NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Centre for Clinical Practice – Surveillance Programme

Recommendation for Guidance Executive (post-consultation)

Clinical guideline

CG120 Psychosis with coexisting substance misuse: Assessment and management in adults and young people

Publication date

March 2011

Surveillance report for GE (post-consultation)

March 2015

Surveillance recommendation

GE is asked to consider the following proposal which was consulted on for two weeks:

- The psychosis with coexisting substance misuse guideline should not be considered for an update at this time.

Key findings

			Potential impact on guidance	
			Yes	**No**
Evidence identified from Evidence Update				✓
Evidence identified from literature search				✓
Feedback from Guideline Development Group				✓
Feedback from stakeholders during consultation			✓	
Anti-discrimination and equalities considerations				✓
No update	CGUT update	Standard update	Transfer to static list	Change review cycle
✓				

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Surveillance review of CG120: Psychosis with coexisting substance misuse: Assessment and management in adults and young people

Recommendation for Guidance Executive (post consultation)

Background information

Guideline issue date: March 2011
4 year review: 2015

NCC: National Collaborating Centre for Mental Health

Four year surveillance review

1. An Evidence Update was produced for the guideline in 2012 and was used as a source of evidence for the review proposal. The Evidence Update considered new evidence from 1st May 2010 to 13th August 2012. The Evidence Update indicated that there is currently insufficient new evidence to invalidate the guideline recommendations.

2. A literature search was conducted for randomised controlled trials and systematic reviews between 13th August 2012 (the end of the search period for the Evidence Update) and 12th December 2014 and relevant abstracts were assessed. Clinical feedback was also obtained from members of the guideline development group (GDG) through a questionnaire survey. Overall, 60% of questionnaire responders were not aware of any evidence that would change the current guideline recommendations and felt that CG120: Psychosis with coexisting substance misuse did not require an update at this time.

3. No new evidence was identified through the literature search which would invalidate the guideline recommendations.

Ongoing research

4. An ongoing randomised controlled trial on improving physical health and reducing substance use in psychosis (ISRCTN58667926) is relevant to the clinical area of psychological and psychosocial interventions for psychosis.

5. An ongoing pilot study to assess the feasibility and impact of a brief motivational intervention on problem drug and alcohol use in adult mental health inpatient units (ISRCTN43548483) is relevant to the clinical area of psychological and psychosocial interventions for psychosis.

Anti-discrimination and equalities considerations

6. No GDG feedback was provided by the GDG questionnaire.

Implications for other NICE programmes

7. No GDG feedback was provided by the GDG questionnaire.

Summary of stakeholder feedback

8. Stakeholders were consulted on the following proposal over a two week consultation period:

The psychosis with coexisting substance misuse guideline should not be considered for an update at this time.

9. In total, ten stakeholders commented on the surveillance review proposal recommendation during the two week consultation period. The table of stakeholder comments can be viewed in Appendix 1.

10. Six stakeholders agreed with the surveillance review proposal to not update the guideline at this time, one stakeholder partially agreed and three stakeholders disagreed.

11. One stakeholder who agreed with the proposal not to update CG120 commented that an upper age limit should not be set for the recommendations. NICE has stated previously in the original scope consultation that people with very late onset psychosis have different needs and a different evidence base for treatment. Their treatment and management should be covered separately, and would be beyond

the available resources to cover in this guideline. Although CG120 does not make specific recommendations for people with very late onset psychosis, it is likely that the guideline recommendations will still be relevant to them.

12. Improving assessment and management during the transition between different service settings
    One stakeholder stated that improving the assessment and management of this population when they transition/interface between different service settings would benefit from consideration next time the guideline is reviewed. In particular, the interface between community-based services and psychiatric wards would benefit from being addressed in any future guidance, due to the sizeable proportion of people with co-morbid severe mental health and substance misuse problems that are admitted and the frequency of admissions to psychiatric wards. No evidence was identified in the surveillance review on this area, but the stakeholder cited an ongoing RCT that has yet to publish (see paragraph 5). This will be considered at the next surveillance review point along with any other emerging evidence.

13. Other stakeholder comments related to the impact of new psychoactive substances, the emerging recovery focus within substance misuse service, clozapine usage, drug interactions, and staffing skills in service provision. The following is a summary of the general comments made by the stakeholders that either disagreed or only partially agreed with the surveillance review proposal:

14. New psychoactive substances
    Two stakeholders felt that the impact on services of new psychoactive substances ('legal highs') should be incorporated into the guidance. One stakeholder commented that it may be useful to update the clinical scenarios in the guideline, to incorporate new psychoactive substances, but this was considered to be beyond the scope of the surveillance review. No evidence was cited or identified in the literature search relating to this area, and new evidence will be considered at the next surveillance review point.

15. Recovery focus
    One stakeholder advocated an update to section 1.5 substance misuse services, to include the increased 'recovery' focus within substance misuse services and the effects that 'recovery' is exerting on (i) increased drug related deaths and (ii) rebound psychosis / mental illness symptomatology. No evidence was cited or identified in the literature search relating to this area, and new evidence will be considered at the next surveillance review point.

16. Clozapine usage
    One stakeholder commented that new research exists on the use of clozapine in comorbid psychosis and substance misuse. No new evidence was highlighted by stakeholder feedback, and insufficient evidence was identified in the surveillance review to address the research recommendation on the effectiveness of clozapine for comorbid psychosis and substance misuse. New evidence will be considered at the next surveillance review point.

17. Drug Interactions

One stakeholder commented that CG120 contains no information or advice on drug interactions, whether these are interactions between prescribed medication and illicit drugs, or other combinations such as licit drugs and prescribed drugs. However, interactions between prescribed medication and illicit drugs and/or alcohol are included in CG120 as part of the recommendation 1.1.14 to assess physical health risks and recommendation 1.2.25 relating to prescribing medication. New evidence in this area and its impact on the guidance recommendations will be considered at the next surveillance review point.

18. Staffing skills in service provision

One GDG member advocated the development of an expert opinion recommendation for commissioners to ensure that substance misuse services employ staff with a mental health background. It was stated that staff lacking an understanding of the complexities of mental health may not be able to advise on how mainstream substance misuse practice needs to be modified to safely meet the needs of people with psychosis (Recommendation 1.5.4). This may have wider implications for staffing level guidance but was out of scope of the surveillance review. No evidence was identified on this topic in the surveillance to impact on the recommendations.

Conclusion

19. Through the 4 year surveillance review of CG120 no new evidence which may potentially change the direction of guideline recommendations was identified. The proposal is not to update the guideline at this time. However, the guideline should remain on the active surveillance list, due to ongoing research that may have a potential impact on recommendations on psychological and psychosocial interventions for psychosis and coexisting substance misuse.

