National Institute for Health and Clinical Excellence

Psychosis with Substance misuse
Scope Consultation Table
10 March – 7 April 2009

#'	Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
32	SH	Association of Nurses in Substance Misuse (ANSA)	1	3.1 a	Other examples of substances should be given as well as alcohol, or the word alcohol preceded by "this includes.."	Thank you, we agree and have attempted to improve the wording of this section to make it clearer how substance abuse will be defined for the purposes of the guideline.
43	SH	Association of Nurses in Substance Misuse (ANSA)	2	3.1 e and 4.3.1 j	'Compliance' and 'adherence' are used when concordance would reflect current best-practice language and also indicates more accurately the desired relationship between service and service user	Thank you, we have amended the text as suggested.
85	SH	Association of Nurses in Substance Misuse (ANSA)	3	4.2 b	Prison medical services should be directly included. They count as primary care services, are run by the NHS and are implementing the 2007 NTA/DoH guidelines together with a suite of NICE guidance and technology appraisals relating to drug misuse. It would seem logical to give this guidance the same status.	Thank you. The guideline will be of relevance to all parts of the NHS although we will not be addressing the evidence specifically developed within prison services.
7	SH	Association of Nurses in Substance Misuse (ANSA)	4	General	Title should be "Severe Mental Illness and Substance Misuse"	We disagree. The problem is to do with the time and resources this guideline will consume by extending the guideline scope to include ALL severe forms of mental illness/disorder. For this reason we have decided to limit the guideline scope to psychosis and substance misuse.
8	SH	Association of Nurses in Substance Misuse (ANSA)	5	General	Severe mental illness and substance misuse should be as defined in 3.1a and used consistently throughout.	Thank you.
98	SH	British Association for Counselling & Psychotherapy	1	4.3.1	The scope states that psychosocial interventions for the management of drug misuse will be covered. BACP suggests that a broad range of psychological interventions, such as	Thank you, we will pass your suggestion to the Guideline Development Group when they first meet to discuss the range

					counselling and psychotherapy should also be covered.	of interventions to be covered.
95	**SH**	Department of Health	1	4.3.1	The guideline covers adults and young people (15 and older) so it should include transition from CAMHS to Adult services.	Thank you for this suggestion, it will be passed to the GDG during the start of the development stage.
68	SH	Department of Health - DH NICE Liaison Team	1	4.1.2 a	We are concerned that 'drug induced psychosis' so frequently turns out to be a misdiagnosis of schizophrenia or bipolar disorder. We suspect that clinicians at times use the diagnosis in the belief that it may be less stigmatising than a diagnosis of schizophrenia, for example. In our opinion, services could benefit from guidance in these cases, as well as those within the current scope. We feel that it is important that you should address this issue, for the guideline to be of practical value.	Given the feedback from the stakeholder meeting, we will not specifically exclude “drug induced mental illness”.
24	SH	DrugScope	1	2	The term 'problematic substance misuse' has a precise meaning within current drug policy - it refers specifically to heroin and/or crack cocaine (see, for example, its use in the current drug strategy 'Drugs: Protecting Families and Communities, Home Office, 2008). It might, therefore, be confusing to use it to describe substance misuse more generally.	We agree. The scope is now psychosis and substance misuse.
30	SH	DrugScope	2	3.1 a	Substance misuse is defined as using drugs or alcohol for 'purposes other than those prescribed', this definition does not appear to be appropriate for alcohol, because it is a legal substance and the issue of prescription does not arise. Also alcohol misuse is a term applied only to harmful patterns of use, and not to all use - as would be implied by a literal reading of the definition provided here.	Thank you, we agree and have attempted to improve the wording of this section to make it clearer how substance abuse will be defined for the purposes of the guideline.
31	SH	DrugScope	3	3.1 a	It is stated that substance misuse is usually regarded as a problem 'if there is evidence of dependence'. While addiction is certainly a focus of work for substance misuse services, it might be said that illicit drug use is generally regarded to be harmful and that it is widely accepted that various forms of drug use are problematic for the population that are being considered in this review.	Thank you, we agree and have attempted to improve the wording of this section to make it clearer how substance abuse will be defined for the purposes of the guideline.
45	SH	DrugScope	4	3.2 a	The NSF for Mental Health (1999) identifies 'dual diagnosis' as a key issue for assessment, service provision, care planning and review, risk assessment and effective service user engagement. In a Foreword, to the Department of Health's, *Mental Health Policy Implementation Guide – Dual Diagnosis Good Practice Guide* (2002), the 'Mental Health Tsar', Louis Appleby, states that supporting people with dual diagnosis is ‘one of the biggest challenges facing frontline mental health services’, and that the	Thank you for your comment. We agree these are important points, but probably more detail than is required for the scope.

					complexity of the issues 'makes diagnosis, care and treatment more difficult, with service users being at higher risk of relapse, readmission to hospital and suicide'. A review of the NSF for Mental Health in 2004 (*The NSF for Mental Health – Five Years*) says that dual diagnosis is 'a key area for further action' and 'the most challenging clinical problem we face'. A Care Services Improvement Partnership Themed Review Report on Dual Diagnosis (CSIP, 2008) reported only limited progress on implementing the 2002 Department of Health Good Practice Guide.	
46	SH	DrugScope	5	3.2 d	Is it strictly true to say that there is no guidance on the preferrable approach? The Department of Health's, *Mental Health Policy Implementation Guide – Dual Diagnosis Good Practice Guide* (2002) stated that Integrated' service models will work better than either 'serial' or 'parallel' models. Given current starting points 'a stepwise progression from a parallel to an integrated model may make sense for many services'. This document cited US evidence. The *Drug Misuse and Dependence - UK Guidelines on Clinical Management*, produced by the Department of Health and devolved health departments recommends 'working in an integrated model' for people with co-occurring substance misuse and mental health problems.	Thank you, we have changed "no" to "little".
65	SH	DrugScope	6	4.1.2 a	Presumably the Guidance will apply to anyone with severe mental illness and substance misuse, regardless of the exact causal relationship between them. What it won't do is address the issue of the extent to which drug use may or may not be a cause of or trigger for serious mental health problems. (Some of this evidence has recently been reviewed by the Advisory Council on the Misuse of Drugs, and is discussed in *Cannabis: Classification and Public Health* (2008).	Given the feedback from the stakeholder meeting, we will not specifically exclude "drug induced mental illness".
84	SH	DrugScope	7	4.2 b	Presumably, these NICE Guidelines will mean that somone being treated by prison services for these conditions will have the same entitlements as someone being treated by NHS services in the community? This is required by the principle of equivalence which was established when responsibility for	Thank you. The guideline will be of relevance to all parts of the NHS although we will not be specifically addressing the evidence derived from prison services so as to limit the size of the guideline and the

