

National Institute for Health and Clinical Excellence

**Drug use disorders quality standard
Quality Standard Consultation Comments Table**

18.05.11 - 19.06.11

PLEASE NOTE: Consultation comments have been grouped for analysis purposes, potentially resulting in some reordering and duplication of comments. Responses are provided in relation to the statement number allocated in the table.

ID	Stakeholder	Statement No	Comments	Responses
			Please insert each new comment in a new row.	
001	Addaction	General	We are glad to see the support of An integrated approach to provision of services is fundamental to the delivery of high quality care to adults with drug use disorders. It is good that evidenced social care interventions is seen as integral to the delivery of drugs services however with so many differing outcomes frameworks, we would query why there is not integrated guidance if there is an expectation of integrated service delivery.	The quality standards process is a secondary user of guidelines and as such the scope of guidelines are generally outside the remit of the quality standards process.
002	Department of Health	General	I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation	Thank you for your response.
003	National AIDS Trust	General	<p>Introduction</p> <p>NAT (the National AIDS Trust) is the UK's leading charity dedicated to transforming society's response to HIV. We provide fresh thinking, expertise and practical resources. We champion the rights of people living with HIV and campaign for change. We welcome this opportunity to comment on the Quality Standard for Drug Use Disorders.</p> <p>This submission is also supported by Terrence Higgins Trust, the UK's largest HIV and sexual health charity.</p> <p>The context for NAT's submission is the immense success of harm reduction, including access to both clean injecting equipment and to Opioid Substitution Treatment (OST) - the result is very low rates of HIV infection amongst injecting drug users, who account for just 2% of people living with HIV in the UK. OST is not only immensely important in reducing risky injecting behaviour, it is also proven to help support HIV positive drug users in their essential adherence to Anti-Retroviral medication. Our emphasis in this submission on the maintenance of evidence-based OST provision is driven by this important record of success. Our comments on HIV testing in drug treatment programmes links to evidence that there is room for improvement in this area, and to the increasing evidence of the vital importance of early HIV diagnosis. Further information on HIV issues relating to injecting drug users can be found in NAT's report, 'Injecting Drug Users and HIV' August 2010:</p>	Thank you for your response.

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			http://www.nat.org.uk/Media%20library/Files/Policy/2011/Injecting_drug_users_and_HIV_-_updated_January_2011.pdf	
004	National Treatment Agency for Substance Misuse	General	Page 3 – given the responsibility of Local Authorities for commissioning drug and alcohol services from April 2013, the statements about NICE not having formal status in the social care sector are a concern and risk diluting the impact of the document. Suggest that it is made clear that all the quality standards are relevant to local authority based public health commissioners, the locally social care sector and that this document is the key reference point for commissioning and delivering evidence based services.	The introduction in the final quality standard has been revised. NICE will be producing a Local Government Briefing drawing together resources for local authorities on drug services which will include the quality standard.
005	National Treatment Agency for Substance Misuse	General	Overall, the statements are rather opiate-focused and therefore not very future-proofed. Since 2005-06 there has been a dramatic fall in new heroin users starting treatment. Meanwhile, internal NTA analysis shows that people being treated for non-opiate drugs now represent a majority of those entering treatment for the first time.	Thank you for your comment. On reflection of the consultation comments the topic expert group modified the statements. The final quality standard focuses on services rather than on specific drugs.
006	National Treatment Agency for Substance Misuse	General	There seems to be a major contradiction between the page 5 statement that “quality statements ... go beyond basic and describe excellence” and the quality statements as they stand, almost all of which describe basic, and not excellent, care.	The topic expert group prioritised those statements they felt provided high quality care for inclusion in the final quality standard.
007	National Treatment Agency for Substance Misuse	General	Many of the statements refer to services or interventions being “offered” to people but the measures then relate to the service/intervention being “received”. These clearly aren’t the same and either need making consistent or the fact that one is being used as a proxy measure for the other needs making clear.	The quality standard uses ‘offer’ in the wording of the headline statements to support patient choice. Often, ‘received’ is used in the measures in order to assist with measurability, audit and reporting. Reflecting choice will be particularly important when measuring achievement against statements using the quality measures.
008	National Treatment Agency for Substance Misuse	General	The following draft quality standards do not have an ‘equality and diversity considerations’ box: QS1,5,6,8,10,11,12,13,14,15 and 16 – is this a deliberate omission?	The topic expert group considered equality issues throughout development of the quality standard. Where required the quality standard contains an equality and diversity considerations section for specific statements. Statements where no equalities issues have been identified do not include an equality and diversity section.
009	Release	General	Release is the national centre of expertise on drugs and drug law. The organisational staff includes a team of qualified lawyers who provide legal assistance and representation directly to those who use drugs problematically. Release finds that this document appears to distance itself slightly from the NICE work on methadone and buprenorphine maintenance and questions this. We insist that abstinence (attaining and maintaining) is one of a number of key desirable outcomes in drug treatment but one that will be compromised by a failure to patently recognise and address the pre-conditions that contribute to the difficulties the vast majority of dependence users face. This goal will be more attainable for some than	Thank you for your comment. All actions and interventions within all quality standards should be performed by appropriately trained and competent healthcare professionals. It was recognised that training and competencies is a generic issue that underpins all quality standards. Please see section 2 (overview) for specific reference to this.

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			<p>others, and will become more attainable for most across time with a full range of available interventions. We must not imply that there is not value in other treatment goals and outcomes and must not punish those who cannot comply. The best way to achieve this, in our view, is not to suggest that all treatment, for each client, is abstinence-orientated. We can find no similar medically driven agenda in the treatment of any condition.</p> <p>While it is perhaps unrealistic to suggest that any field of medical endeavour can operate in a moral vacuum, the age-old requirement that workers and practitioners do not impose their values on their patients should be protected. We are concerned on the insistence on 'recovery' (we question if a workable, realistic definition can exist) and are worried about the idea of 'recovery champions'. While Release has been very active in engaging past (and current prescribed users) as staff and volunteers for 20 years, the guidance is unambiguous about the need for qualified staff in DQS 1, below. While we would argue that users (ex and prescribed) can bring a unique perspective, we are mindful that is often their experience which will not be everybody's experience. We suggest these people get an appropriate minimum qualification, at least, if one can be designed and are incentivised by pay and CPD opportunities.</p>	
010	Royal College of Nursing	General	The Royal College of Nursing welcomes proposals to develop this quality standard for drug use disorder.	Thank you for your response.
011	Royal College of Nursing	General	The RCN is happy to support the quality statements.	Thank you for your response.
012	Royal College of Nursing	General	<p>The RCN is, however, concerned to note that there is no mention of nurses and nursing within this consultation document.</p> <p>We are aware of the reduction in services including nurses as part of the commissioned treatment provided and consider that this will have a detrimental impact on patients. Nurses have a wealth of experience in reducing harm and supporting patients and carers throughout a treatment journey.</p>	Thank you for your comment. It was recognised that training and competencies is a generic issue that underpins all quality standards. Please see section 2 (overview) for specific reference to this.
013	Royal College of Nursing	General	<p>In our view, it is becoming more and more apparent that high quality nursing staff with the relevant skills and knowledge to care and treat clients with complex presentations, are being lost from services and this does risk the health of patients.</p> <p>We are further concerned that NHS services are being eroded to make way for 'non-governmental organisations/charities who are paid from the public purse but often deliver what could be considered lower quality services, have poor clinical governance structures and often do not appear to follow the Department of Health and NICE guidelines.</p>	The quality standard contains statements showing what high quality care should look like. It is for local areas to decide how best to implement these services and who performs the interventions in order to meet the quality standard.
014	Royal College of Nursing	General	We are aware of several complaints from patients which would seem to suggest that they perceive that the financial imperatives that drive these 'charities' are putting a rigid business model before client need.	Quality standards contain statements showing what high quality care should look like. It is for local areas to decide how best to commission

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				these services in order to meet the quality standard.
015	Royal College of Nursing	General	<p>As Nurses we fully support harm reduction. Recent publications from the National Treatment Agency for substance misuse (NTS) are focussing on abstinence which they now term 'Recovery'.</p> <p>While this is an aim that most patients would desire to achieve, it is saddening that it appears we are moving swiftly towards abstinence based treatment as a dominant model of care.</p> <p>There are clients who present with complex presentations such as co-morbidity with serious mental illness who will not be best served by a reductionist approach to services. There needs to be a broad continuum of services which whilst challenging in terms of commissioning must contain services for clients with complex presentations.</p>	Thank you for your comment. The topic expert group are aware of these complex presentations and therefore included a statement on access to psychological interventions for co-morbid mental health problems. Please see final statement 8.
016	Terrence Higgins Trust	General	Terrence Higgins Trust (THT) is the UK's largest HIV and sexual health charity, with 30 service centres across England, Scotland and Wales. THT is a membership and campaigning organisation which works with and advocates on behalf of people living with or affected by HIV. A proportion of our service users have experience of intravenous drugs use. Although our work in HIV prevention largely concentrates on sexual transmission, we maintain an active interest in the issues of BBV prevention among drugs users and the role of harm reduction initiatives in assisting people to manage their drugs use, lifestyle or risk of BBVs.	Thank you for your response
017	Terrence Higgins Trust	General	We do not wish to reiterate the points made by our sector partners National AIDS Trust (NAT). However, we would like to add our name in support of their submission. We share the concerns that they have outlined.	Thank you for your comments. Please see the responses for the National AIDS Trust comments.
018	The Huntercombe Group	General	There is a major omission in the scope – it should include Benzodiazepines as these seem to be becoming increasingly commonly misused with or without other drugs and alcohol – and are very hazardous. Also, it is often not possible to say what is a “primary diagnosis” in dual diagnosis – so perhaps there are areas missed there – especially with concurrent alcohol misuse.	The topic expert group identified the development sources they felt were most relevant to developing the standard within the framework of the quality standards process. The scope was developed based on the remit of this guidance.
019	Release	Question 1	Outcomes- Generally we feel that the guidance should acknowledge the full spectrum of presenting needs among clients who present at very different stages of their 'drug using careers' and some from very diverse backgrounds, although the economically disadvantaged are likely to be over represented. A statement recognising that while there should be a quality care standards, it has long been received wisdom that –'There is no one size fits all solution but treatment is effective and reduces the harm drugs cause to individuals, their families and neighbourhoods'. (http://www.nta.nhs.uk/service-recovery.aspx retrieved19.06.12). We would suggest that goals such as BBV testing and treatment, reduced injecting	The topic expert group prioritised the areas of care they felt were most important for patients and represent key markers of clinical and cost-effective care. The topic expert group discussed in detail the need to tailor interventions for each individual and this is emphasised within the quality standard both within the statements, the definitions and the equality and diversity considerations.