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Centre for Clinical Practice
March 2015

Appendix 1 Surveillance review consultation
Surveillance review consultation comments table 13-27 February 2015

Stakeholder	Do you agree with the proposal not to update the guideline?	Comments on equality issues or areas excluded from the original scope Insert each new comment on a new row	Comments Insert each new comment on a new row	Response
University of Birmingham/Birmingham & Solihull Mental Health Trust	Agree	However, perhaps improving the assessment and management of this client group when they transition/interface between different service settings would benefit from consideration next time the guideline is reviewed. That is better linking up their assessment and management in inpatient settings with what they receive in community mental health services. The interface between community-based services and psychiatric wards would benefit from being addressed in any future guidance due to the sizeable proportion of people with co-morbid severe mental health and substance misuse problems that are admitted and the frequency of admissions to psychiatric wards (i.e. 22-44%). This may represent an opportunity to		Thank you for highlighting the issue of improving assessment and management during the transition between different service settings. This will be considered at the next surveillance review point with the cited evidence and any other emerging evidence on the topic.

Stakeholder	Do you agree with the proposal not to update the guideline?	Comments on equality issues or areas excluded from the original scope Insert each new comment on a new row	Comments Insert each new comment on a new row	Response
		engage service users in addressing their health and social care needs. If treatments addressing health and substance misuse are seamlessly offered between community settings and psychiatric wards this would help to improve integration and care pathways. We have recently completed a randomised controlled trial, funded by the NIHR-RfPB (PB-PG-1010-23138) addressing the issue of the feasibility and impact of delivering brief interventions for substance misuse in mental health inpatient settings to improve engagement with community-based treatment (Graham, H.L., Birchwood, M., Griffith, E., Freemantle, N., McCrone., Stefanidou, C.A., Walsh., Clarke, L., Rana, A. & Copello, A. (2014). A pilot study to assess the feasibility and impact of a brief motivational intervention on problem drug and alcohol use in adult mental		

Stakeholder	Do you agree with the proposal not to update the guideline?	Comments on equality issues or areas excluded from the original scope Insert each new comment on a new row	Comments Insert each new comment on a new row	Response
		health inpatient units: study protocol for a randomized controlled trial. Trials, 15:308.). This study may offer some insight into the possibility of raising service user awareness of their substance misuse and other health needs whilst they are on inpatient wards. We are currently preparing the results for publication.		
Royal College of Paediatrics and Child Health			We have not received any responses for this consultation.	Thank you
Manchester Mental Health and Social Care Trust	Disagree	None	1.5 Substance misuse services – this section needs updating to include the increased 'Recovery' focus within substance misuse services and the effects 'recovery' is exerting on (i) increased drug related deaths and (ii) rebound psychosis / mental illness symptomatology	Thank you for highlighting the issues of recovery within substance misuse services and new trends relating to legal highs/ new psychoactive substances. The cited sources have been considered but they are outside of the scope of the surveillance review which

Stakeholder	Do you agree with the proposal not to update the guideline?	Comments on equality issues or areas excluded from the original scope Insert each new comment on a new row	Comments Insert each new comment on a new row	Response
			1.6 Inpatient mental health services – this section needs updating to incorporate new drug use trends related to legal high / new psychoactive substances that are (i) dangerous to life and limb (ii) atypical in presentation and (iii) very difficult to detect through urine screen or by sniffer dogs References - http://usir.salford.ac.uk/18988/ All Party Parliamentary Group (Dual Diagnosis / Complex Needs) Minutes 19.1.15	considered published evidence. This area will be considered at the next surveillance review point with the cited evidence and any other emerging evidence on the topic.

Stakeholder	Do you agree with the proposal not to update the guideline?	Comments on equality issues or areas excluded from the original scope Insert each new comment on a new row	Comments Insert each new comment on a new row	Response
The Royal College of Psychiatrists	Disagree		It has been 4 years and there is likely to be new evidence on clozapine usage in co-morbid psychosis and substance misuse.	Thank you for your comments. The new evidence on antipsychotics, including clozapine, has been assessed for potential impact on the guideline recommendations. The small sample sizes of the new studies identified reinforces the need for an adequately powered randomised controlled trial to determine whether differences in the effects of antipsychotic drugs exist in this population. The current evidence is unlikely to affect CG120. New evidence will be considered at the next surveillance review point.
University of York	Disagree	The original review contains no information or advice on drug interactions, whether these are interactions between prescribed medication and illicit drugs or other combinations such as licit drugs and prescribed drugs.	Drug interactions are an important issue that impact on a presenting problems, treatment, concordance and recovery. I think this should be explored and included in an updated guideline.	Thank you for highlighting the need to consider drug interactions. Interactions between prescribed medication and illicit drugs and/or alcohol are included in CG120 as part of the recommendation 1.1.14 to assess physical health risks and recommendation 1.2.25 relating to

Stakeholder	Do you agree with the proposal not to update the guideline?	Comments on equality issues or areas excluded from the original scope Insert each new comment on a new row	Comments Insert each new comment on a new row	Response
				prescribing medication. No evidence was identified that may impact on these recommendations, and new evidence in this area will be considered at the next surveillance review point.

Stakeholder	Do you agree with the proposal not to update the guideline?	Comments on equality issues or areas excluded from the original scope Insert each new comment on a new row	Comments Insert each new comment on a new row	Response
Department of Health			The Department of Health has no substantive comments to make, regarding this consultation.	Thank you
GDG member	Partially agree		I agree that there is insufficient research evidence to update the guidance however the clinical perspective observations regarding the changing nature of substance misuse services and the increase in use of New Psychoactive Substances (NPS) by people with psychosis are very important influences on the delivery of care/treatment to this group. In light of the increase in NPS it may be useful to update the 'clinical scenarios' resource to reflect this. Also of note is that NPS cannot be detected in routine urine drug screens (hence the guidance that urine tests may be useful in assessment of substance misuse is not the case for this group) (recc 1.4.15)	Thank you for your comments. No eligible evidence was identified on new psychoactive substances in this surveillance review but any new evidence and its impact on guidance recommendations will be considered at the next surveillance review point. Updating the clinical scenarios resource is out of scope of this surveillance review. Thank you for your comments on service provision. Recommendation 1.5.1 states that Healthcare professionals in substance misuse services should be competent to:

Stakeholder	Do you agree with the proposal not to update the guideline?	Comments on equality issues or areas excluded from the original scope Insert each new comment on a new row	Comments Insert each new comment on a new row	Response
			In relation to the changing nature of SM services - Many substance misuse services (ie those provided by voluntary sector organisations that, at best, have a very small number of staff with a professional background in mental health) are very limited in the extent to which they are able to provide advice, consultation and training to mental health services regarding the assessment and treatment of SM and, in particular SM with psychosis. Their lack of understanding of the complexities of mental health mean that they may not be able to advise on how mainstream substance misuse practice needs to be modified to safely meet the needs of people with psychosis. (recc 1.5.4) It may be beyond the scope of this guideline but consideration of an 'expert opinion' recommendation	• recognise the signs and symptoms of psychosis • undertake a mental health needs and risk assessment sufficient to know how and when to refer to secondary care mental health services. No evidence was identified in the current review to impact on this recommendation or on the cited recommendation 1.5.4. Any new evidence will be considered at the next surveillance review point.