					prison health services was assumed by the NHS.	resources committed thereby.
97	SH	DrugScope	8	4.3.1	A lot of these clinical issues concern treatment either for the mental health problem or the substance misuse problem. It will be particularly interesting to see if there are some interventions that are especially effective for people with this particular combination of problems - for example, is there a psycho-therapeutic approach which has a positive impact on both the substance misuse and mental health problem, rather than (primarily) addressing either one or the other?	Thank you, we agree this will be an important finding.
5	SH	DrugScope	9	General	A lot of the available evidence suggests good outcomes for this group depend as much on the attitudes and interactions between services as on the nature of the clinical interventions they receive. It would be good to be clear about the extent to which NICE can look at - and make recommendations about - the evidence-base on service configurations, etc. The fact that sequencing of treatment is identified as a key issue for this review means it will encompass these issues - but I am unclear of the extent to which it can look at the evidence on 'policy' and the less clinical aspects of effective service delivery.	Thank you for your comment. We believe it is within the remit to look at all aspects of service delivery that the GDG feel are relevant to this guideline. We will follow NICE protocol and examine relevant evidence identified by the literature search.
6	SH	Faculty of Forensic and Legal Medicine of the Royal College of Physicians	1	General	The Faculty was established in 2006 by the Royal College of Physicians of London and has been founded to achieve the following objectives: • To promote for the public benefit the advancement of education and knowledge in the field of forensic and legal medicine. • To develop and maintain for the public benefit the good practice of forensic and legal medicine by ensuring the highest professional standards of competence and ethical integrity. The Faculty includes three different professional groups: • Forensic physicians • Medically qualified coroners • Medico-legal advisers to the medical defence organisations. Forensic Physicians come into regular contact with persons presenting to the Criminal Justice System.	Thank you for your comment.
57	SH	Faculty of Forensic and Legal Medicine of the Royal College of Physicians	2	4.1.2	It is noted that people with drug-induced mental illness will not be covered in the guideline. However, it is important to recognise that it is very difficult to determine whether the mental illness is caused by the substance misuse or not, particularly if	Given the feedback from the stakeholder meeting, we will not specifically exclude “drug induced mental illness”.

					the person is seen for the first time in the police custodial setting.	
79	SH	Faculty of Forensic and Legal Medicine of the Royal College of Physicians	3	4.2.a	Many people who are seen in police custody do not have a GP and consulting a Forensic Physician may be their first contact with a health care professional.	Thank you. Although we will not consider evidence specifically addressing this situation the guideline will be relevant to the practitioners involved.
105	SH	Faculty of Forensic and Legal Medicine of the Royal College of Physicians	4	4.3.1 a	Some people, particularly adolescents, may present acutely as apparently straight forward substance misusers in the criminal justice system. Whilst legal processing in this context may take precedence in the short term, the long term importance of getting these people to engage with health services may be a better way of preventing future problems.	Thank you, we will pass your suggestion to the Guideline Development Group when they meet to discuss this topic.
33	SH	ISPS UK (UK network of the International Society for the Psychological Treatments of the Schizophrenias and other psychoses)	1	3.1 a	It is odd to see no explicit reference to illegal substances in the definition of substance misuse, in particular the widespread use of cannabis by people experiencing psychosis.	Thank you, we agree and have attempted to improve the wording of this section to make it clearer how substance abuse will be defined for the purposes of the guideline.
67	SH	ISPS UK (UK network of the International Society for the Psychological Treatments of the Schizophrenias and other psychoses)	2	4.1.2 a	The exclusion of people with drug-induced mental illness, in a guideline for the 'assessment and management of severe mental illness in conjunction with problematic substance abuse' that is intended to cover young people aged 15 and upwards, is likely to be a cause of puzzlement, frustration and disappointment amongst clinicians and managers. For many clinicians, especially those working with adolescents and in EI services, the increasingly well-documented links between cannabis use, especially stronger varieties, and psychosis in vulnerable young adults, is one of their prime concerns. Recent research has found 47% of people with a drug induced psychosis and who came off drugs went on to have further episodes of psychosis not related to drugs (Arendt et al 2005). The exclusion of this group may therefore delay effective and appropriate treatment for those at the early stages of developing psychosis because of the assumption that it is drug induced. Moreover many of our members report that at the point of assessment it is often impossible to distinguish between drug-induced psychosis and other psychoses, although a 'drying out' period can allow a distinction to be made between the symptoms of drug intoxication and psychosis.	Given the feedback from the stakeholder meeting, we will not specifically exclude "drug induced mental illness".

					The exclusion of young people in whom psychosis is precipitated by drug misuse, who are in particular need of skilled, well-informed care, is likely to make this guideline look oddly peripheral, both to clinicians and the media. They may even ask what the point of the guideline is if one of the main causes of public concern about the link between drug use and mental illness has not been addressed in a guideline with this title. Reference Mikkel Arendt, Raben Rosenberg, Leslie Foldager, Gurli Perto, and Povl Munk-Jørgensen (2005) Cannabis-induced psychosis and subsequent schizophrenia-spectrum disorders: follow-up study of 535 incident cases. British Journal of Psychiatry 187, p. 510-515	
71	SH	ISPS UK (UK network of the International Society for the Psychological Treatments of the Schizophrenias and other psychoses)	3	4.1.2 b	The exclusion of very late onset schizophrenia, bipolar or other affective psychosis patients is also questionable given the number of older persons abusing legal and illegal drugs.	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 will not exclude evidence relating to people older than 60 if the onset of their psychosis was before this age.
86	SH	ISPS UK (UK network of the International Society for the Psychological Treatments of the Schizophrenias and other psychoses)	4	4.2 b	Joined up services between health and criminal justice systems are particularly important for young people who are the focus of this guideline, and who often fall between systems. We suggest omitting the phrase 'but will not cover the practice of', and emphasising the important of joined up co-ordinated services for this vulnerable group.	Thank you. The guideline will be of direct relevance to all parts of the NHS, although we will not be specifically addressing the evidence developed within other services such as prisons.
91	SH	ISPS UK (UK network of the International Society for the Psychological Treatments of the Schizophrenias and other psychoses)	5	4.3.1	There should be a reference to families in this list of key clinical issues. The updated NICE Guideline on Schizophrenia recommends that family intervention should be offered to all families of people with schizophrenia who live with or are in close contact with the service user. It would be consistent with the Schizophrenia Guideline for this Guideline to recognise that families are both affected by and key to the management of a young person whose substance misuse precipitates a psychotic	Thank you for your suggestion. We acknowledge that families/carers are important in the management of young people with psychosis and substance misuse, however we believe that 4.3.1 (c) does not exclude family intervention. Therefore, no change to the scope is necessary.

