines of ensuring that existing services are fully able to meet both mental health and substance misuse.	Thank you for your comment. Suggested amendment has been incorporated into rec-ommendation1.5.6 (recommendation 1.4.1 in the consultation version).
195	SH	Revolving Doors		11	19	This might be taken as discouraging offering families/carers face to face, when it might be appropriate to do so, particularly where there is specialist family provision.	Thank you for your comment. The evidence for family/carers was just restricted to phone interventions.
196	SH	Revolving Doors		12	2	Suggest changing to 'crisis and contingency plan'.	Thank you for your comment. Your suggested amendment to recommendation 1.5.9 (recommendation 1.4.4 in the consultation version) has been made.
197	SH	Revolving Doors		12	11	May be helpful to acknowledge ethnicity and gender.	Thank you for your comment. The committee discussion section outlines the committee's

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							rationale for not specifying factors such as ethnicity or gender.
198	SH	Revolving Doors		14	18	Consider adding 'those in contact with the criminal justice system'.	Thank you for your comment. The criminal justice system is out of scope.
199	SH	Revolving Doors		14	29	While it is likely that someone who is severely mentally unwell will be in contact with secondary mental health services, that may not always be the case.	Thank you for your comment. The committee shared your concern. The heading and the related committee's discussion for this section has been reworded to make it clarify that it is for all services.
200	SH	Revolving Doors		17	5	Consider adding 'treatment'.	Thank you for your comment. The suggested amendment has been incorporated in the context section of the guideline.
201	SH	Revolving Doors		17	22	May be worth explicitly mentioning novel psychoactive substances, particularly given the (anecdotal but persuasive) evidence that its use is particularly prevalent among already marginalised subpopulations that already have an elevated risk of mental ill health – e.g. prison & homeless populations.	Thank you for your comment. The definition for substance misuse is as per the scope.
202	SH	Revolving Doors		43	13	Further research into barriers to service entry relating to capacity, coverage of provision and service thresholds. For people with multiple and complex needs, sub-threshold mental ill health is often compounded by, alongside substance misuse, housing problems and other social vulnerabilities.	Thank you for your comment and helpful suggestion. The committee considered the comment but did not wish to amend the research recommendation.
203	SH	Revolving Doors		General	General	NHS England and Public Health England will shortly be releasing updated guidance on co-occurring mental ill-health and substance misuse, replacing the 2002 Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide. It may be worth referring to this in the guideline.	Thank you for your comment. The forthcoming Public Health England guidance is referred to within the committee's discussion section (section 1.4) of the final guideline (section 1.3 of the consultation version).
204	SH	Royal College of Nursing	General	General	General	The Royal College of Nursing welcomes these draft guidelines. The RCN invited comments from members who care for and work with people with mental illness and substance misuse. The comments include our members' views.	Thank you for your comment.
205	SH	Royal College of Nursing	Full	General	General	We wondered what the rationale was to start this service age at 14 years? Most papers judge adulthood as 18, and so it is not clear why 14 year is suggested for these guidelines? If this is an all age pathway it would be helpful to clarify this?	Thank you for your comment. The age cut off of 14 years was proposed as early intervention services usually start at this age. Also, this was to be consistent with the NICE clinical guideline coexisting severe mental illness (psychosis) and substance misuse: assessment and management in health care settings.

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206	SH	Royal College of Nursing	Full	4	5	'Infectious disease' is an emotive term and can be viewed as stigmatising. Please change. Also many of the cardio vascular conditions are often linked to prescribed medications and are not specifically to do with substance misuse or substance abuse as such?	Thank you for your comment. The committee shared your concern and the terminology has been amended to 'communicable diseases' in recommendation 1.1.2 of the final guideline (recommendation 1.1.3 in the consultation version). The committee was aware that conditions may be linked to side effects of prescribed medications and this is noted in the committee discussion's section of the guideline. Recommendation 1.3.9 on review of the care plan also highlights the need to check for any adverse effects from medications
207	SH	Royal College of Nursing	Full	4	11	Is it care plan or person centred plan?	Thank you for your comment. This is a reference to the person's care plan.
208	SH	Royal College of Nursing	Full		18	A care plan is not an assessment nor an assessment tool. Also a person should be involved in the development and not just the implementation of a care plan.	Thank you for your comment. It was not our intention to indicate that care plans are an assessment tool. Recommendations 1.2.4-1.2.6 addresses involving people in the developing and review of their care plan.
209	SH	Royal College of Nursing	Full	5	7	The care plan should not just be shared with the person. The person should be involved with developing and agreeing that it meets their needs.	Thank you for your comment. This was not the intention. Recommendation 1.2.6 (recommendation 1.2.4 in the consultation version) is now located under the header 'Involving people with coexisting severe mental illness and substance misuse in care planning' to make it clear to the reader that the person is involved in creating their care plan and it is tailored to meet their needs.
210	SH	Royal College of Nursing	Full	8	11	What about more general social needs such as relationships and friendships and positive social support?	Thank you for your comment. The importance of engaging in activities that give 'a sense of belonging or purpose' is recommended in 1.3.5 of the final guideline.
211	SH	Royal College of Nursing	Full	8	22	Is the responsibility here for the person or of their GP? If the responsibility lies with the person, it requires links with the GP? And what sort of physical health checks is being suggested here?	Thank you for your comment. The intention of the recommendation is for the care coordinator to liaise with other organisations/providers such as a GP to meet the person's physical health needs. The physical health check would

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						What about self-care for the person in between and positive health promotion advice?	be in line with the needs that have been identified in the care plan.
212	SH	Royal College of Nursing	Full	8	27	Suggest also include changes in risk level and risky behaviour	Thank you for your comment. The committee felt that using a term such as 'risky behaviour' is potentially stigmatising. Recommendation 1.3.10 (1.2.19 in the consultation version) notes to update care plans in response to changes in needs or circumstances.
213	SH	Royal College of Nursing	Full	9	22	You have to get the commissioners involved so that the funding can be in place otherwise people get stuck and are unable to move on.	Thank you for your comment. The heading for section 1.4 (section 1.3 in the consultation version) has been expanded to include commissioners. The committee shared your concern and noted the importance of leadership from commissioners across health and social care services in the Putting this guideline into practice section of the guideline.
214	SH	Royal College of Nursing	Full	10	20	Bearing in mind there will be a high level of criminal justice service (CJS) involvement there is a need to engage with the criminal Justice service personnel to ensure the person is supported.	Thank you for your comment. The criminal justice system is out of scope for this guideline.
215	SH	Royal College of Nursing	Full	General	General	The definition that is used here includes medicines. Does this mean illicitly purchased or prescribed medication? It would be helpful to clarify what is meant by this definition.	Thank you for your comment. The definition of substance misuse for the purpose of this guideline refers to use of legal or illicit drugs, including medicine. This definition is included in the context and 'terms used in the guideline' sections of the guideline.
216	SH	Royal College of Nursing	General	General	General	In general, the draft guidelines do not appear to be very person centred. They still read as if we are very much doing treatment to the person, rather than working collaboratively with them which is the direction of travel now.	Thank you for your comment. The committee took into consideration your suggestion and the wording in the guideline has been amended to reflect a more person-centred approach.
217	SH	Royal College of Nursing	General	General	General	It would be helpful to see how many service users were consulted during the development of these guidelines. As stated earlier, the guidelines currently do not read as being very empowering to the service user. The guidelines still appear very health orientated i.e. 'doing to the person', rather than working from what the person needs outwards.	Thank you for your comment. Service users and organisations are consulted during the course of guideline development. The committee included 2 lay members, including 1 topic lay member. The committee considered your comment and recommendations, particularly on care planning. This has been reorganised and

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							reworded to reflect a more person-centred approach.
218	SH	Royal College of Psychiatrists	Short	General	General	Having this guideline alongside the Psychosis and substance misuse guideline is a little confusing, and some comment on the relationship between the two might be helpful	Thank you for your comment. Text has been added (in the Recommendations box) to note this guideline should be read in conjunction with the NICE guideline on coexisting severe mental illness (psychosis) and substance misuse: assessment and management in health care settings.
219	SH	Royal College of Psychiatrists	Short	4	15-27	1.2.1. It would be useful if the guideline could refer to the value of developing a formulation that explicitly considers what may be the most important factors contributing to the person's difficulties. This would be particularly relevant to include in view of the fact that formulation is now being recognised as a core skill for all mental health professionals, and NHS England is developing guidance on this.	Thank you for your comment. Diagnosis or any psychological alternative to diagnosis is outside the scope of this guideline. However, the recommendations and the committee section of the guideline highlights the importance of making sense of a person's difficulties in the context of their relationships, social circumstances or life events.
220	SH	Royal College of Psychiatrists	Short	13	2-15	1.4.9-1.4.11. A welcome recognition of the need for support for staff but we think this could go further, e.g. acknowledging how pressures from lack of resources and centralised monitoring can contribute to the difficulties identified here, and acknowledging the potential value of reflective practice groups and similar arrangements in supporting staff to maintain compassionate, non-blaming approaches.	Thank you for your comment. There was no evidence identified in relation to reflective practice groups. So a specific reference to this has not been added to recommendations 1.5.10-1.5.12 on 'support for staff '.
221	SH	Royal College of Psychiatrists	Short	13-14	19-25	1.5.1- 1.5.4. We think the focus on building relationships here is very helpful, particularly recognising the value of continuity of relationships with professionals.	Thank you for your comment.
222	SH	Royal College of Psychiatrists	Short	14	18-25	1.5.4. We wondered why BAME groups are not mentioned?	Thank you for your comment. The committee's rationale for not specifying race is described in the committee's discussion section of the guideline.
223	SH	Royal College of Psychiatrists	Full	general	general	We are concerned this recommendation may imply separation of provision for mental and physical health needs. This may be appropriate in some circumstances but will impair care where serious medical issues (such as drug overdose, self-harm, alcoholic hepatitis etc) require attendance at A&E or acute hospital admission when mental health problems are also relapsing, unstable or	Thank you for your comment. It is unclear from this comment which specific recommendation is being referred to. Recommendation 1.1.1 advises providing help with a range of needs including urgent physical, or social care needs. Recommendation 1.2.3 highlights that all