Stakeholder	Do you agree with the proposal not to update the guideline?	Comments on equality issues or areas excluded from the original scope Insert each new comment on a new row	Comments Insert each new comment on a new row	Response
			highlighting the need for commissioners to ensure that SM services employ staff with a mental health background may be useful.	
GDG member	Agree			Thank you.
The Royal College of Nursing			There are no comments to submit to inform on the surveillance review for the above clinical guideline at this present time.	Thank you.
Greater Manchester West Mental Health NHS Foundation Trust	Agree	I am not convinced an upper age limit should be set for these recommendations		Thank you for your comments. People with very late onset psychosis have different needs (and a different evidence base for treatment). Their treatment and management should be covered separately, and would be beyond our resources to cover in this guideline. Please note that we have not excluded evidence relating to people older than 60 if the onset

Stakeholder	Do you agree with the proposal not to update the guideline?	Comments on equality issues or areas excluded from the original scope Insert each new comment on a new row	Comments Insert each new comment on a new row	Response
				of their psychosis was before this age. Although CG120 does not make specific recommendations for people with very late-onset psychosis, it is likely that the guideline recommendations will still be relevant to them. We do not believe this approach would be justification for excluding any older person from mental health services because of their age.

Appendix 2 Decision matrix

The table below provides summaries of the evidence for key questions for which studies were identified.

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
Recognition of psychosis with coexisting substance misuse – *recommendations* 1.2.1-1.2.2			
120-01 In people with psychosis and coexisting substance misuse, what are the key elements for a comprehensive assessment (of needs and risks)?			
No new evidence identified.	A systematic review[1] (29 studies) examined risk factors for relapse in first episode psychosis. Persistent substance use disorder was found to increase the risk of relapse 3-fold in this sub population. Clinical variables and general demographic variables were found to have little impact on relapse rates. **Self-Rated Assessment** A secondary analysis[2] of a RCT (n=1042) sought to examine the degree to which individuals with schizophrenia disclose their use of drugs on self-rated	No GDG feedback was provided by the GDG questionnaire.	The new evidence on risk factors for relapse is consistent with CG120, which recommends (1.2.1) assessment of substance usage frequency and duration within a comprehensive assessment. The new evidence on self-rated assessment is consistent with CG120, which states (p110) that supplementing self-report with observation is important in the assessment, especially when people are reluctant to reveal their experience or details of their substance use or financial status. It reinforces recommendation 1.2.1, which states that when conducting an assessment

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
	assessments. The findings showed high rates of under-reported drug use among individuals with schizophrenia when compared to laboratory assays, and indicated that self-rated assessments alone should be used with caution. **Self-Harm** A meta-analysis[3] (222 studies, n=31,294) showed that comorbid bipolar disorder and substance misuse was significantly associated with suicide attempts and that this population should be targeted for suicide prevention efforts. A systematic review and meta-analysis[4] (18 studies) examined risk factors for deliberate self-harm before and after treatment for first episode psychosis.		of dependency, corroborative evidence should be sought from families, carers or significant others, where this is possible and permission is given. The new evidence on self-harm is consistent with CG120 1.4.14 which recommends regular assessment and monitoring of risk of harm to self and development of a risk management plan to be reviewed when service users' circumstances or levels of risk change. The evidence partially addresses research recommendation 1 for patients with first episode psychosis and alcohol or other substance misuse, although further research is required on specific sub-populations. The new systematic review evidence on cognitive and social function is consistent with recommendation 1.2.1 to assess dependency and duration of current level of use. The new evidence on service

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
	Alcohol and other substance misuse were associated with an increased risk of deliberate self-harm in addition to duration of untreated psychosis. **Cognitive Function** A systematic review and meta-analysis[5] examined the effect of substance misuse on cognitive function in psychosis. Results showed that substance users performed significantly better than nonusers in the cognitive domains of attention and psychomotor speed and verbal memory, but were limited by methodological limitations. A systematic review and meta-analysis[6] (22 studies) compared the symptoms and social function of patients with psychosis and current substance use to those with psychosis and no history of substance use. Current substance users were found to		disengagement is consistent with CG120 1.4.10 which recommends promoting engagement through a comprehensive multidisciplinary assessment.

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
	have more severe positive symptoms than patients who had never used substances, but the findings were limited by demographic differences. **Disengagement** A systematic review[7] (10 studies) examined rates and definitions of disengagement among services for first-episode psychosis (FEP) and identified the most relevant demographic and clinical predictors of disengagement. Substance misuse and dependence was found to be a risk factor for disengagement, indicating that approaches to reduce risk of service disengagement in this population could increase service effectiveness. A secondary analysis[8] (n=198) of a RCT explored factors predictive		

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
	of incarceration among people with coexisting severe mental illness and substance use disorder. Positive social relationships and substance use treatment engagement were associated with a reduced likelihood of incarceration.		
120-01a: Should the assessment be the same in primary and secondary care?			
No new evidence identified.	No relevant evidence identified.	No GDG feedback was provided by the GDG questionnaire.	No relevant evidence identified.
120-01b: should the assessment be modified for subgroups of people (for example, young people, women, people from BME groups, homeless people, offenders, type of psychosis, type of substance misuse)			
No new evidence identified.	A post hoc analysis[9] of a RCT (n=323) investigated the effects of comorbid substance abuse in first-episode schizophrenia on cognition and psychopathology. Substance use and non-substance use disorder patients showed similar psychopathology and neuropsychological performances at baseline and during the first 6 months of antipsychotic treatment. A	No GDG feedback was provided by the GDG questionnaire.	The new evidence reinforces CG120 recommendation 1.4.10 to offer a comprehensive multidisciplinary assessment to include an assessment of current and past substance misuse and its impact upon their life, health and response to treatment.

