# Public Health Guidelines

## Dual Diagnosis - Consultation on Draft Scope
## Stakeholder Comments Table

## 28 October – 25 November 2014

***Comments forms with attachments such as research articles, letters or leaflets cannot be accepted. If comments forms do have attachments they will be returned without being read. If the stakeholder resubmits the form without attachments, it must be by the consultation deadline***

| Stakeholder Organisation | Section Number | Page Number | Comments<br>Please insert each new comment in a new row. | Response<br>Please respond to each comment |
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| **2gether NHS Foundation Trust 2gether mental health care NHS trust Gloucestershire** | 1 | 2 | The term personality disorder may require further clarification as a number of service users may be receiving treatment, for example in substance misuse services without a formal diagnosis | Thank you for your comment. In response to stakeholder comments concerning the issues surrounding personality disorders, they have been removed from the list of severe mental illnesses. |
| **2gether NHS Foundation Trust 2gether mental health care NHS trust Gloucestershire** | 1.1 | 3&4 | Consideration of older age groups to be included | Thank you for your comment. There is no upper age limit. We will highlight older age groups within the equality impact assessment. |
| **2gether NHS Foundation Trust 2gether mental health care NHS trust Gloucestershire** | 1.2 | 4 | In-patient settings provide ongoing liaison with community settings. Integrated in-reach work considered important and considered best practice. Due consideration should be provided to this model of practice | Thank you for your comment. Care pathways and communication between in-patient settings – including elements of 'in-reach' work- and community settings would be included,. The scope has been re-worded to reflect this. Please note, however, |

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| | | | | that the final recommendations will reflect the Public Health Advisory Committees (PHACs) view on the evidence in these areas, taking into account availability, quality and content. |
| **2gether NHS Foundation Trust 2gether mental health care NHS trust Gloucestershire** | 1.3 | 4&5 | All the outlined functional aspects of integrated care are important. However, emphasis should be focused on clearer recovery processes of care pathway development between mental health and substance misuse services including service level agreements that reflect service provision | Thank you for your comment. 'care pathways' have been included. |
| **2gether NHS Foundation Trust 2gether mental health care NHS trust Gloucestershire** | 1,4 | 5 | In-patient stays can be adversely affected due to pressures on resourcing appropriate accommodation routes. In-patient/community pathways need to reflect this reality; ensuring clearer lines of communication exist between appropriate agencies involved in resourcing such placements for dual diagnosis service users. | Thank you for your comment. The purpose of the scope is to primarily provide details as to what will and will not be covered in the guideline and provide a broad background to pertinent issues. The scope does not provide recommendations - these are made in the guideline. The Public Health Advisory Committee (PHAC) will consider |

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| | | | | all of the available evidence that falls within the scope as they develop the guideline, and their discussion and final recommendations will be based on that evidence. |
| **2gether NHS Foundation Trust 2gether mental health care NHS trust Gloucestershire** | 1.5 | 6 | Epidemiological and the application of best practice and service models are important in establishing mental and physical well-being needs of this popuation group. Service user/carer experiential knowledge and perspective also considered paramount in the development of inclusive service provision | Thank you for your comment. Your concerns are addressed within the scope – we will be including all these aspects under the key questions. |
| **2gether NHS Foundation Trust 2gether mental health care NHS trust Gloucestershire** | 1.6 | 6&7 | Inclusion of novel psycho-active substances (NPS) due to their prevalence and consequences of use e.g. overdoses and potentiation effects with other substances | Thank you for your comment. As stated in section 1 legal or illicit drugs are included if they are being misused. If you are suggesting that evidence concerning the use of medications to treat conditions be included, then unless these are being 'misused' they would not be included as clinical treatment is excluded |

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| | | | | from this guideline (see section 1.3). |
| **2gether NHS Foundation Trust 2gether mental health care NHS trust Gloucestershire** | 2.2 | 8 | The provision of clear guidance on pathway definition is considered vital in light of the increase of multiple service providers delivering NHS services within localities | Thank you for your comment. Care pathways are included in the scope. |
| **2gether NHS Foundation Trust 2gether mental health care NHS trust Gloucestershire** | 3.1.2 | 9 | Local trust data provides important amounts of information regarding mental health and co-existing substance misuse. The CPA risk assessment tool is deemed an accurate method of monitoring and recording. Care clustering may contribute to the process of inaccurate reporting and review of cluster 16s. | Thank you for your comment, which raises an important issue.<br><br>Please note that there will be a call for evidence in which you can submit unpublished evidence – we encourage you to submit relevant evidence. |
| **2gether NHS Foundation Trust 2gether mental health care NHS trust Gloucestershire** | 3.1.3 | 9&10 | High levels of PTSD recorded within the dual diagnosis population. Emphasis on talking therapies and clearer access to these services required | Thank you for your comment. The evidence reviews commissioned for this guideline include an assessment of the service needs of people with dual diagnosis. Access to services will be included.<br>The effectiveness of clinical interventions is |

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| | | | | not included, instead the emphasis of this guideline will be on the optimal configuration of health and wider welfare and social services for this vulnerable group of people. |
| **2gether NHS Foundation Trust 2gether mental health care NHS trust Gloucestershire** | 3.1.4 | 10 | The high prevalence of novel psychoactive substances should be stressed, including alcohol related conditions e.g. Korsakoff's syndrome, affecting both adult and elderly population groups | Thank you for your comment. No drugs have been excluded (except those that are solely tobacco-based). |
| **2gether NHS Foundation Trust 2gether mental health care NHS trust Gloucestershire** | 3.2 | 11 | Emphasis on psychosocial approaches to care should be included such as motivational interviewing and harm minimisation. These interventions are important and have a clear evidence base within clinical practice | Thank you for your comment. This section is on identifying current practice in relation to service models.<br><br>The details – including the effectiveness - of clinical treatments including psychosocial interventions are excluded from this scope, because this guideline is about the optimal configuration of |

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| | | | | health and wider welfare and social services for a vulnerable group of people.. The referral from the Department of Health states the following: 'The Department of Health in England has asked NICE to provide a guideline for local authorities, NHS England, health and wellbeing boards and clinical commissioning groups on effective multi-agency working to improve access to services for people with dual diagnosis living in the community who may have multiple-needs.'<br><br>As part of assessing service models we will ensure that we are aware of the content of what a service provides, including treatment |

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| | | | | (broadly speaking, for example, that medication is provided, psychological therapy, etc) but we will not be evaluating the effectiveness of any clinical treatment, nor providing recommendations on what these treatments should consist of.<br><br>There is existing guidance concerning clinical treatment, for example see the clinical guideline on 'Psychosis with coexisting substance misuse' which provides best practice advice on the assessment and management of people with psychosis and coexisting substance misuse. |
| **2gether NHS Foundation Trust** | 3.3 | 12 | Integrating systems approach essential for future service provision. | Thank you for your |

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| **2gether mental health care NHS trust Gloucestershire** | | | | comment. We will search for evidence on different service and system configuration as the guideline develops. Please note, however, that the final recommendations will reflect the Public Health Advisory Committees (PHACs) view on the evidence in these areas, taking into account availability, quality and content. |
| **2gether NHS Foundation Trust 2gether mental health care NHS trust Gloucestershire** | 3.3.5 | 13 | An integrated recovery service model is required to assist commissioners the ability to comprehend the complex nature and quality of care packages. This process may support commissioners to develop future performance indicators that are realistic and meet service user expectations | Thank you for your comment. The purpose of the scope is primarily to provide details as to what will and will not be covered in the guideline and provide a broad background to pertinent issues. The scope does not provide recommendations - these will be made in the |

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| | | | | guideline. Please note, however, that the final recommendations will reflect the Public Health Advisory Committees (PHACs) view on the evidence in these areas, taking into account availability, quality and content. |
| **Department of Health** | Title | 1 | Does the term “dual diagnosis” remain current? Co-existing substance misuse and mental health issues is one we have seen more recently and widely used. | Thank you for your comment. Dual diagnosis is still a term that is used, although it has been used in a range of different ways across health and social care. We recognise that there are limitations associated with the term, and the title has been changed in order to reach specialist and non-specialist audiences. |
| **Department of Health** | Section 1, para 2 | Page 2 | Suggest using the term “severe and enduring”, though please see later comments on this issue. | Thank you for your comment. This paragraph is based on a review of the literature |

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| | | | | on how dual diagnosis has been defined. 'enduring' was not evident as a defining feature - in fact, we found that the term 'dual diagnosis' has been employed in a variety of ways across health and social care literature. We define what we mean and intend to cover in the scope, and the scope will be used to focus the recommendations and guideline. |
| **Department of Health** | Section 1, para 6 | Page 3 | The severe mental illnesses listed seem to provide too narrow a definition. Individuals with severe anxiety, severe OCD and severe anorexia may also need engagement of secondary mental health services and secondary substance misuse services. | Thank you for your comment on the definition of dual diagnosis. As with the literature on defining dual diagnosis, stakeholders' views are mixed on the issue of the range and severity of mental illnesses which should be included. We have based the definition |