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						otherwise difficult to manage by non-mental health professionals. We suggest highlighting this population who, in addition to recommendations made, require Liaison Psychiatry services with substance misuse expertise based in the acute hospital to both support mental health needs in hospital and link to community follow up.	needs are assessed for and addressed in liaison with other relevant services once the person is on a care plan. Liaison psychiatry services are now listed along with other services in section 1.1.
224	SH	Royal College of Psychiatrists	Full	General	General	There is little in the guideline that talks about considering their benefits and monetary situation or employment. There probably needs to be some more detail to provide guidance about what services should be accessed. Transfer between services should incorporate a period of joint working not just be responsive to the idea. This again needs a little more depth and detail. For example joint working for at least 1-2 months in complex cases. There needs to become clear consideration of the role of early intervention in psychosis and psychiatric rehabilitation services. A lot of the guidance is in effect good CPA. There is no guidance regarding the nature of interventions available. Most Drug and Alcohol Services do not provide interventions for people who misuse alcohol and illicit substances intermittently and are not dependent, but with significant detrimental effect on their mental state, and often this is used is to cope with symptoms related to the mental disorder.	Thank you for your comment. The guideline refers to 'support needs' which includes benefits, monetary situation or employment. Recommendations in section 1.1 are directed to all services, including those administering benefits. Recommendations 1.2.4, 1.3.2 and 1.4.4 also highlight the services that people with coexisting severe mental illness and substance misuse need help accessing. There was limited evidence from rehabilitation services or early intervention in psychosis services. However, the committee did take into account expert testimony in early intervention in psychosis and therefore made a recommendation highlighting transition to adult services. The remit of the guideline was on organisation and delivery of services The committee acknowledge the concern that some of the actions in the recommendations in relation to care planning are good CPA, but felt this is lacking in some services for people with coexisting severe mental illness and substance misuse. Therefore, the committee made these types of recommendations.
225	SH	Royal College of Psychiatrists	Full	General	General	Dual diagnosis is a concept that most people understand, however not everyone will understand the term. There should be an adequate explanation of the definition at the start of the document. Also, dual diagnosis suggests two disorders when multi-morbidity is the reality	Thank you for your comment. In light of stakeholder feedback, the committee agreed to change the term 'dual diagnosis' to coexisting severe mental illness and substance misuse. The term 'dual diagnosis' has been added to the glossary.
226	SH	Royal College	Full	General	General	Exclusion of personality disorder appears to be a gap in this	Thank you for your comment.

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		of Psychiatrists				guideline.	Personality disorder is included in the definition of severe mental illness.
227	SH	Royal College of Psychiatrists	Full	General	General	The presence of alcohol related brain damage is a major exclusion in this draft guideline. This is also a form of dual diagnosis and brings with it a unique set of challenges for care planning , partnership working, improving service delivery and encouraging people to stay in contact with services	Thank you for your comment. The inclusion and exclusion criteria were set at the scoping stage of guideline development.
228	SH	Royal College of Psychiatrists	Full	3	5-14	Stigma may influence help-seeking; ageism may delay referral of older people with dual diagnosis	Thank you for your comment. The committee shared the concern and took the needs of older people into consideration and amended recommendation on people who transition between services (1.3.12).
229	SH	Royal College of Psychiatrists	Full	3	12	We are concerned this recommendation may lead to neglect of mental health assessment in urgent and emergency care settings. We suggest adding 'mental health' to the list of needs to be assessed.	Thank you for your comment. The intention of recommendations in section 1.1 is that it is for all services to meet any urgent needs. Recommendation 1.2.1 clarifies that a full assessment of a person's mental health needs to be made in secondary care mental health services,
230	SH	Royal College of Psychiatrists	Full	4	15	Section 1.2.1: "any substance misuse problems they may have" – surely they *will* have substance misuse problem(s) since this guideline is for individuals with mental health and substance misuse? It is not clear if the mental health service is expected to assess substance misuse or in collaboration with an addiction service. This is important given the changes in community addiction services being delivered by 3rd sector which may have more limited experience with and capacity for individuals with complex mental health needs.	Thank you for your comment. That was not the intention and has been now amended. Recommendation 1.2.1 cross-refers to NICE's guideline on coexisting severe mental illness (psychosis) and substance misuse: assessment and management in health care settings. This guideline includes recommendations on working relationships between mental health and substance misuse services.
231	SH	Royal College of Psychiatrists	Full	4	18	We are concerned that the care plan does not address directly the issue of substance misuse. We would suggest including the point "includes a treatment or risk mitigation for the substance misuse issue"	Thank you for your comment. Recommendation in sections 1.2 and 1.3 include substance misuse needs.
232	SH	Royal College of Psychiatrists	Full	4	25	We are concerned that this recommendation mainly care plans for management within the mental health service. We suggest an expectation of development of a single care plan addressing physical, social and mental health needs formed by	Thank you for your comment. Section 1.3 of the final guideline clarifies that the care plan is developed using a multi-agency approach but the lead will remain

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						collaboration between mental health and physical health services and, as required other agencies.	secondary care mental health services (section 1.2).
233	SH	Royal College of Psychiatrists	Full	4	25	We are concerned that this recommendation does not cover planning for crises. We recommend that all such care plans make specific mention of how to consider mental and physical health needs should the person present in an emergency care setting.	Thank you for your comment. Recommendations 1.1 provides actions that need to take place if a person needs immediate assistance. Crisis planning for those who are on the care plan or have been discharged from the care plan are in recommendations 1.3.11 and 1.5.9.
234	SH	Royal College of Psychiatrists	Full	5	3	We are concerned that the recommendations for assessment do not address safeguarding issues for any dependents of the service user.	Thank you for your comment. The recommendation on safeguarding (now in section 1.1) has been amended to reflect this.
235	SH	Royal College of Psychiatrists	Full	5	9	Children should also be explicitly mentioned and offered support. Organisations such as Al-ateen, NACOA etc	Thank you for your comment. 'Young carers' have been added to the recommendation 1.2.7 (recommendation 1.2.5 in the consultation version).
236	SH	Royal College of Psychiatrists	Full	6	24	We are concerned that this recommendation may not overcome the practical difficulty people with severe mental illness and substance misuse have in engaging with care plans. We suggest adding a bullet point 'motivational interviewing' to help engagement with services	Thank you for your comment. Recommendations on interventions that can help improve engagement are listed in section 1.5 (recommendations 1.5.7 and 1.5.8) of the final guideline.
237	SH	Royal College of Psychiatrists	full	6	29	We are concerned that this recommendation does not cover cross-agency planning for crises. We recommend that all inter-agency liaison and care plans make specific mention of how to consider mental and physical health needs should the person present in an emergency care setting (eg. With a drug overdose, self-harm, acute physical problem and relapsed mental state). Liaison Psychiatry services should be included in this planning.	Thank you for your comment and helpful suggestions. Recommendations 1.3.11 and 1.5.9 now cover planning for crises.
238	SH	Royal College of Psychiatrists	Full	7	4	Re: "As part of developing and reviewing the care plan, the person's care coordinator needs to:" …… "consider involving staff in substance misuse services" – this should not be consider – the substance misuse services must be involved if they are to provide care. Or is this suggesting that substance misuse is solely dealt with by generic mental health services. Since many people in mental health services have no or limited experience in substance misuse this could result in lack of optimal treatment for their substance	Thank you for your comment. The recommendations in this section have been reorganised and recommendation 1.3.1 (recommendation 1.2.10 in the consultation version) reworded to clarify that care coordinators (in secondary mental health services) collaborate with other services

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						misuse. P9 1.3 recommends partnership working so should be consistent throughout.	(including substance misuse services).
239	SH	Royal College of Psychiatrists	Full	7	4-18	Consider sensory impairment and poor mobility in older people. Also consider over the counter medication that may contain substances.	Thank you for your comment. The points listed in recommendation 1.3. 2 (1.2.10 in the consultation version) is not meant to be exhaustive. The term 'personal care and hygiene' aims to encompass varied physical needs.
240	SH	Royal College of Psychiatrists	Full	7	15	Employment and/or education	Thank you for your comment. Employment and education are both included in recommendation 1.3.2 of the final guideline.
241	SH	Royal College of Psychiatrists	Full	7	23	Alcohol: alcohol is a psychoactive substance and therefore should be covered alongside other substances. It is therefore not clear if alcohol is being seen as separate to other substances of misuse in this guideline. Alcohol is the most common substance of misuse and therefore should be central to this guideline and any assessments of substance use.	Thank you for your comment. For the purpose of this guideline substance misuse refers to the use of legal or illicit drugs, including alcohol and medicine.
242	SH	Royal College of Psychiatrists	Full	7	24	Clarify if smoking is of tobacco or other substances; and whether includes e-cigarettes	Thank you for your comment. 'Smoking' refers to tobacco smoking (including smokeless tobacco) covered within the NICE pathways
243	SH	Royal College of Psychiatrists	Full	7	27	We are concerned that this recommendation may fail to deliver expected gains because reasons behind poor self-care are not addressed. We recommend including a bullet point 'exploring barriers to self-care and planning strategies to overcome these, using a motivational and psychologically informed approach'	Thank you for your comment. The committee shared your concern and a recommendation has been added (1.3.4). This section also includes practical strategies that can help address poor self-care.
244	SH	Royal College of Psychiatrists	Full	8	21	We are concerned that this recommendation may fail to deliver expected gains where people have frequent crises. We recommend including a bullet point 'emergency care where applicable'	Thank you for your comment. Emergency care setting has been included in the list of providers in recommendation1.3.9 of the final guideline.
245	SH	Royal College of Psychiatrists	Full	9	10-13	Ensure support to help older people with dual diagnosis move to older adult health or social care services.	Thank you for your comment and helpful suggestion. The committee agreed and developed a new recommendation to reflect people who transition between services and recognised that older people as one of the groups who may need particular help (recommendation