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
	correlation between longer duration of cannabis use and higher cognitive performance as well as reduced symptom improvement and more extrapyramidal motor symptoms in patients with higher frequency of cannabis consumption.		
120-01c: What factors should trigger a reassessment?			
No new evidence identified.	No relevant evidence identified.	No GDG feedback was provided by the GDG questionnaire.	No relevant evidence identified.
Clinical area: Service models – *recommendations* 1.5.1-1.5.6			
120-02 In people with psychosis and coexisting substance misuse, does an integrated service model (usually involving the model of assertive community treatment) when compared with an alternative management strategy lead to: Critical outcomes: • Reduced mortality (all causes) • Reduced relapse rates (measured by exacerbation of symptoms requiring change in healthcare management) • Reduced substance misuse (however measured) • Improved global and social functioning (for example, employment, accommodation) • Improved subjective quality of life • Improved satisfaction with care • Reduced physical morbidity			

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
Secondary outcomes: • Insight • Improved medication adherence • Improved access to services (reduced dropout) • Reduced relapse rates (measured by admission to hospital; number of bed days) • Improved mental state with respect to psychosis (for example, Positive and Negative Syndrome Schedule [PANSS]) • Reduced offending behaviour.			
No new evidence identified.	A systematic review[10] (66 studies) found that community-based strategies for integrated treatment from the first outbreak of schizophrenia significantly reduced negative and psychotic symptoms, days of hospitalization, and comorbidity with substance abuse and improved global functioning and adherence to treatment. A meta-analysis[11] (13 studies n=2824) found that integrated treatment of co-occurring	No GDG feedback was provided by the GDG questionnaire.	The systematic review evidence on community based strategies for integrated treatment is consistent with CG120 recommendation 1.4.5 which states that for most adults with psychosis and coexisting substance misuse, treatment for both conditions should be provided by healthcare professionals in secondary care mental health services such as community-based mental health teams. The evidence on outpatient versus residential care setting for integrated care is unlikely to impact on CG120 recommendations for staffed accommodation and reinforces the

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
	substance use and mental health disorders resulted in modest, non-statistically significant improvements in psychiatric outcomes and alcohol use when compared to treatment as usual. Further examination of the effectiveness of integrated treatment in outpatient versus residential treatment settings revealed that the effectiveness of integrated care varies by setting. The impact of the evidence is weakened by the inclusion of small heterogeneous studies and geographical specificity to the USA. A secondary analysis[12] (n=383) of an RCT examined quality of life among patients with bipolar disorder in primary care versus community mental health settings**.** The effect of treatment setting on quality of life was		recommendation for further research to decide if staffed accommodation is more cost effective than a combination of hospital and home treatment.

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
	adjusted for hazardous drinking and substance abuse. Participants reported similar impairments in mental and physical health related quality of life across both treatment settings, indicating the need for integrated care regardless of the setting they present at. The limitations of the study, including reliance on self report without formal diagnostic interview, weaken its impact on CG120.		
120-02a What are the elements in an integrated service model that are most likely to be associated with better outcomes?			
No new evidence identified.	A systematic review[13] (280 studies) and consensus building technique identified essential evidence based components of first episode psychosis services. 32 components were established, including acceptance of referrals with potential comorbid psychosis and substance misuse, a comprehensive assessment upon admission, and integrated mental	Clinical feedback indicated that psychiatric and addiction services have changed greatly in the last 5 years and this group of patients is likely to be affected by the changes e.g. in commissioning for substance misuse services. However, no evidence was cited that may impact on CG120.	The new evidence on components of first episode psychosis services is consistent with CG120 recommendation 1.5.2 for patients with psychosis and coexisting substance misuse attending substance misuse services to be offered a comprehensive, multidisciplinary mental health assessment in addition to an assessment of their substance misuse.

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
	health and addictions treatment. A systematic review[14] (14 studies) assessed the evidence of component interventions in effective outpatient integrated treatment for patients with comorbid schizophrenia and substance use disorders. The findings suggested that behavioural treatment and specific interventions (e.g. motivational interviewing, family interventions) were effective. Programs integrating multiple interventions were also found to be more effective. The impact of the review is weakened by the heterogenous study designs, and further research is needed to corroborate the findings. **Service delivery** A systematic review[15] (8 studies)	Clinical feedback stated that there are some advances in online computer aided substance misuse programmes not considered in the original guideline and not tested in those with a dual diagnosis of psychosis and substance misuse, but only in depression and anxiety. This was stated as an area for future research, with two references cited that were outside the scope of the surveillance review.	

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
	of evidence supporting the efficacy of mental health apps for mobile devices found significant reductions in substance use. However, it should be noted that although trials on psychotic disorders were included, coexisting substance misuse was not reported in the abstract. The evidence was of low quality and is unlikely to impact on CG120.		
120-02b Are there any subgroups of people (for example, young people, BME groups) that benefit from some elements of the service model more than others?			
No new evidence identified.	No relevant evidence identified.	No GDG feedback was provided by the GDG questionnaire.	No relevant evidence identified.
120-02c Are there subgroups of people (for example, based on severity of substance misuse and severity of psychosis; young people, BME groups) who may benefit from alternatives strategies (non-integrated service models, serial treatment, for example)?			
No new evidence identified.	No relevant evidence identified.	Clinical feedback indicated that people over the age of 60 were incorrectly excluded from the scope of CG120. This might have greater relevance in services which are not age stratified i.e. old age services that are not separated from adult services.	No evidence was cited or retrieved in the surveillance review to support the clinical feedback indicating that people over the age of 60 were incorrectly excluded from the scope of CG120. Any emerging research in this area will be considered at the next surveillance review.

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
		No evidence was cited or retrieved in the surveillance review to support this feedback. The scope of CG120 incorporated a cutoff age of 60 because people with very late onset psychosis were considered to have different needs and a different evidence base for treatment. Their treatment and management should be covered separately, and were considered beyond the resources available for CG120. Clinical feedback indicated that there are emerging novel psychoactive substances (NPS) that may have relevance for people who may be susceptible because of serious mental illnesses. Feedback also indicated that the variability and unpredictability of these	No evidence was cited or retrieved in the surveillance review relating to the clinical feedback about the implications of novel psychoactive substance dependence. Any emerging research in this area will be considered at the next surveillance review.

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
		substances adds an extra level of concern for this sub-group of patients and creates a need for enhanced competence. No evidence was cited or retrieved in the surveillance review on this sub-topic.	
Clinical area: Secondary care mental health services – recommendations 1.4.16-1.4.25			
120-03 In people with psychosis and coexisting substance misuse, do the psychological/psychosocial interventions listed below (delivered within an integrated service model) when compared with an alternative management strategy lead to improved outcomes? (for outcomes see 1.2.1) • Individual interventions • Group interventions • Family intervention • Contingency management • Combined interventions			
No new evidence identified.	**Behavioural and Contingency Management** A secondary analysis[16] (n=96) of an RCT investigated predictors of treatment response of individuals receiving contingency management treatments for addictions who suffer from co-occurring severe mental illness. The findings suggested that	No GDG feedback was provided by the GDG questionnaire.	**Behavioural and Contingency Management** The evidence from the 4 year surveillance review was insufficiently robust to impact on CG120, which does not recommend any specific psychological or psychosocial intervention or combination of interventions to people with psychosis and coexisting substance misuse. Recommendations 1.4.18-1.4.20 make general cross referrals