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			and poly drug use, improvements in housing, employment and relationships, health and self-care are valid and measurable outcomes. Some patients' experience of attempting to achieve abstinence will suggest other more adaptive targets are identified and set down. Many clients, particularly the older ones, will have pain related/addiction co-morbidity, and it is our experience that this population may be poorly served, often due to be suspicion of their motivation. We suggest this is addressed in the guidance.	
020	Addaction	Question 2	We are glad to see references to the use of mutual aid. However from a service user or recovery organisation point of view there does not appear to be too much to generate excitement. There appears to be of emphasis on providers – 'providing', but not references to working in partnership or alongside. There are references to mutual aid; but on consideration of the number of Recovery sponsored NTA/Government/Commissioner events/policies etc then there may be a gap in how providers are expected to work. If this is a draft standard then should there not be a large element of joint or partnership working actually built into it? Again this also reflects on the expectation of integrated commissioning but separate guidance.	Statements in the quality standard are developed to show what high quality care looks like for patients. It is for local teams to determine how these services are commissioned to ensure high quality care is provided.
021	National Treatment Agency for Substance Misuse	Question 2	<p>The NTA's view is that as well as having an additional, separate standard covering prison treatment, it would also be helpful to have stand alone standards covering:</p> <p>(1) Involving networks and families (separate to giving families support in their own right in QS2)</p> <p>(2) Facilitated access to Mutual Aid networks (already included as part of a list in QS9, but we feel this would benefit from specific focus)</p> <p>(3) Fatal and non-fatal overdose incidence. Evidence suggests that the more non-fatal overdoses a person has, the more likely they are to have a fatal overdose. Interventions such as training and advice on overdose prevention, and supervised consumption protocols, can reduce fatal and non-fatal overdose incidence. While supervised consumption as a protective factor against opioid overdose is addressed in draft QS12, many overdoses happen outside the arena of substitute prescribing. Low-threshold interventions like overdose training can be an important avenue into structured treatment. Interventions can be undertaken in high-risk environments such as prison or abstinence-based residential treatment to minimise fatal or non-fatal overdose. Relevant NICE guidance:</p> <ul style="list-style-type: none"> • NICE TA114 Methadone and buprenorphine for the management of opioid dependence, e.g. sections 3.1.4; 4.3.2 • NICE TA115 Naltrexone for the management of opioid dependence, e.g. section 3.3 • NICE CG52 Drug misuse opioid detoxification, e.g. section 1.1.1.2 	The topic expert group prioritised the areas of care they felt were most important for patients and represented key markers of clinical and cost effective care based on the development sources listed.
022	Release	Question 2	To us the single most exceptional feature of the consultation is the extraordinary	NICE technology appraisals including TA114 are

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			<p>absence of the emphasis on OST, client retention and harm reduction goals as desirable and optimal outcomes. Not only is the evidence base for the above not sufficiently referenced in the consultation, the previous NICE paper TA 114 is not even mentioned yet it provides an imperative to providers. It is hard to see how this can be medically justified.</p> <p>We have contributed to previous NICE, NTA and RCGP guidance papers, including the last two D.o.H/ RCGP editions of the 'Orange Guidelines' (1999, 2007). We believe that to look at 'numbers in treatment', as 'stuck' or 'parked' against 'numbers exiting treatment' as 'cured', is simplistic and unhelpful (see Dunn et al. 'Towards successful treatment completion'. NTA, July 2009. http://www.nta.nhs.uk/uploads/completions0909.pdf.retrieved17.06.12.) We are concerned that the unplanned cessation of treatment and client exclusion should not be exacerbated by a moral or political imperative to 'get people off drugs'. There is no evidence that coercing those who are prescribed OST into forced detoxification is successful. This approach also fails to recognise wider gains made by those on OST in terms of life satisfaction, family stability, general health and social functioning. Our experience suggests that insistence on 'time limited prescribing' or forced detoxification could have very damaging consequences. It is essential that the quality standards make clear that such proposals do not form part of treatment orthodoxy and must not displace evidence based treatment.</p> <p>We would also recommend a section on re-engagement for clients who are unsuccessful in their attempts to detox. People will be less likely to try to achieve abstinence if they feel there is no safety net. We would suggest a national guidance to re-engage, and if necessary re-stabilise people with a fast-track ('critical episode') debrief to try to identify and address any enduring difficulties that may need attention in order to prevent the same circumstances reoccurring in later detoxification attempts.</p>	<p>mandatory so issues relating to this would not be addressed by the quality standard. Therefore statements on supervision and choice have been removed from the final quality standard. The final statements have been developed so as not to prevent people accessing treatment as and when it is needed. The topic expert group recognised continued treatment and support following a period of drug treatment was important to maintain abstinence and prevent relapse and included a statement to this effect.</p>
023	Royal College of Psychiatrists (Shaw)	Question 2	<p>We strongly suggest there is an additional quality statement to the effect that health and social care professionals designated appropriate to work with individuals with Drug Use Disorders have a DUTY to assess the welfare of any children having contact with that person by virtue of being off-spring or sharing accommodation with the identified patient. To do this the team will need systems for recording the presence of children in their patient's lives and competence to assess welfare and take the necessary steps where children are at risk.</p>	<p>The topic expert group prioritised the areas of care they felt were most important for patients and represented key markers of clinical and cost effective care based on the development sources listed. Statement 2 in the final quality standard states as part of a comprehensive assessment, information should be obtained on any dependent children and any risks they may be exposed to.</p>
024	St Mungos	Question 2	<p>Integrated local approaches to coordinated support</p> <ul style="list-style-type: none"> • Quality statement nine emphasises the importance of people in drug treatment 	<p>Thank you for your comments. It was recognised that appropriate training, competencies and supervision is a generic issue that underpins all</p>

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			<p>being supported to access other services such as housing, education, employment, personal finance, health care and mutual aid. While support to access these services is important, it is not enough.</p> <p>The quality standard should call for commissioners, keyworkers and service providers to offer people drug treatment as part of a coordinated, flexible, multi-agency response that can address multiple needs simultaneously. The drug use disorders standard should be used to support local areas to meet a broad range of outcomes, such as those from the public health outcomes framework and the health commissioning outcomes framework. NICE should work with other agencies to ensure that these other frameworks and the drugs quality standard develop to promote integrated service delivery.</p> <ul style="list-style-type: none"> • Services should not be ‘silos’ that only address one type of need, instead they should work together to address a range of needs commonly faced by people in drug treatment, including housing, mental health issues, training and skills and physical health problems. Commissioners should ensure that they commission services that can provide this holistic support, while service providers must routinely coordinate the support they offer to individual people and cooperate strategically when planning services. • There is a need for staff across a range of services to be competent when working with people who have substance use issues, even when substance use may not be their primary area of expertise. St Mungo’s would like the draft standard to call for commissioners, service providers and key workers to work with relevant local non drug treatment services to ensure that they can offer better support to people with substance use issues. <p>This would include working with social workers, general practitioners, mental health practitioners, housing workers and benefit advisors. NICE should also work with other national agencies to ensure that these professionals are trained to have competencies which will allow them to provide a better service to people who use drugs.</p> <p>A transparent referral process that allows people in drugs treatment to choose personalised services</p> <ul style="list-style-type: none"> • Commissioners and service providers should make the funding and referrals service more transparent, with reference to objective criteria that are based on services’ capacity to meet service users’ treatment needs. • Throughout the treatment process people should have a choice between providers and should be able to challenge decisions about the level and duration of the 	<p>quality standards. Please see section 2 (overview) for specific reference to this. Quality statements are developed to show the key points on a care pathway showing what high quality care looks like. It is for local teams to decide how these services are best provided. The statements were revised following consultation and there is now more emphasis on services rather than specific drugs.</p>

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			<p>treatment that they receive. They should also be able to make choices around how services are delivered, for example through choosing their keyworker.</p> <ul style="list-style-type: none"> • Service user choice is a key concept in the reforms brought in by the Health and Social Care Act 2012, but is missing from this standard. Our clients can often only access services that are not suitable and do not support them to make a sustained recovery, which partly explains why many go through rehab and detox programmes several times. • Our clients tell us that if people are given more choice then they are likely to ‘buy in’ to services to a greater extent. Detox and rehab can be extremely difficult to complete. If people actively choose to enter a service after selection of their preference from a range of options then their determination to succeed is likely to be strengthened. They can also be reminded of the good reasons they had for this choice when they experience difficulty, which may improve completion rates. Service user involvement in the planning of services • Although quality statement five makes clear that people in drug treatment should be involved in their individual care planning and review arrangements, there is no mention in the standard of service user involvement at the organisation level. Service users should be systematically involved at all levels of the commissioning and treatment process, in order to have a voice in determining the organisation and operation of treatment service structures in their local area. They have firsthand experience of services and are often best placed to identify services’ strengths and weaknesses. St Mungo’s has an extensive client involvement programme, Outside In, which gives service users a voice and has driven innovation at all levels of the organisation. The National Treatment Agency and the Making Every Adult Matter coalition, which includes Clinks, Drugscope, Homeless Link and Mind, have recognised the importance of involving users in the planning of services. Good examples in the field include Hampshire DAAT’s success in involving clients in service design and planning, evaluation of performance and throughout the commissioning cycle. <p>Standards that focus on need rather than specific drugs</p> <ul style="list-style-type: none"> • There are references throughout the guidance to opioids and opioid specific services, but fewer for services that provide treatment for problematic use of other drugs. Although there are still more heroin users than users of crack cocaine, widespread reports of a decline in the number of people using heroin, and of heroin users supplementing heroin with or switching to other drugs, are supported by the experiences of our staff. For example, we have observed a marked growth of 	

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			<p>problematic use of benzodiazepines mixed with opiates, which makes detoxification more complex than for opiates alone.</p> <ul style="list-style-type: none"> • Rather than focusing on specific drugs, the standard should focus on addressing the needs of people in drug treatment. This would help to ensure that the needs of particular cohorts were recognised and the response of services improved in effectiveness. For example, the focus on Class A drugs can make it difficult for clients who have long term heavy dependency on amphetamines to progress and obtain suitable treatment. • A proportion of amphetamine users begin their dependency with self-medication to address conditions such as ADHD. The need for recognition and parallel support and treatment for such conditions is illustrative of the more general need to address conditions more highly prevalent among drug users than the general population, such as learning disabilities. • Another area of concern is the uneven availability of services offering effective specialised support for women. Specific drug issues for this group include cocaine dependency, which women suffering from trauma, especially sexual abuse, are particularly susceptible to. • Particular cohorts, including young people, have specific needs regarding drugs such as cannabis. There are also a number of emerging drugs for which evidence of problem use is growing including ketamine, methderone, methamphetamine, GHB/GBL and Khat. Drug services therefore need to be able to respond to a wider range of potential problems. <p>Support when abstinent</p> <ul style="list-style-type: none"> • Standard fifteen should specify that people are given support to access appropriate housing. For homeless people, or those with unstable housing arrangements, post-detox accommodation can be especially problematic, as the only available supported or temporary accommodation may be shared with people who are heavy drug users. <p>Drug workers who support their clients to obtain suitable housing are often faced with resistance from housing departments to accommodate drug services users at various stages of recovery. This lack of appropriate housing can undermine high quality drugs services' efforts to empower clients towards self-efficacy, since workers find themselves disempowered by systematic obstacles to housing clients with drug problems. The need to tackle stigmatisation is broadly applicable to all the</p>	

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			<p>standards, but is especially in addressing housing.</p> <ul style="list-style-type: none"> • For many people, abstaining or reducing drug use is accompanied by isolation as their prior social networks were entirely based around drug use. Peer support should be expanded in statement fifteen to include support in building appropriate relationships. 	
025	Turning Point	Question 2	Audit. It should be incumbent upon service providers of PSI to ensure Recovery Planning quality audits are carried out to ensure the frequency and quality of Recovery Plans meet the NICE/Industry standard with SMART objectives and using Nodelink Maps whenever possible.	Thank you for your comment. The quality standard references mapping techniques in the definitions as a form of support in providing psychosocial interventions.
026	National Treatment Agency for Substance Misuse	Question 3	<p>QS1: People with drug use disorders receive interventions only from staff competent and trained in delivering the interventions, and receiving appropriate supervision.</p> <p>QS3: People who inject drugs have access to needle and syringe programmes in accordance with NICE guidance.</p> <p>QS5: People in drug treatment review their agreed recovery care plan with their keyworker at least every 3 months to inform their treatment.</p> <p>QS6: People accessing drug treatment services are offered testing and treatment for hepatitis C, hepatitis B and HIV and vaccination for hepatitis B.</p> <p>QS8: People in drug treatment are offered appropriate psychosocial interventions by their keyworker.</p> <p>QS9: People in drug treatment are offered support, by their keyworker, to access services that promote recovery and reintegration, including housing, education, employment, personal finance, healthcare and mutual aid.</p> <p>QS10: People in drug treatment are offered appropriate formal psychosocial interventions.</p> <p>QS15: People who have achieved abstinence following a period of drug treatment are offered continued treatment, support and monitoring, designed to maintain abstinence for at least 6 months.</p> <p>QS16: People in drug treatment are considered for residential rehabilitative treatment</p>	Thank you for your comments. Please see revised statements 1, 4, 6, 7, 8, 9 and 10 in the final quality standard.
027	Release	Question 3	The most important statements? The guidance should state that services and support to problematic drug users will be provided rapidly and without judgement to those in need by appropriately qualified staff in a safe environment. It should acknowledge that while a cause of distress for many users, problematic drug use is	The topic expert group prioritised the areas of care they felt were most important for patients and represent key markers of clinical and cost-effective care.