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							1.3.12 of the final guideline).
246	SH	Royal College of Psychiatrists	Full	9	16	We are concerned that this recommendation fails to cover the emergency and urgent setting where people often present in a physical and/or mental health crisis. We recommend including 'secondary care' in the list of organisations.	Thank you for your comment. This recommendation (1.3.1 in consultation version) has been removed to avoid repetition of recommendations in this section. The wording 'health, social care and other support services' has been added to the heading for this set of recommendations (section 1.4 of the final guideline) to capture the various settings people often present in a physical or mental health crisis.
247	SH	Royal College of Psychiatrists	Full	9	20	We are concerned that the recommendation to 'could consider working together' may not be effective and changing this to 'should work together' would be more appropriate.	Thank you for your comment. The wording in the recommendation (1.4.2 of the final guideline) has been amended.
248	SH	Royal College of Psychiatrists	Full	10	9	We suggest including 'Liaison Psychiatry can aid joint working between physical and mental health services for people presenting to a general hospital.	Thank you for your comment. The committee considered the suggestion but did not feel this was the most appropriate place to refer to liaison psychiatry. This service has been included in section 1.1.
249	SH	Royal College of Psychiatrists	Full	Section 1.4	Section 1.4	We are aware of an example of good practice in South East London that has adapted its mainstream mental health of older service to the needs of older people with dual diagnosis. In particular, it has successfully implemented mandatory drug and alcohol screening, as well as developing bespoke training and identifying dual diagnosis champions. The Mental Health Trust in which it operates has also developed a dual diagnosis pathway for older people.	Thank you for your comment. We will pass this information to our local practice collection team. More information on local practice can be found here.
250	SH	Royal College of Psychiatrists	Full	11	10	This does not make clear which existing services are being referred to. Who does this refer to and who shall fund this?	Thank you for your comment. The recommendations in section 1.5 (section 1.4 in the consultation version)have been reorganised and specify which recommendations are for health, social care and other support services and recommendations for specialist services.
251	SH	Royal College of Psychiatrists	Full	11	13	Relapse – consider making clear that relapse can be to mental health and/or substance use	Thank you for your comment. The term relapse has been defined as 'A recurrence or exacerbation of a person's mental health problems, a return to substance

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							misuse, or both'. The term has now been added to the 'terms used in this guideline' section.
252	SH	Royal College of Psychiatrists	Full	11	16	We are concerned that this recommendation may omit the high risk group with severe mental illness and substance misuse who present with self-harm, which may be recurrent. We recommend including the NICE pathways for 'short term management of self-harm'	Thank you for your comment. The committee agreed with your suggestion and a cross-reference to the NICE pathway on self-harm has been added to recommendation 1.5.7.
253	SH	Royal College of Psychiatrists	Full	12	5, 6	See comment 251	Thank you for your comment. The term 'relapse' has been defined as 'A recurrence or exacerbation of a person's mental health problems, a return to substance misuse, or both'. The term has now been added to the 'terms used in this guideline' section.
254	SH	Royal College of Psychiatrists	Full	12	19	Who should provide this service? Is this referring to mental health or substance misuse services? Who would fund this change?	Thank you for your comment. Recommendations in section 1.5 have been reorganised to clarify the set of recommendations for health, social care and other support services and recommendations for specialist services.
255	SH	Royal College of Psychiatrists	Full	13	12	We are concerned that the support for staff does not highlight the need for Mental Health services to ensure staff to have a foundation of knowledge and basic skill of substance misuse treatment.	Thank you for your comment. The committee acknowledged this concern and recommendation 1.5.11 (recommendation 1.4.11 in the consultation version) has been amended to reflect the need to recognise that different knowledge of mental health or substance misuse problems may exist between agencies and that this may present a barrier to delivering services.
256	SH	Royal College of Psychiatrists	Full	13	13	See comment 251	Thank you for your comment. The term 'relapse' has been defined as 'A recurrence or exacerbation of a person's mental health problems, a return to substance misuse, or both'. The term has now been added to the 'terms used in this guideline' section.
257	SH	Royal College of Psychiatrists	Full			NPS should be specifically mentioned	Thank you for your comment. It is unclear from the comment where in the guideline NPS should be specifically mentioned. For the

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							purpose of this guidelines substance misuse refers to the use of legal or illicit drugs, including alcohol and medicine, in a way that causes mental or physical damage. This may include low levels of substance use that would not usually be considered harmful or problematic, but may have a significant effect on the mental health of people with a mental illness such as psychosis. The term substance misuse has been added to the 'terms used in this guideline' section of the guideline.
258	SH	Royal College of Psychiatrists	Full			The Alcohol dependence guidelines also refer to dual diagnosis eg with depression, anxiety etc and its management and therefore should be described	Thank you for your comment. Recommendations 1.3.3 and 1.5.7 of the final guideline and section *More information* has links to the NICE pathway on Alcohol (which includes the Alcohol dependence guidelines CG100 and CG115).
259	SH	Royal College of Psychiatrists	Full	28	9	Add : or in withdrawal. Individuals in withdrawal can be very challenging to manage and as with intoxication may require urgent medical intervention.	Thank you for your comment. The suggested amendment has been incorporated in the relevant section of the committee's discussion.
260	SH	Royal College of Psychiatrists	Full			No mention is made of older adults and any particular needs they may have	Thank you for your comment. The committee considered your helpful suggestion and made amendments to recommendations 1.3.12 and 1.6.4 (recommendations 1.2. 21 and 1.5.4, respectively). The guideline recommends that older people may be a particularly vulnerable group who may be higher risk of not using or losing contact with services (recommendation 1.6.4). The guideline also recommended that people who may be transition to older people services may need of additional support (recommendation 1.3.12).
261	SH	Royal College of Psychiatrists	Full	32	23	In this section no mention is made of appropriate pharmacological approach with regard to optimising treatment for their mental health disorder or managing their substance misuse where medication to	Thank you for your comment. The emphasis of this guideline is on service delivery of wider health and social care needs of people with

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						manage withdrawal/detoxification or for substitution or relapse prevention. There is a significant gap in our knowledge about this and it is important in order to minimize any potential adverse impact on either disorder. Currently only adverse effects of medications are mentioned in this document and there is more to consider than just this aspect. In addition there is a substantial gap about the optimal combination of medication and psychosocial approaches for mental health disorder and/or substance misuse.	dual diagnosis. Studies that evaluated solely pharmacological interventions or psychosocial interventions were excluded from the scope. Studies evaluating psychosocial approaches or pharmacotherapy delivered as part of a service delivery intervention were evaluated and considered by the committee. Recommendations on treatment (including pharmacological approaches) are covered in the NICE guideline on Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in health care settings and other NICE guidelines referred to in recommendation 1.5.7. This recommendation cross-refers to NICE guidelines that have evaluated interventions to support harm reduction or prevent relapse.
262	SH	Royal Pharmaceutical Society	Full	General	General	**General Comments** The Royal Pharmaceutical Society is the professional membership body for pharmacists and pharmacy in Great Britain. We welcome this guidance and the issues it addresses as a positive step to raising the profile of the mental health conditions.	Thank you for your comment.
263	SH	Royal Pharmaceutical Society	**Full**	**3**	**5-6**	**First Contact** Pharmacists have always played an essential role in the treatment, medication counselling, and education of patients with mental health conditions in various environments including criminal justice system, community and hospital. Pharmacists have also been trained as independent prescribers, being able to adjust dosage, change medication type, prescribe new medication and even stop medicines as appropriate. Some Independent prescribers also specialise in substance misuse and alcohol dependence. Harnessing these clinical skills presents significant opportunities for the management of patients with mental health conditions.	Thank you for your comment. The list of settings in section 1.1 is not meant to be exhaustive. Pharmacy has now been included in recommendations 1.2.4 and 1.4.4.
264	SH	Royal Pharmaceutical Society	**Full**	**4**	**20**	**Care Planning** The Royal Pharmaceutical Society Mental Health Toolkit http://www.rpharms.com/support-resources-a-z/mental-health-toolkit.asp is a toolkit to support the integration of pharmacy into care pathways for mental health in primary care.	Thank you for your comment and helpful suggestion. As there are several providers whose care pathways need to be integrated with pathways for mental health, we have not made reference to any specific resource in this

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							recommendation. We will pass this information to our local practice collection team. More information on local practice can be found here.
265	SH	Royal Pharmaceutical Society	**Full**	**7**	**21-27**	Pharmacists are providers of advice on lifestyle changes and are well placed to offer advice on health behaviours listed from line 21-27.	Thank you for your comment. The guideline recognises pharmacies are part of the range of health care providers that can support people with coexisting severe mental illness and substance misuse need. Pharmacy is now included in recommendations1.2.4 and 1.4.4 of the final guideline.
266	SH	Royal Pharmaceutical Society	**Full**	**9**	**1-13**	**Discharge or transfer** The Royal Pharmaceutical Society has produced guidance on the information that should be transferred about a person's medicines when they move between different care settings and this can be found at http://www.rpharms.com/previous-projects/getting-the-medicines-right.asp	Thank you for your comment and helpful suggestion. We have added a reference to the NICE guideline on transition between inpatient mental health settings and community and care home settings.in this section. This guideline cross-refers to related NICE guidelines on recommendations on medicines-related communication systems and medicine reconciliation.
267	SH	South London and Maudsley NHS Foundation Trust	Questions: Dual diagnosis as term	General	General	Despite its limitations we think 'dual diagnosis' is as good as any other term. An alternative may have been Psychosis with Coexisting Substance Misuse, thus being consistent with CG120 – but given that severe depression without psychosis is included in this guidance the populations differ. We do not think 'coexisting alcohol and drug misuse with mental health issues' is helpful. It is 'too much of a mouthful'. Also the PHE guidance is much broader than this NICE guidance including, as its name suggests, people with a broad range of MH issues and not only those with severe mental illness.	Thank you for your comment. The committee took into consideration feedback from all stakeholders and agreed to amend the title of the guideline to Coexisting severe mental illness and substance misuse.
268	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	General	General	Language/tone: There are several places in the text where we think the wording is rather vague. There are other places where we think that the language used does not convey the collaborative nature of work with service users and their central role in care planning. Some specific examples have been highlighted as individual comments below.	Thank you for your comment and helpful suggestion. The language and tone in the guideline has been amended to make it more person-centred.