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
	individuals with low levels of stimulant use and psychiatric severity, as well as those actively engaged in services are most likely to succeed in a typical contingency management intervention. For other sub-groups, modifications to contingency management may be required. A systematic review[14] (14 studies) assessed the evidence of component interventions in effective outpatient integrated treatment for patients with comorbid schizophrenia and substance use disorders. The findings suggested that behavioural treatment and specific interventions (e.g. motivational interviewing, family interventions) were effective. Programs integrating multiple interventions were also found to		to related guidelines CG38, CG82, CG100, CG115, CG51 and CG52 to ensure that evidence-based treatments are offered for both conditions. Recommendation 1.4.22 states that adults and young people with psychosis and coexisting substance misuse should not be excluded from contingency management programmes because of their psychosis, based on weak evidence in favour of this intervention. The new evidence is consistent with this recommendation. **Family Intervention** The new evidence supports the utility of family intervention for the CG120 population, but also indicates the need to modify programs to retain more families in treatment. This evidence is consistent with CG120 recommendation 1.1.8 which cross refers to CG82 schizophrenia recommendation 1.3.7 on family intervention. This recommends a specific supportive, educational or treatment function and inclusion of negotiated problem solving or crisis

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
	be more effective. The impact of the review is weakened by the heterogenous study designs, and further research is needed to corroborate the findings. **Family Intervention** An RCT[17] (n=108) found that both brief (2-3 months) and longer term (9-18 months) family education programs for co-occurring severe mental illness and substance misuse led to improved psychiatric, substance abuse and functional outcomes. The longer term program, which also incorporated communication and problem solving training, had significantly less severe overall psychiatric and psychotic symptoms and improved more in functioning. Substance abuse severity and family burden were not significantly different.		management work. Further evidence is required on the specific longer term program (FIDD) to justify incorporating it in the recommendations.
Clinical area: Staffed accommodation – *recommendations 1.7.1-1.7.3*			

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
120-04 In people with psychosis and coexisting substance misuse, does staffed accommodation when compared with an alternative management strategy lead to improved outcomes? (for outcomes see 1.2.1)			
No new evidence identified.	A meta-analysis[11] (13 studies n=2824) found that integrated treatment of co-occurring substance use and mental health disorders resulted in modest, non-statistically significant improvements in psychiatric outcomes and alcohol use when compared to treatment as usual. Further examination of the effectiveness of integrated treatment in outpatient versus residential treatment settings revealed that the effectiveness of integrated care varies by setting. The limitations of small heterogenous studies and geographical specificity to the USA should be noted.	No GDG feedback was provided by the GDG questionnaire.	The new evidence identified in the 4 year surveillance is unlikely to impact on CG120 recommendations for staffed accommodation. It reinforces the recommendation for further research to decide if staffed accommodation is more cost effective than a combination of hospital and home treatment.
Clinical area: Secondary care mental health services			
120-05 When a person with psychosis and coexisting substance misuse is admitted to an inpatient mental health setting (including forensic settings), should treatment follow the same principles as interventions delivered in a community setting?			

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
No new evidence identified.	No relevant evidence identified.	No GDG feedback was provided by the GDG questionnaire.	No relevant evidence identified.
120-05a Are there subgroups of people for whom we would alter our approach to treatment?			
No new evidence identified.	No relevant evidence identified.	No GDG feedback was provided by the GDG questionnaire.	No relevant evidence identified.
Clinical area: Primary care *recommendations* 1.3.1-1.3.2 Secondary care mental health services *recommendations* 1.4.3-1.4.9			
120-06 In people with psychosis and coexisting substance misuse, what is the most appropriate care pathway (involving all NHS and non-NHS providers) and referral guidance at each transition?			
Evidence Update (2012) An 8-week study[18] of 102 veterans in the USA comparing a time-limited care coordination intervention (n=55) compared with a matched attention control (n=47) to evaluate the effects on engagement with outpatient treatment following discharge from a psychiatric unit. Participants had a schizophrenia spectrum or bipolar I disorder and a substance misuse or dependence disorder and had used drugs or alcohol within the past 3 months. The study began in an inpatient facility and continued in the community after the patient's discharge from hospital. The results of this study provide limited evidence that an intervention with a specific focus on	No relevant evidence identified.	Clinical feedback advocated a review of current inpatient discharge policy, in order to reduce the length of inpatient stays. The current national practice is to retain patients in inpatient care for testing with the use of gradual exposure into the community. This was stated as incurring a high cost to the NHS, and having no evidence base. However, no new evidence was cited and no further evidence was identified in the surveillance review.	The limitations of the evidence identified in the Evidence Update mean it is unlikely to impact on CG120 recommendation 1.6.6. This recommends that when adults and young people are discharged from an inpatient health service, they should have an identified care coordinator and a care plan considering their needs associated with both their psychosis and their substance misuse. No evidence was cited or retrieved in the surveillance review relating to the clinical feedback about inpatient discharge policy and inpatient length of stay. Any emerging

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
promoting engagement across the transition from inpatient to community care that includes assertive outreach and peer support components may increase engagement with outpatient treatment in people with psychosis with coexisting substance misuse who are discharged from inpatient psychiatric care. However, the Evidence Update concluded that this study was unlikely to impact on CG120 due to the limitations of the evidence.			research in this area will be considered at the next surveillance review.
Clinical area: Principles of care *recommendations* 1.1.1-1.1.25			
120-07 For people with psychosis and coexisting substance misuse, what are their experiences of having problems with psychosis and substance misuse, of access to services, and of treatment?			
No new evidence identified.	A secondary analysis[19] of an RCT aimed to validate a three factor model of perceived empowerment in patients with and schizophrenia with coexisting drug and alcohol misuse. The findings showed some evidence of associations between empowerment and both symptoms and global functioning, suggesting that empowerment should be assessed in treatments	No GDG feedback was provided by the GDG questionnaire.	The new evidence on perceived empowerment is unlikely to impact on CG120. Further evidence and a standardised definition of empowerment is required before it can be incorporated into CG120, which lists the following critical outcomes: • Reduced mortality (all causes) • Reduced relapse rates • symptoms requiring change in healthcare management) • Reduced substance misuse

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
	in addition to traditional outcome measures.		(however measured) • Improved global and social functioning (for example, • employment, accommodation) • Improved subjective quality of life • Improved satisfaction with care • Reduced physical morbidity
120-08 For families, carers or significant others of people who have psychosis and coexisting substance misuse, what are their experiences of caring for people with psychosis and coexisting substance misuse, and what support is available for families, carers or significant others?			
No new evidence identified.	No relevant evidence identified.	No GDG feedback was provided by the GDG questionnaire.	No relevant evidence identified.
Clinical area: Treatment *recommendation* 1.4.19			
120-09 For people with psychosis and coexisting substance misuse, should the medical treatment of their psychosis be modified as a result of substance misuse and the treatment provided (for example, methadone, buprenorphine, and so on)? (a) During the acute phase (b) During non-acute phase If so, how should treatment be modified?			
No new evidence identified.	No relevant evidence identified.	No GDG feedback was provided by the GDG questionnaire.	No relevant evidence identified.
120-09a Are there sub-groups of people (for example, young people, people with a particular type of psychosis, BME groups) who may benefit from alternative strategies?			
No new evidence identified.	A subgroup analysis[20] of a RCT of unstable patients with	No GDG feedback was provided by the GDG questionnaire.	Further evidence is required on long acting injectable risperidone in the subgroup of