					episode, or a parent whose psychosis is combined with substance abuse.	
102	SH	Janssen-Cilag UK	1	4.3.1 a	Janssen-Cilag suggests that as part of the identification and assessment of substance misuse in this population that the guideline should give clear recommendations on the questions that healthcare professionals should ask. “Beliefs About Medications Questionnaire” and the “Drug Attitude Inventory” may contain some relevant questions.	Thank you, we will pass your suggestion to the Guideline Development Group when they meet to discuss this topic.
103	SH	Janssen-Cilag UK	2	4.3.1 a	Janssen-Cilag suggests that the GDG explore whether this population has different treatment outcomes than that of people with psychosis without substance misuse	Thank you, we will pass your suggestion to the Guideline Development Group when they meet to discuss this topic.
104	SH	Janssen-Cilag UK	3	4.3.1 a	Janssen-Cilag asks that the GDG identify the key outcome goals for people with psychosis and substance misuse	Thank you, we will pass your suggestion to the Guideline Development Group when they meet to discuss this topic.
107	SH	Janssen-Cilag UK	4	4.3.1 c	Janssen-Cilag suggests that a clinical question relevant to this section should be included to explore the most appropriate treatment for those non-adherent with medication in this population	This is addressed in 4.3.1(k)
108	SH	Janssen-Cilag UK	5	4.3.1 c	Janssen-Cilag suggests that a clinical question should explore the attributes of drug treatments that are most important in relapse prevention, such as efficacy, adherence, side effects, decrease in substance misuse	Thank you, we will pass your suggestion to the Guideline Development Group when they meet to discuss this topic.
109	SH	Janssen-Cilag UK	6	4.3.1 c	Janssen-Cilag suggests that a clinical question identify the key attributes of drug treatment following an acute episode, such as onset of action, efficacy, titration, side effects, pill burden, drug-drug interactions and potential for medication diversion	Thank you, we will pass your suggestion to the Guideline Development Group when they meet to discuss this topic.
110	SH	Janssen-Cilag UK	7	4.3.1 c	Janssen-Cilag asks that the choice of medication in people with hepatic or renal impairment be explored as a clinical question	Thank you, we will pass your suggestion to the Guideline Development Group when they meet to discuss this topic.
111	SH	Janssen-Cilag UK	8	4.3.1 c	Janssen-Cilag asks that for those patients where medication diversion may be an issue, that the preference for the appropriate formulation, as well as the molecule be considered	Thank you, we will pass your suggestion to the Guideline Development Group when they meet to discuss this topic.
112	SH	Janssen-Cilag UK	9	4.3.1 c	Janssen-Cilag asks that the GDG consider how substance misuse alters the metabolism of antipsychotic medications	Thank you, we will pass your suggestion to the Guideline Development Group when they meet to discuss this topic.
120	SH	Janssen-Cilag UK	10	4.3.1 j	Janssen-Cilag would like the GDG to explore the prevalence of non-adherence in this patient population compared to non-adherence in people with psychosis without substance misuse.	Thank you, we will pass your suggestion to the Guideline Development Group when they meet to discuss this topic.
121	SH	Janssen-Cilag UK	11	4.3.1 j	Janssen-Cilag asks that the GDG identify the most appropriate package required to improve adherence to treatment in this population	Thank you, we will pass your suggestion to the Guideline Development Group when they meet to discuss this topic.
20	SH	Lighthouse Project	1	1	Suggest ‘The assessment and management of severe mental illness with substance misuse’. Our experience has been that	Thank you. So as to ensure that this guideline is manageable we will restrict

					specifying psychosis results in clients with significant mental illness being excluded from mental health services.	the scope to people with psychosis.
22	SH	Lighthouse Project	2	1.1	Severe mental illness with substance misuse Take out the word problematic	We agree. Thank you
64	SH	Lighthouse Project	3	4.1.2 a	The diagnosis of drug induced psychosis is generally poorly defined and we view this as a dangerous exclusion. The guidance would need to make clear that patients thought to have drug induced psychosis would not be excluded from mental health services, but that the guidance would not include separate, specific management advice for drug induced psychosis.	Given the feedback from the stakeholder meeting, we will not specifically exclude "drug induced mental illness".
83	SH	Lighthouse Project	4	4.2 b	It should be clear that the guidance does not include separate, specific advice regarding patients in these settings, but that management in these settings would be covered by the general guidance. May be useful to replace the heading with 'Groups not specifically addressed'	Thank you, we have amended the text in line with your suggestion.
117	SH	Lighthouse Project	4	4.3.1 g	We suggest 'Ways to improve access to mental health services for people from socially excluded groups including black and minority ethnic communities'.	Whilst it would be very good if all guidelines dealt with all socially excluded groups, we have limited our focus to the group with the greatest need, not a broader range. Of course, it is possible that NICE may ask us to extend our evaluation of services to a broader range of socially excluded groups depending on needs and resources.
4	SH	Lighthouse Project	5	General	Despite the National Service Framework for Mental Health, there remains in many regions, including ours, a situation where patients with severe mental illness and drug misuse are receiving inadequate care because there is a lack of clarity over which agencies are responsible for their care. We find that mental health services are often reluctant to take on patients who misuse substances. These patients are therefore managed by substance misuse services which do not necessarily have any expertise in managing mental illness. Furthermore, even patients with diagnosed severe mental illnesses and substance misuse are expected to be managed by substance misuse services. With these facts in mind, we feel it is essential that the guideline contains clear advice and direction on the responsibilities of different services in managing patients with varying degrees of mental illness and substance misuse.	Thank you for your comment. We agree that a very important function of this guideline will be to focus on providing clear recommendations regarding the organisation of services.