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269	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	General	General	Safeguarding: Although safeguarding is mentioned (eg the committee discussion section states that people with DD are at risk of other people taking advantage of them (p18, line 8-9) we think it has been given insufficient attention in the recommendations, particularly given that this guidance has a focus on social care services. A dedicated section highlighting the risks and providing guidance on addressing them would be beneficial. People with a dual diagnosis are at increased risk of abuse – financial, sexual (including issues associated with sex working), emotional (eg from carers, family), physical harm, institutional harm (eg services not understanding dual diagnosis, neglecting essential needs). Under section 42 of the Care Act the local authority has a duty to undertake a safeguarding 'enquiry' if there is a reason to believe a person is at risk of abuse or neglect or unable to protect themselves because of those needs. The Care Act requires practitioners to work with partner organisations to undertaken the enquiry and protect the service user from harm (or further harm). Many enquiries need a lot of input from a social care practitioner, but there will be aspects that should be carried out by other professionals.	Thank you for your comment. The committee acknowledged the concern that safeguarding needs ought to be prominently noted in the guideline but did not agree with the suggestion of developing a dedicated section. The committee agreed to add a recommendation on safeguarding to section 1.1 of the guideline. This recommendation also cross-refers to existing NICE guideline coexisting severe mental illness (psychosis) and substance misuse: assessment and management in health care settings (CG120) which has a section on safeguarding issues.
270	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	General	General	There is a tendency in the recommendations to suggest that they are relevant to all services and providers. While some of the recommendations are appropriate for all personnel/agencies involved, others are more likely to be specifically relevant for care co-ordinators/2ndry MH teams given their particular care co-ordination/leading role. ??	Thank you for your comment. The statement 'relevant to all services and providers' has been removed and where appropriate the 'actors' have been noted within a recommendation or in the heading of a section.
271	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	General	General	We think that throughout the recommendations document more attention should be given to substance misuse services. Given that use of substances is a defining criteria for this group and substance misuse services are likely to be one of the agencies that could be involved in care/treatment provision.	Thank you for your comment. The role of substance misuse services is now noted in sections 1.2, 1.3 and 1.5 of the guideline.
272	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	General	General	We think that throughout the recommendations document more attention should be given to the criminal justice system. As highlighted in the evidence review , people with a dual diagnosis are more likely to have contact with the CJ system that people that do not have co-existing substance misuse problems. We note that the scope for this guidance excluded custodial settings, however, many people with DD are in contact with the CJ system in the community and staff working with them will be required to liaise with police, courts, solicitors, the substance misuse criminal justice options (eg	Thank you for your comment. The committee understood the concern raised but noted that the criminal justice system is out of scope. The evidence reviews also did not specifically search for studies on the transition between the criminal justice systems and healthcare services which means we are unable to make recommendations specific to this setting.

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						DIPs) etc	
273	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	General	General	Costs. Although not based on any robust financial analysis our experience is that services' ability to meet some of the recommendations will depend on available resources. Staff thought that many of the recommendations were good but would view them as aspirational rather than realistic in the current financial climate. Many or the recommendations require that staff have the time to develop relationships with partner agencies, work more flexibly, assertively, hold joint sessions etc. In the current climate case loads tend to be large and acuity can be high. If people are to have the time to work in this way there are cost implications. - Offer face to face appointments (p11, line 17): in many substance misuse services group work is the mainstay of treatment because it is a cheaper option than individual work. There is little, if any, individual work for people that are unable to engage in groups (eg due to paranoia, significant anxiety, persistent auditory hallucinations). To provide this will require additional funding. - Determining how often sessions take place based on person's needs (p11, line 27): in reality resources often dictate the frequency of sessions. To genuinely provide sessions according to need may require additional funding. - Flexible opening times, drop in sessions, meeting people in their preferred locations (p12, line 21-22) – again this has resource implications - Ensuring people are not discharged before equipped to cope (p13, 14-15) –limited resources result in staff feeling pressured to discharge people before they are ready - Outreach work (p13, lin3 27) Taking an assertive/outreach approach is more labour intensive and therefore has cost implications. - Using proactive and flexible approaches – as above. Safeguarding – the requirements for investigation of safeguarding issues can be very time consuming. With the requirements of the Care Act the volume of alerts is increasing. This has a significant resource/cost implication. As noted in the evidence review people with dual diagnosis often	Thank you for your comment. We have passed this to the NICE resource impact assessment team to inform their support activities for this guideline.

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						have unmet housing needs. Also as noted on p24 line 3-4 unmet housing needs can have a detrimental impact on health and recovery. Not having a safe place to live can have a detrimental impact on mental health and make it almost impossible for people to address their substance use. Housing is a significant issue in relation to costs. There is a dearth of good quality mental health residential/rehabilitation projects that include a strong focus on substance misuse as well as mental health. People with more complex dual diagnosis issues are more likely to require supported housing (rather than less supported hostels) which is more expensive. We have also experienced tensions/debates in relation to funding for accommodation/rehabilitation. It is not uncommon for someone with a severe mental illness to be stable in relation to their mental health but experiencing physical and social difficulties associated with their substance misuse. The person does not need supported accommodation because of their mental health needs but to address the other needs. Debates ensue about which/whose budget should cover this.	
274	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	General	General	There are several places in the recommendations when 'relapse' is used generically. It would be helpful to clarify whether in each context this relates to mental health relapse, substance misuse relapse, or both.	Thank you for your comment. The term 'relapse' has been defined as 'A recurrence or exacerbation of a person's mental health problems, a return to substance misuse, or both'. The term has now been added to the 'terms used in this guideline' section.
275	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	1	4	We think employment and housing are social care needs – if they are going to be mentioned specifically we suggest this is framed as illustrative.	Thank you for your comment. The committee considered your suggestion but agreed that housing and employment should be specified and listed separately to social care needs.
276	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	1	7	No mention is made of commissioners of services. In our view if some of the recommendations are to be implemented commissioners need to ensure that they are a requirement of contracts.	Thank you for your comment. Commissioners have been added to the heading in section1.4, and the role of commissioners has been added in the preamble to the recommendations and in the overview of the guideline.
277	SH	South London	Draft for	3	Recom	Commissioners of mental health services are identified as needing	Thank you for your comment and helpful

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		and Maudsley NHS Foundation Trust	consultation		mendations box	to ensure service specifications take into account the recommendations, but not commissioners of other services. Given that this guidance is relevant for health, social care, community and voluntary sector services other commissioners should also be included. Of particular importance are also substance misuse commissioners.	suggestion. The text in this section has been amended
278	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	3	5-8	Substance misuse services have not been included. We think they should be.	Thank you for your comment. This is not intended to be an exhaustive list but this recommendation is aimed at services where specialist knowledge of coexisting severe mental illness and substance misuse may not exist.
279	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	3	9	It is not the responsibility of staff to meet the needs of people, perhaps to assess or identify needs in collaboration with the person and support him/her to meet their needs	Thank you for your comment. It was not the intention of this recommendation to imply that needs would not be identified *with* the person. However, the committee did note that in some instances the needs may be identified opportunistically therefore they recommended that either direct help or help from other services should be provided wherever possible.
280	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	3	13	'putting in touch' is rather vague. Given the chaotic lifestyles and service exclusion often experienced (as identified in the previous bullet point) we think a more proactive approach to supporting the person's engagement with other services is required.	Thank you for your comment. The wording has been amended in recommendation 1.1.4 (recommendation 1.1.1 in the consultation version) to reflect a proactive approach.
281	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	3	15	Given that this guidance is for organisations offering services for people with SMI who misuse substances (p1) there is an assumption that this will have already been identified. Perhaps this should say something like: If someone thought to have a severe mental illness and substance misuse problem in in contact with social care, community and voluntary sector (suggest also include CJS and substance misuse) refer the person to secondary care MH services for assessment and care planning.	Thank you for your comment. The aim of recommendations in section 1 is to identify any needs identified and recommendation 1.1.6 recommends further referral to secondary care mental health services. This is to help address the person's mental health and substance misuse.
282	SH	South London and Maudsley NHS Foundation	Draft for consultation	4	1-7	Perhaps consider adding to this list in line with the recent DH (2016) document - Improving the Physical Health of People with MH problems which includes: obesity, sexual health, oral hygiene. It may be helpful to include examples of infectious diseases eg	Thank you for your comment. The conditions listed in recommendation 1.1.2 is to make staff within services aware of the range of physical health issues that can affect

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		Trust				hepatitis B, C, HIV, TB. We note that health behaviours are included on page 7. Perhaps some consideration needs to be given to whether these two health focussed sections could be brought together (?)	people with coexisting severe mental illness and substance misuse. The health behaviours listed in recommendation 1.3.3 are areas that could be addressed in the care plan developed in secondary care mental health services.
283	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	4	9	Is this a relapse in mental health or substance misuse or both?	Thank you for your comment. This was not clear in the evidence. However the term 'relapse' has been defined as 'A recurrence or exacerbation of a person's mental health problems, a return to substance misuse, or both'. This term has been added to the 'terms used in this guideline' section.
284	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	4	10	Such unmet needs may also make it difficult for people to engage with services	Thank you for your comment. The committee acknowledged your concern but wanted to emphasise that services are hard to access in recommendation1.1. The point you have raised is included in the committee's discussion section of the guideline.
285	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	4	12-13	Should this state that the recommendations in this section are for secondary care MH staff, given that they are responsible for care co-ordination/CPA? We think staff in other agencies need to be part of the planning process, eg by being involved in CPA discussions/meetings	Thank you for your comment. The recommendations in the Care planning section (section 1.2 of the draft guideline) have been split. The care coordinator has been identified as the 'actor' for developing the care plan in section 1.2. A separate section on the contents of the care plan is now covered in section 1.3. Recommendation 1.3.1 clarifies that the care plan is developed or reviewed in collaboration with a range of agencies.
286	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	4	18	We think the care plan should be based on an assessment, and while ongoing assessment may be part of the plan, the plan needs to be wider than assessment. Perhaps this should be 'addresses' (rather than assesses) the person's social care etc? It may be appropriate to have another point(s) that emphasises the importance of comprehensive initial assessment (cross reference to NICE 2011 PSM) and that assessment is reviewed/updated at CPA	Thank you for your comment. It was not the intention in the recommendation to indicate that the care plan be restricted to assessment. The recommendations have been amended to make it clear that the care plan is based on an assessment and addresses the person's physical, social care, mental health or substance misuse needs. Recommendation 1.2.1 now includes a cross-reference to the NICE coexisting severe mental illness