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| | | | | in the final scope on an initial review of the literature and on the balance of stakeholder responses: The Public Health Advisory Committee (PHAC) who will be developing this guideline may consider whether and how the final recommendations could apply more broadly. |
| **Department of Health** | Section 1.1, para 1 /general | Page 3 | As this guidance is about multi-agency working to improve care, there is no obvious reason why it should be limited to those in need of secondary care and who have been diagnosed with “severe and enduring” mental illness.<br><br>The specific inclusion of “personality disorder” but not other, sometimes more severe disorders does not appear to be consistent. Greater consideration should be given to a wider range of severe disorders seen in secondary care. | Thank you for your comment. This section refers to the groups covered: all people aged from 14 years upwards who ‘have been diagnosed as having a severe mental illness and who misuse substances (that is, dual diagnosis) who live in the community’. There is no limit to secondary care, |

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| | | | | all health care within community settings is included (please see sections 1.2 and 1.3).<br><br>We have based the definition in the final scope on an initial review of the literature and on the balance of stakeholder responses: The Public Health Advisory Committee (PHAC) who will be developing this guideline may consider whether and how the final recommendations could apply more broadly. |
| **Department of Health** | Section 1.2, para 2 | Page 4 | There may need to be a clearer explanation of why the "setting that will not be covered" have been excluded, especially because these settings typically have a high prevalence of such patients - is guidance in respect of these settings possibly covered elsewhere? | Thank you for your comment. Yes, there is a guideline in development on 'mental health of people in prison' |
| **Department of Health** | Section 1.3, para 3 | | Greater explanation of "changes to waiting times" would be helpful – what does this mean? | Thank you. This has been changed to 'improvements in waiting |

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| | | | | times'. |
| **Department of Health** | General | n/a | The PH guideline may actually be most helpful if it doesn't limit itself to diagnosed (or diagnosable) conditions. Thus even if someone's substance misuse falls short of dependence, or if their lack of mental well-being doesn't in itself meet the threshold for access to services, the guideline should offer advice to its audience on the help that should be available to people whose substance use and poor mental health taken together warrant the provision of help. | Thank you for your suggestion, however all definitions of dual diagnosis include reference to a mental illness, and the DH referral is on improving access to services for people with 'dual diagnosis'. The only practical way of identifying the evidence in this area is by using diagnostic terms that refer to mental illness. We have based the definition in the final scope on an initial review of the literature and on the balance of stakeholder responses: The Public Health Advisory Committee (PHAC) who will be developing this guideline may consider whether and how the final |

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| | | | | recommendations could apply more broadly.<br><br>Please note that substance misuse includes harmful use, not just dependence. |
| **DrugScope** | General | | DrugScope is the leading UK charity supporting professionals working in drug and alcohol treatment, drug education, prevention and criminal justice. It is the primary independent source of information on drugs and drug related issues. DrugScope has just under 400 members, primarily treatment providers working to support individuals in treatment for, and recovery from, drug and/or alcohol use. Our member agencies are among those providing support to over 200,000 people receiving community and residential treatment.<br><br>www.drugscope.org.uk | Thank you for this information on your organisation. |
| **DrugScope** | General | | DrugScope is a member of the Making Every Adult Matter (MEAM) coalition alongside Clinks, Homeless Link and Mind. Together the charities represent over 1,600 frontline organisations working in the criminal justice, drug and alcohol, homelessness and mental health sectors.<br><br>www.meam.org.uk | Thank you for this information on your organisation. |
| **DrugScope** | Title | 1 | The term dual diagnosis is well understood in drug and alcohol services and is therefore likely to be appropriate in this context. | Thank you for your comment. |
| **DrugScope** | 1 | 3 | We understand the desire to restrict the scope of the guidance to severe mental health problems, but would want to be clear that there is also a need for guidance for dual diagnosis services for less severe mental health | Thank you for your comment and the information you have |

<table>
<tr><th>Stakeholder Organisation</th><th>Section Number</th><th>Page Number</th><th>Comments<br>Please insert each new comment in a new row.</th><th>Response<br>Please respond to each comment</th></tr>
<tr><td></td><td></td><td></td><td>problems and substance misuse.<br><br>The current version of UK guidelines on clinical management for substance misuse (often known as the orange book) provides some data on the prevalence of co-morbidity for people in drug and alcohol services.<br><br>
<table>
<tr><td></td><td>Drug Services</td><td>Alcohol Services</td></tr>
<tr><td>Schizophrenia</td><td>3%</td><td>3%</td></tr>
<tr><td>Bipolar affective disorder</td><td>1%</td><td>5%</td></tr>
<tr><td>Non-specific psychosis</td><td>5%</td><td>11%</td></tr>
<tr><td>Personality disorder</td><td>37%</td><td>53%</td></tr>
<tr><td>Affective and anxiety disorders</td><td>68%</td><td>81%</td></tr>
<tr><td>Severe depression</td><td>27%</td><td>34%</td></tr>
<tr><td>Mild depression</td><td>40%</td><td>47%</td></tr>
<tr><td>Severe anxiety</td><td>19%</td><td>32%</td></tr>
</table>
<br>Drawing on research entitled the Comorbidity of substance misuse and mental illness in community mental health and substance misuse services (Weaver et al, 2003), the guidelines suggest that 75% of clients of community drug services and 85% of community alcohol services (with a caveat about sample size and confidence intervals in the case of the latter) will also rate positive for at least one psychiatric disorder.</td><td>provided. We are aware of this data. We refer to data on dual diagnosis rates in section 3.1, based on a 2008 systematic review (Variations in rates of comorbid substance use in psychosis between mental health settings and geographical areas in the UK)<br><br>We have based the definition in the final scope on an initial review of the literature and on the balance of stakeholder responses: The Public Health Advisory Committee (PHAC) who will be developing this guideline may consider whether and how the final recommendations could apply more broadly.</td></tr>
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| | | | Further, the guidance suggests that almost one in three of the drug treatment population and over half of those in treatment for alcohol problems "experienced 'multiple' morbidity (co- occurrence of a number of psychiatric disorders or substance misuse problems). In the National Treatment Outcome Research Study, 29% of new admissions reported having suicidal thoughts in the previous three months and 10% reported having a psychiatric hospital admission."<br><br>It also points out "44% of community mental health patients had reported problem drug use or harmful alcohol use in the previous year". | |
| **DrugScope** | 1.2 | 4 | We understand the desire to restrict the scope of the guidance to community settings, but we are concerned that for some of those that the guidance is aimed at helping will experience periods in prison; and it would therefore be helpful if the guidance could ensure that transitions to and from prison services are explicitly dealt with.<br><br>The work we have done as part of the MEAM coalition including listing to the voices from service users and frontline practitioners suggests that interruptions to treatment and support are amongst the most damaging occurrences in the lives of people with multiple needs.<br><br>http://meam.org.uk/wp-content/uploads/2013/04/DRGJ2700_MEAM_report_11.14_WEB.pdf<br><br>We would also want to be sure that residential substance misuse treatment settings are included in the scope of this guidance. | Thank you for your comment. There is a guideline in development on 'mental health of people in prison' which will include transitions to and from prison.<br><br>Please note that there will be a call for evidence in which you can submit unpublished evidence – we encourage you to submit relevant evidence.<br><br>Service models including residential substance |

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| | | | | misuse treatment settings are included in the guideline. |
| **DrugScope** | 1.4 | 5 | We support taking economic aspects into account when developing the review and in making recommendations.<br><br>As the scoping document recognises economic analysis for complex health interventions is not always straightforward or comparable from one country to another. We would suggest that NICE make contact with the Social Research Unit who have been working on adapting the work of the Washington State Institute for Public Policy for the UK.<br><br>http://investinginchildren.eu/ | Thank you very much for this information.<br><br>Please note that there will be a call for evidence in which you can submit unpublished evidence – we encourage you to submit relevant evidence. |
| **Lancashire Care NHS Trust** | General | | Re title of the Document- the definition of dual diagnosis used for this document could be confusing as the DoH (2002) Mental Health Policy Implementation Guide- Dual Diagnosis Good Practice Guide defines DD as "Dual diagnosis can be defined as mental illness with substance misuse (drugs/alcohol). The term covers a broad spectrum of mental health & substance misuse problems that an individual may experience concurrently." In this draft document the definition just covers severe mental illness. I might be better not to include the term "dual diagnosis in the title of the document | Thank you for your comment. The title has been amended in light of stakeholder's comments.<br><br>We have based the definition in the final scope on an initial review of the literature and on the balance of stakeholder responses: The Public Health Advisory Committee (PHAC) who will be |

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| | | | | developing this guideline may consider whether and how the final recommendations could apply more broadly. |
| **Lancashire Care NHS Trust** | General | | There should not be an upper age limit as substance misuse affects all ages and is a growing problem in our ageing population | Thank you for your comment. There is no upper age limit. We will highlight older age groups within the equality impact assessment. |
| **Lancashire Care NHS Trust** | General | | Severe depression should be included as the guidance should focus on the effects of the person's illness on their functioning and not solely on diagnosis | Thank you for your comment. |
| **Lancashire Care NHS Trust** | 1.1 | 4 | "*People who have a severe mental illness and misuse substances, but who are not living in the community."* Will this include people living in supported accommodation or residential rehab facilities? | Thank you for your question. If "supported accommodation" is referring to any accommodation where the occupier receives some sort of help to enable them to live in the accommodation safely, then yes people living in supported accommodation would be included. Service models that |