51	SH	National Mental Health Development Unit (NMHDU)	1	4.1.1 a	Does the population group include older adults?	The population group includes older adults, but not older adults with very late onset psychosis (see section 4.1.2 b).
54	SH	National Mental Health Development Unit (NMHDU)	2	4.1.1 .b	It is good to see the guideline is including the consideration of the needs of people with co existing learning difficulties as this is a growing area of concern and debate.	Thank you for your comment. We agree that people with learning difficulties are an important population to cover.
69	SH	National Mental Health Development Unit (NMHDU)	3	4.1.2 a	It is noted that the guideline does not intent to cover people with drug induced mental illness. This seems a missed opportunity as there are strong links between cannabis use and the onset of a psychotic illness. Several recent studies (Arsenault et al 2002, Zammit et al 2002) have suggested a causal link between the use of cannabis, especially if started at an early age, and the subsequent development of psychosis. Despite this debate, the use of cannabis among young people with a vulnerability to psychosis can be a dangerous behaviour. This area could warrant a separate guideline in the future possibly?	Given the feedback from the stakeholder meeting, we will not specifically exclude “drug induced mental illness”.
74	SH	National Mental Health Development Unit (NMHDU)	4	4.1.2 b	Alcohol related dementia is an area of growing concern. It does not appear to be covered in this guideline.	Thank you, this topic is covered by another NICE guideline on alcohol dependence (please see www.nice.org.uk)
113	SH	National Mental Health Development Unit (NMHDU)	5	4.3.1 d	Will the guidance be drawing on the evidence from the MIDAS study which is due to report later this year?	Thank you, we will contact the author of this study to ensure the Guideline Development Group see any relevant evidence.
62	SH	National Mental Health Development Unit (NMHDU)	1	4.1.2 a	We note that the guideline does not intend to cover people with drug induced mental illness. However, the link between using Cannabis and experiencing an onset of a psychotic illness has been widely debated in recent years and is a complicated one. Several recent studies (e.g. Van Os et al 2002, Arsenault et al 2002, Zammit et al 2002) have suggested a causal link between the use of cannabis, especially if started at an early age, and the subsequent development of psychosis. Despite the continued debate, one irrefutable fact is that the use of cannabis among young people with a vulnerability to psychosis can be a dangerous behaviour. A systematic review of the evidence pertaining to cannabis use and the occurrence of psychotic or affective mental health outcomes published in the Lancet in July 2007 (Moore et al 2007) showed an increased risk of any psychotic outcome in individuals who had ever used cannabis. Some young people seem to be “super-sensitive” to even quite small amounts of the drug. Certain high potency types of the drug particularly the “super-strength” varieties (often known by the general name of “skunkweed”) seem to be particularly	Given the feedback from the stakeholder meeting, we will not specifically exclude “drug induced mental illness”.

					associated with the development of psychotic symptoms, possibly due to the high levels of the psychoactive substance THC found in them.	
80	SH	National Mental Health Development Unit (NMHDU)	2	4.2 a	We note the focus on care received from healthcare professionals in primary and secondary care. However, we wish to highlight that the development of substance misuse and co-morbid mental health difficulties in young people does not respect traditional adult mental health service age transition boundaries of 16 or 18 years. Adolescents with dual diagnosis problems often can fall in the gap between child and adult mental health services and between mental health and drug treatment service boundaries. Restrictive 'gate keeping' practices between services have resulted in some services being 'exclusive' rather than 'inclusive'. The result has been that some of the most vulnerable and chaotic clients have received the poorest of services, while commissioners of services have argued about responsibilities and funding streams. These issues need to be addressed through both provision of improved joint training, supervision and support of staff across agencies and encouraging closer integration between services, enhanced joint working protocols and inter-agency care planning. This needs to be supported by joined up commissioning and funding processes to enable joint working to support the most complex dual diagnosis clients	Thank you. We cannot deal with evidence here but you raise important points which the guideline will have to address.
49	SH	National Mental Health Development Unit (NMHDU)	3	4.1.1	We would support the focus on young people with psychosis problems who use drugs (aged 15 and older) as there is a high prevalence of drug problems in this particular population particularly young males with psychosis who have been identified as a very high risk and vulnerable group. This is consistent with Dual Diagnosis Mental Health Policy Implementation Guidance (DH, 2002) and NICE guidance aiming to reduce substance misuse among vulnerable and disadvantaged young people where young people with mental health problems are specifically identified as a high risk group (NICE, 2007). High rates of substance use have been reported in clients entering mental health services for the first time. Cantwell et al (1999), in a study of 168 young people presenting with first-episode psychosis, reported that the criteria for drug use, drug misuse and alcohol misuse were met by 37% of the sample. Those most at risk of substance use in this group were young males. A recent study into the prevalence of substance use among people with a first episode psychosis was undertaken by	Thank you for your comment and these useful references.

					Barnett et al (2007). They used a representative sample of young people entering into an early intervention service to record and measure current and lifetime substance use and to compare this with general population prevalence estimates from the British Crime Survey. They found that substance use among people with a first episode of psychosis was twice that of the general population and was more common in men than women. 51% of their clients reported cannabis abuse and 43% reported alcohol abuse. More than half the young people said that they had used Class A drugs and 38% said that they were using several substances at once. There appeared to be an association with the age at which the young person used cannabis, cocaine, ecstasy and amphetamine and the age at which they later developed a psychosis.	
36	SH	National Mental Health Development Unit (NMHDU)	4	3.1 b	We note the general prevalence rates reported but wished to note that a recent study investigating prevalence rates of 'dual diagnosis' across Manchester Mental Health and Social Care Trust (Holland and Schulte 2006), which serves a culturally diverse and socially deprived urban population, showed wide variations in the reported rates of dual diagnosis among clients from different parts of the service where reported rates among clients on psychiatric intensive care units (PICUs) were approximately 90%. 71% of patients under the care of the assertive outreach service were also found to have co-morbid drug and/or alcohol problems. In the same study, one community mental health team (CMHT) reported prevalence rates of 75%; while other CMHTs in different sectors of the city stated that they had rates as low as 10%. The mean rate across CMHTs was 29%.	Thank you for this information. We acknowledge that there is wide variation in reported prevalence rates, which also depends on how "dual diagnosis" is defined. We think the prevalence rates we have reported for people with psychosis and substance misuse provide an accurate reflection of the clinical need for this guideline.
93	SH	National Mental Health Development Unit (NMHDU)	5	4.3.1	Family support appears to have been omitted from the 'key clinical issues' yet families are often the first to make a link and inform services that the young person they care for, first experienced problems with thoughts, feelings and behaviours at the same time that they first noticed that cannabis was being used. The use of illicit substances causes families and carers great concern. It leads to arguments, bewilderment and, sometimes, despair for family members who see major changes in the young person and reach the conclusion that drug use is directly leading to mental health problems. Sometimes families decide that if the young person would stop using drugs, all the problems would disappear. Unfortunately, this is not always the case. Families need accurate information and support in managing drug problems at home and in understanding the	Thank you for your suggestion. We acknowledge that families/carers are important in the management of young people with psychosis and substance misuse, however we believe that 4.3.1 (c) does not exclude family intervention. Therefore, no change to the scope is necessary.