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
	schizophrenia showed no superiority of long acting injectable risperidone to psychiatrist's choice of oral antipsychotic in most clinically defined subgroups, although the white patients benefited more than the other groups on substance abuse outcomes.		white patients and other subgroups before it can be incorporated into CG120.
Treatment *recommendation* 1.4.19			
120-10 For people with psychosis and coexisting substance misuse, should the psychological and psychosocial treatment (family intervention, CBT, arts therapies) of their psychosis be modified as a result of the substance misuse problem and the treatment provided (for example, methadone, buprenorphine, psychological treatment)? (a) During the acute phase (b) During non-acute phase If so, how should treatment be modified?			
	A RCT[21] (n=103) of patients with cannabis use disorder and psychosis found that specialised psychosocial treatment plus treatment as usual did not reduce the frequency of cannabis use, but produced a non-significant reduction in the amount of	No GDG feedback was provided by the GDG questionnaire.	Further research is necessary to demonstrate effectiveness of specialised psychosocial treatment plus treatment as usual before it can be incorporated into CG120, which cross refers to CG178 Schizophrenia guideline for the psychosocial treatment of the schizophrenia

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
	cannabis used.		population.
120-10a Are there sub-groups of people (for example, young people, people with a particular type of psychosis, BME groups) who may benefit from alternative strategies?			
No new evidence identified.	A secondary analysis[22] (n=506) of a RCT of middle aged versus younger adults receiving web-delivered psychosocial treatment for substance use disorders identified unique features of middle aged substance abusers to inform age-specific substance abuse treatment planning.	No GDG feedback was provided by the GDG questionnaire.	The new evidence identifying unique features of middle aged substance abusers to inform age-specific substance abuse treatment planning is insufficient to impact on CG120. CG120 only makes recommendations for adapting adult recommendations for young people (1.8.7) but does not differentiate between adult age groups. Further evidence is required before adult age sub group treatment planning can be incorporated into CG120.
Clinical area: Treatment *recommendation* 1.4.20			
120-11 For people with psychosis and coexisting substance misuse, should the medical/physical treatment of substance misuse be modified as a result of the presence of psychosis and the treatment provided (for example, antipsychotics, lithium)? (a) During the acute phase (b) During non-acute phase If so, how should treatment be modified? Sub-question 1: Are there sub-groups of people (for example, young people, people with a particular type of psychosis, BME groups) who may benefit from alternative strategies?			
No new evidence identified.	A pilot RCT[23] (n=55) found that Varenicline treatment of	No GDG feedback was provided	The new evidence is unlikely to impact on

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
	concurrent alcohol and nicotine dependence in schizophrenia may be problematic because of safety concerns limiting recruitment and poor tolerability. Although there were no serious neuropsychiatric adverse events in the varenicline group, gastrointestinal adverse effects limited study completion.	by the GDG questionnaire.	CG120. CG120 cross refers to CG100 and CG115 for alcohol misuse treatment, which do not recommend varenicline for off label use. Varenicline is covered by TA123 and is licensed for smoking cessation but not alcohol dependence. Further research on off label use of varenicline is required before it could be considered for the CG120 population. CG120 also cross refers to CG178 Schizophrenia, which states that there is reasonable evidence of a benefit of varenicline for smoking cessation for people with schizophrenia. However, there are concerns about possible neuropsychiatric adverse effects as stated in the Summary of Product Characteristics, and found in the evidence review. The GDG considered that varenicline should be prescribed cautiously for smoking cessation for an adult with

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
			psychosis and schizophrenia. The new evidence is consistent with this recommendation.
120-11a: Are there sub-groups of people (for example, young people, people with a particular type of psychosis, BME groups) who may benefit from alternative strategies?			
No new evidence identified.	No relevant evidence identified.	No GDG feedback was provided by the GDG questionnaire.	No relevant evidence identified.
120-12 For people with psychosis and coexisting substance misuse, should psychological and psychosocial treatment for substance misuse be modified as a result of the presence of psychosis and the treatment provided? (a) During the acute phase (b) During non-acute phase If so, how should treatment be modified? Sub-question 1: Are there sub-groups of people (for example, young people, people with a particular type of psychosis, BME groups) who may benefit from alternative strategies? Sub-question 2: Should interventions be matched to stages of the treatment process (that is, engagement, persuasion, active treatment, relapse prevention)?			
No new evidence identified.	A secondary analysis[16] (n=96) of an RCT investigated predictors of treatment response of individuals receiving contingency management treatments for addictions who suffer from co-occurring severe mental illness. The findings suggested that	No GDG feedback was provided by the GDG questionnaire.	The new evidence identified in the 4 year surveillance review is insufficient to impact on CG120, which cross refers to related guidelines' recommendationson psychological and psychosocial treatment. Further research is needed on specific sub groups specifically with psychosis and

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
	individuals with low levels of stimulant use and psychiatric severity, as well as those actively engaged in services are most likely to succeed in a typical contingency management intervention. For other sub-groups, modifications to contingency management may be required. It should be noted that the proportion of patient with psychosis was not specified in the abstract.		coexisting substance misuse to justify alternative strategies.
120-12a: Are there sub-groups of people (for example, young people, people with a particular type of psychosis, BME groups) who may benefit from alternative strategies?			
No new evidence identified.	No relevant evidence identified.	No GDG feedback was provided by the GDG questionnaire.	No relevant evidence identified.
120-12b: Should interventions be matched to stages of the treatment process (that is, engagement, persuasion, active treatment, relapse prevention)?			
No new evidence identified.	No relevant evidence identified.	No GDG feedback was provided by the GDG questionnaire.	No relevant evidence identified.
120-13 In people with psychosis and coexisting substance misuse, is there any evidence that the management of drug interactions or adverse effects from pharmacological treatments should be different from those people without coexisting disorders?			

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
If so, how should management of drug interactions be modified?			
No new evidence identified.	No relevant evidence identified.	No GDG feedback was provided by the GDG questionnaire.	No relevant evidence identified.
Research Recommendations			
RR1 What are the prevalence, risk and protective factors, and course of illness for different combinations of psychosis and coexisting substance misuse (for example, schizophrenia and cannabis misuse or bipolar disorder and alcohol misuse)?			
No new evidence identified.	A systematic review and meta-analysis[24] (9 studies) investigated the potential impact of cannabis use on duration of untreated psychosis (DUP). Although in most studies DUP was shorter in cannabis using patients, meta-analysis did not detect a significant relationship between DUP and cannabis use. A systematic review[25] assessed comorbidity rates of alcohol use disorders (AUDs) in bipolar disorder and found that AUDs are highly prevalent in bipolar disorder, indicating that patients	No GDG feedback was provided by the GDG questionnaire.	**Prevalence** New systematic review evidence showed alcohol use disorders to be highly prevalent in bipolar disorder, indicating that patients with bipolar disorder should be assessed for current and previous alcohol use disorders. New primary research evidence indicated a high prevalence of cannabis use among patients with co-occurring alcohol use disorders and severe mental illness. **Risk and protective factors** Systematic review evidence suggested that chronic cannabis abuse could alter brain morphology in schizophrenia.