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| | | | | include communication and care pathways with residential rehab facilities would also be included. |
| **Lancashire Care NHS Trust** | General | | Does the term substance misuse cover all substances including prescription medication e.g. opiate analgesia as this is a growing problem | Yes. As stated in section 1, it includes 'harmful or dependent use of legal or illicit drugs', but tobacco alone is not included (section 1.1). |
| **Leeds Addiction Unit** | 1 The term 'dual diagnosis' | 2-3 | Addictions work commonly involves dealing with complex problems of substance misuse, dependence, mental health, physical health, and social wellbeing – it is often said that dual diagnosis should include all of these. We disagree - this is the nature of addiction; it is what we do in the field of addiction. If we are to have a term such as 'Dual Diagnosis' then it has to have some different meaning and purpose to addiction. 'Dual Diagnosis' arose as a concept to bridge the gap between specialist addiction services and mental health services. The difference with physical health is that if somebody has Hepatitis C it is clear that they will see a substance misuse service and a hepatologist - the two have separate roles and there is no overlap in treatment. For people with severe and enduring mental illness this is not the case - treatment overlaps are considerable and yet both specialist addiction services and mental health services are essential to the care package. In contrast mild/moderate mental health problems are very commonly part and parcel of addiction/dependence and treated in exactly the same way as the dependence- they should be dealt with by specialist addiction services. Yes there are individuals who have severe forms of social anxiety/PTSD/PD/mood | Thank you for your comment on the definition of dual diagnosis. As with the literature on defining dual diagnosis, stakeholders' views are mixed on the issue of the range and severity of mental illnesses which should be included. We have based the definition in the final scope on an initial review of the literature and on the balance of stakeholder responses: The Public |

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| | | | disorder and so forth that will need expert treatment - again, if we listen to service user views, best if provided within addiction services. In short there is no logic to back a change in the particular meaning of 'Dual Diagnosis' but there will be calls for a broader definition – see also competence below. | Health Advisory Committee (PHAC) who will be developing this guideline may consider whether and how the final recommendations could apply more broadly. |
| **Leeds Addiction Unit** | 3.2.2 service users get only one problem addressed and 3.3.4 commissioning. | 11 & 13 | The real issue with 'Dual Diagnosis' is the service delivery model. In the world of targets and high case loads practitioners are motivated to discharge people as soon as they possibly can. Of course the fragmentation of services and fragmentation of delivery within services does not help. The logic is to set up 'Dual Diagnosis' services but this was not a great success when tried before - a huge proportion of general psychiatry can be labelled 'Dual Diagnosis'. Service models should be in scope and the evidence revisited. | Thank you for your comments. |
| **Leeds Addiction Unit** | 3.1 competence | | Finding practitioners competent to determine a diagnosis in people who have both mental illness and misuse psychoactive substances is increasing difficult as a result of decommissioning NHS addiction services. Prescribing is symptom/demand, rather than diagnosis, driven. A better quality of diagnosis/assessment would help reduce inappropriate prescribing and help prevent services users being handed from one service or one practitioner to another. Competence of practitioners is a key issue that needs careful consideration in scope. | Thank you for your comment. 'staff roles and their views and skills, including their training and education needs' are included in section 1.3 under 'areas covered'. |
| **Leicestershire partnership nhs trust** | 1 guidance is about | 3 | It is never 2 issues it is multiple complex issues including social care issues | Thank you for your comment. We highlight in the scope the multiple complex needs of people who have a severe |

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| | | | | mental illness and misuse substances. Please see section 3. Section 1 is providing information on how dual diagnosis is defined. |
| **Leicestershire partnership nhs trust** | | | Anxiety is a key feature in presentation | Thank you for your comment. |
| **Leicestershire partnership nhs trust** | 1.1 | 3 | 12 yrs and over would be realistic | Thank you for your comment but we cannot make substantial changes such as this without a rationale for the change. The rationale for including children aged 14 years and above is because many early intervention services start at age 14, and there are relatively small numbers of children with a dual diagnosis below this age. |
| **Leicestershire partnership nhs trust** | 1.2 | 4 | Although forensics are excluded many will have forensic histories in community mental health teams who don't fit the criteria for a forensic team despite history | Thank you for your comment. There is a guideline in development on 'mental health of people in prison' which |

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| | | | | will include transitions to and from prison. |
| **Leicestershire partnership nhs trust** | 1.5 | 6 | What about current provision and how it differs from trust to trust | This is included in the scope. Section 1.6, bullet point 3 states that we will include 'Details of types of health, social care, community and voluntary **services that are provided** and how these vary according to sociodemographic characteristics. This would include: the timing and delivery of diagnosis, treatment, waiting times, transfer and referral to other services; the availability and uptake of services; information on type of staff involved and staffing levels.'<br><br>The evidence used to support the development of this guideline will include a review of the |

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| | | | | published and grey literature on the above. We are not commissioning primary research on the different services delivered between trusts. |
| **Leicestershire partnership nhs trust** | 1.6 | 6 | Data recording can be poor or non existent so hidden populations | Thank you for your comment. We will be looking at ways in which services can reach groups of people who are hard to reach. Specific groups have been identified in the equality impact assessment.<br><br>We have highlighted that the outcomes of interest include 'processes to help [potential] service users access, attend and continue to use services'. |
| **Leicestershire partnership nhs trust** | 3.1.3 | 9 | Provision in care clusters difficult only fit one cluster does not apply to non psychoses diagnosis so many excluded | Thank you for your comment. We recognise that this is a complex, |

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| | | | | area, and the scope sets out what the guideline will and will not cover. If we identify evidence on the issue you raise here, then the Public Health Advisory Committee will consider it as they develop the recommendations. |
| **Leicestershire partnership nhs trust** | 3.1.4 | 10 | Increased suicide risk and provision by a and e and links with emergency services exclusion by crisis services | Thank you for your comment. We have noted in 3.1.4 the higher risk of suicide. A&E and crisis services are included in the scope. |
| **Leicestershire partnership nhs trust** | 3.2.2 | 11 | Exclusion because of substance use | Paragraph 3.2.2 is reporting on users' views of health and social care services as reported in the reference identified. The purpose of the scope is to primarily provide details as to what will and will not be covered in the guideline and provide a broad background to pertinent |

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| | | | | issues. |
| **Leicestershire partnership nhs trust** | 3.3.3 | 13 | Not all areas commission services why are some areas not commissioning | Thank you for your comment. We are not able to answer questions concerning local commissioning decisions – this consultation exercise was carried out in order to obtain stakeholder views on the draft scope of a new NICE guideline. The purpose of the scope is to primarily provide details as to what will and will not be covered in the guideline and provide a broad background to pertinent issues. |
| **Lundbeck Ltd** | **General** | **n/a** | Lundbeck is an ethical research-based pharmaceutical company specialising in central nervous system (CNS) disorders, such as **depression and anxiety, bipolar disorder, schizophrenia, Alzheimer's, Parkinson's disease, and alcohol dependence.**<br><br>Lundbeck welcomes the publication of this public health guideline consultation on the scope of delivering effective multi-agency working to improve access to services for people with dual diagnosis living in the community who may have | Thank you for this information.<br><br>We recognise that this is a complex area. People with severe mental illness who misuse alcohol are included in |

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| | | | multiple-needs.<br><br>Whilst Lundbeck acknowledges that the interplay between substance misuse and mental illness is a complex one, there is a strong body of evidence demonstrating the link between the two areas, including the link between mental illness and alcohol misuse.<br><br>Alcohol can be a form of self-medication for people with serious mental illnesses, and research demonstrates that individuals with schizophrenia can be three times more likely to abuse alcohol compared to those without a psychiatric disorder.[1]<br><br>While mental illness may be a predisposing factor to alcohol dependence, it can also affect the way an individual may use alcohol. For example, it may influence the clinical course of alcohol dependence; the individual's response to treatment and their risk of relapse.[2]<br><br>Evidence also demonstrates that the consumption of alcohol rarely acts to improve pre-existing psychiatric symptoms, but instead serves to intensify them, as well as being associated with increased psychotic symptoms and higher rates of emergency and psychiatric admissions and homelessness.[3,4] | the scope. |
| **Lundbeck Ltd** | **1.3 - Activities, services or aspects of care** | **4** | Whilst Lundbeck acknowledges that the delivery and management of clinical treatment for individuals with dual diagnosis, including pharmacological, psychological or psychosocial therapies, is outside the scope of this guidance, it is important that alcohol services are commissioned through an integrated approach, between local authorities and Clinical Commissioning Groups, and with clear lines of responsibility outlined for service provision, in order to ensure the delivery of effective referral pathways at a local level. | The purpose of the scope is to primarily provide details as to what will and will not be covered in the guideline and provide a broad background to pertinent |