					potential complex links between continued drug use and subsequent mental health difficulties	
94	SH	National Mental Health Development Unit (NMHDU)	6	4.3.1	There is a growing evidence base surrounding effective interventions for dual diagnosis (DD) clients with mental health and substance misuse difficulties. These are based on comprehensive, integrated approaches that deal with all aspects of clients' complex lives. Eight fairly recent studies support the effectiveness of integrated dual diagnosis treatments for DD clients (Godley et al 1993; Jerrell et al 1995; Drake et al 1997; Carmichael et al 1998; Drake et al 1998; Ho et al 1999; Brunette et al 2001; Barrowclough et al 2001; Haddock et al 2003) The critical components of successful trials appeared to be staged interventions, assertive outreach, motivational interviewing, counselling about drug use and its effect on mental health and social support. Interventions are offered based on a long-term perspective and on comprehensive integrated treatments. Successful interventions also display an element of cultural sensitivity. Interventions should be based around collaborative care planning and agreement on prioritizing needs. Motivational interviewing techniques, relapse prevention work and cognitive-behavioural therapy appear to provide the basis for successful interventions. Research has been mainly directed at outpatient & community treatments. Few intervention studies have taken place in in-patient settings where drug use has shown to be highest (see earlier)	Thank you for your comments. We will ensure we have the references you identified for our review of integrated models of care.
122	SH	National Mental Health Development Unit (NMHDU)	7	4.4	In relation to assessing cost effectiveness, there is limited information within research on the cost implications of providing comprehensive integrated treatment services. It is still unclear if there would be savings resulting from more effective services for dually diagnosed clients. There is also a lack of specificity in the treatments described in research and it is therefore hard to say which interventions are most efficacious and for whom. One recent study suggested caution in assuming more intense and complex interventions will yield better outcomes. In a randomized controlled trial by Edwards et al (2006) an intensive cannabis focused intervention for young people with a first episode of psychosis was compared with a less detailed psycho-education package. The cannabis-focused intervention, known as Cannabis and Psychosis (CAP), provided one to one therapy sessions designed to use motivational interviewing principles to enhance the change process. The 'control' group received a basic education package concerning cannabis use and its	Thank you, we will pass this information to the Guideline Development Group when they meet to discuss this topic.

					connection with mental health problems. There were no significant differences between the cannabis focused intervention group and the psycho-education group on cannabis use at the end of treatment and 6 months later. These authors therefore recommended that simple interventions based around providing acceptable information about cannabis use may be worth considering before attempting more intensive therapeutic input.	
90	SH	National Mental Health Development Unit (NMHDU)	8	4.3	In relation to clinical management, Hughes (2006) has written an excellent document called “Closing the Gap” designed to assist in the implementation of the Department of Health Dual Diagnosis Practice Implementation Guide (2002). It highlights the training and service developments required to implement this in practice and represents the first time that capabilities for working with combined mental health and substance use problems have been clearly identified and defined. The document offers a comprehensive ‘Capability Framework’. It highlights the roles and responsibilities of the various agencies in providing care for people with dual diagnosis. It states that care for those with serious mental illness and substance use should be provided by the mental health services (mainstreaming). The framework is divided into three sections: values and attitudes; knowledge and skills; and practice development. Each capability has three levels: core, generalist and specialist. Its aim is to establish core competencies for all staff that work with clients with co-existing mental health and substance use problems. This document complements other indicators of service and clinical development: The Knowledge & Skills Framework (2003); The National Occupational Standards for Mental Health (MHNOS, 2004); The Capable Practitioner Framework (2001); The Ten Essential Shared Capabilities (SCMH/NIMHE 2004); and The Drug & Alcohol National Occupational Standards (DANOS, 2004).	Thank you for these references.
118	SH	National Mental Health Development Unit (NMHDU)	9	4.3.1 i	A good example of ‘dual diagnosis’ information that has been tailored to younger people can be found in the “Out of Your Head” Guides (Holland and Linnell 2007). These booklets tell four people’s stories and were written following extensive collaboration with service users. <u>Main reference source used:</u> I.Wilson (2009, in press) Substance Misuse in First Episode	Thank you for your comment. We have noted the references.

Psychosis.
In P. French, M. Reed, J. Smith, M. Rayne, D. Shiers (eds.) Early Intervention in
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11	SH	National Treatment Agency for Substance Misuse	1	General	Although the National Treatment Agency's primary remit is for illicit drug misuse in England (as well as specialist alcohol treatment for young people), we recognise the importance of the NICE guideline adequately covering alcohol misuse.	Thank you for your comments
12	SH	National Treatment Agency for	2	General	We understand the need to keep the scope of the guideline manageable and focused on areas in which there is likely to be	Thank you for your comment. We have attempted to improve the wording of the

		Substance Misuse			sufficient research evidence on which to base recommendations. However, the resulting guideline also needs to be genuinely useful to the mental health and substance misuse fields. We are concerned that the scope as drafted may be - or at least may appear to be - too limited for the guideline to be useful. In part, this is about language. Suggesting that some groups and settings will not be "covered" risks those working with those groups and in those settings believing that the guidelines will not have any relevance or application to them. The scope could perhaps just be clearer that some groups and settings will not be specifically investigated but that the resulting guideline will still be of relevance and interest to these. Some of our specific comments below cover some of these exclusions.	scope and removed some limits to the groups that will be covered.
25	SH	National Treatment Agency for Substance Misuse	3	2	We are not persuaded that it is appropriate for the guideline scope not to include severe personality disorders, which – like psychosis – are also likely to be seen by both adult mental health and substance misuse services and for whose patients access to specialist services can be problematic. Personality disorder services have variable levels of access across the country and may specifically exclude those who use illicit drugs.	The problem is to do with the time and resources this guideline will consume by extending the guideline scope to include ALL severe forms of mental illness/disorder. For this reason we have decided to limit the guideline scope to psychosis and substance misuse. We have recently produced two guidelines on personality disorder.
26	SH	National Treatment Agency for Substance Misuse	4	2	We are similarly not persuaded that it is appropriate for the guideline scope not to include common psychiatric disorders such as anxiety, depression and PTSD. In drug treatment services these are the most commonly seen dual diagnoses. The risk is that the guideline is seen primarily as being directed at adult mental health services and of little relevance to specialist substance misuse services.	The problem is to do with the time and resources this guideline will consume by extending the guideline scope to include ALL severe forms of mental illness/disorder. For this reason we have decided to limit the guideline scope to Psychosis and substance misuse.
50	SH	National Treatment Agency for Substance Misuse	5	4.1.1 a	We are unclear why the scope covers “young people (15 and older)”. The usual “cut-off” ages for young people are 16 or 18. Where NICE guidelines consider young people we are aware that some go considerably younger than this (e.g. Depression in YP (CG28) refers to 12-18; substance misuse in YP (PH4) 11-16, and smoking (PH14) all under 18s). Whatever the age cut-off finally agreed – and the justification for	Thank you, we have now changed the age range to “14 and older” to reflect the fact that early intervention services generally use 14 as a cut-off.