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
	with bipolar disorder should be assessed for current and previous AUDs. A systematic review[26] (20 studies) found no significant differences between former substance users with psychosis and non-substance users with psychosis in ratings of positive symptoms, negative symptoms, depression or global function. The findings indicated that a history of substance use is not a poor prognostic indicator for patients who are able to stop using substances. A secondary analysis[27] (n=61) of a RCT of adults with co-occurring alcohol use disorders and severe mental illness found a 54% prevalence of cannabis use during the study, some of which was obtained via medical		The systematic review evidence of cannabis impact on duration of untreated psychosis was inconclusive Systematic review evidence indicated that opiates are the only sedative drugs that possess an anti-psychotic effect, despite possessing a similar addictive process. Further research is warranted on the value of opiate agonism in psychosis treatment. **Course of Illness** New systematic review evidence on current versus former substance misuse in psychosis patients indicated that a history of substance misuse among former users has potential value as a prognostic indicator. The research recommendation has not been fully addressed and remains ongoing.

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
	prescription. Among those who used cannabis, most used it frequently. Cannabis use prevalence was considerably higher than in non-severely mentally ill adults with alcohol use disorders. A systematic review[28] found some evidence that chronic cannabis abuse could alter brain morphology in schizophrenia in patients continuing their cannabis consumption, but that there is no convincing evidence that this alteration takes place before the onset of schizophrenia when looking at first-episode patients. A systematic review[29] investigated the distinction between pro-psychotic and anti-psychotic substances and found opiates to be the only sedative drugs that possess an anti-		

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
	psychotic effect, despite possessing a similar addictive process.		
RR2 What and how should training be provided to healthcare professionals working with people with psychosis and substance misuse?			
No new evidence identified.	No relevant evidence identified.	No GDG feedback was provided by the GDG questionnaire.	No relevant evidence identified.
RR3 Is providing treatment for psychosis and substance misuse services within staffed accommodation more cost effective than a combination of hospital and home treatment?			
No new evidence identified.	See 120-04	No GDG feedback was provided by the GDG questionnaire.	No relevant evidence identified.
RR4 What service delivery models allow people with psychosis and coexisting substance misuse to remain living outside hospital?			
	No relevant evidence identified.	No GDG feedback was provided by the GDG questionnaire.	No relevant evidence identified.
RR5 Are interventions for psychosis or substance misuse clinically and cost effective when compared with standard care for people with psychosis and coexisting substance misuse?			
A study[30] of a subset (n=141) sample taken from a larger cohort study examined patients who were taking a single antipsychotic drug (risperidone, olanzapine or clozapine) and who had a diagnosis of cannabis dependence. People with cannabis dependence were more likely than those in a comparator group on risperidone, olanzapine and clozapine who did	A systematic review[33] investigated the evidence base for the different treatment options in residual insomnia in schizophrenia, that may be secondary to coexisting substance misuse. No conclusive evidence was found for specific	No GDG feedback was provided by the GDG questionnaire.	No conclusive evidence was found for the following interventions, due to small sample sizes or inconclusive results: • Interventions for residual insomnia in schizophrenia secondary to substance misuse

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
not have cannabis dependence (n=363) to have used nicotine, alcohol or other illicit drugs in the past year. The group taking clozapine had significantly lower nicotine use in the previous 12 months compared with those taking risperidone or olanzapine. People taking risperidone had significantly higher scores than those on clozapine or olanzapine for OCDUS total score, thoughts subscale and craving subscale. No significant differences were seen between clozapine and olanzapine. Nicotine use was significantly lower in the clozapine group, which could have been a factor contributing to the lower craving for cannabis in this group. A secondary analysis[31] of a RCT (n=120) compared risperidone and olanzapine in people with first-episode schizophrenia. This new analysis looked at data only for the first 16 weeks of treatment in 49 people meeting (DSM) - IV criteria for a lifetime history of cannabis misuse or dependence. No significant differences were seen between the rates of treatment completion or treatment	interventions. A secondary analysis[34] of a RCT of lithium- or quetiapine-treated patients with bipolar disorder found that there was no significant effect of adjunctive benzodiazepine use on any outcome measure in patients with comorbid substance use disorders. A RCT[35] (n=60) of patients with bipolar depression or major depressive disorder and methamphetamine dependence treated with citicoline found that there was a significant improvement in depressive symptoms but no significant differences in memory or methamphetamine use. A RCT[36] (n=45) of patients with amphetamine-induced psychotic disorder found that both aripiprazole and risperidone were		• Adjunctive benzodiazepine for bipolar disorder with comorbid substance misuse. • Olanzapine and risperidone for schizophrenia and coexisting cannabis use. • Specific treatments for reducing cannabis use in people with schizophrenia • Citicoline for methamphetamine dependence in bipolar disorder • Aripiprazole or risperidone for amphetamine-induced psychotic disorder • Quetiapine as monotherapy or adjunctive treatment to lithium or valproate semisodium in people bipolar I disorder and alcohol dependence For other interventions, the research recommendation remains ongoing for the

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
response for either drug. Rates of cannabis use at the end of the study were also not significantly different between people on olanzapine and people on risperidone. The new evidence shows conflicting results for comparisons or olanzapine and risperidone, and the small sample size for clozapine (n=23) may prevent any firm conclusions about its effects. Therefore, these studies reinforce the need for an adequately powered randomised controlled trial to determine whether differences in the effects of antipsychotic drugs exist in this population. The current evidence is unlikely to affect NICE CG120. A RCT[32] compared quetiapine with placebo as an add-on treatment to lithium (n=185) or valproate semisodium (n=177) in people with DSM-IV diagnosed bipolar I disorder and alcohol dependence assessed by the Structured Clinical Interview for DSM. The results of this study provide limited evidence that quetiapine has no effect on alcohol use in people with bipolar I disorder who drink heavily, and may not have additive effects on mania, depression or anxiety in people taking lithium or valproate semisodium.	effective in reducing positive and negative symptoms. Risperidone had a statistically significantly greater effect on positive psychotic symptoms while aripiprazole had a non-significantly greater effect on negative symptoms. A systematic review[37] (8 trials) investigated specific psychological treatments, antipsychotics and cannabinoids for cannabis reduction in people with schizophrenia. Results were inconclusive due to the small number and size of trials and indicated that further research is required. A systemetic review[38] on aripiprazole for bipolar disorder in adults found that data does not support its use as a first choice maintenance monotherapy but it may be useful as a combination therapy for bipolar disorder		specific CG120 comorbid population. The totality of new evidence is unlikely to affect CG120, which defers to the related NICE guidelines for the treatment of specific psychosis and substance misuse conditions.