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| | | | Indeed, NICE reports that commissioning high quality alcohol services using an integrated, whole-system approach can increase access to evidence-based interventions, which could improve outcomes for people, such as better health, wellbeing and relationships - key recovery aspects for individuals with dual diagnosis.[5]<br><br>Lundbeck therefore recommends that NICE clinical guideline 115 *'Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence'* is signposted within the final guidance document. | issues. The scope does not provide recommendations; these will be made in the guideline. The Public Health Advisory Committee (PHAC) who will be developing this guideline will consider appropriate links to other NICE guidelines as they draft recommendations. |
| **Manchester Mental Health and Social Care Trust** | 1 | 3 | Specific personality disorder requires clarification due to the tendency for labelling without diagnosis. This is important because many PD patients who fit the DD criteria may currently be managed in substance misuse services and not received the necessary diagnosis.<br>In addition the inclusion of PD with SMI remains contentious within front line teams therefore greater clarity and definition would be of benefit. | Thank you for your comment. In response to stakeholder comments concerning the issues surrounding personality disorders, they have been removed from the list of severe mental illnesses. We have based the definition in the final scope on an initial review of the literature and on the balance of stakeholder responses: The Public |

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| | | | | Health Advisory Committee (PHAC) who will be developing this guideline may consider whether and how the final recommendations could apply more broadly. |
| **Manchester Mental Health and Social Care Trust** | 1.1 | 3&4 | Emphasise that Later Life clients are included. Manchester LL CMHT's have a 30% prevalence rate for DD. Reference available. | Thank you for your comment. We will highlight older age groups within the equality impact assessment. |
| **Manchester Mental Health and Social Care Trust** | 1.2 | 4 | Settings. Whilst excluding inpatient settings we have found that drug service IN-REACH has strengthened community engagement. It may be beneficial to emphasise that in-reach to inpatient settings is permissible and encouraged. | Thank you for your comment. Care pathways and communication between in-patient settings and community settings would be included. The scope has been re-worded to reflect this. |
| **Manchester Mental Health and Social Care Trust** | 1.3 | 4&5 | All aspects relevant however integrated commissioning for recovery in both domains should be emphasised. The overlap in recovery philosophy and practice is enormous however community settings and the continued specific substance misuse / mental health cultures prevail. This contributes to disjointed recovery pathways. It is also, to an extent, duplication of service provision, some distinct mental helaht and SM recovery models are | Thank you for your comment. 'care pathways' have now been included in 1.3. Please note that the purpose of the scope is |

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| | | | appropriate. | to primarily provide details as to what will and will not be covered in the guideline and provide a broad background to pertinent issues. The scope does not provide recommendations; these will be made in the guideline. |
| **Manchester Mental Health and Social Care Trust** | 1.3 | 5 | There may be circumstances relating to a person's lack of formal diagnosis that necessitates identification of diagnosis. | Thank you for your comment. This guideline is about service delivery, guidelines on clinical practice are provided elsewhere, for example see NICE 'Psychosis with coexisting substance misuse' guideline. |
| **Manchester Mental Health and Social Care Trust** | 1.4 | 5 | The impact on extended duration of stay due to diminishing tenancy options for DD in the community is costly. Economic analysis of this phenomena could enable the DD pathway from inpatient to community to be linear. In addition it could encourage inpatient funding to be invested elsewhere. | Thank you for your comment. |
| **Manchester Mental Health and Social Care Trust** | 1.5 | 6 | Epidemiology, current practice, innovations and user/ care opinions are vital. The generalised US and Australian data has been over emphasised in the UK | Thank you. |
| **Manchester Mental Health and** | 1.6 | 6&7 | Point 2,3 &7 need to include emergencies and overdoses particularly in light of | Thank you for your |

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| **Social Care Trust** | | | the increasing amount of use of unknown and unpredictable substances (Legal Highs, NPS) Points 9-11 are essential and welcomed. | comments. Points 2 and 3 relate to people's health and social needs and details of services provided respectively. Point 7 covers 'Changes in mental and physical health outcomes' and so would include changes in rates of overdose and use of emergency services. Incidents of overdose have been included as an example outcome. |
| **Manchester Mental Health and Social Care Trust** | 2.2 | 8 | Pathway definition essential. | Thank you for your comment. Section 2.2 refers to NICE pathways, not clinical or care pathways. These 'bring together all related NICE guidance and associated products on a topic in an interactive topic-based flow chart'. Please see http://pathways.nice.org.uk/ for further information. |

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| **Manchester Mental Health and Social Care Trust** | 3.1.2 | 9 | An enormous amount of local NHS Trust data is available regarding co-occurring SM&MI. The CPA is a good source and far more accurate than Care Clustering. Care Clustering has shown a substantial under reporting of Cluster 16's. Progress (Nurse Consultant National Forum) supports this view from their local data. | Thank you for this information. There will be a call for evidence at a later date in which you can submit unpublished evaluations or on-going research. If we identify relevant evidence about the issue you raise, then the Public Health Advisory Committee (PHAC) who are developing the guideline will consider it in the course of their work. |
| **Manchester Mental Health and Social Care Trust** | 3.1.4 | 10 | The increased use of legal highs and novel psychoactive substances should be emphasised as should the misuse of alcohol in later life and the alcohol related brain disease in both adult and later life groups. | Thank you for your comment. The purpose of the scope is primarily to provide details as to what will and will not be covered in the guideline and provide a broad background to pertinent issues. |
| **Manchester Mental Health and Social Care Trust** | 3.2 | 11 | Both items (3.2.1 and 3.2.2). Please include the philosophical approaches around motivation; this includes the client's motivation to change and the services motivation to engage. There are harm reduction interventions that can be very effective however motivation is often the caveat used by services | Thank you for your comment. The purpose of the scope is to primarily provide details |

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| | | | not to engage. | as to what will and will not be covered in the guideline and provide a broad background to pertinent issues. The guideline is on service delivery and as such the content of treatments, including psychosocial interventions are excluded. If there are interventions around motivating people to use a service these would be included as they are interventions to promote the use of services (see section 1.3) |
| **Manchester Mental Health and Social Care Trust** | 3.3 | 12 | The policy direction is indisputable but could be expanded to emphasise the inclusion of Later Life drinkers and also all age ARBD clients. | Thank you for your comment. This section reflects current policy and highlights how the guideline relates to the policy. |
| **Manchester Mental Health and Social Care Trust** | 3.3.5 | 13 | Dual diagnosis clients move of their own volition or are moved by services and between services. An integrated SM&MH model for recovery should be developed in order to (i) assist commissioners in their conceptualisation of | Thank you for your suggestion. The purpose of the scope is to |

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| | | | services (ii) help commissioners monitor performance and (iii) define the fair expectations service users can hold. | primarily provide details as to what will and will not be covered in the guideline and provide a broad background to pertinent issues. The scope does not provide recommendations; these will be made in the guideline. |
| **NHS England** | General | | Thank you for the opportunity to comment on the above Public Health guideline. I wish to confirm that NHS England has no substantive comments to make regarding this consultation. | Thank you. |
| **Public Health England** | Section 1 / General | 3 | There needs to be guidance to cover the whole range of mental health and addictions diagnoses.<br><br>The scope as currently drafted is too narrow, by excluding some additional severe mental illness and all common mental health problems:<br>1. There is a range of other diagnoses of severe mental illness, currently omitted, that have higher mortality (anorexia) and equal impact on quality of life (severe anxiety disorders, OCD).<br>2. The broad issues pertaining to accessing appropriate interventions are as relevant for common mental health problems as they are for severe mental illness. A broader scope could address these general concerns. | Thank you for your comments. We recognise that mental health and mental illness are hugely important areas, which impact on large numbers of the population. The referral from the Department of Health has asked us to focus on the groups defined in the scope. We have based the definition in the final scope on an initial review of the |

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| | | | | literature and on the balance of stakeholder responses: The Public Health Advisory Committee (PHAC) who will be developing this guideline may consider whether and how the final recommendations could apply more broadly, and /or whether there are gaps in the evidence or recommendations for future research that should be noted in the guideline. |
| **Public Health England** | 1.1 | 3 | The scope is too narrow in terms of setting. The distinction between residential and community care is generally blurred with people moving between these modes of support.<br><br>Communication and continuity of care can be an issue in managing patients with dual diagnosis and a broader scope could address this. It's not clear from the scope whether patients in police custody and A&E departments with dual diagnosis would be covered. | Thank you for your comment. Care pathways and communication between residential settings and community settings would be included. A&E departments are included. The scope has been re-worded to reflect |

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| | | | | this.<br><br>People in police custody are not included as there is a guideline in development on 'mental health of people in prison' which will include people with dual diagnosis in police custody. |
| **Public Health England** | | 4 | There will be exceptionally high levels of tobacco use in this population and not addressing this in the scope seems a missed opportunity. | Thank you for your comment, however tobacco use is only very rarely included in the definition of dual diagnosis. For example, it is excluded from the Dual diagnosis good practice guide (Department of Health).<br><br>NICE has a suite of guidance on smoking prevention and cessation across populations and settings, including secondary care settings. |