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			<p>symptomatic of a deeper lack of life-satisfaction, usually rooted in abuse or neglect. A full range of treatment options should be set out at induction. It should acknowledge that people present with a range of problems and that a full range of options contingent on a reviewable treatment plan should be available to all. It should make a statement that service users will be supported at an appropriate pace through treatment and accept that all patients should feel that their engagement is constructive. It should insist that substitution therapy, in-patient and community detoxification, aftercare and relapse prevention initiatives all have a role and that patients and their families and carers (where appropriate) will form a working 'therapeutic alliance' with services. Exclusion will be a last resort measure and where this happens, a plan for the client addressing relapse and overdose possibilities will be agreed.</p>	
028	Turning Point	Question 3	The amended statement 8.	Thank you for your comments. Please see revised statement 6 in the final quality standard. The quality statement does not preclude psychosocial interventions being delivered by other professionals.
029	British Psychological Society	Question 4	<p>The BPS recommends that assessment of drug users' needs should include an appropriate level of attention to cognitive functioning, such as memory ability. The disruption of cognitive functioning, on a selective rather than global basis, has been identified in users of cannabis (Montgomery et al., 2012; Sollowij & Battisti, 2008), ecstasy (Murphy et al., 2012), and cocaine (Connolly et al., 2012). In addition, diagnosed conditions such as attention deficit hyperactivity disorder (ADHD) that pre-date drug use have the potential to exacerbate impaired cognitive functioning (Severtson et al., 2012). We suggest that such an assessment be focused on current functioning with regard to coping with the demands both of following treatment and of daily life in general, rather than upon long-term functioning since, in the latter case, the research literature gives little clear guidance as yet.</p> <p>References: Connolly, C.G., Foxe, J.J., Nierenberg, J., Shpaner, M., & Garavan, H. (2012). The neurobiology of cognitive control in successful cocaine abstinence. <i>Drug and Alcohol Dependence</i>, 121, 45-53. Montgomery, C., Seddon, A.L., Fisk, J.E., Murphy, P.N. & Jansari, A. (2012). Cannabis-related deficits in real world memory. <i>Human Psychopharmacology: Clinical and Experimental</i>, 27, 217-225. Murphy, P.N., Bruno, R., Wareing, M., Ryland, I., Fisk, J.E., & Montgomery, C. (2012). The effects of ecstasy (MDMA) on visuospatial memory performance: Findings from a systematic review with meta-analysis. <i>Human Psychopharmacology: Clinical and Experimental</i>, 27, 113-138. Severtson, S.G., Hedden, S.L., Martins, S.S. & Latimer, W.W. (2012). Patterns of</p>	Thank you for your comment. The topic expert group agreed to use the definition of assessment from the key development sources.

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			cognitive impairments among heroin and cocaine users: the association with self-reported learning disabilities and infectious disease. <i>Journal of Learning Disabilities</i> , 45, 139-150. Solowij, N., & Battisti, R. (2008). The Chronic Effects of Cannabis on Memory in Humans: A Review. <i>Current Drug Abuse Reviews</i> , 1, 81-98.	
030	Release	Question 4	There may be value in looking at reducing the number of points and implicitly connecting services that, in the course of a treatment episode may form a continuum of care. Some points seem repetitious and while they are nuanced to address different populations at different stages of engagement we would suggest that some points be consolidated under one heading. We have no comment on the denominators.	The topic expert group prioritised the statements they felt were most important for patients and represented key markers of clinical and cost effective care. The final quality standard now contains 10 statements.
031	Addaction	Question 5	We believe that there should be a standard for drug treatment in prisons. Even if the standard is not adhered to immediately it can become an aspiration or 'working towards' it, in the same way that the CQC has defined a standard. On the other hand it may be the case that a service can show that they go beyond the standard, but the quality standard would probably more apply to those parts of the country where there is no highly developed service at all.	The topic expert group agreed it was important for drug treatment services to be available in prisons however the majority of the statements in the quality standard would be applicable within this setting. It was decided to highlight prisons as a setting in the scope of the quality standard.
032	British Psychological Society	Question 5	The BPS recommends that a quality standard for the availability of drug treatment services in prisons be created. We recommend that, in particular, this should address the alarmingly high mortality rate for prisoners with a history of opiate dependence in the first two weeks following their discharge from prison (Farrell & Marsden, 2008; Krinsky et al., 2009; Singleton et al., 2003): this two week period should be regarded as a priority for healthcare interventions. References: Farrell, M., & Marsden, J. (2008). Acute risk of drug related death among newly released prisoners in England and Wales. <i>Addiction</i> , 103, 251-255. Krinsky, C.S., Lathrop, S.L., Brown, P., and Nolte, K.B. (2009). Drugs, detention, and death: a study of the mortality of recently released prisoners. <i>American Journal of Forensic Medical Pathology</i> , 30, 6-9. Singleton, N., Pendry, E., Taylor, C., Farrell, M., and Marsden, J. (2003). Drug-related mortality among newly released offenders. <i>Findings 187</i> . London: Home Office.	The topic expert group prioritised the areas of care they felt were most important for patients and represent key markers of clinical and cost-effective care. The topic expert group agreed it was important for drug treatment services to be available in prisons however the majority of the statements in the quality standard would be applicable within this setting. It was decided to highlight prisons as a setting in the scope of the quality standard.
033	National AIDS Trust	Question 5	C. Prisons NAT has undertaken work on blood-borne viruses in prison, including the development of a framework of best practice produced with support from the Department of Health. We believe a Quality Statement for prisons would be helpful, if only to re-state the importance of the principle of equivalence of treatment with that in the community (which should in line with international recommendations	The topic expert group agreed it was important for drug treatment services to be available in prisons however the majority of the statements in the quality standard would be applicable within this setting. It was decided to highlight prisons as a setting in the scope of the quality standard.

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			<p>include availability of both needle and syringe exchange and OST), and of informed consent to all aspects of treatment (in particular in any consideration of opioid detoxification). There are also particular challenges around confidentiality, non-stigmatising healthcare, and around the processes of prison reception, moves between prisons and release, which require specific consideration if drug treatment is to be maintained effectively and appropriately.</p> <p>NAT recommends a separate Quality Statement be developed on the availability of drug treatment services in prisons.</p>	
034	National Treatment Agency for Substance Misuse	Question 5	<p>The NTA supports the inclusion of a separate statement within the quality standard covering the need for evidence based prison based drug treatment (and its integration with community drug treatment provision).</p> <p>In our view, this would help ensure that local areas consider appropriate treatment pathways across community, acute and prison settings and could, we believe, make a meaningful contribution to the stated aims of this quality standard, particularly the aim of preventing premature death. (See explanatory note below)</p> <p>Prisons in England and Wales get 130,000 admissions every year, about 70 per cent of whom have recently taken drugs. A busy remand prison treats over 3,000 new drug dependent prisoners a year.</p> <p>A government review in 2004 found that prison drug treatment lacked a sound evidence base, and was out of step with treatment services in the community. This was against a backdrop of high levels of suicide and self-harm among drug-using prisoners, and also of fatal overdoses on release.</p> <p>An evidence-based approach (the Integrated Drug Treatment System) was introduced in 2006 to improve the quality and consistency of treatment, and is now delivered across all 131 adult prisons. However, disjointed funding and commissioning arrangements hampered progress. While local drug partnerships commissioned community treatment, Primary Care Trusts commissioned clinical treatment in prisons, and NOMS commissioned psychosocial interventions in prison.</p> <p>In 2010 the Prison Drug Treatment Strategy Review Group chaired by Lord Patel exposed these arrangements and set out a vision for a recovery orientated, evidence based and outcome focused treatment system commissioned and delivered at a local level.</p> <p>In order to establish an integrated approach to commissioning, DH was given overall responsibility for treatment and recovery activity in prison through the 2010</p>	<p>The topic expert group agreed it was important for drug treatment services to be available in prisons however the majority of the statements in the quality standard would be applicable within this setting. It was decided to highlight prisons as a setting in the scope of the quality standard.</p>

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			<p>Spending Review. In April 2011, local partnerships took responsibility for commissioning treatment services in both community and prison settings. These relatively new, current arrangements promote integrated recovery pathways (between community and prison settings) and facilitate continuity of care when prisoners leave custody, and reduce the risk of overdose, relapse and reoffending.</p> <p>From April 2013, reforms set out in the Health and Social Care Bill, give the NHS Commissioning Board (NCB) responsibility for commissioning drug and alcohol treatment in prison while local authorities will commission community treatment. This change poses a potential threat to the gains made through integration. The NTA is working with DH, NOMS and local authorities to ensure these new overarching commissioning responsibilities do not jeopardise existing improvements to the continuity of care created through the local integration of commissioning. But, we believe that a separate quality standard covering the need for evidence based prison based drug treatment to be well integrated with community services could make a contribution to the stated aims of these quality standards, particularly the aim of preventing premature death.</p>	
035	Release	Question 5	We agree that a statement relating to all people, in all 'restrictive environments', not just prison, has a place. We suggest that a member of RCGP 'restrictive environment group' is approached to feed in.	The topic expert group agreed it was important for drug treatment services to be available in prisons however the majority of the statements in the quality standard would be applicable within this setting. It was decided to highlight prisons as a setting in the scope of the quality standard. The topic expert group discussed the suggested statement and decided it was outside the scope of the development sources.
036	Terrence Higgins Trust	Question 5	Terrence Higgins Trust also supports NATs suggestion that a separate Quality Standard be developed on the availability of drug treatment services in prisons.	See response to comment 33.
037	Turning Point	Question 5	Yes	The topic expert group agreed it was important for drug treatment services to be available in prisons however the majority of the statements in the quality standard would be applicable within this setting. It was decided to highlight prisons as a setting in the scope of the quality standard.
038	Addaction	Question 6	There should be a standard for drug treatment for pregnant women. However, if a service can demonstrate that they fulfil all the requirements of such a standard then there may be no need to transfer the woman to the service that does meet the standard; so there may not be a need to unnecessarily transfer the woman to another service if she is having all her needs met in her current service.	The topic expert group discussed the inclusion of a statement on integrated services for pregnant women, recognising its importance, but decided these services were outside the scope of this particular quality standard but may be better addressed by other relevant quality

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				standards. Please see the quality standard on antenatal care .
039	British Psychological Society	Question 6	Given the inherent complexity of providing healthcare for pregnant women with drug use disorders, the BPS considers it would be appropriate to have an explicit quality statement concerning the availability of integrated care in such cases.	The topic expert group discussed the inclusion of a statement on integrated services for pregnant women, recognising its importance, but decided these services were outside the scope of this particular quality standard but may be better addressed by other relevant quality standards. Please see the quality standard on antenatal care .
040	Release	Question 6	We agree that this group should be included. However, the needs of this group are complex and often women fear that contact with services will have negative 'net' ramifications. These difficulties should be explored and addressed.	The topic expert group discussed the inclusion of a statement on integrated services for pregnant women, recognising its importance, but decided these services were outside the scope of this particular quality standard but may be better addressed by other relevant quality standards. Please see the quality standard on antenatal care .
041	The Huntercombe Group	Question 6	Yes there should be a statement for pregnant women as this is a very important area needing proper integrated services.	The topic expert group discussed the inclusion of a statement on integrated services for pregnant women, recognising its importance, but decided these services were outside the scope of this particular quality standard but may be better addressed by other relevant quality standards. Please see the quality standard on antenatal care .
042	Turning Point	Question 6	Yes	The topic expert group discussed the inclusion of a statement on integrated services for pregnant women, recognising its importance, but decided these services were outside the scope of this particular quality standard but may be better addressed by other relevant quality standards. Please see the quality standard on antenatal care .
043	British Psychological Society	Question 7	The BPS does not consider there to be value in restricting the application of this QS to people who become abstinent as a result of a healthcare intervention. In the field of opiate misuse, for example, it is widely acknowledged that abstinence, however achieved, is difficult to maintain. It is therefore reasonable to suggest that the cost-effective option with somebody who achieves abstinence independently is likely to be to support them at that time. Should they relapse, then the cost of subsequent interventions is likely to outweigh the cost of supporting their abstinence.	The statement has been updated to include all people who have become abstinent. Please see statement 9 in the final quality standard.