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							(psychosis) and substance misuse: assessment and management in health care settings guideline.
287	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	4	20	Suggest - Involve practitioners who can help to meet or support the person to meet their needs... We do not think it is the practitioners that should be meeting the person's needs. Also see back to comment re the recommendations in 1.2 being for all practitioners – that does not appear to then be consistent with involving other practitioners (hence previous suggestion)	Thank you for your comment. The wording has been amended accordingly (recommendation 1.2.3 of the final guideline).
288	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	4	23/24	It may not be appropriate to review all needs at every contact. Suggest: Identify how the person's needs will be met and reviewed	Thank you for your comment. The committee acknowledged in the discussion section that the frequency of contact will vary and will depend on individual's circumstances.
289	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	4	25	We think the tone/emphasis here needs to change – it is the person's care plan, not the services. This implies that the service need help from the person to implement the plan. Suggest: includes how the person can be supported to meet their plan/achieve their goals	Thank you for your comment and helpful suggestion. Recommendations in sections 1.2 and 1.3 have been amended to reflect this.
290	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	5	7	The intention here is unclear. The care plan should have been developed in collaboration with the service user so it should not need to be shared with the person. If this is about ensuring that everyone has copies of the care plan then perhaps: Offer a copy of the care plan to the service user (some will refuse). If it is about ensuring that all agencies involved in care/treatment have copies then: In line with local information sharing agreements, ensure that all agencies/services have copies of the care plan.	Thank you for your comment. The intention is that a copy of the care plan is shared with family or carers (if the person agrees). The wording in recommendation 1.2.6 (recommendation 1.2.4 in the consultation version) has been amended to reflect this.
291	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	5	9	We think the wording should be strengthened. Carers should be offered a carers assessment not merely made aware that they are entitled to one.	Thank you for your comment. The committee shared your concern and the wording in recommendation 1.2.7 of the final guideline (recommendation 1.2.5 in the consultation version) has been amended to reflect this.
292	SH	South London and Maudsley NHS	Draft for consultation	5	21	May be helpful to be more explicit and include examples. Eg staff with specific responsibility for working with carers, carers support organisations (for mental health and substance misuse eg Al-Anon,	Thank you for your comment. The committee considered the suggestion but did not wish to add any examples in the recommendation in

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		Foundation Trust				SMART Friends and Families)	case it is construed as advocating a particular organisation.
293	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	5	23	Tone/emphasis – we think this needs to be stronger than 'involve' – perhaps: Developing care plans in partnership with service users/patients	Thank you for your comment. The order of the recommendations have been amended so it is clear that when 'involving people' the care plan is developed with the person (see recommendations 1.2.4-1.2.6).
294	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	5	25	Tone/emphasis – Suggest - Develop the care plan in partnership with the person …etc	Thank you for your comment. This was the intention of the recommendation. This is reflected in recommendations 1.2.4 and 1.2.5 of the final guideline.
295	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	6	7	Tone/emphasis – Suggest - Offer the person information about the range of service available to enable them to decide which would best meet their needs	Thank you for your comment. Suggested amendment has been incorporated to recommendation 1.2.4 in the final guideline.
296	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	6	9	We prefer the terms hope and optimism that were used in the committee discussion	Thank you for your comment. The bullet point in recommendation 1.2.5 (recommendation 1.2.6 in the consultation version) has been amended from 'positive' to 'optimistic'.
297	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	6	15	Tone/emphasis – rather than remain involved, suggest - be active partners in developing and implementing their care plans	Thank you for your comment and helpful suggestion. The committee felt this idea of people using services as 'active partners' is reflected within this set of recommendations in the revised sections 1.2 and 1.3.
298	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	6	25-26	Tone/emphasis – Working in partnership with (rather than Liaising). Also we think criminal justice and substance misuse should be included here	Thank you for your comment. This section has been revised and the heading changed to: The care plan: multiagency approach to address physical health, social care, housing and other support needs. Substance misuse service has been added in

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							the list of agencies that secondary care mental health services should work with. The committee acknowledged the partnership working that may arise with the criminal justice system for this population but noted that this is outside of the scope.
299	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	6	27	'Co-ordinated' may not be best in this context, given that care co-ordination implies specific responsibilities. Perhaps adopt a collaborative approach…	Thank you for your comment. Suggested amendment has been included in recommendation 1.3.1 (recommendation 1.2.8 in the consultation version).
300	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	7	1	Who should be doing this? Which local service? For what? Wording of this recommendation is rather woolly.	Thank you for your comment. To address this ambiguity, recommendation1.2.9 (in the consultation version) has been moved from the care planning section to section 1.4 on partnership working between specialist services, health, social care and other support services and commissioners (bullet point 3 in recommendation 1.4.4).
301	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	7	4-5	See earlier comments re role of care co-ordinator in care planning – here this is recognised.	Thank you for your comment. The recommendations in section 1.2 and 1.3 have been reordered to clarify the role of the care coordinator.
302	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	7	7	Suggest ..to ensure that the physical health care needs of people with DD are met.	Thank you for your comment. The wording in recommendation 1.3.2 (recommendation 1.2.10 in the consultation version) has been amended.
303	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	7	10-16	Suggest including legal/criminal justice needs/contact with CJ system. As previously noted we know people with DD are more likely to have contact with CJ system than people with mental illness alone. Care co-ordinators often liaise with police, solicitors, take people to court, write reports.	Thank you for your comment. The committee acknowledged the concern but did not agree with the suggestion as the criminal justice system setting is out of scope for this guideline. NICE is currently developing a guideline on

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							mental health of adults in contact with the criminal justice system.
304	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	7	20-27	Need to include drugs, also sexual practices/health. See previous comment about possibly linking with physical health recommendations.	Thank you for your comment and helpful suggestions. These have been added to the recommendation 1.3.3 of the final guideline (1.2.11 in the consultation version).
305	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	8	8	'Type of support' is very broad. The wording of this recommendation is rather vague. We are unclear exactly what is intended.	Thank you for your comment. Recommendation 1.3.7 (recommendation 1.2.14 in the consultation version) addresses the point whether the needs that were identified in the care planning stage have been addressed, is appropriate for the person in relation to where they are in their recovery plan and whether their preferences have been considered. The recommendation lists the situations where a person may need additional help with, although this list is not exhaustive.
306	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	8	12	See more general comment about our view that a separate safeguarding section is needed. It does not seem to fit well here.	Thank you for your comment. The reference to safeguarding has been removed from this section.
307	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	8	18	It is the responsibility of the secondary care MH team, in particular the care co-ordinator to arrange care reviews/CPA meetings	Thank you for your comment. Recommendation 1.3.9 of the final guideline (recommendation 1.2.16 in the consultation version) has been amended to clarify this.
308	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	8	18-21	We think criminal justice workers should also be included here (eg probation)	Thank you for your comment. This is outside the scope of the guideline. NICE is currently developing a guideline on mental health of adults in contact with criminal justice system. This covers probation setting as well.

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309	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	8	22	Who should be doing this? Doesn't this link with 1.2.10 on page 7 lines 6-8	Thank you for your comment. Recommendation 1.3.9 clarifies the role of the care coordinator working with primary care to ensure physical health checks (recommendation 1.2.17 in the consultation version) are carried out.
310	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	8	23	Whose responsibility is this?	Thank you for your comment. The responsibility for ensuring that a person's physical health care needs are met is for primary care providers with coordination of the services being led by the care coordinator in secondary care mental health services. Please see the revised recommendation 1.3.9.
311	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	8	27	We think substance misuse and criminal justice needs could usefully be included here.	Thank you for your comment. The committee agreed to include substance misuse services in recommendation 1.3.9 (recommendation 1.2.19 in the consultation version) but not the criminal justice system as it is out of scope. However, the list is not exhaustive.
312	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	9	4	All practitioners that are involved should be invited, not only those that are new.	Thank you for your comment. This was not our intention and the wording in recommendation 1.3.11 (recommendation 1.2.20 in the consultation version) has been amended to reflect this.
313	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	9	7-9	Consider including 'safety' as an alternative or as well as 'risk' – many service users prefer 'safety'. Also include ensuring that crisis and contingency plans are in place for if the person's MH deteriorates.	Thank you for your comment and helpful suggestions. 'Safety' has been added to the bullet point in recommendation 1.3.11 (recommendation 1.2.20 in the consultation version).
314	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	9	16	Suggest include the criminal justice system here too	Thank you for your comment. Recommendation 1.3.1 (in the consultation version) has been removed. The heading for the set of recommendations in section 1.4 (section 1.3 Partnership working in the consultation version) has been amend to reflect the wide range of audience the recommendations are aimed at.