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| **Public Health England** | 1.2 | 4 | See previous point about settings (1.1, page 3). There are common issues across these settings and the community. | Thank you. Please see response above. |
| **Public Health England** | 1.3 | 5 | It is unclear why interventions are not part of this scope. It is difficult to see how staff training and education needs can be considered without reference to interventions. This applies equally to service configuration.<br><br>Our concern is that this will be rather empty guidance about organisational structures with no reference to the kinds of interventions that might be useful. | Clinical treatment is excluded because this guideline is about the optimal configuration of health and broader welfare and social services for a vulnerable group of people. The aim of this guideline is to meet the requirements of the DH referral for this guideline: 'The Department of Health in England has asked NICE to provide a guideline for local authorities, NHS England, health and wellbeing boards and clinical commissioning groups on effective multi-agency working to improve access to services for people with dual diagnosis living in the community who may have multiple-needs. |

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| | | | | As part of assessing service models we will ensure that we are aware of the content of what a service provides, including treatment (broadly speaking, for example, that medication is provided, psychological therapy, etc) but we will not be evaluating the effectiveness of any clinical treatment, nor providing recommendations on what these treatments should consist of.<br><br>There is existing guidance concerning clinical treatment, for example see the clinical guideline on 'Psychosis with coexisting substance misuse' which provides best practice |

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| | | | | advice on the assessment and management of people with psychosis and coexisting substance misuse. |
| **Public Health England** | 1.5 | 6 | We think the issue should be extended beyond "what services people receive" to include what interventions they receive in these services. Clients may reside in a mental health service but receive no interventions that might address their dual diagnosis. | Please see comment above. We will not be including an assessment of clinical treatment. |
| **Public Health England** | 1.6 / 2 | 6 | In terms of health and social care needs – tobacco use will be an issue here (see previous point – page 4). | Please see response above. |
| **Public Health England** | 1.6 /3 | 6 | Please see previous point about interventions not just service configuration (1.3, page 5). What people actually get as treatment is more important than whether it is delivered by a particular type of organisation. | Please see response above. |
| **RCGP** | General | general | Those with dual diagnosis who misuse substances do not always misuse them. It is a feature of an exacerbation and inadequate treatment of their mental health condition very often that lead them to self harm through substances or seek solace. They should not be stigmatised because many hold professional jobs most of the time and are hidden to services. They are among the most needy because the services are geared for the socially disadvantaged and "vulnerable".<br>The guidance should include approach to toxic overdose and emergency treatment? (JA) | Thank you for your comment. 'Substance misuse' is a recognised term. In section 1 we state that 'The interplay between substance misuse and mental illness is complex and can change over time' and highlight the possible ways in which they interact. |

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| | | | | No population groups that experience severe mental health and substance misuse are excluded from the guideline. We are not yet aware of evidence that indicates that the majority of people with a severe mental illness who also misuse substances 'hold professional jobs'. If we identify evidence on the issue you raise here, then the Public Health Advisory Committee will consider it as they develop the recommendations.<br><br>Please note that there will be a call for evidence in which you can submit unpublished evidence – we encourage you to submit relevant |

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| | | | | evidence.<br><br>Guidelines are developed in a way to ensure that no groups are stigmatised. Please see http://www.nice.org.uk/about/who-we-are/policies-and-procedures/nice-equality-scheme for further information.<br><br>The guideline does not cover the effectiveness of clinical treatments: NICE has a range of relevant clinical guidelines that cover these, for example Psychosis with substance misuse |
| **RCGP** | 3.3.1 | | The Department of Health's Dual diagnosis good practice guide is a key UK policy document that provides a framework for planning services. Cannot access this document either from the consultation document or the DH website. (EE) | Thank you for alerting us to this. We have changed the weblink to an earlier version of the DH archived content. |

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| | | | | You should now be able to access the policy document here: Dual diagnosis good practice guide. |
| **RCGP** | General | | In many areas, the commissioning of DA S is only just starting to take place and it may not be the most helpful time to evaluate what is provided and experienced on the basis that these will all have changed in 6 months time. (EE) | Thank you for alerting us to possible changes in the commissioning of drug abuse services.<br><br>We recognise that many areas of NHS and public health service have undergone significant change and transformation over the last two years, and that this process is ongoing for some. The Public Health Advisory Committee (PHAC) who will be developing this guideline will include topic experts drawn from local health and public health backgrounds involved in commissioning, and we |

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| | | | | will monitor relevant changes as the guideline develops. Work on this guideline is only just beginning, and the PHAC meet for the first time in June 2015. The evidence development phase of this guideline runs from 01/15 – 01/16, which means there will be time within the development phase to take any changes or learning from this early commissioning into account, it we are able to identify appropriate evidence on it. Consultation on the draft guideline, which will take place from March – May 2016, will provide a further opportunity for stakeholders to input into the guideline, commenting on the draft recommendations and |

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| | | | | alerting NICE to significant issues that may impact on the guidelines implementation. |
| **RCGP** | General | | Given the high number of people with both mental health problems of all severities and substance misuse problems, there is a risk that the new commissioning arrangements will not provide appropriate and sufficient care for this group of people. I think the consultation needs to look at the risks of not joint commissioning dual diagnosis services particularly in terms of severe crime and suicide outcomes. (EE) | Thank you for your comment. This consultation is on the scope: what we will and will not be covering in the proposed guideline. Recommendations on commissioning will be made in the guideline, depending on the available evidence. |
| **RCGP** | General | | Given the pivotal role primary care plays in providing physical and mental health care to people in this group who often disengage from other services, the pathways into services, outreach into primary care and support within primary care settings need to be priorities. (EE) | Thank you for your comment. This consultation is on the scope: what we will and will not be covering in the proposed guideline. |
| **The Royal College of Psychiatrists** | 1 | 2 | RE: whether dual disorder is correct term. Comorbidity is more generally used currently and I think would better term,<br>RE: What is a severe mental disorder? I agree there are different definitions and understand that the original guidance focused on psychosis. However, (excluding nicotine) the most common comorbidity is alcohol and depression and not just severe depression. NICE has not produced guidance for this key | Thank you for your suggestion. On the basis of stakeholders' responses, the term dual diagnosis appears to still be in use and a |

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| | | | and challenging population. Given all the changes happening with reduced psychiatric input to addiction services, it is critical that NICE covers this population to guide the non-specialists in terms of managing abuse/addiction. Ideally anxiety should also be covered. | recognised and welcomed term by some. We have based the definition in the final scope on an initial review of the literature and on the balance of stakeholder responses: The Public Health Advisory Committee (PHAC) who will be developing this guideline may consider whether and how the final recommendations could apply more broadly. As co-morbidity can refer to the co-occurrence of any illnesses, not just a mental illness and substance misuse it is not specific enough for the purpose of the guideline. |
| **The Royal College of Psychiatrists** | 1.1 | 3 | I understand that there is no upper age limit, but I suggest that particular reference should be made to older adult population. cf Invisible addicts RCPsych report. | Thank you for your comment. We will highlight older age groups within the |

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| | | | | equality impact assessment. |
| **The Royal College of Psychiatrists** | 1.3 | 4 | Consider statement about 3rd sector providers | Thank you for your comment. Third sector providers are included under settings covered. The scope has been re-worded to reflect this. |
| **The Royal College of Psychiatrists** | 1.3 | | Covering “<br>Interventions to promote the ongoing use of services. This includes interventions to encourage adherence to treatment programmes, transfer and referral protocols and changes to waiting times. “<br>But not “<br>RE: Clinical treatment including pharmacological, psychological or psychosocial therapies. “<br>I am not sure why this is not included - does not seem sensible / joined-up thinking. | Clinical treatment is excluded because this guideline is on service delivery. The aim of this guideline is to meet the requirements of the DH referral for this guideline: ‘The Department of Health in England has asked NICE to provide a guideline for local authorities, NHS England, health and wellbeing boards and clinical commissioning groups on effective multi-agency working to improve access to services for people with dual diagnosis living in |

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| | | | | the community who may have multiple-needs.<br><br>As part of assessing service models we will ensure that we are aware of the content of what a service provides, including treatment (broadly speaking, for example, that medication is provided, psychological therapy, etc) but we will not be evaluating the effectiveness of any clinical treatment, nor providing recommendations on what these treatments should consist of.<br><br>There is existing guidance concerning clinical treatment, for example see the clinical guideline on 'Psychosis with coexisting |

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| | | | | substance misuse' which provides best practice advice on the assessment and management of people with psychosis and coexisting substance misuse. |
| **The Royal College of Psychiatrists** | General | | The definition of "severe mental illness" to specific clinical diagnoses is limited, as it seems far from clear why this should be so. Severe anxiety disorders (equivalent risk of suicide or self-harm to schizophrenia in 2014 Oxford study Singhai et al JRSM), the health-related quality of life impact of generalised anxiety disorder (UK Adult Psychiatric Morbidity Surveys?), anorexia nervosa (highest mortality of all) and Obsessive-compulsive disorder could all be included.<br><br>The anxiety spectrum, mood disorders, sleep disorders that remain unrecognised and leading to self medication, post trauma consequences are groups that seem to belong in no man's land and if not included can risk status quo and lack of adequate quality of care. Whilst it can be recognised that not everything can be brandished under the name of Dual Diagnosis and there may be a case to argue to have stricter definitions- restricting to only named diagnoses as in the document may not be the best approach. I would rather have the severity defined by dimensions of dysfunction, risks and resources needed to manage these people.<br><br>With respect to co-morbid psychiatric disorder and substance misuse, it often seems harder to access good care for people with anxiety | Thank you for your comment. Whilst we recognise the importance of the issues that you raise, the referral from the Department of Health has asked us to focus on the groups set out in the scope.<br><br>We have based the definition in the final scope on an initial review of the literature and on the balance of stakeholder responses: The Public Health Advisory Committee (PHAC) who will be |