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044	National Treatment Agency for Substance Misuse	Question 7	No, regardless of how a person becomes drug free, they should be offered appropriate support to maintain their abstinence. However, we are not sure we fully understand the question of its implications.	The statement has been updated to include all people who have become abstinent. Please see statement 9 in the final quality standard.
045	Release	Question 7	In our view it is entirely desirable that people who have achieved abstinence either partly or completely unaided by services should have access to support and relapse prevention aids. Any insistence on 'measurably' should be subordinate to the end of assisting people with their difficulties. In any event, much could theoretically be learnt about why conventional treatment pathways were not accessed and the nature of their needs post- detox.	The statement has been updated to include all people who have become abstinent. Please see statement 9 in the final quality standard.
046	Turning Point	Question 7	Yes, this statement should be restricted to service users following detox – if not, it is not measurable and loses its efficacy as a quantifiable treatment indicator.	The statement has been updated to include all people who have become abstinent. The topic expert group decided the revised statement was measurable. Please see statement 9 in the final quality standard.
047	Addaction	QS1	We are very pleased to see training and competencies as statement one as this underpins the rest of the quality statements. We fully support the use of specified competencies to identify training needs, define training delivery and to ensure ongoing assessment of competence as part of staff appraisals and supervision. Whilst we agree that appropriate supervision should focus on the application of relevant techniques and competencies and their impact on care and that this should be distinguished and distinct from managerial supervision, we would like to see an acknowledgement that both managerial and appropriate supervision could be delivered by the same supervisor where appropriate.	Draft statement 1 did not progress to the final quality standard as it was recognised that appropriate training, competencies and supervision is a generic issue that underpins all quality standards. Please see section 2 (overview) for specific reference to this.
048	College of Occupational Therapists	QS1	Staff need to be trained in the assessment and recognition of co morbid mental health and substance misuse problems. They will need to be able to signpost those with more complex needs and deliver the treatment outlined in statement 11. This training could be offered using e-learning, Dual Diagnosis teams, or mental health teams. Often those with comorbidities are not recognised, and this affects treatment outcomes and engagement in treatment.	Draft statement 1 did not progress to the final quality standard as it was recognised that appropriate training, competencies and supervision is a generic issue that underpins all quality standards. Please see section 2 (overview) for specific reference to this.
049	London Respiratory Team	QS1	Interventions should take place in an environment free from secondary smoke from other clients, carers or healthcare professionals	Thank you for your response. The TEG felt secondary smoke was outside the scope of this quality standard based on the evidence from the development sources.
050	National Treatment Agency for Substance Misuse	QS1	Suggest removing the phrase “and trained”. Competence is the important point. How it is achieved isn't. Similarly with “knowledge, skills and competence”, which is a tautology as competences are a combination of knowledge, skills and behaviour	Draft statement 1 did not progress to the final quality standard as it was recognised that appropriate training, competencies and supervision is a generic issue that underpins all quality standards. Please see section 2 (overview) for specific reference to this.
051	National Treatment Agency	QS1	Reference to the need for appropriate supervision is positive but there are few	Draft statement 1 did not progress to the final

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	for Substance Misuse		published standards, which may make it difficult to measure	quality standard as it was recognised that appropriate training, competencies and supervision is a generic issue that underpins all quality standards. Please see section 2 (overview) for specific reference to this.
052	National Treatment Agency for Substance Misuse	QS1	Reference to 'accredited by the relevant professional body' may require clarification.	Draft statement 1 did not progress to the final quality standard as it was recognised that appropriate training, competencies and supervision is a generic issue that underpins all quality standards. Please see section 2 (overview) for specific reference to this.
053	National Treatment Agency for Substance Misuse	QS1	Not right to distinguish formal psychosocial interventions from "those delivered by keyworkers". Formal psychosocial interventions may well be delivered by keyworkers, they just require additional competences to those required to deliver the psychosocial interventions that are a core part of keyworking.	The statement on formal psychosocial interventions does not preclude the interventions being delivered by keyworkers if they have the competencies required. Please see revised statements 6 and 8 in the final quality standard.
054	Release	QS1	Clearly Release supports this statement. This has been an issue for generic drug workers (as opposed to doctors, therapists, nurse specialists etc.) who all have at least one professional qualification. Implementing a recognised specific drug worker (as opposed to a generic keyworker) standard of achievement is overdue. The RCGP implemented such a qualification for 'specialised - generalist' GP s after the Orange Guidelines 2006 as an example. One area of concern we have is the use of 'recovery champions'. Whilst personal experience is valuable, we are concerned about the involvement of this role in delivering care – clear guidance needs to be provided regarding their remit.	Draft statement 1 did not progress to the final quality standard as it was recognised that appropriate training, competencies and supervision is a generic issue that underpins all quality standards. Please see section 2 (overview) for specific reference to this. It is not within the remit of NICE and the quality standard to set or provide guidance on the appropriate level of training.
055	Royal College of Psychiatrists	QS1	<p>"People with drug use disorders receive interventions only from staff competent and trained in delivering the interventions, and receiving appropriate supervision".</p> <p>This is fully supported. It is recommended that this description be extended to include 'assessment' as well as 'intervention'. It is imperative that a fully competent practitioner completes thorough, initial assessment of an individual's drug use disorder.</p> <p>The Royal College of Psychiatrists and Royal College of General Practitioners 'Roles and Responsibilities for doctors working in substance misuse' should be included in the references.</p>	Draft statement 1 did not progress to the final quality standard as it was recognised that appropriate training, competencies and supervision is a generic issue that underpins all quality standards. Please see section 2 (overview) for specific reference to this.
056	British Association for Psychopharmacology	QS2	In reference to the Description of Quality Statement 2: "Where the families of people who misuse drugs have not benefited, or are not likely to benefit, from guided self-help and/or support groups and continue to have significant problems, staff should consider offering individual family meetings. These should: provide information and education about drug misuse help to identify sources of	Thank you for your comment. The statement has been modified so that it focuses on assessment of families and carers needs. The topic expert group discussed the suggestion of family interventions training and decided it was outside

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			<p>stress related to drug misuse explore and promote effective coping behaviours normally consist of at least five weekly sessions.”</p> <p>Service Providers</p> <p>There should be evidence of family interventions training</p> <p>From my experience teaching Health Professionals who work in contact with drug users (in a variety of settings), staff may not feel competent or confident to work with family members (Copello et al. 2006).</p> <p>References: Copello, A. G., Templeton, L. and Velleman, R., 2006. Family interventions for drug and alcohol misuse: is there a best practice? Current Opinion in Psychiatry, 19 (3), pp. 271-276.e.g. Comment about quality statement 1.</p>	the scope of this quality standard based on the development sources. Please see section 2 (overview) for specific reference to training and competencies.
057	British Psychological Society	QS2	Appropriate healthcare outcomes in respect of this Quality Statement (QS) may include reductions in levels of anxiety, depression, and other distressing symptoms.	Thank you for your comments. The topic expert group felt that the measures chosen were most reflective of the statement.
058	National Treatment Agency for Substance Misuse	QS2	Only refers to the need to offer “information and advice” but the definitions are clear about the specific interventions and services that should be offered, which are much more than just information and advice. Suggest adding “and interventions” and maybe drop the advice too or “access to interventions in accordance with NICE guidance”	Thank you for your comments. The statement has been modified to focus on assessment of families and carers needs. The definitions have also been updated to reflect the new statement wording.
059	National Treatment Agency for Substance Misuse	QS2	Suggest considering expanding this to cover the importance of families and carers being (where appropriate) involved in supporting clients in achieving goals in their recovery plan.	Thank you for your comments. The quality statements need to be clear and concise and should not include more than one concept. The statement has been modified to focus on assessment of families and carers needs.
060	National Treatment Agency for Substance Misuse	QS2	The NTA is unaware of any existing systems that could record or report on this, however a proxy quality standard measure could be improved “quality of life” scores (defined as “able to enjoy life, gets on well with family and partner”) on the Treatment Outcome Profile	It is expected that local data sources and audits where appropriate will be considered in order to measure the quality statements in full.
061	Release	QS2	Families and carers - we concur with the statement but would highlight that families and their roles differ massively across the spectrum, and families and carers are not necessarily the same, often by nature of their relationship with and expectations of the user. Client confidentiality remains key to how services can respond to family’s needs.	Thank you for your comments. The topic expert group were aware of the different needs of family members and carers but wanted to ensure anyone affected by the drug use disorder received appropriate assessment of their needs.
062	Addaction	QS3	Outcome a) Denominator - you need to be careful if you base outcomes on estimated prevalence. There are too many examples of disputed statistics creating difficulties, as prevalence data can be either wide of the mark or between two very wide numeric boundaries.	Thank you for your comment. The topic expert group were aware of the difficulties of using estimates however felt the measures chosen were most reflective of the statement.
063	British Psychological Society	QS3	Appropriate healthcare outcomes here may include measures of the prevalence of HIV, hepatitis, and other injecting-related infections, over time. As injecting drug use is a high risk behaviour in many ways, we recommend that the outcomes be made more explicit with regard to reductions in the prevalence of this behaviour as a	Thank you for your comment. The topic expert group felt the measures chosen were most reflective of the statement.

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			consequence of contact with services.	
064	National Treatment Agency for Substance Misuse	QS3	If the drug use disorders cover performance and image-enhancing drugs, then should perhaps specify "People who inject illicit drugs, and performance and image-enhancing drugs ..."	Thank you for your comment. The statement should be inclusive of anyone who injects the drugs covered by the scope of the quality standard.
065	National Treatment Agency for Substance Misuse	QS3	We believe NICE public health guidance 18 recommendations 4, 5 and 6 are also relevant here, so suggest changing to 1 to 6	Thank you for your comment. The source clinical guideline references now include all recommendations from NICE public health guidance 18.
066	National Treatment Agency for Substance Misuse	QS3	Suggest that it is easier and/or better to measure prevalence than incidence (as the HPA does in its Unlinked Anonymous IDU survey).	Thank you for your comment. The topic expert group felt the measures chosen were most reflective of the statement.
067	National Treatment Agency for Substance Misuse	QS3	Suggest replacing "drugs with BBVs" with "blood-borne viruses among people who inject"	Thank you for your comment. The outcome has been updated.
068	National Treatment Agency for Substance Misuse	QS3	Suggest replacing "Needle and syringe equipment" (which is not comprehensive) with "injecting equipment" instead.	Thank you for your comment. The terminology used 'needle and syringe equipment' is taken from the source clinical guideline recommendation.
069	Release	QS3	We suggest emphasis is kept on the unconditional access to NSPs. Information on safer injecting, and transitions away from injecting, for users, must be prioritised, and while we understand the attraction of data collection from programmes, any intervention that keeps injectors away from services increases infection risk across the using and wider community. We feel the role of peer suppliers, particularly in the steroid injecting community, might be addressed.	Thank you for your comment. The topic expert group agreed the key development sources to be used to develop this quality standard. The NICE public health guidance 18 makes reference to needle and syringe programmes therefore any other services were outside the scope of this quality standard.
070	Royal College of Psychiatrists (Bowden-Jones)	QS3	In the section, 'equality and diversity', an additional special group should be added. This group includes those who inject other substances such as steroids and methamphetamine. The injecting 'packs' for these substances needs to be different to those for heroin and crack (e.g. no need for citric or filters).	Thank you for your comment. The equalities and diversity considerations have been updated to include users of anabolic steroids and other performance-and image-enhancing drugs.
071	British Association for Psychopharmacology	QS4	Assessing risk behaviour including domestic violence and offending The above might be interpreted as referring to cases where the drug user is a perpetrator of domestic violence, In the guideline in the Drug misuse and dependence: UK guidelines on clinical management (3.2.3.2) domestic violence is included in the "Social Problems" category (- Identifying social problems, including housing, employment and domestic violence, band offending) hence it includes cases where the drug user might be a victim or perpetrator or both. I actually suggest that "identifying risks of being victim or/and perpetrator of domestic violence" should be in a separate item. References: Chermack S.T., Murray R.L., Walton M.A., Boothc B.A., Wryobeck J.,	Thank you for your comment. The topic expert group felt assessing risk behaviour was an important issue and therefore should be separate from social problems.