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315	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	9-10	29-9	The wording here is rather woolly/the points rather varied and all encompassing. The bullet points do not seem to be specifically related to joint working arrangements (first part of recommendation) Further, it is suggested on page 9 line 15 that this is a recommendation for services/providers, however, other bodies are key and have the leverage to make some of this happen eg joint strategic needs assessments are the responsibility of the local authority, CCGs, HWBs. Governance arrangements (p10 line 17) need to be at a higher level than the individual service. We think this recommendation needs a re-think.	Thank you for your comment. The heading for recommendation 1.4 (section 1.3 Partnership working in the consultation version) has been amended to reflect the wider audiences this recommendation is aimed at.
316	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	10	23	Suggest include criminal justice	Thank you for your comment. The criminal justice system setting is out of scope.
317	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	11	3	This is a bit vague/unclear. Would this be in relation to individual service users that present particular challenges?	Thank you for your comment. Yes, this is in relation to individual service users. This recommendation (recommendation 1.3.8 in the consultation version) has now been removed from this section and added to section 1.3.11 of the final guideline.
318	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	11	10	Perhaps add: working with dual diagnosis is the responsibility of all services	Thank you for your comment. The committee acknowledge this but wanted to ensure that the responsibility to lead clearly lies with secondary care mental health services. Therefore sections 'Adapting existing services' and 'Making services inclusive' in section 1.4 in the consultation version have been reordered and two subsets of recommendations have been developed. Recommendation 1.5.1-1.5.5 are for health, social care and other support services and 1.5.6-1.5.9 are for specialist services.
319	SH	South London and Maudsley NHS	Draft for consultation	11	12	Rather than 'uptake' perhaps 'engagement with'	Thank you for your comment. Suggested amendment has been incorporated in recommendation 1.5.7 of the final guideline

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		Foundation Trust					(recommendation 1.4.2 in the consultation version).
320	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	11	13	Preventing relapse – is this of mental health, substance misuse or both? May be helpful to be explicit.	Thank you for your comment. The term relapse has been defined as 'A recurrence or exacerbation of a person's mental health problems, a return to substance misuse, or both'. The term has now been added to the 'terms used in this guideline' section.
321	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	11	17	Face to face sessions may also be helpful for families/carers.	Thank you for your comment. Recommendation 1.5.8 (recommendation 1.4.3 in the consultation version) was based on the evidence which entailed phone intervention for family/carers.
322	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	12	1	Who is to consider the following? Should this be: All services involved in a person's care treatment should consider ensuring that … We think this should include **crisis** and contingency plans	Thank you for your comment. The audience for recommendation 1.5.9 (recommendation 1.4.4 in the consultation version) is for secondary care mental health services –this has been clarified in the subheading to this section. Suggested amendment to recommendation 1.5.9 (recommendation 1.4.4 in the consultation version) has also been completed.
323	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	12	12	Suggest – existing services and ways of working are adapted	Thank you for your comment and helpful suggestion. The recommendations in this section have been reorganised so it is clear which existing services are adapted. The committee felt that 'ways of working' was implied in the wording of the recommendation.
324	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	12	21	Suggest rather than **or** meeting people in their preferred locations, this should be **and**	Thank you for your comment. The strength of the evidence contributing to recommendation 1.5.3 (recommendation 1.4.7 in the consultation version) is weak (so the evidence of benefit is less certain), hence we

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							have used the terms 'consider' and 'or'.
325	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	13	3	Any suggestions on who or how support should be provided and what this might entail? – again this is rather vague	Thank you for your comment. The recommendation 1.5.10 has been amended to clarify the role of supervision and professional development (recommendation 1.4.9 in the consultation version).
326	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	13	12	It is common for care co-ordinators to report being pressured into discharging people before they are fully equipped to cope. It is beyond the authority of the care co-ordinator to ultimately make the decision.	Thank you for your comment. The intention of recommendation 1.5.12 (1.4.11 in consultation version) was to highlight that practitioners, including care coordinators may be particularly under pressure. Therefore resilience and tolerance is needed so that services are able to help people work through relapse, poor attendance or a crisis to ensure they are not discharged too soon.
327	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	14	1	Typo – if there **are** any reasons (are is missing)	Thank you for your comment. This recommendation has been amended.
328	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	14	2-3	Why only services to improve physical health or receive social care support? Suggest also include to address substance misuse. For substance misuse services, a period of being barred from the service, or previous negative experiences of the services may inhibit people accessing or engaging with substance misuse.	Thank you for your comment. Although the focus of this guideline is on multiagency working to ensure people with coexisting severe mental illness and substance misuse can access and remain engaged with wider health and social care needs, the committee shared your concern and the sentence has been amended.
329	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	14	27-	Could this be more explicit – non-attendance at any appointment is viewed by all practitioners involved in the person's care/treatment …..? The wording here may also be seen as implying it is the responsibility of the 2ndry care MH services - perhaps add: and who is going to take them.	Thank you for your comment. Recommendation 1.6.5 (recommendation 1.5.5 in the consultation version) has been amended to include 'involved in the person's care'.
330	SH	South London and Maudsley NHS	Draft for consultation	15	7	In our experience premature discharge from substance misuse services can be an issue. While we recognise that if someone really does not want to engage with a service it is important to respect	Thank you for your comment. The intention of this recommendation is to highlight premature discharge from any service

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		Foundation Trust				their wishes, for some people low key, ongoing engagement and flexibility from the substance misuse service can produce positive outcomes. As noted on p36 line 29	the person is engaged with.
331	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	18	22	Our understanding of the scope was that custodial criminal justice services were excluded. People with dual diagnosis frequently have contact with a range of other parts of the criminal justice system in the community eg police, probation, courts, Drug Intervention Programmes. We think a greater emphasis on these links and the work that is entailed in supporting service users in their contacts with the CJS would be helpful throughout the recommendations – we have suggested various places above.	Thank you for your comment. The criminal justice system setting is outside the scope for this guideline and the searches for evidence reviews did not include this area.
332	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	18	29	We agree that 2ndry MH services are usually the lead organisation responsible for co-ordination (rather than 'delivery' perhaps) of services. As noted in the 'general' comments above, in the recommendations it would be helpful to be clearer where there is some specific responsibility for care co-ordinators/2ndry care mental health teams, and where the recommendations relate more to general principles to guide working practices regardless of the service/organisation.	Thank you for your comment. The recommendations have been reorganised or wording amended (for example, in the heading of recommendations) to clarify who the actors are for these recommendations.
333	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	21	21-22	This text links back to page 6 line 9 – we prefer the terminology of 'hope and optimism' used here (as noted)	Thank you for your comment.
334	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	22	5-6	As highlighted previously, we think that insufficient attention is given to the criminal justice and substance misuse needs and that more explicit statements should be made about them.	Thank you for your comment. The committee shared your concern regarding substance misuse services and this has been amended. However, criminal justice system is outside the scope for this guideline.
335	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	22	19	We agree that direct referrals, rather than access via open-access drop in clinics, can help to ensure a timely response (p7, line 1). Outreach/inreach from the service can be extremely useful in promoting engagement and facilitating smooth pathways. This is particularly the case when supporting people to access substance misuse services.	Thank you for your comment. The committee felt this point is reflected in the committee's discussion and did not wish to amend this sentence.
336	SH	South London and Maudsley NHS	Draft for consultation	26	7	In our experience a further challenge when considering the needs of people with dual diagnosis is that substance misuse service contracts may exclude provision of mental health work (eg mental	Thank you for your comment. The committee shared your concern and this point has been added in the committee's discussion section of

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		Foundation Trust				health assessments, prescribing for mental health conditions).	the final guideline.
337	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	26	24-25	Buy in from commissioners across mental health and substance misuse is critical if change is to be achieved. This has long been identified as a challenge. Hopefully the forthcoming PHE commissioning guidance will be influential. Greater emphasis on the important role of commissioners in the recommendations would be welcome.	Thank you for your comment. The role of commissioners will be noted in the overview to the guideline and the preamble to the recommendations. The committee shared your concern and noted in the Putting this guideline into practice section that leadership is needed from commissioners across health and social care services.
338	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	27	23-24	We agree that JSNAs should include the needs of people with dual diagnosis. Leverage may be needed to ensure that this happens. Perhaps something for another specific recommendation?	Thank you for your comment. This has been noted in recommendation 1.4.3 (recommendation 1.3.3 in the consultation version).
339	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	28	19-20	Although we agree that the focus needs to be on improving existing services, we think it will be extremely challenging to genuinely achieve the recommendations in the guidance with existing capacity and resources – as is noted in the guidance on p30 line 14-15 lower caseloads are needed to provide consistent, co-ordinated services, to have more contact with people and provide stability. We think this has resource/cost implications.	Thank you for your comment. The committee agreed and noted this in the Putting this guideline into practice section.
340	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	29, 32, 37	through out	Some care and perhaps clarity is needed regarding terminology in this section: integrated/integration. The integrated treatment model (ie mental health and substance misuse being addressed at the same time in one setting, by one team) is different from a looser interpretation of 'integration' meaning services working collaboratively together. Both are mentioned and it seems that, to some extent, both are being advocated in the guidance – depending on context.	Thank you for your comment. In the committee's discussion section it is highlighted that based on the committee's experience, it was noted that 'integration' should be about joint working and coordinated care. The terms integrated approach /integrated intervention has been used to reflect the terminology used in the studies.
341	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	33 & 34	9-10 18-19	We agree that long-term work is often required to see small improvements – a statement acknowledging this within the guidance would be helpful – we think this is an area where services need to be flexible. Increasingly a range of services are required to provide short term work with people, but in this context of particular importance is substance misuse services. Not offering longer term work, or moving people on prematurely can be unhelpful – as noted continuity is important.	Thank you for your comment. Recommendation 1.6.1 (1.5.1 in the consultation version) has been amended to 'building a relationship with the person and seeing even small improvements may take a long time'.