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| | | | disorders/PTSD/obsessive-compulsive disorder than for those with psychosis. | developing this guideline may consider whether and how the final recommendations could apply more broadly. They will also consider whether there are gaps in the evidence or recommendations for further research which should be included in the final guideline. |
| **Royal College of Nursing** | General | | The Royal College of Nursing have no comments to submit to inform on the draft scope of the above consultation.<br><br>We look forward to participating in the next stage of development.<br><br>Thank you for the opportunity. | Thank you. |
| **Self management uk** | 1.5 (2) | 6/13 | A growing body of evidence underscores the importance of effective self-management of long-term conditions. (Epping-Jordan et al. 2004) People who recognise that they have an important role in self-managing their condition and have the skills and confidence to do so, experience better health outcomes. (Greene and Hibbard, 2002) With effective support and education, evidence shows that these skills can be developed and strengthened, through self-management training, even among those who are initially less confident; less motivated or have low levels of health literacy. (Hibbard and Greene, 2013) | Thank you for your comments.<br><br>This consultation was undertaken to obtain stakeholder views on the draft scope for this guideline. The purpose |

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| | | | Self-management training can also produce social outcomes such as improved diet, development of stronger networks, increased self-awareness and better self-worth. As a result of this, people are more able to make important life changes regarding relationships, volunteering, further education, employment and general health improvements.<br><br>The social impact of self-management training is estimated at three times the healthcare return on investment. (Healthy lives equal Healthy Communities – the social impact of self-management – Expert Patients Programme 2002)<br><br>Self management uk has delivered our lay-led self-management programmes to people with mental health and substance misuse, which have been very well received. In fact one or two people have gone on to train to co-deliver the programme providing peer modelling. This has also enabled people to feel it is ok to access services and tests such as Hepatitis C, as the group reassures.<br><br>Self-management tools and techniques support people to live well on a day to day basis, by understanding the role of medication, the impact of eating healthily and exercising on their condition, medication, work, and life balance for example. | of the scope is primarily to provide details as to what will and will not be covered in the guideline and provide a broad background to pertinent issues.<br><br>While we recognise the importance of the issues that you raise, we would not include this information in the scope. If we identify relevant evidence on these approaches which fall within our scope and inclusion criteria, then the Public Health Advisory Committee (PHAC) who will be developing the guideline will consider it in the course of their work. The final recommendations will reflect the PHACs collective view on the content, quality, strength |

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| | | | | and applicability of the available evidence.<br>Please note that there will be a call for evidence in which you can submit unpublished evidence.<br>All stakeholders for this guideline will be contacted and offered the opportunity to submit relevant evidence. |
| **Self management uk** | | | Self-management refers to the way people look after their health needs when living with a long-term health condition. This might mean making changes to:<br>*Their diet<br>*How they handle pain<br>*How they manage their medication<br>*How they relax<br>*How they communicate with clinicians, managers, family<br>*Their exercise routine<br>*How they cope with difficult emotions<br>*How they plan their daily activities<br>*How they maintain their social or work life and so on.<br><br>They recognise they may need to make some adjustments to their life but living with a long-term condition doesn't mean they have to give up, on all the things that are important to them. | Thank you for your comments.<br><br>Please see our response above. |
| **Self management uk** | 1.5 (2i) | 6/13 | The benefits for those attending a course are:<br>•Increase confidence, optimism, energy and self-esteem | Thank you for your comments. |

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| | | | •Reduce attendances at A&E and outpatient visits<br>•Improve relationships with family, friends and work colleagues<br>•Improve communication with health care professionals<br>•Increase social inclusion<br>•Reduce pain, tiredness, depression and isolation<br>•Re-introduce structure into daily life<br>•Improve quality of life<br>•Provide opportunities for volunteering<br>•Identify shared experiences with others in a similar situation<br>•Provide the potential for further support through contact with others with self-management experience and access to a wider network.<br><br>The self-management programmes are cost effective as examples by data from approximately 1000 EPP course questionnaires (Jan 2003 – Jan 2005) has revealed that, four to six months after completing the course:<br>• A&E attendances decreased by 16%<br>• Outpatient visits decreased by 10%<br>• GP consultations decreased by 7%<br>• Pharmacy visits increased by 18%<br>There is a great deal of evidence to support such as: the Kings Fund and NHS. | Please see our response above |
| **Self management uk** | 1.5 (2ii) | 6/13 | Self management uk also delivers Carers specific programmes as it is just as important to support those supporting service users. participants benefit from attending this by:<br>•Learning a range of skills which help to support them in their role as a carer<br>•Meet other people in similar situations<br>•Become aware of how their thoughts and feelings affect the way they behave, and ultimately the outcomes | Thank you for your comments.<br>Please see our response above. |

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| | | | •Explore ways to reduce stress<br>•Build a resource of information to support them in their role as a carer<br>•Improve their confidence in working with professionals and getting their needs heard<br>•Consider the way they eat and exercise, and the importance of being as healthy as possible<br>•Become a goal setter and goal reacher through the application of Action Planning and Problem Solving Skills<br>•Share their thoughts, ideas, fears and concerns, and seek to find positive solutions | |
| **Self management uk** | 1.6 (3) | 6/13 | All of our self-management programmes are delivered across the week and the on-line programme is 24/7 in order to fit in with people's lives. | Thank you for this information.<br>Please see our response above. |
| **Self management uk** | 1.6 (5) | 7/13 | One participant reported:<br><br>'I used drugs for 30 years, my life was in a mess and I couldn't take it anymore. I contracted Hepatitis C because of my drug use and while in recovery, someone recommended the Alcohol Misuse (SAM) course to me. It came at a crucial time as I really needed the support as it was still early days in my recovery. The things I learnt and the group I was part of helped my confidence to grow and I started to achieve things I hadn't thought I was able to do before.' - *D, Wirral* | Thank you for this information. There will be a call for evidence at a later date in which you can submit unpublished evaluations or on-going research. |
| **Self management uk** | 1.6 (7) | 7/13 | Self-management strategies support people in all areas of their life including mental well-being and physically.<br>Key research findings from a randomised trial carried out by the National Primary Care Research and Development Centre (Rogers A; Bower P; Gardner H; Gravelle H; Kennedy A; Reeves D – 2007) found course | Thank you for the reference. There will be a call for evidence at a later date. All stakeholders for this |

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| | | | participants have:<br>• Improved partnerships with doctors<br>• Increased confidence to manage their condition<br>• Improved quality of life and psychological wellbeing<br>• Increased energy<br>• A high satisfaction with the course. | guideline will be contacted and offered the opportunity to submit relevant evidence. |
| **Self management uk** | 1.6 (8) | 7/13 | Most of our self management courses are delivered by trained lay-tutors who live with a long-term condition. | Thank you for this information. |
| **Self management uk** | 1.6 (12) | 7/13 | After attending a self management course people feel better equip to adhere to medication or able to discuss the problems with their clinician that might be stopping them, for example.<br><br>On a self-management course working with a clinician in equal partnership is discussed, encouraged and for many people is an important outcome. | Thank you for this information. |
| **South London and Maudsley NHS Foundation Trust** | 1 | 2 | Definition of substance misuse. Some consideration of consistency with the Psychosis and Substance Misuse guidance (CG120) may be useful, although the definition there is rather more protracted and differentiates hazardous and harmful use. Some reference to 'supersensitivity' may be appropriate – ie low levels of substance use that would not usually be considered harmful or problematic in people with psychosis can have a significant impact on the mental health of people with psychosis (see NICE PSM p11 QRG) | Thank you for your comment. We are aware of the definition in CG120 and did consider its use. 'The definition of substance misuse has been re-worded to: '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 |

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| | | | | 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.)' |
| **South London and Maudsley NHS Foundation Trust** | 1 | 2 | Despite the Todd reference in day to day practice 'severe mental illness' does not usually include personality disorder. Much of the dual diagnosis policy guidance focuses solely on SMI (schizophrenia, bipolar, schizo-affective) which does leave a gap but including PD here will create some inconsistency with other guidance. | Thank you for your comment. In response to stakeholder comments concerning the issues surrounding personality disorders, they have been removed from the list of severe mental illnesses. We have based the definition in the final scope on an initial review of the literature and on the balance of stakeholder responses: The Public Health Advisory Committee (PHAC) who will be |