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			<p>Blow F.C. (2008) Partner aggression among men and women in substance use disorder treatment: Correlates of psychological and physical aggression and injury. Drug and Alcohol Dependence 98 (1–2): 35–4. □□</p> <p>Galvani S. and Humphrey S. (2007) The impact of violence and abuse on engagement and retention rates for women in substance use treatment. National Treatment Agency</p> <p>I suggest to add - obtaining information on any siblings of clients who misuse drugs, and any drug-related risks to which they may be exposed. See report by Barnard (2005)</p> <p>References: Barnard M. (2005) Drugs in the family. The impact on parents and siblings. University of Glasgow.</p>	
072	National AIDS Trust	QS4	<p>Drug Quality Statement 4: Assessment</p> <p>There is reference in this Quality Statement to ‘recovery’ which could be a helpful concept but is also used, as mentioned above, to refer to freedom from any dependence including OST. The term is loaded and open to misunderstanding, and is not used in the relevant sections of NICE and DH documents cited.</p> <p>NAT recommends omission of reference to ‘resources for recovery’ since the phrase is not used in evidence-based NICE and DH Guidance, and is open to misinterpretation.</p>	Thank you for your comment. Reference to ‘resources for recovery’ has been removed from the statement.
073	National Treatment Agency for Substance Misuse	QS4	<p>Suggest wording on comprehensive assessment needs to reflect that this should involve consideration of much more than “drug use and ... resources for recovery”. The NTA supports the inclusion of the term “recovery resources” in this statement, however we believe a revised wording could helpfully make clear that assessment should cover a wide range of physical and mental health and other needs/problems/risks (including consideration of issues such as safeguarding and domestic violence and young carers needs). All of these elements are often covered by the four standard domains of: (1) drug and alcohol use, (2) physical and psychological health, (3) criminal involvement and (4) offending, and social functioning.</p>	Thank you for your comment. The definition of a comprehensive assessment has been taken from the key development sources with agreement from the topic expert group.
074	National Treatment Agency for Substance Misuse	QS4	<p>Comprehensive assessment is not needed for all “people accessing drug treatment services”. Some will be triaged to a non-specialist service or, after initial assessment, will have all their needs met by an initial care plan, for which comprehensive assessment is not needed. The statement and denominator are therefore inaccurate. This could be rectified by revising the statement to read, “people in structured drug treatment services”.</p>	Thank you for your comment. The topic expert group agreed with the suggestion and the statement has been modified to ‘people in drug treatment’
075	National Treatment Agency for Substance Misuse	QS4	<p>It would be helpful to spell out the following components of a comprehensive assessment: family involvement, parental responsibility, safeguarding and domestic</p>	Thank you for your comment. The definition of a comprehensive assessment has been taken

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			violence and young carers. The accompanying indicators of quality could include 'having a local safeguarding lead within service', 'number of risk assessments' and 'evidence of protocols in place covering joint working with wider children and family services'.	from the key development sources with agreement from the topic expert group.
076	National Treatment Agency for Substance Misuse	QS4	The NDTMS data source on healthcare assessment has no relevance to the comprehensive assessment that is the subject of the standard.	Thank you for your comment. 'Healthcare assessment' has been removed from data sources in the final quality standard.
077	National Treatment Agency for Substance Misuse	QS4	Not necessarily assessing the "degree" of dependence but establishing whether there IS dependence	Thank you for your comment. The definition of a comprehensive assessment has been taken from the key development sources with agreement from the topic expert group.
078	National Treatment Agency for Substance Misuse	QS4	Not just determining the need for substitute medication but any medical intervention/medicine...What about determining the need for other non-medical psychosocial interventions?	Thank you for your comment. The definition of a comprehensive assessment has been taken from the key development sources with agreement from the topic expert group.
079	National Treatment Agency for Substance Misuse	QS4	Not just "drug-related risks" to children. There may be other risks too.	Thank you for your comment. The definition of a comprehensive assessment has been taken from the key development sources with agreement from the topic expert group.
080	National Treatment Agency for Substance Misuse	QS4	Add risk of vulnerability to and exploitation from others.	Thank you for your comment. The definition of a comprehensive assessment has been taken from the key development sources with agreement from the topic expert group.
081	National Treatment Agency for Substance Misuse	QS4	Suggest re-wording to spell out what 'TEG consensus' is.	Thank you for your comment. The definitions have been modified and no longer make reference to 'TEG consensus'.
082	Release	QS4	People accessing treatment are given a comprehensive assessment of their drug use/resources for recovery. We feel this may be expressed with more clarity -while the sentiment seems fine, 'a comprehensive assessment of their drug use and their own resources for recovery' feels contrived. We are also concerned about the use of 'recovery' which has not been properly defined within the consultation document, nor as far as we are aware, by NICE specifically in relation to drug treatment. This term has become increasingly politicised and is at risk of becoming a byword for 'abstinence'. Whilst we support the goal of abstinence for anyone in treatment where they so desire, equally valid outcomes include stabilising on OST or improving social capital despite continued (non-problematic) drug use. It would be helpful if the final quality standards could address this issue. In terms of identifying risks faced by dependent children, clearly this is an important part of the assessment, however, guidance must also be given on where it is appropriate/necessary to breach the confidentiality of the client.	Thank you for your comment. The statement has been modified and no longer makes reference to the aspects of a comprehensive assessment. The definitions have been taken from the key development sources and include reference to OST, social assets and risk to dependent children.
083	Royal College of	QS4	"People accessing drug treatment services are offered a comprehensive	Thank you for your comment. Physical and

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	Psychiatrists (Bowden-Jones)		assessment of their drug use INCLUDING PHYSICAL AND MENTAL HEALTH and their own resources for recovery". 'Including physical and mental health' to be added. It is important that the core physical and mental aspect of the comprehensive assessment are emphasised along with the appropriate competence to complete these assessments.	mental health are included in the definitions as components of a comprehensive assessment.
084	Turning Point	QS4	That the provision of a comprehensive assessment should not act as a barrier to treatment or delay treatment. The comprehensive assessment itself should be a therapeutic tool designed to motivate and enlighten the service users, not only to provide data/information to the treatment provider. Workers should be competent in delivering assessments, particularly in being able to maintain an effective therapeutic rapport during this process and encourage the service user to return back for more treatment if this is required.	Thank you for your comment. This statement focuses on the provision of a comprehensive assessment. The topic expert group recognised the importance of competencies to perform an assessment. Please see section 2 (overview) for specific reference to this.
085	British Association for Psychopharmacology	QS4	"People accessing drug treatment services are offered a comprehensive assessment of their drug use, (I would suggest to add) THEIR PHYSICAL, PSYCHOLOGICAL AND SOCIAL WELL BEING, and their own resources for recovery." The comprehensive assessment includes "physical, psychological and social well being" (See Drug misuse and dependence: UK guidelines on clinical management paragraph 3.2.3.2). Although this is later specified in the DEFINITIONS section, the quality statement could be interpreted as limiting the comprehensive assessment to drug use only (in addition to resources of recovery).	Thank you for your comment. The statement has been revised to be more concise. All components of a comprehensive assessment are listed in the definitions.
086	Terrence Higgins Trust	QS4 (5 and 9)	Most notably we would like to support the points they make about the use of the phrase 'recovery' throughout the document, particularly in statements 4, 5, 9. We share NATs concern that recovery has become a loaded statement which risks alluding to rejection of OST as a legitimate option for some people. We would encourage consideration of this issue and clarity on what is meant by 'recovery'. We would strongly urge NICE to adhere to an evidenced based approach in this instance.	Thank you for your comment. The statement has been modified and no longer makes reference to the specific aspects of a comprehensive assessment. The definitions make reference to determining the need for OST.
087	British Psychological Society	QS5	An appropriate healthcare outcome here would be the number of people who had achieved agreed care plan objectives, including the initiation and maintenance of abstinence, respectively, from drug use. In effect, this may entail revision of the denominator to include, in some way, those successfully discharged from drug treatment.	Draft quality statement 5 was not progressed to the final quality standard. The topic expert group did not feel this was an area for quality improvement when compared to other statements. The topic expert group also noted that a measurable statement relating to care plan did not address the dynamic nature of a care plan which was considered to be of particular importance.
088	London Respiratory Team	QS5	Definitions – this is the only section in which a specific reference to physical health	Draft quality statement 5 was not progressed to

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			(other than blood borne viruses) is made. It would be fantastic to specifically mention other physical issues here such as: •Referral to stop smoking services when appropriate. •Specific consideration of other physical health problems (COPD, TB) which may be more prevalent in this group especially if smoking cannabis or other drugs. •Communication with GP or other healthcare professionals regarding assessment and management.	the final quality standard. The topic expert group did not feel this was an area for quality improvement when compared to other statements. The topic expert group also noted that a measurable statement relating to care plan did not address the dynamic nature of a care plan which was considered to be of particular importance .Please see statements 3 and 7 in the final quality standard for reference to assessment and information about physical health.
089	National AIDS Trust	QS5	Drug Quality Statement 5: Care planning and review The content is helpful apart from the use throughout of the term 'recovery care plan'. This is not a term used in the NICE sources quoted, which refer rather to a 'care or treatment plan'. NAT recommends use of the phrase 'care or treatment plan' instead of 'recovery care plan' throughout the NICE Quality Standard	Draft quality statement 5 was not progressed to the final quality standard. The topic expert group did not feel this was an area for quality improvement when compared to other statements. The topic expert group also noted that a measurable statement relating to care plan did not address the dynamic nature of a care plan which was considered to be of particular importance.
090	National Treatment Agency for Substance Misuse	QS5	Suggest re-titling QS5 to "Recovery care planning and review" – and using the term 'recovery care plan' consistently throughout QS5	Draft quality statement 5 was not progressed to the final quality standard. The topic expert group did not feel this was an area for quality improvement when compared to other statements. The topic expert group also noted that a measurable statement relating to care plan did not address the dynamic nature of a care plan which was considered to be of particular importance.
091	National Treatment Agency for Substance Misuse	QS5	Suggest the "Treatment Outcome Profile" is a data source for local areas to measure 3 monthly recovery care plan reviews	Draft quality statement 5 was not progressed to the final quality standard. The topic expert group did not feel this was an area for quality improvement when compared to other statements. The topic expert group also noted that a measurable statement relating to care plan did not address the dynamic nature of a care plan which was considered to be of particular importance.
092	Release	QS5	People in drug treatment review their agreed recovery care plan with their keyworker at least every 3 months to inform their treatment. The idea is sound in theory but we are concerned about resources being sufficient to assure this is not merely an audit	Draft quality statement 5 was not progressed to the final quality standard. The topic expert group did not feel this was an area for quality

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			exercise. We suggest that 'agreed plan' in this context needs to embrace both: the difficulty of changing an 'agreed plan', often where there is a period of change and self-reflection for the client and which is acceptable to both parties; and accept the limitations of fixing goals within time periods. We strongly recommend that instead of a 'recovery care plan' (see DQS 4) that a 'treatment and care plan' is the term used.	improvement when compared to other statements. The topic expert group also noted that a measurable statement relating to care plan did not address the dynamic nature of a care plan which was considered to be of particular importance.
093	Terrence Higgins Trust	QS5 (4 and 9)	<p>Most notably we would like to support the points they make about the use of the phrase 'recovery' throughout the document, particularly in statements 4,5,9. We share NATs concern that recovery has become a loaded statement which risks alluding to rejection of OST as a legitimate option for some people.</p> <p>We would encourage consideration of this issue and clarity on what is meant by 'recovery'. We would strongly urge NICE to adhere to an evidenced based approach in this instance.</p>	Draft quality statement 5 was not progressed to the final quality standard. The topic expert group did not feel this was an area for quality improvement when compared to other statements. The topic expert group also noted that a measurable statement relating to care plan did not address the dynamic nature of a care plan which was considered to be of particular importance.
094	National AIDS Trust	QS6	<p>Drug Quality Statement 6: Blood-borne viruses There is important content on service users being tested for blood-borne viruses (BBVs). However, the testing recommendations imply testing is a single, one-off event when in fact for people at ongoing risk testing should be repeated regularly. Someone could be tested on entering treatment and have an HIV negative result but subsequently get HIV through the sharing of injecting equipment – the Quality Standard in its current form risks that person not being tested again and remaining undiagnosed, with serious potential consequences not just for their own health but also that of sexual partners and others with whom they might possibly share injecting equipment.</p> <p>The UK National Guidelines for HIV Testing 2008 (produced by the three key clinical bodies, BHIVA, BASHH and BIS) recommend not just universal HIV testing in drug dependency programmes but also at para.4.3 testing of injecting drug users 'annually, or more frequently if clinical symptoms are suggestive of seroconversion'. Whilst this recommendation is specifically in relation to HIV, of course for the same reasons the service users should also be regularly tested for other BBVs, in particular hepatitis B and hepatitis C.</p> <p>NAT recommends further elements to the Process section, the denominator being the number of people accessing drug treatment not known to have hepatitis B, hepatitis C and HIV respectively, who are tested at least annually whilst in treatment for these BBVs.</p> <p>In the case of HIV (NAT's field of expertise), treatment is of course not a short-term or always a straightforward process. It is lifelong, and once anti-retroviral therapy</p>	Thank you for your comment. Further information has been added to the definitions stating testing should not be performed only once but repeated when necessary as a person's circumstances may change. The topic expert group felt the process measures chosen were most reflective of the revised statement.