					this – it will be important that transition between young people's and adult services is considered, and that appropriate, relevant expertise in this area is represented on the GDG.	
63	SH	National Treatment Agency for Substance Misuse	6	4.1.2 a	We understand that the intention of the scope is NOT to exclude drug-induced psychosis but we are concerned that this is how the scope will be interpreted. It would perhaps be appropriate to include a section on how a diagnosis of drug-induced psychosis can (and cannot) be arrived at. Currently the drug-induced psychosis diagnosis can be used as a way of excluding clients with genuine dual diagnosis from accessing specialist mental health services. The validity of this diagnosis is at times questionable. There is a risk that clients with schizophrenia or bipolar disorder who use illicit drugs may be labelled as having a drug-induced psychosis, even when they do not meet ICD-10 criteria for this diagnosis.	Given the feedback from the stakeholder meeting, we will not specifically exclude "drug induced mental illness".
73	SH	National Treatment Agency for Substance Misuse	7	4.1.2 b	We understand and support the rationale behind restricting the scope to exclude those with late onset mental illness. We would just suggest that some consideration is given to how this fits with the recent findings of the Healthcare Commission that "Older people are often excluded from key mental health services because of their age … The study showed older people were often unable to access the full range of services, including: out of hours services; crisis services; psychological therapies; drug and alcohol misuse services".	Thank you for your comment. Although we will not be making 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.
76	SH	National Treatment Agency for Substance Misuse	8	4.2	In the substance misuse field a growing proportion of specialist interventions are provided by the non-statutory and private sectors. The competencies of non-NHS staff in the assessment and management of dual diagnosis may not be as high as those of NHS staff. Even within NHS specialist substance misuse services many staff do not have psychiatric training. Any consideration of settings should also include a consideration of the skills and competencies of the staff working in these settings.	This is an NHS guideline. We will cover identification and assessment (4.3.1.(a)).
77	SH	National Treatment Agency for Substance Misuse	9	4.2	It will be important that services providing Tier 4 interventions (residential rehabilitation and inpatient assessment, stabilisation and detoxification) for drug users are covered.	Thank you. The treatment for drug users is covered in previous guidelines. We will be addressing the treatment/management of psychosis with co-existing substance misuse in inpatient settings including forensic ones.
88	SH	National Treatment Agency for Substance Misuse	10	4.2 b	We are not persuaded that it is appropriate to exclude prison medical services from the scope. These are now commissioned by NHS PCTs and expected to provide the same standards of	Thank you. The guideline will be of relevance to all parts of the NHS including prison services, although we will not be

					care as in the community.	addressing evidence specifically developed within prison services.
92	SH	National Treatment Agency for Substance Misuse	11	4.3.1	At present only psychosocial interventions for drug misuse (and for acute psychosis) are mentioned but we would expect to see psychosocial interventions for other mental health disorders also covered in the scope. Many clients with substance misuse problems and dual diagnosis have difficulty accessing psychosocial interventions for their mental health problems, including those interventions for severe enduring mental health problems.	Thank you for your comment. In order to ensure that the scope of this guideline is manageable in the timeframe allowed, we believe the guideline should be limited to people with psychosis; therefore, the relevant interventions would be for the treatment of psychosis and substance misuse.
115	SH	National Treatment Agency for Substance Misuse	12	4.3.1 f	In addition to inpatient care, we would wish to see residential rehabilitation covered	Thank you, we have added “Residential rehabilitation and inpatient assessment, stabilisation and detoxification”.
3	SH	NHS Direct	1	Gen eral	After consultation no specific comments on scope. Guideline welcome by NHS Direct.	Thank you for your comment.
21	SH	Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust	1	1	We question the narrowness of the scope in focussing only on psychosis. While we understand that the guideline needs to retain a focus that is practicable, we think it would be better to extend the guideline to cover severe mental illness. There is a significant body of literature which uses severe mental illness as its operational definition in examining treatment effectiveness and this evidence will not be available to the guideline group if the focus is only on psychosis. In addition the group of patients with severe mental illness without psychosis e.g. severe depression, bipolar disorder (many bipolars do not experience psychosis), OCD etc. and substance misuse will be excluded from the guideline, and this may have a significant impact on their treatment by mental health services.	The problem is to do with the time and resources this guideline will consume by extending the scope beyond psychosis to include ALL severe forms of mental illness/disorder. For this reason we have opted to limit the guideline scope to psychosis and substance misuse.
27	SH	Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust	2	2	Echoing our comments pertaining to 1. We note that the remit from DoH asks for guidelines relating to severe mental illness, not just psychosis, we therefore question the equation of severe mental illness with psychosis.	The problem is to do with the time and resources this guideline will consume by extending the guideline scope to include ALL severe forms of mental illness/disorder. For this reason we have decided to limit the guideline scope to psychosis and substance misuse.
34	SH	Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust	3	3.1 a	We would advocate for the use of substance misuse rather than substance dependence as the level of problem that the guideline should be aimed at. We believe that if we do not intervene until a substance dependence level of problem has developed, then the cost and duration of successful treatment for this population will be significantly increased	Thank you, we agree and have attempted to improve the wording of this section to make it clearer how substance abuse will be defined for the purposes of the guideline.