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| | | | | developing this guideline may consider whether and how the final recommendations could apply more broadly. |
| **South London and Maudsley NHS Foundation Trust** | 1 | 3 | 'Specific personality disorder' – see above. If it is 'specific' which does it include/exclude? People with PD are often the people that fall between services. | Thank you for your comment. We have removed reference to personality disorder. |
| **South London and Maudsley NHS Foundation Trust** | 1.1 Groups not covered | 3 | Groups not covered - ....no evidence of 'current' substance misuse. Suggest removing current? Otherwise what is the definition of current? Eg past week/month/? It is almost certainly appropriate to include people that have recently become abstinent – they may quickly relapse if community services are not effectively meeting their needs | Thank you for your comment. We have removed reference to 'current'. |
| **South London and Maudsley NHS Foundation Trust** | 1.1/1.2 | 4 | Exclusion of people 'not living in the community' – specifically psychiatric wards. Given the brief admissions of may people to psychiatric wards and the fact that good communication between services and well-planned transition may be crucial in providing consistent, co-ordinated care excluding wards may be an omission and prevent useful learning/recommendations. | Thank you for your comment. Care pathways and communication between in-patient settings and community settings would be included. The scope has been re-worded to reflect this. |
| **South London and Maudsley NHS Foundation Trust** | 1.3 | 5 | Point 3 - May be useful to include explicit mention of engagement strategies | Thank you for your suggestion. We understand that engagement strategies |

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| | | | | may include such things as befriending, outreach and practical assistance – these sorts of practices are highlighted in section 1.6 on outcomes under 'Processes to help service users access, attend and continue to use services' and are included in the scope of this guideline.. |
| **South London and Maudsley NHS Foundation Trust** | 1.6 | 7 | It is good to see that service user and family/carer experiences have not been included together as their experiences and views may be different (points 4 and 5) Commissioner and provider views could usefully be separated (point 6) – they are quite different groups | Thank you for your comment. Having commissioner and provider together does not mean that their views will be seen as one group together – we will be mindful of this comment as we identify and appraise the evidence. |
| **South London and Maudsley NHS Foundation Trust** | 1.6 | 7 | Point 8 – may be useful to include as an example assertive outreach: the demise of these teams in many parts of the country is reducing the extent to which the measures that were employed by such teams can be provided. Possibly also include inreach (eg inreach from substance misuse to mental health inpatient wards) | Thank you for your suggestion. The list of examples is not meant to be exhaustive. |

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| **South London and Maudsley NHS Foundation Trust** | 3.2 | 11 | Care is needed in using the terms 'integration'/'integrated'. They are often used loosely in relation to dual diagnosis to refer to services working together in a co-ordinated way. This is different from the 'integrated' treatment model which is only partially defined here and therefore may be misleading. A more explicit definition is required. See DH (2002) p22: *The integrated treatment model implies the concurrent provision of both psychiatric and substance misuse interventions but requires the same staff member (or clinical team), working in a single setting, to provide relevant psychiatric and substance misuse interventions in a co-ordinated fashion*. Building on this the NICE PSM guidance recommends that treatments are sequenced to take account of the relative severity of both conditions at different times, person's ***social*** and treatment context (possibly something to pick up in relation to this new guidance) and person's readiness to change.<br>Suggest: integrated – addressing both mental health and substance misuse needs at the same time, in the same setting, by one team. | Thank you for your comment. We have made changes in line with your suggestion. |
| **South London and Maudsley NHS Foundation Trust** | 3.3.2 | 12 | Other documents/guidance that might usefully be included: Health Advisory Service Dual Diagnosis Standards (2001), possibly also the National Confidential Inquiry Reports into Suicide and Homicide by People with Mental Illness (eg Avoidable Deaths 2006) – these have frequently included recommendations about dual diagnosis eg the need for mental health and substance misuse services to work together, the need for staff training | Thank you for these suggestions. In line with the new template for scopes we have limited the policy section to select key policies that the guideline will relate to.<br><br>Confidential Inquiry Reports into Suicide and Homicide by People with Mental Illness would not |

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| | | | | be included in the policy section but we have highlighted in section 3.1.4 on key facts and figures that people with a dual diagnosis are at high risk of suicide. |
| **South West Yorkshire Partnership NHS Foundation Trust** | 1 | 2 & 3 | *Is this definition appropriate? If not, why not; and what changes would you make? Please provide information supporting any proposed change to the definition of dual diagnosis.*<br><br>The definition seems exclusive and therefore a disadvantage for people experiencing common mental health problems and excludes them from services. An example of a working definition within SWYFT is *"An individual who experiences both substance misuse and mental health issues that are detrimental to their own life and the lives of others"*<br>*Further up to date research (Grant et al 2006) in relation to common mental health problems and alcohol / Substance misuse.* Recent good practice papers (Drug scope, NTA, IAPT 2012) recognise importance of including Common mental health problems into any definition, service provision. *Severe depression requires inclusion.*<br><br>The definition of substance misuse within this document need to relate to any substance or alcohol (either illicit, prescribed, over the counter medications, legal highs & alcohol) which are defined as problematic either by the service user, carers or professionals involved in the clients care. | Thank you for your comments.<br>We have based the definition in the final scope on an initial review of the literature and on the balance of stakeholder responses: The Public Health Advisory Committee (PHAC) who will be developing this guideline may consider whether and how the final recommendations could apply more broadly.<br><br>The definition in the scope on substance misuse has been |

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| | | | | reworded to clarify what is meant by harmful. |
| **South West Yorkshire Partnership NHS Foundation Trust** | 1.2 | 4 | *Settings – all community settings. This requires further definition. Older peoples nursing homes? Residential placements where clients are subject to restrictions?* | Thank you for your comment. Due to the large number of settings included we have not listed all but we have highlighted that the settings include 'a range of services provided by the NHS, social care and schools, as well as the community and voluntary sectors'. |
| **South West Yorkshire Partnership NHS Foundation Trust** | 1.3 | 4 | Commissioning – Recognition of local variation in commissioning arrangements re Dual diagnosis.<br>Discussion around joint commissioning dual diagnosis provision via Substance Misuse Services and mental health services is a t concern. A new national Drug & Alcohol Dependence Strategy was published in 2010 (HMG 2010) and a Mental Health Strategy (HMG 2011) which both acknowledge the association between mental health problems and substance misuse. If services are to offer people with dual diagnosis integrated treatment, joint commissioning of mental health and substance or alcohol services needs to become the norm. The existing gap between services may continue or worsen unless commissioning groups ensure that all contracts with providers stipulate effective joint working and clear care pathways for this client group (Centre for Mental Health, Drug Scope & UKDPC 2011). The DoH 2010 document (No health without mental health) mirrors these recommendations suggesting that | Thank you for your comment. The policy documents you highlight are referenced in the policy section of the scope (3.3): Reducing demand, restricting supply, building recovery and No health without mental health. Commissioning is included under 'key areas that will be covered'. The purpose of |

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| | | | "*dual diagnosis (co-existing mental health and drug and alcohol problems) covers a wide range of problems. It is important that the appropriate services are available locally in the right settings including the provision of fully integrated care, when this is appropriate, to meet this breadth of need. The Government will continue to actively promote and support improvements in commissioning and service provision for this group, their families and carers".* (DoH 2010 pg 41) | the scope is to primarily provide details as to what will and will not be covered in the guideline and provide a broad background to pertinent issues. The scope does not provide recommendations; these will be made in the guideline. |
| **South West Yorkshire Partnership NHS Foundation Trust** | 1.3 | 5 | *Measures to ensure people are provided with a service* –<br>Recommending local strategies are in place., clear care pathways between agencies.<br>Inclusive rather than exclusive. | Thank you for your suggestion. Care pathways have been added to the areas covered.<br><br>The purpose of the scope is to primarily provide details as to what will and will not be covered in the guideline and provide a broad background to pertinent issues. The scope does not provide recommendations; these |

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| | | | | will be made in the guideline. |
| **South West Yorkshire Partnership NHS Foundation Trust** | | | *Older age limit - in relation to equality impact*<br>Alcohol and substance misuse in older people is being increasingly recognised as a growing public health problem. A report of the *UK Enquiry into mental health and wellbeing in later life* (age concern 2007) reports the significant increase in alcohol related deaths in the 55 – 74 age groups. There is also the need to pay closer attention to this "invisible group".<br>Age concern (2003) suggest that older people are much less likely to be referred to alcohol treatment services than adults of working age, reasons suggested are<br>Ageist assumptions about the lifestyles of older people<br>Many older people unaware of safe drinking limits<br>Older people are less likely to exhibit antisocial behaviour as a result of alcohol use; therefore the problem is often hidden.<br>Older people are less likely to admit to the problem and ask for help. | Thank you for your comment. There is no upper age limit. We will highlight older age groups within the equality impact assessment. |
| **Turning Point** | General | | Turning Point is a health and social care organisation providing support to people with complex needs, including those with a dual diagnosis. We also provide the secretariat to the All Party Parliamentary Group on Complex Needs and Dual Diagnosis (APPG). We established this group in 2007 due to the number of people falling through gaps in service provision, due to having a dual diagnosis or multiple complex needs. The group is currently chaired by Lord Victor Adebowale and David Burrowes MP. On behalf of Turning Point and the membership of the APPG we welcome this consultation and the proposed guidance set out within it. | Thank you for this information on your organisation. |
| **Turning Point** | Topic | 1 | Guidance to support multi agency working is greatly needed. We hear on a regular basis how people with a dual diagnosis are turned away from services either due to their psychosis or because they have addiction issues. Very few | Thank you for this information. |