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342	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	33	7-8	Assertive outreach teams are also rare in the UK with many/most (?) having been disbanded. In our experience service users and staff valued these services. We have evidence from one of our AO services that bed days were significantly reduced and serious incidents (often which included substance use as a factor) were reduced, with a cost saving. The lower case loads of these teams and flexible, assertive engagement ethos are in keeping with many of the recommendations in this guidance.	Thank you for your comment.
343	SH	South London and Maudsley NHS Foundation Trust	Draft for consultation	39	14-21	Despite the lack of evidence for mutual aid in people with dual diagnosis we think mention of the groups in the recommendations would be helpful. This would be in line with the approach taken in the NICE (2011) Psychosis with Coexisting Substance Misuse guidance where, in the absence of robust evidence for any treatments, the guidance recommends offering treatment for both conditions based on the existing NICE guidance for each. Mutual aid groups are therefore recommended within this. Given the social isolation often experienced by people with dual diagnosis, as noted, and the fact that for many people their only social contacts are with other drinkers/drug users, mutual aid groups can offer contact with a community of people that are achieving recovery (many are abstinent) and support to engage with these groups (eg through the 12 step 'sponsors'). Given that we don't have evidence that they are not helpful, we think they should be mentioned.	Thank you for your comment and helpful suggestion. The committee was also aware of the Public Health England guidance (A briefing on the evidence-based drug and alcohol treatment guidance recommendations on mutual aid) but noted it was not aware of evidence establishing use of mutual aid in people with coexisting severe mental illness and substance misuse. In addition, because peer support and mutual aid were areas identified for a research recommendation, the committee did not recommend specific examples of mutual aid groups in the guideline recommendations.
344	SH	South London and Maudsley NHS Foundation Trust	Evidence review: Question 1.2	89-93 298		Lewisham DD service: This service no longer operates. The funding was largely from the DAAT. Given that National Treatment Agency targets were focused on class A drug users (mainly opiates and cocaine/crack cocaine) and, as highlighted in the evidence review, people with severe mental illness primarily use alcohol and cannabis, there was a mismatch between the teams work and the funders priorities. As funding reduced the service was cut. The service was valued in the borough and people in a range of services across the borough still talk with regret about the loss of the service.	Thank you for your comment. This has been amended in the evidence review.
345	SH	South London and Maudsley NHS Foundation Trust	Evidence review: Question 1.2	96-98 277 294		Croydon Managers Forum and Croydon DD service: The Croydon DD service no longer exists. Its demise was also linked to funding cuts. The forum still operates but has evolved and is open to any staff working with people with dual diagnosis in the borough. It is facilitated by South London and Maudsley front line staff with a special interest and expertise in dual diagnosis. The majority of	Thank you for your comment. This has been amended in the evidence review.

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						people that attend are Trust employees, numbers attending fluctuate. The focus is clinical discussion but it also provides an opportunity to update staff on policy, research, re-configuration of services etc – anything that may be of relevance to working with dual diagnosis.	
346	SH	South London and Maudsley NHS Foundation Trust	Info on content and configuration of service models	General	General	Some examples from SLaM services/boroughs that may be of interest 1. As part of a service reconfiguration and refocus on promoting recovery/preventing relapse, the Promoting Recovery Teams (ie Psychosis teams) in two boroughs have: - reduced case load size (to promote a focus on proactive, therapeutic work rather than 'fire-fighting'/crisis management with a view to preventing mental health relapse) - undertaken level 2 dual diagnosis training as a whole-team - identified one team member to have dual diagnosis as an 'intervention specialty'. It is intended that this person will have one day a week protected time for this role which focuses on promoting evidence based practice across the team and promoting links with partner agencies, particularly substance misuse. Across the teams a variety of disciplines have taken on this role: medical, psychology, social work, nursing. This breadth of disciplines helps to bring a range of perspectives when planning how the work can continue to be taken forward. Alongside the above in one borough the substance misuse service commissioned to work with people with the most complex needs have identified a dual diagnosis nurse role. She accepts referrals of people that are ready to work on their substance misuse and discusses with the care co-ordinator the best approach for supporting the person's engagement with the substance misuse service eg booked appointment at the SM service, joint home visit with care co-ordinator, appointment at mental health team. Several staff from the Promoting Recovery teams have spent time at the substance misuse service, gaining a better understanding of the service, developing relationships with colleagues in the other service, and enhancing their own skills. The substance misuse nurse goes out to the PR teams to promote	Thank you for your comment. We will pass this information to our local practice collection team. More information on local practice can be found here. The committee acknowledge and noted in the committee discussion that a reduced caseload, training and collaborative working and outreach work are factors that can help with improving service delivery.

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						information sharing about service users in treatment with both services. 2. Across the Trust each team is required to identify a staff member to take a lead on dual diagnosis. The local substance misuse services are also encouraged to do this. Every three months the dual diagnosis leads meet within their borough for a development day, facilitated by the dual diagnosis consultant nurse - to network, better understand each other's services, share learning, discuss complex cases, develop and review policies and protocols (including those re care pathways between services), share audit findings, set objectives for their own development and that of their teams (etc). In some boroughs (ex) service users also participate. At some meetings staff from partner agencies are invited to talk about their services and, with the Trust leads, consider ways in which services can better work together to meet service user needs. Examples include: domestic abuse service, SMART recovery. 3. MEAM Approach – Making Every Adult Matter- http://www.themeamapproach.org.uk/ may be useful to consider however, it should be noted that it does not focus on people with severe mental illness and substance misuse. It considers a much wider group.	
347	[office use only]	St Mungo's	**Full**	3	15-16	This recommendation may be challenging to implement in practice. Previous guidance has recommended that mental health services take the lead on treatment and care for people with mental health and substance use, but in practice our staff report that clients who have active drug or alcohol problems are often excluded from mental health services upon referral. St Mungo's proposes that the guideline should go beyond recommending that people with a dual diagnosis are referred to mental health services. We recommend that the guidance specifically state that referrals to mental health services should not be rejected due to substance use. Examples of clients excluded from mental health services are included in our earlier evidence on this guideline: http://www.mungos.org/documents/6172/6172.pdf (11)	Thank you for your comment. The committee shared your concern and took this into account when developing the new recommendation 1.2.1. The guideline now includes the following recommendations: 'Do not exclude people with severe mental illness because of their substance misuse' and 'Do not exclude people from physical health, social care, housing or other support services because of their coexisting severe mental illness and substance misuse'.

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348	[office use only]	St Mungo's	**Full**	9	1-13	We welcome the commitments to understanding and addressing housing need throughout this guideline. With this in mind, we recommend that housing and homelessness is explicitly mentioned in this section on discharge or transfer. Appropriate and safe housing is vital for sustainable mental health and substance use recovery. Discharge from inpatient care into homelessness or poor housing can undermine progress made through treatment and care. We recommend: • That housing need is identified as early as possible during an inpatient stay, rather than at the point of discharge, and that safe discharge plans are put in place; • That housing providers are involved in discharge or transfer meetings and information is shared appropriately.	Thank you for your comment. The committee agreed that housing providers are involved in the review, discharge or transition meetings and that housing needs are identified before discharge. Please see revised recommendation 1.3.9 (1.2.16 in the consultation version) and the latter point has been added to recommendation 1.3.11 (recommendation 1.2.20 in the consultation version).
349	[office use only]	St Mungo's	**Full**	11	9-11	We are concerned about the recommendation to adapt existing services rather than providing specialist support for people with mental health and substance use problems. St Mungo's experience suggests that our clients struggle to engage with traditional services and interventions. Specialist services have a place within a range of treatment and care options for people with concurrent mental health and substance use. Specialist services may include small residential projects which have expert knowledge in working with people with dual diagnosis, for example St Mungo's Brent Dual Diagnosis service. Further information about the Brent service model is available to download here [PDF]: http://www.mungos.org/documents/1485 St Mungo's identified lack of specialist staff as a key issue with current statutory service provision in January 2015 evidence on this guideline: http://www.mungos.org/documents/6172/6172.pdf (12)	Thank you for your comment. The findings from the review on effectiveness of service delivery model were inconclusive. The economic model highlighted that the standard care currently being delivered could be improved with enhanced engagement. Therefore the committee felt that specialist services (secondary care mental health services and specialist dual diagnosis services) should adapt existing services using the expertise that is available instead of creating a specialist 'dual diagnosis' service The Brent Dual Diagnosis service model has now been included in evidence review 1.
350	SH	Tees Esk and Wear Valleys NHS Foundation	Full	8	1.2.18	NICE state 3 monthly reviews needed post health event. Would it be prudent to clarify if this was meant to be medical or multidisciplinary?	Thank you for your comment. This was referring to medical reviews. The recommendation has been merged with recommendation 1.3.9 (1.2.16 in consultation

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		Trust					version) and amended to reflect that multidisciplinary reviews are undertaken involving practitioners from a range of agencies.
351	SH	Tees Esk and Wear Valleys NHS Foundation Trust	Full	General	General	The emphasis on inter service working in section 1.2 (care planning) is positive.	Thank you for your comment.
352	SH	Tees Esk and Wear Valleys NHS Foundation Trust	Full	General	General	It is appreciated that in section 1.3 (partnership working) NICE recognise the difficulties due to differing streams of funding.	Thank you for your comment.
353	SH	Tees Esk and Wear Valleys NHS Foundation Trust	Full	General	General	In relation to section 1.4 (improving service delivery), adaptation is key for Mental Health Services for Older People: The small number of patients involved does not warrant a specialised service.	Thank you for your comment.
354	SH	Tees Esk and Wear Valleys NHS Foundation Trust	Full	General	General	It would be helpful to highlight in section 1.5 (encouraging contact) that this is a multidisciplinary responsibility, not just that of the care co-ordinator.	Thank you for your comment. The heading for section 1.6 (section 1.5 in the consultation version) has been amended to make it clear it is for all services.
355	SH	Turning Point				The overarching aim is to ensure that all services are able to respond equally to dual diagnosis, not just the mental health or substance misuse element. To achieve this, system-wide changes are required to ensure a fully integrated approach to service design and deliver. Mental health and substance misuse service should be co-commissioned as one service, as opposed to mental health and substance misuse provision existing as two different entities. Mental health services still tend to exclude those with substance misuse issues and will continue to do so unless commissioned, funded and designed in a way that stops this.	Thank you for your comment. It is beyond the remit of the guideline to make any recommendations on changes to commissioning arrangements. Recommendations in section 1.4 highlight the importance of information sharing. Recommendations on 'Support for staff' (recommendations 1.5.10-1.5.12) and the committee's discussion section emphasise the importance of practitioners' knowledge of both