37	SH	Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust	4	3.1 b	We would suggest the review of the prevalence rates documented should include prevalence rates in inpatient Psychiatric care (about 30-40%) and Forensic Mental health Medium and low security (fall between 50-70%) as these patients form a huge part of the unmet need. We note that NHS substance misuse teams and voluntary agencies do not commonly see inpatients so the need is often much greater within this population.	Thank you, we have amended the text with these prevalence rates; with further data from: Phillips P, Johnson S 2003 Drug and alcohol misuse among in-patients with psychotic illnesses in three inner-city psychiatric units Psychiatric Bulletin 27:217-220).
39	SH	Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust	5	3.1 c	It may be worth mentioning that all of the outcomes of poor treatment of patients with a Psychotic Disorder and a substance misuse problem, have increased cost implications. Drake (et al 1998 and 1996)suggested, in their studies around providing an Integrated Model of care (considered preferable to Parallel and Sequential), that improved treatment outcomes could be delivered at a rate in which any initial expenditure to set up this type of service was recouped in 5yrs.	Thank you for your suggestion. We have made a general statement about cost implications in 3 (g), and the guideline development group will look at health economic evidence where appropriate, as described in 4.3 (i).
48	SH	Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust	6	3.2 d	We would suggest that Enhanced Parallel models of care are also included as a separate treatment model. There is evidence (and national guidance) that integrated models of care provide best practice and outcomes for this client group. It is however a large jump from existing service models and we would hope the Guideline Development Group consider Enhanced Parallel models of care initially with guidance and timeframes to work towards providing an Integrated Service Model. This was advocated in the DoH guidelines on dealing with patients with a Dual Diagnosis in inpatient settings.	Thank you for your suggestion. We don't believe that 'enhanced parallel models of care' represent a separate model, but rather a transition from parallel to integrated, and as such will be covered in the review if evidence is available.
70	SH	Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust	7	4.1.2 a	We would suggest that this term is dropped. We feel strongly that 'drug-induced mental illness' is not a helpful nosological entity and is often used as a way of excluding needy individuals from treatment	Given the feedback from the stakeholder meeting, we will not specifically exclude "drug induced mental illness".
75	SH	Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust	8	4.1.2 b	It seems a little unbalanced to include the needs of those with Learning Difficulty and not the needs of those with a primary diagnosis of Personality Disorder. The group with Personality Disorder and substance misuse are noted to be a very high-risk group in terms of suicide and homicide in the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, they also make up the majority of patients in our assertive outreach teams.	The problem is to do with the time and resources this guideline will consume by extending the guideline scope to include ALL severe forms of mental illness/disorder. For this reason we have decided to limit the guideline scope to psychosis and substance misuse. Most assertive outreach teams provide services for people with psychosis rather than personality disorder, although we understand that this does vary in some places. Nevertheless the implementation

						guide produced by the Department of Health does specify people with severe mental illness and equates this as effectively people with psychosis
81	SH	Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust	9	4.2 a	Mental Health tertiary settings e.g. forensic psychiatry, are where a huge amount of unmet need regarding treatment provision for substance misuse falls, and a huge amount of Multidisciplinary Teams are already having to make decisions about these patients care without practice guidelines (such as NICE). This population should not be missed in these guidelines	Thank you. We have added inpatient and forensic settings.
114	SH	Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust	10	4.3.1 d	We hope that psychosocial interventions for drug and alcohol use will be included	Thank you, we have changed the word "drug" to "substance" to make it clear that alcohol will be covered.
89	SH	Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust	11	4.2.1 e	As above: interventions for alcohol in addition to drug problems should be assessed.	Thank you, the word "drug" has been replaced by "substance".
116	SH	Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust	12	4.3.1 f	We would hope that in-patient settings will include rehabilitation and secure environments – assuming evidence is available.	Thank you, we have added "Residential rehabilitation and inpatient assessment, stabilisation and detoxification".
35	SH	PROGRESS: National forum for consultant nurses in dual diagnosis and addictions	1	3.1 a Line 8 onwards	We recommend considering a broader conceptualisation of problematic substance misuse than is suggested here. Although the criteria noted are typically identified as characterising problematic substance misuse, for people with severe mental illness even relatively small amounts of substance use can be a significant problem - the 'supersensitivity' model (Mueser, K T, Drake R E, Wallach M A (1998) Dual diagnosis: a review of aetiological theories, *Addictive Behaviour* 23 (6): 717-734). It will be important to pay attention to this. Also hazardous and harmful alcohol use would not meet the 'problem' substance misuse criteria described but such drinking patterns should be targets for interventions.	Thank you, we agree and have attempted to improve the wording of this section to make it clearer how substance abuse will be defined for the purposes of the guideline.
38	SH	PROGRESS: National forum for consultant nurses in dual diagnosis and addictions	2	3.1 b	The prevalence data here seem rather modest. The Epidemiological Catchment Area Study (Regier et al 1990) found that 47% of people with schizophrenia had a lifetime prevalence of problematic drug and/or alcohol use (Regier D A, Farmer M E, Rae D S et al 1990 Co-morbidity of mental disorder with alcohol and other drug abuse: results from the ECA study *Journal of the American Medical Association* 264: 2511-2518)	Thank you, we took the prevalence rates from UK studies, rather than using US studies such as Regier et al. We have added further information about the prevalence of substance misuse in people in inpatient mental health services

					Phillips and Johnson (2003) found that 49% of people admitted to London psychiatric wards with a psychotic disorder were also misusing substances (Phillips P, Johnson S 2003 Drug and alcohol misuse among in-patients with psychotic illnesses in three inner-city psychiatric units *Psychiatric Bulletin* 27:217-220).	(based on Phillips & Johnson, 2003, and data from other stakeholders).
40	SH	PROGRESS: National forum for consultant nurses in dual diagnosis and addictions	3	3.1 d	Although it is important to highlight the links between crime and substance misuse, DTTOs were rarely used for people with a severe mental illness. Indeed such a diagnosis was often an exclusion criterion.	Thank you, this is useful information, although doesn't necessitate a change to the scope.
44	SH	PROGRESS: National forum for consultant nurses in dual diagnosis and addictions	4	3.2 a	It would also be appropriate to highlight standards 6 and 7. The carers of people with a 'dual diagnosis' can experience very significant challenges in supporting their family member. Standard 7 is especially pertinent given the findings of the National Confidential Inquiry Reports. Using a narrow definition of dual diagnosis (ie severe mental illness and substance misuse) Avoidable Deaths reported that 27% of the suicides in their sample were committed by this group and that this was an increase since the 2001 report (University of Manchester 2006 *Avoidable Deaths* National Confidential Inquiry into Homicides and Suicides by People with Mental Illness, Manchester) CPA: It is worth noting that Refocusing the CPA (DH 2008) identified people with a dual diagnosis as a 'key group'. It is clear that care for people with a psychotic disorder and substance misuse problem should be within the CPA framework (DH 2008 *Refocusing the CPA,* DH, London) Assertive Outreach and Crisis Resolution: While AO guidance makes it clear that people with psychosis and substance misuse problems are a target group for such teams (DH 2001: *Mental Health Policy Implementation Guide* DH, London), Crisis Resolution guidance is less clear. There are anecdotal accounts of Crisis Resolution/Home Treatment Teams excluding people with substance misuse problems.	Thank you for your comment. The information you provide is useful for guideline development, but is probably more detail than is required for the scope.
52	SH	PROGRESS: National forum for consultant nurses in	5	4.1.1 a	See 3.1a regarding ensuring a broad definition of substance misuse	Thank you, we agree the definition needs to be kept broad.