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			<p>begins it cannot be suspended or interrupted without serious risks to the patient. It must be taken every day. In the case of some drugs there are side-effects which can mean the patient needs additional advice and support. Evidence shows that OST can support drug users in adherence to HIV medication. But the life circumstances of some drug users can pose real challenges for them in the management of their HIV status and treatment, and also for those who care for and treat them. It will be vitally important in assessing performance against the quality measures that drug treatment services ensure they have current knowledge that someone referred to HIV treatment services in the past is still actually accessing them and engaging with the HIV clinic.</p> <p>Quality standards are separately being developed for HIV treatment (for example around time to enter into care once diagnosed, and around achieving an undetectable viral load once ART begins) and of course these are primarily the responsibility of the HIV care team. But this complex area of care should nevertheless be addressed in some more detail in the Quality Standard since relying simply on the bare description of the proportion who receive treatment for HIV does not address anything about its quality or whether it is appropriately sustained.</p> <p>NAT recommends NICE discuss with BHIVA an additional Process element, and Description element, which focus on joint working and integrated care between HIV and drug treatment teams for relevant service users, appropriately evidenced.</p> <p>The phrasing of Process paragraphs (b), (d) and (f) appears to focus only on those accessing the service undiagnosed who are then tested and found to be BBV-positive, in relation to the proportion then receiving treatment. Should there also be a Process statement about those already known to have a BBV (and who thus do not need to be tested by the service), in terms of the proportion receiving treatment? If the denominators for these treatment process statements include those diagnosed prior to accessing the service, this should be made clearer.</p>	
095	National Treatment Agency for Substance Misuse	QS6	Drug treatment services and their commissioners cannot treat (or fund treatment for) hep C. And you don't want treatment for all people accessing drug treatment, only when appropriate. Suggest adding "referral to" before treatment and "where appropriate" after.	The topic expert group considered the revised wording and agreed to change the statement to 'referral to treatment'. The process measures provide further information and only measure referral for treatment for people with drug use disorders who test positive.
096	National Treatment Agency for Substance Misuse	QS6	As above, suggest adding "referral to" before treatment and "where appropriate" after.	The topic expert group considered the revised wording and agreed to change the statement to 'referral to treatment'. The process measures provide further information and only measure referral for treatment for people with drug use

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				disorders who test positive.
097	National Treatment Agency for Substance Misuse	QS6	Important for clearing the virus that people complete hep C treatment so suggest changing “who receive treatment” to “and completing treatment for hepatitis C” in (b) and “receiving” to “completing” in the numerator	Thank you for your comment. The topic expert group felt that the process measures chosen were most reflective of the revised statement which includes referral for treatment and not completion of treatment as service providers can only refer.
098	National Treatment Agency for Substance Misuse	QS6	As above, important that people complete hep B treatment so suggest changing “who receive treatment” to “and completing treatment for hepatitis B” in (d) and “receiving” to “completing” in the numerator	Thank you for your comment. The topic expert group felt that the process measures chosen were most reflective of the revised statement which includes referral for treatment and not completion of treatment as service providers can only refer.
099	National Treatment Agency for Substance Misuse	QS6	Important that a full course of hep B vaccination is completed so suggest adding “fully” before “vaccinated” in (g) and numerator	Thank you for your comment. The definitions have been modified to include a full course of hepatitis B vaccination should be received.
100	National Treatment Agency for Substance Misuse	QS6	A number isn’t an outcome and not all those with HIV, for example, are drug-related anyway. Shouldn’t it be more like “Reduction in the number of drug users / people who have accessed drug treatment services who test positive for hepatitis C, hepatitis B, or HIV.	Thank you for your comment. The outcome has been modified to include people with drug use disorders. Outcomes in quality standards do not state the direction of change.
101	National Treatment Agency for Substance Misuse	QS6	Similar to earlier, service providers can only refer for treatment and will only do so where appropriate. Suggest adding “referral to” before “treatment” and “where appropriate” after “HIV” in all mentions.	Thank you for your comment. The statement and measures have been modified to include 'referral for treatment'.
102	National Treatment Agency for Substance Misuse	QS6	Don't think we use “problematic use of drugs” any more. Suggest changing process to “for their drug use”.	Thank you for your comment. The data source has been updated.
103	Release	QS6	HCV - We suggest this goal is included as a desirable treatment outcome. This anticipates that the offer of vaccination, testing and implications of possible treatment are clearly explained and, subject to the standard medical caveats, these procedures are carried out as rapidly as is practical. It is worth noting that a client attempting to undergo both interferon treatment and opioid detoxification will be at high risk of relapse and the HCV treatment should be prioritised. This should also be incentivised as there are many important considerations in terms of the infection pool and the residual physical and psychological damage to users. This initiative encourages planning for the future.	Thank you for your comment. The topic expert group felt that the outcome measures already chosen were most reflective of the appropriate outcomes for this quality statement.
104	Royal College of Psychiatrists (Bowden-Jones)	QS6	People accessing drug treatment services are offered testing and treatment for hepatitis C, hepatitis B and HIV and vaccination for hepatitis B. The ‘process’ section of this quality standard quite rightly describes testing, rather than the ‘offer’ of a test, as the measure. This is strongly supported. Many services have unfortunately considered ‘offering’ rather than ‘testing’ the most important target to meet.	Thank you for your comments. The quality statements should promote patient choice and involvement in decision-making so the use of the term ‘offer’ is preferred to ‘receive’. Reflecting choice is important when measuring achievement against statements using the process measures. However, the quality

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			To emphasis this important point, it is suggested that the quality standard reads; "People accessing drug treatment are TESTED AND TREATED for hepatitis C, hepatitis B and HIV and VACCINATED for hepatitis B where clinically appropriate"	standard uses the term "receive" in the quality measures so as to facilitate measurability, audit and reporting.
105	Terrence Higgins Trust	QS6	We also support NATs statement on the status of repeat testing within the document. We would suggest that annual testing for BBVs be appropriately outlined in this standard as the model of best practice.	Thank you for your comment. The definitions section has been modified and states testing should not be performed only once but repeated when necessary.
106	National Treatment Agency for Substance Misuse	QS7	No reference to the frequency with which information and advice about treatment options might be given. It would be helpful to specify as needing to happen at assessment and then at regular care plan reviews so that options are continually adapted to on-going treatment experience.	Thank you for your comment. It is important that each statement is concise and covers one concept or requirement. The topic expert group prioritised those areas they felt were most important for patients.
107	National Treatment Agency for Substance Misuse	QS7	Why (a) evidence to ensure people have a keyworker? Doesn't relate to the statement. Or, in as much as it does, also then true of QS8 and QS9.	The structure measure has been removed from the final quality standard.
108	National Treatment Agency for Substance Misuse	QS7	The treatment options specified are limited – it may be helpful to expand on this to include setting (community or residential) and broader psychosocial options, in particular engagement with Mutual Aid, involvement of family & network members.	Thank you for your comment. The topic expert group agreed the treatment options to be included.
109	National Treatment Agency for Substance Misuse	QS7	Not sure "taking a substitute drug" and "substitution" are helpful singled out as options like this. Abstinence and harm reduction are treatment options within which a package of interventions can be provided. But substitution is a specific intervention that could form a part of different treatment options/pathways.	Thank you for your comment. The topic expert group decided to include those treatment options they felt were important.
110	National Treatment Agency for Substance Misuse	QS7	Detail of treatment options only under what the statement means for "people in treatment" should perhaps be in the definitions instead.	Thank you for your comment. The topic expert group agreed the necessary definitions needed for each statement.
111	National Treatment Agency for Substance Misuse	QS7	"Morphine" a slightly odd choice. Not very common.	Thank you for your comment. 'Morphine' has been removed from the patient descriptor.
112	Release	QS7	Treatment options: We agree with this statement but it sits better in this list between points 4 and 5. There should also be an effort to explain to service users what their rights are under the NHS Charter and how they can implement those rights - we feel it is in the interests of providers and service users that a quality standard should include this.	Thank you for your comment. The topic expert group agreed the most appropriate order of the statements. They also felt it was not appropriate to include the NHS charter in the quality standard. Please see the quality standard on patient experience in adult NHS services .
113	Turning Point	QS7	That the information provided to service users should be in an accessible format, in a variety of different media and in plain English. It should be recognised that many service users have limited literacy skills and many do not speak/read English as a first language.	Thank you for your comment. Please see the equalities and diversity considerations published alongside the statement for reference to alternative formats of information.
114	National Treatment Agency for Substance Misuse	QS7 (8 and 9)	All these standards refer to interventions carried out by keyworkers. In practice information and advice would be part of the whole treatment process and occur alongside other psychosocial interventions. Suggest that 7 and 8 are merged and	Thank you for your comment. Following consultation 'by their keyworker' was removed from the statement. It is important that each

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			renamed 'Information, advice and interventions'. This would be a better single descriptor for the core keyworking platform. And might help with clarity and differentiation from more formal psychosocial interventions (10 and 11). QSTD 9 works well as a stand-alone standard.	statement covers just one concept or requirement. The topic expert group prioritised those areas they felt were important for patients and decided not to merge draft statements 7 and 8.
115	British Psychological Society	QS8	Appropriate healthcare outcomes here would be measures of achievement for objectives generated by appropriate psychosocial interventions.	Thank you for your comments. The topic expert group felt the measures chosen were most accurately reflective of the statement.
116	National Treatment Agency for Substance Misuse	QS8	As with QS7, there is no reference to the frequency with which psychosocial interventions are offered. It would again be helpful if it was specified as at assessment and care plan review so that options are continually adapted to on-going treatment experience.	Thank you for your comment. It is important that each statement is concise and covers one concept or requirement. The topic expert group prioritised those areas they felt were most important for patients.
117	National Treatment Agency for Substance Misuse	QS8	Mapping techniques are not in themselves a psychosocial intervention (they are a method for using psychosocial interventions). Suggested a reword of the final paragraph in the description of "what the quality statement means" – "People in drug treatment are offered psychosocial support ... to help increase motivation. Mapping tools may enhance the delivery of these interventions". Suggest listing; goal setting and problem solving, brief motivational interventions, relapse prevention, facilitating access to mutual aid, family support, recovery planning and then adding a statement that all of the above can be supported through the use of mapping techniques.	Thank you for your comment. The definitions have been updated and no longer make reference to mapping techniques as a psychosocial intervention but as a means of support.
118	National Treatment Agency for Substance Misuse	QS8	The interventions listed are limited and do not include interventions to involve/engage family and network members, or Mutual Aid facilitation. In this context do keyworker interventions also refer to low-intensity psychosocial interventions for co-existing mental health problems as referred to in NTA/BPS psychosocial toolkit?	Thank you for your comment. The topic expert group agreed the psychosocial interventions to be included. Psychological interventions for co-existing mental health are stated a separate quality statement. Please see quality statement 8 in the final quality standard.
119	Release	QS8	Psychosocial Interventions: We assume this is about differentiating between services that might be delivered in- house or out-sourced where a referral is appropriate/preferable. It is our experience that very few specialist drug teams are able to appropriately deal with traumatised clients in-house.	Thank you for your comment. The two forms of psychosocial interventions have been separated because of the differences in the training and competencies needed by those who deliver the particular interventions.
120	Turning Point	QS8	People should be offered PSI by all workers and clinicians not only their key worker. It is incumbent upon doctors, nurses, pharmacists employed within specialist treatment services and in Primary Care when working with people in drug treatment to deliver some form of Psycho-Social Intervention, be it a Brief [Motivational] Intervention or more structured interventions. PSI is not merely a formal didactic exchange or a Group intervention.	Thank you for your comment. The topic expert group prioritised this area of care to ensure people in drug treatment were receiving psychosocial interventions from their keyworker. The statement does not preclude any other health professionals from delivering the