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
This evidence is unlikely to affect NICE CG120, which recommends that people should have treatment according to the underlying psychotic disorder.	patients with comorbidities such as drug abuse. A systematic review[39] (11 studies) examined the cost effectiveness of interventions to promote the physical health of people with mental health problems. Although most studies suggested that that value for money actions in specific contexts and settings are available, none were reported for psychosis and coexisting substance misuse which weakens the impact on CG120. A systematic review[40] investigated the effectiveness of antipsychotic treatments for cocaine dependence in schizophrenic patients. The results were inconclusive and reinforced the CG120 research recommendation for further research.		

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
	A RCT[41] (n=90) of quetiapine in patients with bipolar disorder and alcohol dependence found no significant between-group differences on the primary outcome measure of drinks per day or other alcohol-related or mood measures. A RCT[42] (N=37) of methamphetamine dependent patients with a history of psychosis found that aripiprazole significantly decreased psychotic symptoms without serious adverse events. No statistically significance was found between the two groups in maintaining abstinence.		
RR6 Are psychosocial interventions clinically and cost effective when compared with standard care for people with psychosis and coexisting substance misuse?			
A single-centre RCT[43] studied a motivational intervention to reduce cannabis use compared with treatment as usual over 12 months (n= 62)	A RCT[44] (n=110) of phase-specific psychological therapy for people with problematic cannabis	No GDG feedback was provided by the GDG questionnaire.	The totality of new evidence is inconclusive and is unlikely to affect CG120, which defers to the related NICE guidelines for the

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
for psychosis and coexisting cannabis use. Participants were aged 18–35 years and smoked at least 3 cannabis joints per week in the month before joining the study. This evidence suggests that a specifically designed motivational intervention may reduce cannabis use in people with psychosis to a greater extent than usual care in the 6 months in which the intervention is delivered, but this difference may not be sustained at 12 months. The intervention is more time-intensive and resource-intensive than the general brief motivational intervention recommended in CG51, so is not likely to affect current recommendations.	use following a first episode of psychosis. Results showed that neither extended nor brief psychological therapy (motivational interviewing and with CBT) conferred benefit over standard care in terms of reductions in frequency or amount of cannabis use. A secondary analysis[45] (n=103) of a RCT of patients with cannabis use disorder and psychosis found that specialised psychosocial treatment (motivational interviewing and cognitive behaviour therapy) plus treatment as usual resulted in a higher risk of psychiatric emergency room contact and admission, but fewer days admitted to psychiatric hospitals. An updated systematic review[46] (32 studies) of psychosocial		treatment of specific psychosis or substance misuse conditions.

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
	interventions for people with both severe mental illness and substance misuse found no compelling evidence to support any one psychosocial treatment over another for people to remain in treatment or to reduce substance use or improve mental state. A systematic review[37] (8 trials) investigated specific psychological treatments, antipsychotics and cannabinoids for cannabis reduction in people with schizophrenia. Results were inconclusive due to the small number and size of trials and indicated that further research is required. A secondary analysis[47] (n=121) of a RCT of adult inpatients with a psychiatric disorder or dual diagnosis found that gender, dual		

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
	diagnosis status, age and education may be important predictors of aftercare treatment adherence and that gender may be a moderator of motivational interviewing. A RCT[48] (n=176) found that contingency management plus treatment as usual was associated with increased abstinence from stimulant drug use in stimulant-dependent patients with serious mental illness. It should be noted that the serious mental illnesses were not specified in the abstract, which weakens the impact on CG120.. A systematic review of meta-analyses[49] (61 meta-analyses) showed that effect sizes of psychotherapies vs placebo for major psychiatric disorders tended to be higher than those of		

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
	medication, but direct comparisons did not reveal consistent differences. It should be noted that the number of meta-analyses covering psychosis with coexisting substance misuse was not specified in the abstract, which weakens the impact on CG120. A RCT[50] of patients with psychosis and comorbid cannabis dependence found that a group psychological intervention, based on cognitive behavioural therapy and motivational interviewing improved quality of life but did not improve cannabis use, symptoms, global functioning insight or attitude to treatment. An RCT[51] (n=121) of individuals with serious mental illness and alcohol or drug dependence found that a 12-session 12-step		

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
	facilitation therapy resulted in greater participation but not did not demonstrate greater improvement in alcohol and drug use.		
RR7 Are environmental interventions clinically and cost effective when compared with standard care for people with psychosis and coexisting substance misuse?			
	No new evidence identified.	No GDG feedback was provided by the GDG questionnaire.	No relevant evidence identified.
RR9 Is clozapine clinically and cost effective when compared with other pharmacological interventions for people with psychosis and coexisting substance misuse?			
A study[30] of a subset (n=141) sample taken from a larger cohort study examined patients who were taking a single antipsychotic drug (risperidone, olanzapine or clozapine) and who had a diagnosis of cannabis dependence. People with cannabis dependence were more likely than those in a comparator group on risperidone, olanzapine and clozapine who did not have cannabis dependence (n=363) to have used nicotine, alcohol or other illicit drugs in the past year. The group taking clozapine had significantly lower nicotine use in the previous 12 months compared with those taking risperidone or olanzapine.	A pilot RCT[52] (n=30) of dually diagnosed (DD) patients with schizophrenia and cannabis use disorders found that both clozapine and ziprasidone reduced cannabis use. Clozapine treatment was associated with less positive symptoms of schizophrenia, more side effects and poorer compliance with treatment.	No GDG feedback was provided by the GDG questionnaire.	The small sample sizes of the new studies identified reinforces the need for an adequately powered randomised controlled trial to determine whether differences in the effects of antipsychotic drugs exist in this population. The current evidence is unlikely to affect CG120.

Conclusions from Evidence Update (2012)	Is there any new evidence/intelligence identified during this 4-year surveillance review (2015) that may change this conclusion?	Clinical feedback from the GDG	Conclusion of this 4-year surveillance review (2015)
People taking risperidone had significantly higher scores than those on clozapine or olanzapine for OCDUS total score, thoughts subscale and craving subscale. No significant differences were seen between clozapine and olanzapine. Nicotine use was significantly lower in the clozapine group, which could have been a factor contributing to the lower craving for cannabis in this group. The small sample size for clozapine (n=23) may prevent any firm conclusions about its effects. Therefore, these studies reinforce the need for an adequately powered randomised controlled trial to determine whether differences in the effects of antipsychotic drugs exist in this population. The current evidence is unlikely to affect CG120.			
RR10 What risk factors predict the onset of substance misuse in young people with psychosis?			
No new evidence identified.	No new evidence identified.	No GDG feedback was provided by the GDG questionnaire.	No relevant evidence identified.

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