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						Coordination between staff and services will be a key challenge, given the funding and commissioning structures in place. Without the separation at this level, services will continue to be delivered separately. Data sharing is the other area which has a significant impact on practice – without it people continue to fall through the gaps in service provision. By ensuring data is shared, individual's will have a far better experience, and most likely improved outcomes. Staff training is another potential challenge. There is no mention of staff competency in both mental health and substance misuse within the guidance. Those working in this kind of environment need to be aware of and able to respond to both areas of need. Dual diagnosis is not a new phenomenon. The All-Party Parliamentary Group on Complex Needs and Dual Diagnosis was set up almost ten years ago in recognition of the fact that people seeking help often have a number of over-lapping needs, of which the services they approach are operated by separate providers. The barriers presented to the group have not changed a great deal over the last decade. The NICE guidance goes someway to recognising and addresses these, but while this approach to supporting people's multiple needs is optional, the guidance will have limited impact on patient experience and outcomes.	mental health and substance misuse.
356	SH	Turning Point				Ultimately, commissioning needs to be carried out in a different way which may have cost implications initially. Far too often, dual diagnosis services are seen as being far too costly. With regards to cost benefit analysis, there will be an initial upfront cost to factor in, but the savings will be seen over a longer period of time as opposed to short term. Therefore the stance must be proactive and community based as opposed to reactionary and acute based. Similar to co-commissioning, appropriate and effective data-sharing has upfront costs in terms of new IT systems, but again, this is another tool to help with being more proactive and a better patient experience.	Thank you for your comment. We have passed this to the NICE resource impact assessment team to inform their support activities for this guideline.

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357	SH	Turning Point				We know that people with multiple complex needs face many barriers when seeking support or making their journey towards recovery. None of these will come as a surprise, in fact many of these have been challenges faced by people for decades. **Available services** In an ideal world, those living with a mental health issue as well as experiencing substance misuse or dependence simultaneously, would be supported and provided with treatment to help with both elements of their condition. Treatment is responsive to the needs of the service user and a one size model does not fit all. Health and care services, on the whole, are still commissioned for a primary need, often at the cost of others. The co-existence of mental health issues and substance misuse is more difficult to treat than if these two elements were separated. Commissioning in silos with the focus being on either mental health or drugs and alcohol means there are few services that exist which are able to provide the holistic approach that individuals with dual diagnosis and multiple needs require. As a result, this fragmented system means there are multiple gaps in provision through which people can fall if there isn't strong navigation between services or transitions are not seamless. This can perpetuating their conditions and could potentially mean they acquire more needs including homelessness and involvements in the criminal justice system. **Diagnosis** We often hear from experts by experience that getting a diagnosis or recognition of the complexity of their multiple needs was a challenge in itself. This is largely because of the fragmented way services are commissioned which focus on a primary diagnosis, sometimes to the exclusion of other needs or issues that exist. **Payment by Results (PbR)** We have heard that PbR models are working against those with multiple complex needs due to the disconnect between payment models for substance misuse, reducing reoffending, mental health	Thank you for your comment. The committee share your concerns. Recommendations on first contact with services (section 1.1), referral to secondary care mental health services (section 1.2) and partnership working between specialist services, health, social care and other support services and commissioners (section 1.4) aim to address the fragmented system often faced by people with severe mental illness and substance misuse. The committee shared your concern in relation to challenges people face in receiving a diagnosis. Therefore a recommendation was added to section 1.2 to ensure people are not excluded because of either of their severe mental illness or substance misuse from accessing services to meet their wider health or social care needs. Thank you for raising Payment by results, however this is out of scope for the guideline and was not considered by the committee.

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						and employment. Instead of supporting a joined up approach to service delivery, they risk fostering a culture of silo working where investment is only made where savings will be gained. Often, when people have multiple needs, those savings may occur elsewhere in the system, acting as a disincentive. While these barriers continue to exist some of the most vulnerable people in our society will continue to fall through gaps in service provision and therefore not the support they need. This lack of support leads to significant frustration for individuals and their families; puts undue pressure on families to look after individuals with sometimes very severe and entrenched needs; and delays people's recovery.	
358	SH	Turning Point				Turning Point has been a service provider for those with mental health and substance misuse issues for over 50 years. We also provide the secretariat for the All Party Parliamentary Group on Complex Needs and Dual Diagnosis. We held a snap poll and asked our members, officers, supports and stakeholders whether they think this term is still relevant when talking about this group of individuals. 60% of respondents do not think it is still an appropriate term to use. 'Comorbidity', 'Collective Diagnosis', 'Co-existing Health Needs', 'Overlapping Needs', 'Multiple Needs', 'Complex Clients' and 'Co-occurring Disorders' were amongst some of the suggestions from those that responded.	Thank you for your comment and helpful suggestions. The committee agreed to amend the title of the guideline to Coexisting severe mental illness and substance misuse.
359	SH	Turning Point				**Herts CNS** Turning Point runs an outreach project in Hertfordshire jointly funded by Health and Community Services, Public Health and both Hertfordshire CCGs. The service provides support for people with overlapping needs who are living in the community. Close partnership working has enabled the team to take a holistic approach to address a wide range of needs. This type of service also supports individuals navigating complex health and social care systems which without support they would be unable to do so. As well as improved experience, previous cost benefit analysis by the LSE found that for every £1 invested there was a net reduction in demand for public services worth at least £4.40 based on individual need. This reinforces how essential it is for staff to build trust and respect before dealing with mental health and substance misuse	Thank you for your comment. We will pass this information to our local practice collection team. More information on local practice can be found here.

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						issues. **Veterans** Matt Flynn, a Specialist Substance Misuse Nurse from a Turning Point service in Wiltshire, is the person behind the collaboration between Turning Point and Combat Stress, the Charlie Charlie One programme. He believes that wanted to make the point that if you seek out partnerships, they can pay huge dividends but, it should not be down to individual professionals, like him, that just happen to have a passion for the group to set up these sorts of services. They should not be adhoc, they should be a sector standard. Bill Nevill**,** a Veteran, former Turning Point service user and now peer mentor with Turning Point in Wiltshire said he started drinking whilst still in the service as it was part of the culture. Described as an angry man with a quick temper, he knew alcohol was having a negative impact on him. In 2010, he was told that he would no longer be able to work and soon the hospital visits started. He frequently ended up in the hospital wards, being admitted at least fifty times due to his alcohol misuse. His wife unexpectedly passed away during this time and the prospect of having to return to a cold, dark and lonely house was hard to cope with. He said that at this point in his life, he just wanted it all to end. Bill said that at some stage down the line, Turning Point and Combat Stress contacted him to help him. This is when things changed in his life. Alongside being a peer mentor for Turning Point, Bill also started work for the NHS, so he can identify and help veterans going through what he did. He has also started to build back the relationship he had with his children. His recommendations for change are that multiple visits to hospital by veterans ought to be recorded and flagged up each time they are admitted. This would then allow a support worker to intervene sooner rather than later. Support from family and friends naturally ebb away over time.	

Document processed	Organisation name – Stakeholder or respondent	Disclosure on tobacco funding / links	Number of comments extracted	Comments
[Addaction] comments form.doc	Addaction	Nil	26	

[Avon Wilts] comments form.doc	Avon and Wiltshire Mental Health Partnership (NHS) Trust	None	6	
[Cambridgeshire DAAT] comments form.doc	Cambridgeshire Drug & Alcohol Trust, Cambridgeshire & Peterborough Foundation Trust, Anna Freud Centre	No current or past links	18	
[CNWL NHSFT] comments form.doc	Central and North West London NHS Foundation Trust	Central and North West London NHS FT has had no past and no current direct or indirect links to, or funding from the tobacco industry	5	
[DH] comments form.doc	Department of Health	[Not applicable]	6	
[Framework] comments form.doc	Opportunity Nottingham	[None]	10	
[Greater Glasgow Clyde] comments form.doc	NHS Greater Glasgow & Clyde Area Psychology Committee	None	4	
[Hampshire DAAT] comments form.doc	Hampshire Drug & Alcohol Action Team	None	17	
[Leics Part] comments form.doc	Leicestershire Partnership NHS Trust	none]	5	
[MEAM] comments form.doc	Making Every Adult Matter coalition (Clinks, Homeless Link and Mind)	n/a	9	
[MMHSCT] comments form.docx	Manchester Mental Health and Social Care Trust	[None]	11	
[NHS England] comments form.doc	NHS England	[NA]	10	
[NICE MPC] comments form.doc	Medicines and Prescribing Programme, NICE	None	2	
[NICE Social Care] comments form.doc	NICE Social Care	[Insert disclosure here]	17	
[Pathway] comments form.docx	Pathway	None	2	
[PHE] comments form.doc	Public Health England (PHE)	N/A	23	
[RCGP] comments form.doc	RCGP	None	2	
[RCN] comments form.doc	Royal College of Nursing	[Insert disclosure here]	14	
[RCPsych] comments form.doc	Royal College of Psychiatrists	[Insert disclosure here]	44	
[Rethink] comments form.doc	Rethink Mental Illness	N/A	7	

[Revolving Doors] comments form.doc	Revolving Doors	No current or historical funding	24	
[RPS] comments form.doc	Royal Pharmaceutical Society	N/A	5	
[South London Maudsley] comments form.docx	South London and Maudsley NHS Foundation Trust	None	80	
[Southern Trust] comments form.doc	Community Addiction Service, St Luke's Hospital, Armagh	None	18	
[St Mungos] comments form.doc	St Mungo's	St Mungo's has received donations from British American Tobacco, most recently an unrestricted donation of £31,420 in February 2016. Unrestricted donations are used to help fund a range of St Mungo's charitable activity. We have no other links with the tobacco industry.	3	
[TEWV NHSFT] comments form.doc	Tees Esk and Wear Valleys NHS Foundation Trust	None	5	
[Turning Point] comments form.doc	Turning Point	N/A	5	