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				interventions if they feel it is appropriate.
121	Turning Point	QS8	People should be offered PSI by all workers and clinicians not only their key worker. It is incumbent upon doctors, nurses, pharmacists employed within specialist treatment services and in Primary Care when working with people in drug treatment to deliver some form of Psycho-Social Intervention, be it a Brief [Motivational] Intervention or more structured interventions; these interventions should not only to 'prevent relapse' but to 'manage lapses to use'- this modification stems from more emphasis in current treatment on relapse management, rather than relapse prevention, in the understanding that lapses are seen as a 'normal' part of recovery. PSI is not merely a formal didactic exchange or a Group intervention.	Thank you for your comment. The topic expert group prioritised this area of care to ensure people in drug treatment were receiving psychosocial interventions from their keyworker. The statement does not preclude any other health professionals from delivering the interventions if they feel it is appropriate.
122	National Treatment Agency for Substance Misuse	QS8 (7 and 9)	All these standards refer to interventions carried out by keyworkers. In practice information and advice would be part of the whole treatment process and occur alongside other psychosocial interventions. Suggest that 7 and 8 are merged and renamed 'Information, advice and interventions'. This would be a better single descriptor for the core keyworking platform. And might help with clarity and differentiation from more formal psychosocial interventions (10 and 11). QSTD 9 works well as a stand-alone standard.	Thank you for your comment. The topic expert group felt all three aspects were important for patients and therefore decided to keep each as an individual statement. Draft statement 7 has been updated and no longer makes reference to a keyworker as it was felt information and advice could be given by a range of health professionals.
123	National AIDS Trust	QS9	Drug Quality Statement 9: Keyworking – recovery and reintegration Again in none of the 'Source clinical guideline references' cited is 'recovery' used in relation to drug dependence apart from at para.4.3.2.5 of the 'Drug misuse and dependence: UK guidelines on clinical management' – the only such reference in all its 128 pages. NAT recommends that references to recovery in this Quality Statement should be removed. Or, should the concept of recovery be retained in this Quality Statement, the phrase 'recovery from drug-related harms' should always be used.	Thank you for your comment. The topic expert group agreed the use of the term 'recovery' to reflect current thinking and policy.
124	National Treatment Agency for Substance Misuse	QS9	It would be useful to make explicit that support to access recovery supports should be appropriate to current need of the service user. Appropriate supports early on in treatment will be very different to later in treatment; accessing support at the wrong time may be very unhelpful.	Thank you for your comment. Please see the equalities and diversity considerations which state support should be tailored to individual need.
125	National Treatment Agency for Substance Misuse	QS9	Suggest amending current wording - these services don't "promote" recovery and reintegration, they help support it.	Thank you for your comment. The topic expert group the current wording of the statement accurately reflected its intent and decided not to change the wording.
126	Release	QS9	Recovery and reintegration: agreed.	Thank you for your response.
127	Turning Point	QS9	In addition to employment and education, there should also be reference to 'meaningful activity'. It should also be stated that the offer of meaningful activity should not be limited to the key worker: other staff, including volunteers or peer mentors should be utilised to help service users access 'Recovery Capital' in the	Thank you for your comment. The topic expert group agreed the services to be included in the statement.

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			<p>community, including meaningful activities.</p> <p>The current economic climate means it may not be realistic to ensure access to employment; services need to be creative with sometimes few community resources. The Community Reinforcement Approach emphasises finding meaningful alternative activities (ideally employment but availability is generally not determined by services).</p>	
128	Terrence Higgins Trust	QS9 (4 and 5)	<p>Most notably we would like to support the points they make about the use of the phrase 'recovery' throughout the document, particularly in statements 4,5,9. We share NATs concern that recovery has become a loaded statement which risks alluding to rejection of OST as a legitimate option for some people.</p> <p>We would encourage consideration of this issue and clarity on what is meant by 'recovery'. We would strongly urge NICE to adhere to an evidenced based approach in this instance.</p>	Thank you for your comment. The topic expert group agreed the use of the term 'recovery' to reflect current thinking and policy.
129	National Treatment Agency for Substance Misuse	QS9 (7 and 8)	All these standards refer to interventions carried out by keyworkers. In practice information and advice would be part of the whole treatment process and occur alongside other psychosocial interventions. Suggest that 7 and 8 are merged and renamed 'Information, advice and interventions'. This would be a better single descriptor for the core keyworking platform. And might help with clarity and differentiation from more formal psychosocial interventions (10 and 11). QSTD 9 works well as a stand-alone standard.	Thank you for your comment. The topic expert group felt all three aspects were important for patients and therefore decided to keep each as an individual statement. Draft statement 7 has been updated and no longer makes reference to a keyworker as it was felt information and advice could be given by a range of health professionals.
130	British Psychological Society	QS10	Appropriate healthcare outcomes for this QS would also be measures of achievement for objectives generated by appropriate psychosocial interventions.	Thank you for your comment. The topic expert group decided the measures already chosen were the most appropriate for this statement.
131	College of Occupational Therapists	QS10	The College recommends that the importance of purposeful occupation is included here, as in order to achieve abstinence or reduction people who use drugs often need to find alternative occupations and thus give increased structure to their day. Specific work around increasing self-care and productivity should be highlighted. This could be applied to statement 15 on ways in which abstinence can be achieved in the long term. The work of the occupational therapist is key (alongside that of non-statutory agencies).	Thank you for your comment. Please see final statement 7 on support for employment and education.
132	National Treatment Agency for Substance Misuse	QS10	It would be useful to align these definitions with those proposed for the next NDTMS Core Dataset as this will provide a useful way to measure this.	Thank you for your comment. The NDTMS is referenced in the quality standard as a proposed data source.
133	National Treatment Agency for Substance Misuse	QS10	QS10 could easily be confused with QS8. Please see comments above and below for suggested resolution.	Thank you for your comments. The topic expert group agreed the concepts in both draft statements were important areas of care. Following consultation the wording for both statements has been updated with further

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				definitions to prevent any confusion.
134	National Treatment Agency for Substance Misuse	QS10	<p>There is no definition of 'formal interventions' and many of the stated interventions can be deployed a different levels.</p> <p>"Formal interventions" should be defined to distinguish them from the basic keyworking platform. Existing guidance suggest that "formal interventions" have three aspects:</p> <ol style="list-style-type: none"> 1. They require specific competencies to deliver them 2. They are supported by the relevant training and supervision. 3. They are an enhanced level of intervention (above and beyond the standard keyworking platform) <p>The NTA/BPS psychosocial toolkit only outlines the NICE recommended interventions. There are other resources for other interventions accessed through the skills hub. http://www.skillsconsortium.org.uk/skillshub.aspx</p> <p>Some of the listed interventions would be delivered by appropriately trained keyworkers; Contingency Management, and Community Reinforcement Approach, Cognitive Behavioural Therapy relapse prevention and possibly Social Behaviour and Network Therapy within the context of keyworking. Behavioural Couples Therapy and psychodynamic therapy would not and probably be an additional intervention delivered by another professional. It might be worth highlighting this difference in the definition because it highlights the potential in developing the keyworking platform.</p>	<p>Thank you for your comments. Following consultation the definitions section has been updated with the proposed suggestion.</p>
135	Release	QS10	<p>This point, along with 8 (and possibly 9), may be better expressed in one comprehensive point. See suggestion under 'GQ 4' below.</p>	<p>Thank you for your comments. The topic expert group prioritised those areas for the final quality standard they felt were most important for patients, based on the development sources.</p>
136	Royal College of Psychiatrists	QS10	<p>"People in drug treatment are offered formal psychosocial interventions SUPPORTED BY THE EVIDENCE/ NICE GUIDANCE".</p> <p>This would help clarify that all formal psychosocial treatments should be underpinned by strong evidence supporting their value.</p>	<p>Thank you for your comment. The definitions have been updated to include that all interventions must be evidence based.</p>
137	British Psychological Society	QS11	<p>With regard to depression and anxiety, whilst the BPS supports the objective of ensuring access to evidence-based psychological therapies, it is important to take account of the fact that the mood disturbances observed in users of cannabis, cocaine, ecstasy, and opiates may be independent of, or induced by, the drug abuse (Dakwar et al., 2011; Fisk et al., 2011). People with drug use disorders who present with pre-existing anxiety and depression should not be excluded from appropriate psychological interventions where they are appropriate. However, symptoms which</p>	<p>Thank you for your comment. The topic expert group felt symptom onset was not within the scope of this quality standard. Please refer to the published depression quality standard and the newly referred library of topics.</p>

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			<p>occur following drug use may potentially (but not necessarily) be resolved when abstinence is established. Whilst it is possible to generalise too far regarding the treatment implications of these respective manners of symptom onset, consideration still needs to be given to this variable in choosing appropriate interventions.</p> <p>References: Dakwar, E., Nunes, E.V., Bisaga, A., Carpenter, K.C., Mariani, J.P., Sullivan, M.A., Raby, W.N., & Levin, F.R. (2011). A comparison of independent and substance-induced depression in cannabis-, cocaine-, and opiate-dependent treatment seekers. <i>The American Journal on Addictions</i>, 20, 441-446. Fisk, J.E., Murphy, P.N., Montgomery C., & Hadjiefthymoulou, F. (2011). Modelling the adverse effects associated with ecstasy use. <i>Addiction</i>, 106, 798-805.</p>	
138	National Treatment Agency for Substance Misuse	QS11	Statement, measure, description and definitions all refer only to NICE CG90 and CG113 but source is given as CG51 and 2007 Clinical Guidelines – is that right? CG51 only suggests “consideration” of psychological treatments for depression and anxiety for “people who misuse cannabis or stimulants, and for those who have achieved abstinence or are stabilised on opioid maintenance treatment” – shouldn’t the quality standard reflect this?	Thank you for your comment. The source guidelines have been updated. The draft statement has been merged with psychosocial interventions. Please see final statement 8.
139	National Treatment Agency for Substance Misuse	QS11	New NDTMS dataset will include “Evidence-based psychological interventions for co-existing mental health problems”. Shouldn’t this be referenced as it is in, e.g. QS8 and QS9?	Thank you for your comment. Following consultation the data source has been modified. The draft statement has been merged with psychosocial interventions. Please see final statement 8.
140	National Treatment Agency for Substance Misuse	QS11	Might be worth making the distinction between high and low intensity interventions as per NTA toolkit. Also those low intensity mental health interventions may be delivered by keyworkers.	Thank you for your comment. The NTA toolkit is referenced in the definitions section. The statement does not state who should be providing the psychological intervention. The draft statement has been merged with psychosocial interventions. Please see final statement 8.
141	Release	QS11	There is a robust school of thought that suggests that conventional humanistic and psychoanalytic treatments were unrepresented at the NICE psychological working group and subsequently the value of these interventions in treatment settings have not been fully appreciated. Where the problem is clearly rooted in past abuse or neglect these enhanced therapies should be reappraised. ‘BACP has concerns, therefore, about gaps in the evidence and in service recommendations based on a restricted evidence base. Reliance on a limited range of evidence based treatments may disadvantage patients through restricting patient choice for and access to a range of interventions and over-resource standard treatments that are not panaceas and will not suit all patients’ (Source; Evidence submitted by BACP- NICE 92 http://www.bacp.co.uk/research/about_research/health_select_committee.php.retrieve	Thank you for your comment. The topic expert group identified the development sources they felt were most relevant to developing the standard, within the framework of the Quality Standards development process. It is not within the quality standard process to revisit the evidence base of the clinical guideline.