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| | | | services are commissioned in a joint way, to meet coexisting needs without one being used as a means of exclusion. | |
| **Turning Point** | Who the guideline is for | 1 | Given the nature of current commissioning it is important for the guideline to be designed for commissioners and providers across the NHS and local authorities, and we welcome the recognition of the important part the voluntary sector play in supporting people with a dual diagnosis. However, the criminal justice system is a critical friend to ensuring people with a dual diagnosis, while in prison or in police custody, are properly diagnosed and receive the support they need. There could, therefore, be further benefit of this guidance if it were also shared with prisons and the police. 2 | Thank you for your comment. There is a NICE guideline in development on 'mental health of people in prison'. |
| **Turning Point** | What the guideline is about | 2 | We welcome the use and recognition of the term dual diagnosis and the clarification of what this term means. We would include severe depression within this definition due to the sometimes debilitating nature of depression that is compounded, and often causes, harmful levels of substance misuse. We hope that with this definition in mind, local services will be commissioned and able to deliver services that meet the needs of this group. Activity to raise awareness amongst professionals will be required to ensure that this term is understood and the needs of those with a dual diagnosis, and their families/carers are catered for. At the moment people's experience of getting their dual diagnosis diagnosed is an often very difficult and stressful experience. Guidance on what a dual diagnosis is, how to diagnose and the support that is required would vastly improve people's experience of support services. | Thank you for your comments. We have based the definition in the final scope on an initial review of the literature and on the balance of stakeholder responses: The Public Health Advisory Committee (PHAC) who will be developing this guideline may consider whether and how the final recommendations could apply more broadly. They will also consider whether there are significant gaps in |

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| | | | | the evidence or recommendations for future research which should be included in the final guideline. |
| **Turning Point** | 1.1 Who is the focus? | 3 | It seems sensible to base this guidance on people over 14, with no upper age limit, given our current knowledge of those with a dual diagnosis. However given the hidden nature of substance misuse and some mental health issues, it is important that this guidance can be applied to those younger than 14 if required in exceptional circumstances and is is complemented by existing preventative strategies around young people's mental health and wellbeing. | Thank you for your comments. As we will only be looking at evidence that relates to services for people aged 14 years and over we would not be able to state that the recommendations are generalisable to under 14s. |
| **Turning Point** | 1.3 Key areas that will be covered | 4 | 1. The integration of community-based services is key as we often hear that even when people are diagnosed there is a lack of available services and/or adequately trained professionals to provide people with the support they need. Taking an integrated approach to this work will help spread an understanding of what dual diagnosis is but also an expectation that local areas must meet the needs of their constituents, however complex their needs may be. The current system seems to have too many points where people can fall through the gaps in provision due to handing over of cases between teams. Only in Hertfordshire are Turning Point commissioned to jointly support people with mental health and coexisting substance misuse issues. Elsewhere commissioning remains fragmented. | Thank you for this information. The purpose of the scope is to primarily provide details as to what will and will not be covered in the guideline and provide a broad background to pertinent issues. The recommendations in the final guideline will be |

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| | | | Staff training is a critical component of improving services. The lack of staff training is a barrier highlighted by the APPG in its recent factsheet on Complex Needs and Dual Diagnosis. People seeking help are often met by staff who do not understand dual diagnosis and therefore try to focus only on one issue, or exclude people from support due to coexisting issues.<br><br>2. Measures are critical as data is woefully lacking at present in terms of compulsory measuring of people with a dual diagnosis. Instead data is often captured as primary/ secondary diagnosis, which can be misleading. | determined by the collective views of the Public Health Advisory Committee (PHAC) who are developing it on the content, strength, quality and applicability of the evidence. |
| **Turning Point** | 1.4 Economic aspects | 5 | Just to reiterate the need to measure cost effectiveness but also to take into account the interdependencies, social value and where savings versus costs are made. Current Payment by Results arrangements, as well as the fragmented commissioning approach, mean that there are currently a lack of incentives in the system to support people with a dual diagnosis. | Thank you. |
| **Turning Point** | 1.5 Key issues and questions | 6 | If the APPG can help at all in terms of engaging with stakeholders, gathering evidence or case studies please do get in contact. We have over 200 stakeholders across health, local authorities, criminal justice, commissioning, service providers, service users and families. | Thank you very much. |
| **Turning Point** | 1.6 Main outcomes | 6 | It is imperative that any engagement work to ascertain the sociodemographic characteristics of those with a dual diagnosis along with service user experience engages not only with those easily accessed but those seldom heard from, for example BME communities, the homeless and Gypsy Roma Traveller groups where the rates of dual diagnosis are higher than in the general population but far more hidden due to the challenges that exist around service access. | Thank you. We recognise that this group are important, and they are of course included within the scope and . equality impact assessment. We will look for evidence relating to these groups as we |

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| | | | | develop the guideline. |
| **University of Birmingham/Birmingham & Solihull Mental Health Trust** | 1.2 | **Pg. 4.** | **Settings that will not be covered-Psychiatric wards**<br>*– Although Psychiatric wards will not be the focus of the guidelines the interface between community-based services and psychiatric wards would benefit from being addressed in this guidance due to the sizeable proportion of people with co-morbid severe mental health and substance misuse problems that are admitted and the frequency of admissions to psychiatric wards (i.e. 22-44%). Often health and social care needs are identified on psychiatric wards and this may represent an opportunity to engage service users in addressing their health and social care needs. If treatments addressing health and substance misuse are seamlessly offered between community settings and psychiatric wards this would help to improve integration and care pathways. We have just completed a randomised controlled trial addressing the issue of the feasibility and impact of delivering brief interventions for substance misuse in mental health inpatient settings to improve engagement with community-based treatment (Graham, H.L., Birchwood, M., Griffith, E., Freemantle, N., McCrone., Stefanidou, C.A., Walsh., Clarke, L., Rana, A. & Copello, A. (2014). A pilot study to assess the feasibility and impact of a brief motivational intervention on problem drug and alcohol use in adult mental health inpatient units: study protocol for a randomized controlled trial. Trials, 15:308.). This study may offer some insight into the possibility of raising service user awareness of their health and social care needs whilst they are on psychiatric wards.* | Thank you for your comments.<br><br>Care pathways and communication between in-patient settings and community settings would be included. The scope has been re-worded to reflect this.<br><br>The details of treatments including behavioural interventions are excluded because this guideline is focusing on the optimal organisation of health and wider welfare and social services for a vulnerable group of people.<br><br>There is existing guidance concerning clinical treatment, for example see the clinical guideline on 'Psychosis |

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| | | | | with coexisting substance misuse' which provides best practice advice on the assessment and management of people with psychosis and coexisting substance misuse.<br><br>As part of assessing service models we will ensure that we are aware of the content of what a service provides, including treatment (broadly speaking, for example, that medication is provided, psychological therapy, etc) but we will not be evaluating the effectiveness of any treatment, nor providing recommendations on what these treatments should consist of. |
| **University of** | 1.3 | Pg. 5 | **Areas that will not be covered-** Clinical treatment including pharmacological, | Thank you for your |

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| **Birmingham/Birmingham & Solihull Mental Health Trust** | | | psychological or<br>psychosocial therapies.-<br>*Although psychological or*<br>*psychosocial therapies will not be the focus of the guidelines, it may be beneficial to mention the role that brief motivational based interventions may play in increasing engagement of those with co-morbid severe mental health and substance misuse problems in accessing health or social care and making health-related behaviour changes* | suggestion; however treatments are excluded because this guideline is on service delivery. The aim of this guideline is to meet the requirements of the DH referral for this guideline: 'The Department of Health in England has asked NICE to provide a guideline for local authorities, NHS England, health and wellbeing boards and clinical commissioning groups on effective multi-agency working to improve access to services for people with dual diagnosis living in the community who may have multiple-needs.<br><br>As part of assessing service models we will ensure that we are aware of the content of what a service provides, |

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| | | | | including treatment (broadly speaking, for example, that medication is provided, psychological therapy, etc) but we will not be evaluating the effectiveness of any clinical treatment, nor providing recommendations on what these treatments should consist of.<br><br>There is existing guidance concerning clinical treatment, for example see the clinical guideline on 'Psychosis with coexisting substance misuse' which provides best practice advice on the assessment and management of people with psychosis and coexisting substance misuse. |

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| **University of Birmingham/Birmingham & Solihull Mental Health Trust** | 1.6 | | **Main outcomes, The main outcomes that will be considered when searching for and assessing the evidence are-**<br>*It may be worth considering the role brief motivational based interventions may play in increasing the engagement of those with co-morbid severe mental health and substance misuse problems in accessing health or social care and making health-related behaviour changes.* | Thank you for your comment. If the intervention is designed to increase engagement with services then it would be included as part of the outcome 'processes to help service users access, attend and continue to use services (also see section 1.3 bullet 3). The intervention would however not be included if it is about changing health behaviour (please see responses above). |