		dual diagnosis and addictions				
82	SH	PROGRESS: National forum for consultant nurses in dual diagnosis and addictions	6	4.2 a /b	It would be appropriate to consider the role of third sector provider agencies. They often play a key role in the care and treatment provision of this group but would not fall into the primary/secondary healthcare category. Perhaps they should be included under b) but their role may span several 'types' of service provider. b) Housing providers should also be added to this list.	Thank you. We have amended 4.3.1.(g) to include working with non NHS organisations
16	SH	Royal College of Nursing	1	General	With a membership of over 400,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations. The RCN welcomes proposals to develop this guidance. It is very timely.	Thank you for your comment.
17	SH	Royal College of Nursing	2	General	It seems for far too that long patients with severe mental health and substance misuse problems have been to some degree ignored. It would seem an ideal time to look at this after the new Department of Health and NICE guidelines on substance misuse are developed, but it would have of course been better to have them both produced at the same time.	Thank you for your comment.
53	SH	Royal College of Nursing	3	4.1.1 a	If Bi polar disorders are covered within this document why is Mania not included as a separate entity? If Mania would be included in some way in the Bi Polar tag line, this should be clarified.	Thank you for your comment. Although there is some heterogeneity between the major diagnostic classification systems in the criteria for bipolar disorder, ICD-10 requires two discrete mood episodes, at least one of which must be manic. In DSM-IV a single episode of mania or a single episode of hypomania plus a single major depressive episode would warrant a diagnosis of bipolar disorder.
18	SH	Royal College of Nursing	4	General	There should be some acknowledgement of the Dual Diagnosis good practice guide from 2002 and how the two documents would potentially link. If this is missed this it looks as if	Thank you for your suggestion. The Dual Diagnosis Good Practice Guide was identified during the scoping search, as

					government departments are not acknowledging any form of joined up working.	were many other DH documents. It is not usual practice to cite non-NICE documents in the scope. Nevertheless, the GDG will be made aware of the good practice guide, and follow NICE methodology with regard to reviewing evidence of this type.
42	SH	Royal College of Nursing	5	3.1 e	This statement is rather confusing and the inference within this section is unclear. When the word 'inpatient' is used here, one assumes this means mental health inpatient, however a drugs worker may well read this as in patient for their substance misuse in a substance misuse specific facility.	Thank you, we have amended this section to make the point clearer.
61	SH	South East Development Centre	1	4.1.2 a	Exclusion of people with a drug induced mental illness. Whilst I can appreciate the arguments surrounding exclusion of this group from the guideline I am concerned that by excluding this group an important clinical issue will be missed. On a practical clinical level the diagnosis of 'drug induced psychosis' can be used to exclude people from ongoing support from mental health services on pretty inconclusive evidence and this is of particular significance for individuals presenting to acute inpatient units as part of their first episode. Evidence suggests that a timely intervention during first episode and good psychiatric follow up after inpatient admission can reduce the risk of relapse, however for those excluded as having a 'drug induced psychosis' this support is delayed. I would argue that a significant number of those given this initial diagnosis do revolve back into the psychiatric system at a later date. Though I don't think the guideline should concentrate on this group I do think there should be some inclusion of these issues in the guideline to challenge the efficacy of a 'pure' diagnosis of drug induced psychosis in these cases.	Given the feedback from the stakeholder meeting, we will not specifically exclude "drug induced mental illness".
101	SH	Sussex Partnership NHS Foundation Trust	1	4.3.1 a	Could identification and assessment include a multi-disciplinary formulation process including mental health and substance misuse expertise	Thank you, we will pass your suggestion to the Guideline Development Group when they meet to discuss this topic.
96	SH	The Princess Royal Trust for Carers	1	4.3.1	As an overall point on this section, the final guidelines would be strengthened if they included points on how carers can, for example, improve identification and assessment, insight and adherence to treatment. A wealth of information in support of this is available in the National Treatment Agency's Carers Guidance (www.nta.nhs.uk) and the Partners in Care website, produced by The Royal College of Psychiatrists and The Princess Royal Trust for Carers (see www.partnersincare.co.uk). Involving families and carers in the treatment process can help	Thank you for your suggestion. This information will be passed to the Guideline Development Group. We do not believe the scope needs to be changed to specifically include carers.

					to provide better focus on patient's individual needs, and promote better outcomes.	
28	SH	WEST LONDON MENTAL HEALTH NHS TRUST	1	3.1	I would comment on 3.1 in which psychosis is identified as a condition characterised by hallucinations and delusions. Particularly for the purpose of this scoping I would like it emphasised that psychosis is as characterised by disturbance of thinking and language as well as of motivation, executive planning and organisation.	Thank you. There are numerous variations that could be included. Our aim is not to be too specific beyond characterising the major psychoses.
13	SH	WEST LONDON MENTAL HEALTH NHS TRUST	2	General	The guideline looks like it will be helpful for those working in primary and secondary care settings but may not cover tertiary care/specialist services such as ours at Broadmoor. In this setting, we are not dealing with individuals who simply have a diagnosis of psychosis and substance misuse, but with the complex treatment requirements of mentally disordered offenders detained in conditions of maximum security. As such we aim to look at the relationship between patients' substance misuse, their (complex) mental health issues (arising from a range of Axis I and II diagnoses) and offending in an integrated way. While the proposed review of the evidence base into integrated treatment will be of value and interest to us, I am wondering whether a separate guideline is to be developed for specialist services such as High Security? This would certainly be helpful, in particular it would be helpful to have questions answered regarding the extent to which work on substance misuse should be conducted in conditions of maximum versus medium security.	Thank you for your comment. We agree that treatment within the prison setting is complex and would be better covered in a separate guideline. Please suggest this to NICE through their website.
14	SH	WEST LONDON MENTAL HEALTH NHS TRUST	3	General	A review of the evidence base for the three models of care, serial, parallel and integrated treatment, will be helpful. The last of these would seem to be largely referring to mainstreaming of care within multi-disciplinary community mental health teams (CMHT), and the implications for service configuration, capacity building and training would need to be addressed. It would also be helpful to see whether the evidence suggests relevant criteria that could be applied to identify cases where parallel treatment between a CMHT and a specialist substance use service would be most appropriate.	Thank you, we agree that reviewing the evidence base for the three models of care will be an important part of this guideline.
15	SH	WEST LONDON MENTAL HEALTH NHS TRUST	4	General	The development of a guideline in this area is welcome, as substance use is a common problem amongst people with psychotic illness and associated with a range of negative outcomes. However, while the scope mentions substance use and drug use, alcohol is not mentioned specifically. Given the high rates of psychosis in heavy alcohol users, this may need to be addressed as a distinct evidence base.	Thank you, we agree and have attempted to improve the wording of section 3.1 (a) to make it clearer how substance abuse will be defined for the purposes of the guideline.