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			ved 18.06.12)	
142	Addaction	QS12	3 months is a long time for a service such as Shared Care and does not generally make a distinction between different services or paths along the recovery continuum. For example, if someone has wobbled and come back into service and receipt of a prescription, has demonstrated adherence to prescribing package (taking medication as required without using illicit drugs) then there needs to be flexibility in whether or not this person is put on supervised consumption for a period of three months, particularly as this would and could interrupt employment, education or caring responsibilities. This also has the potential of becoming unnecessarily expensive where it is not needed. We are suggesting that the 3 months is a guideline with scope given for a clinical judgement to be made in individual circumstances.	Draft quality statement 12 did not progress to the final quality standard. The topic expert group felt the statement as worded may prevent people accessing substitution services or moving on to other treatment.
143	British Psychological Society	QS12	An appropriate healthcare outcome here would be abstinence from illegal drug use whilst receiving substitution treatment. This could be monitored by urine screening. As an outcome, this is consistent with the existing stated outcome for this QS, as such abstinence would diminish the likelihood of opioid overdosing. In this context, urine screening would also contribute to the reviewing of care plans outlined in QS 5.	Draft quality statement 12 did not progress to the final quality standard. The topic expert group felt the statement as worded may prevent people accessing substitution services or moving on to other treatment.
144	National Treatment Agency for Substance Misuse	QS12	Although the standard accurately reflects the NICE guideline, we suggest that the statement should not be confined to use of methadone and buprenorphine only and should consider including diamorphine which is licensed for opioid treatment in the UK and is prescribed outside the RIOTT/IOTpilots.	Draft quality statement 12 did not progress to the final quality standard. The topic expert group felt the statement as worded may prevent people accessing substitution services or moving on to other treatment. The statement would only be able to refer to drugs recommended in the underlying development sources.
145	National Treatment Agency for Substance Misuse	QS12	Suggest replacing the word “undergoing” opioid substitution which suggests an unpleasant imposition rather than a jointly agreed treatment strategy.	Draft quality statement 12 did not progress to the final quality standard. The topic expert group felt the statement as worded may prevent people accessing substitution services or moving on to other treatment.
146	Release	QS12	We strongly oppose the daily pick up requirement, it is unnecessary, expensive and a disincentive to treatment entry and retention. ‘The Orange guidelines draft’ (2007) offers variation and flexibility for those with mobility issues, or who are in employment, or have childcare issues, or are in rural settings, but we regret that the final 2007 version was more prescriptive on this point, possibly affected by concerns over the ‘Shipman’ case and the perception of grey market methadone availability. We have had clients tell us that they have been told by treatment providers ‘you will have to choose which you want more, the job or your script’. To us, this is the antithesis of providing quality care or a path to reintegration. We are aware of no evidence of the advantage of a 3 month daily collection imperative.	Draft quality statement 12 did not progress to the final quality standard. The topic expert group felt the statement as worded may prevent people accessing substitution services or moving on to other treatment.
147	The Huntercombe Group	QS12	The statement is very prescriptive. It says all prescriptions should be supervised	Draft quality statement 12 did not progress to the

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			daily for 3 months. There are several problems with this: 7 day supervised consumption (SC) is not always available due to pharmacy opening days. There may be mobility or mental health problems restricting the amount of travel possible – there may be severe anxiety or problems with intimidation by other people in or around the pharmacy. Some people do not need this level of supervision for 3 months – this is really important and is a clinical issue and joint decision with the team and the patient. People with jobs can find it very difficult to have SC daily for so long – this is important as we want people to keep working if possible. There may be financial problems travelling. This does not encourage patient centred working and seems punitive for no real reason. Yes, overdose and diversion can be problematic but this is not the way to do it. Some people can be off daily SC within 4 weeks with no problems. Some people cannot be off daily SC at all. Clinicians should not be hampered by arbitrary timescales like this.	final quality standard. The topic expert group felt the statement as worded may prevent people accessing substitution services or moving on to other treatment.
148	Turning Point	QS12	The suggestion that service users receive opioid substitution daily under supervision for the first 3 months of treatment – does this refer to daily supervised consumption at the pharmacy or does supervision mean monitoring of the client by the drug service? If the former, how does this fit with ideas of use of client recovery resources? i.e. if the client stops heroin use before 3 months, a form of contingency management is to decrease the level of supervision required at the pharmacy – something that is known to be highly negatively reinforcing for service users.	Draft quality statement 12 did not progress to the final quality standard. The topic expert group felt the statement as worded may prevent people accessing substitution services or moving on to other treatment.
149	Royal College of Psychiatrists	QS12 (13 and 14)	<p>People who are opioid dependent and undergoing opioid substitution receive methadone or buprenorphine daily under supervision for at least the first 3 months of treatment AS PART OF A COMPREHENSIVE TREATMENT PLAN.</p> <p>Similarly, it is important in QS 13 and 14 to emphasise that pharmacological treatment is one aspect of a wider, recovery focused treatment plan including psychological and social elements.</p>	Draft quality statement 12 did not progress to the final quality standard. The topic expert group felt the statement as worded may prevent people accessing substitution services or moving on to other treatment.
150	British Association for Psychopharmacology	QS13	<p>Service providers ensure systems are in place for people undergoing opioid detoxification to be offered an INFORMED (staff should be able to explain clearly the differences between methadone and buprenorphine and should be able to give advice – if requested - depending on the drug user’s individual circumstances) choice of methadone or buprenorphine</p> <p>Healthcare professionals offer people undergoing opioid detoxification an INFORMED choice of methadone or buprenorphine.</p> <p>Commissioners ensure they commission services that offer people undergoing opioid detoxification an INFORMED choice of methadone or buprenorphine.</p> <p>People undergoing opioid detoxification (a treatment programme that helps drug withdrawal) are offered an INFORMED and their choice of medication; either</p>	Draft quality statement 13 did not progress to the final quality standard. The topic expert group felt the statement did not accurately reflect the recommendations in the development sources.

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			methadone or buprenorphine.	
151	National Treatment Agency for Substance Misuse	QS13	The statement is about offering a choice of medication and it references CG52 but, as the definitions from CG52 make clear, the guideline priorities aren't about offering choice but about the criteria healthcare professionals should apply when deciding between medications.	Draft quality statement 13 did not progress to the final quality standard. The topic expert group felt the statement did not accurately reflect the recommendations in the development sources.
152	National Treatment Agency for Substance Misuse	QS13	Measures a, b and c don't measure the offer of choice, only what is being received. Measure d is entirely unrelated to the quality statement.	Draft quality statement 13 did not progress to the final quality standard. The topic expert group felt the statement did not accurately reflect the recommendations in the development sources.
153	Release	QS13	If this is a recommendation that services offer both OST and/or detoxification to their general treatment population, we concur that this is desirable. We would also support the inclusion of diamorphine, and other internationally recognised pharmacotherapies, where appropriate.	Draft quality statement 13 did not progress to the final quality standard. The topic expert group felt the statement did not accurately reflect the recommendations in the development sources.
154	The Huntercombe Group	QS13	Choice in opiate detox should include non opiates such as Lofexidine etc as some people who have not got a long term or severe addiction may want to get off opiates without using a substitute –especially young people.	Draft quality statement 13 did not progress to the final quality standard. The topic expert group felt the statement did not accurately reflect the recommendations in the development sources.
155	Royal College of Psychiatrists (Bowden-Jones)	QS13 (12 and 14)	People who are opioid dependent and undergoing opioid substitution receive methadone or buprenorphine daily under supervision for at least the first 3 months of treatment AS PART OF A COMPREHENSIVE TREATMENT PLAN. Similarly, it is important in QS 13 and 14 to emphasise that pharmacological treatment is one aspect of a wider, recovery focused treatment plan including psychological and social elements.	Draft quality statement 13 did not progress to the final quality standard. The topic expert group felt the statement did not accurately reflect the recommendations in the development sources.
156	National Treatment Agency for Substance Misuse	QS14	Not sure this is useable/useful. "People ... for whom a community-based programme is not appropriate" is not defined and could be used to define everyone out of inpatient or residential detoxification.	Thank you for your comment. This statement did not progress to the final quality standard. The topic expert group prioritised those areas of care they felt would lead to quality improvement.
157	National Treatment Agency for Substance Misuse	QS14	Local investment in inpatient or residential detoxification will often not be regarded as offering value for money unless funding has been secured for residential rehabilitation – suggest the wording of QS14 could reflect this.	Thank you for your comment. This statement did not progress to the final quality standard. The topic expert group prioritised those areas of care they felt would lead to quality improvement.
158	Release	QS14	We concur, mindful of the restriction of cost in actual delivery.	Thank you for your comment. This statement did not progress to the final quality standard. The topic expert group prioritised those areas of care they felt would lead to quality improvement.
159	Royal College of Psychiatrists (Bowden-Jones)	QS14 (12 and 13)	People who are opioid dependent and undergoing opioid substitution receive methadone or buprenorphine daily under supervision for at least the first 3 months of treatment AS PART OF A COMPREHENSIVE TREATMENT PLAN. Similarly, it is important in QS 13 and 14 to emphasise that pharmacological	Thank you for your comment. This statement did not progress to the final quality standard. The topic expert group prioritised those areas of care they felt would lead to quality improvement.

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			treatment is one aspect of a wider, recovery focused treatment plan including psychological and social elements.	
160	Addaction	QS15	The statement is counter intuitive. Outcomes are being determined only by their ability to be measured (in convenience terms). The challenge must surely be to measure the outcomes for drug users who present as abstinent by any means (not specified in the text). What if someone got themselves drug free, could not quite manage their abstinence period and then approached a drug agency for help? Would the answer be that their outcomes could not be 'measured' so they could not be properly helped?	Thank you for your comment. The statement has been modified to include all people who have achieved abstinence by any means.
161	National Treatment Agency for Substance Misuse	QS15	As currently worded, the definition is confusing (“people who complete treatment should receive continued treatment”) Suggest alternative wording: to reflect that it's “continued treatment, support and monitoring” that should be provided for at least 6 months”, not the maintenance of abstinence.	Thank you for your comment. The statement has been modified to include all people who have achieved abstinence and no longer makes reference to monitoring.
162	National Treatment Agency for Substance Misuse	QS15	It is not clear how this outcome measure be work if people have left treatment and are not, for example, being drug tested.	The measures are intended to be a starting point for use at a local level. The measure could be used to measure outcomes for those who are still in contact with services. Services could decide to include all people who were known to have achieved abstinence in the denominator but only those they know about 6 months later in the numerator.
163	National Treatment Agency for Substance Misuse	QS15	New NDTMS dataset will include “Recovery support”. Shouldn't this be referenced as it is in QS8 and QS9?	Thank you for your comment. The topic expert group agreed the data sources to be included in the quality standard. This source was not added to the data sources section.
164	National Treatment Agency for Substance Misuse	QS15	Bearing in mind this the difficulty in measuring this outcome outlined above, one alternative is to echo the drugs outcome metric (indicator 2.15) within the PH Operating Framework (PHOF) which is “the number of drug users that left drug treatment successfully (free of drug(s) of dependence) who do not then re—present to treatment again within six months as a proportion of the total number in treatment.	Thank you for your comment. The topic expert group agreed the measures chosen were most reflective of the statement.
165	National Treatment Agency for Substance Misuse	QS15	Align with suggested NDTMS codes for recovery support	Thank you for your comment. The topic expert group agreed the data sources to be included in the quality standard. This source was not added to the data sources section.
166	Release	QS15	We support the standards outlined in this statement but would ask that the comments about access to relapse prevention for people who have detoxed themselves are considered (please see GQ3). Release is concerned about the Government's payment by results pilots which include 'abstinence' with no return to treatment within 12 months as a paid outcome. It would be helpful if the quality standard explicitly included that services should ensure that those who relapse at any point are able to seamlessly re-access services.	Thank you for your comment. The statement has been modified to include all people who have achieved abstinence by any means. In order to ensure statements remain as clear and concise as possible, each statement should only focus on one key quality concept. The key quality concept of this statement is the treatment and

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				support following abstinence.
167	British Association for Psychopharmacology	QS15	<p>Although the quality statement states specifies “At least” 6 months, support should be put in place to continue abstinence after the 6 months. Community based resources for long term support should be explored (e.g. self-help groups), research shows that the duration of treatment is normally much longer than 6 months and it includes several episodes of relapse.</p> <p>For example, a US based study (Dennis et al. 2005) monitored 1,271 of 1,326 (96%) people recruited from a stratified sequential sample of admissions to publicly funded treatment programs, it was found that the median time from first treatment episode to last use was 9 years. In addition, years to recovery were significantly longer for males, people starting use under the age of 21 (particularly those starting under the age of 15), people who had participated in treatment 3 or more times, and for people high in mental distress; therefore, it is suggested that particular attention should be offered to people with the aforementioned characteristics.</p> <p>References: Dennis M.L., Scott C.K., Funk R., Foss M.A. (2005) The duration and correlates of addiction and treatment careers. Journal of Substance Abuse Treatment 28: 51–62.</p>	<p>Thank you for your comment. The topic expert group identified the development sources they felt were most relevant to developing the standard, within the framework of the Quality Standards development process. It is not within the quality standard process to revisit the evidence base of the clinical guidelines.</p>
168	National Treatment Agency for Substance Misuse	QS16	<p>Current wording relies exclusively on the criteria within CG51. Suggest the wording could usefully be expanded to reflect consideration of an individual patient's need, choice and the value for money offered by different providers.</p>	<p>Thank you for your comment. The statement has been modified and now focuses on the provision of information and advice about residential rehabilitation.</p>
169	National Treatment Agency for Substance Misuse	QS16	<p>NICE specifies (and therefore the definition says) that residential/inpatient detox has to precede residential rehab but actually community detox (or acute hospital or prison) could be equally effective. - suggest amended wording to reflect this.</p>	<p>Thank you for your comment. Community detoxification has been added to the definitions.</p>
170	Release	QS16	<p>We concur, mindful of the restriction of cost in actual delivery. While we see a nuanced difference in the treatment populations, we suggest these points (14 and 16) are consolidated.</p>	<p>Thank you for your comment. The topic expert group decided not to merge these statements as they addressed different areas of residential treatment.</p>

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