National Institute for Health and Clinical Excellence

Psychosis and Schizophrenia in Children and Young people
Guideline Consultation Comments Table
9am Thursday 9th August – 5pm Thursday 27th September 2012

Type	Stakeholder	Order No	Document	Page No	Line No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	Bristol-Myers Squibb and Otsuka Pharmaceuticals	1	Full	37	1	The safety profile of available anti-psychotics, which is what mostly differentiates them, is never clearly compared, which could help clinicians not only choose the most appropriate treatments for individual patients, but also improve the relevant monitoring of potential adverse events, which remains poor, even in adults (as underlined on page 37, first paragraph). We suggest that a table summarising the risks associated with each antipsychotic, similar to what can be found, for example, in the eleventh Maudsley guidelines (page 151), albeit updated with younger patients data when available, would be very useful in bringing together scattered data that readers might otherwise overlook. In particular, summarising the potential of sedation of the different drugs, and maybe how to best address the issue, would be useful as, as stated in this draft, 'the onset of schizophrenia during childhood disrupts social and cognitive development'. **Ref:** The Maudsley Prescribing Guidelines in Psychiatry, 11th Edition edition. Wiley-Blackwell. (2 Mar 2012). ISBN 978-0470979488	Thank you for your comment, but we are not at all sure to what you are referring because your comment is about drugs but the paragraph referenced is about teams and primary and secondary care interface. In any event, the bulk of the evidence upon which recommendations are made resides in the adult schizophrenia guideline, in which there is a detailed analysis of side effects and side-effect profiles of different drugs. The evidence regarding side effects in children is nowhere near as comprehensive. It would not make sense for us to produce a Maudsley-style table with an evidence base that mainly shows that children and young people are perhaps more

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							likely to experience side effects at lower doses and they may be more severe - the evidence is not great in this regard.
SH	Bristol-Myers Squibb and Otsuka Pharmaceuticals	2	Full	General		The NICE Clinical Guidelines for the management of bipolar disorder in adults, children and adolescents, in primary and secondary care, specifically recommend, in children and adolescents, the use of an antipsychotic that is associated with low weight gain and non-elevation of prolactin levels as the first-line prophylactic agent for prevention of mania relapse. Given that the present guidelines address a population of similar age which is also treated with antipsychotics, we believe that a similarly careful approach here would be worthy and ensure consistency between the two recommendations.	Thank you for your comment, we feel this is addressed in recommendation 1.3.14 of NICE guideline. The emphasis in this guideline is on coming to a joint decision with parents and children based on a discussion of benefits and harms and this includes weight gain.
SH	Bristol-Myers Squibb and Otsuka Pharmaceuticals	3	Full	General		While it is acknowledged that 'Many of the antipsychotic drugs,…, will not have been granted a Marketing Authorisation (Product Licence) for use in children and adolescents', it is never specified which ones have, and which ones do not have, this authorisation. We believe that, before engaging their 'professional responsibility inherent in their (off-label) use', prescribers should be made aware of which options have sought and received authorisation, and in which populations, i.e. have demonstrated in a rigorous way both their efficacy and favourable safety profile in this sensitive population.	Thank you for your comment, however a NICE guideline is not restricted to recommending drugs authorised for marketing. In the NICE guideline it states that 'The guideline will assume that prescribers will use a drug's summary of product characteristics (SPC) to inform decisions made with individual patients'
SH	Bristol-Myers Squibb and Otsuka Pharmaceuticals	4	Full	General		We note the comment in NICE Technology Appraisal 213, regarding the use of aripiprazole in this age group, and believe the text in this draft guideline should be adapted to ensure consistency with TA213. Reading the whole document, one might have the impression that all antipsychotics are potential first-line treatments for a given	Thank you for your comments. The recommendations made in TA213 have been included, verbatim, into this guideline as per NICE processes. This was also validated

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						individual (6.5.14.1; 6.6.12.1; 7.27.1.1 'For children and young people with first episode psychosis offer – oral antipsychotic medication'…), but in the case of aripiprazole, the overall impression is that it can only be recommended after unsatisfactory treatment with risperidone and only in patients aged 15-17. While this certainly reflects TA213, it is at odds with the wider scope of these guidelines, where the vast majority of pharmacotherapeutic options considered are to be used out-of-label, sometimes with very little supporting evidence, and where none are recommended to be used in any particular order, or in any definite subgroup of patients. We think all the possible out-of-label pharmacological options can not appear as recommended above one of the few drugs being approved for use in these patients: wording of 7.27.4.2 should be adapted, or explained/clearly put in context of guidance 213.	when NICE reviewed this guidance.
SH	Bristol-Myers Squibb and Otsuka Pharmaceuticals	5	Full	General		We read with great interest the summary of the unpublished AZ D1441C00112 data on the use of quetiapine in adolescents with schizophrenia. Given the acknowledged paucity of data in the long-term impact of antipsychotic treatment in the considered age group (7.20; 95 patients identified in total), it would be relevant also to include the 6-month (Study 31-03-241; N=237) and the ongoing (Study 31-05-243) open-label follow-up studies of aripiprazole in children and adolescents. We were not contacted about providing unavailable data that might be relevant to these guidelines, but these results have been published as posters, the details of which are included in TA213.	Thank you for highlighting the as yet unavailable data for studies 31-03-241 and 31-05-243, however the status of these studies was ongoing at the cut off date for the evidence search and, as NICE guidelines do not include data from ongoing trials, you were not contacted for this data.
SH	Bristol-Myers Squibb and Otsuka Pharmaceutical	6	Full	General		We believe that the clear-cut differentiation that is often being made between FGAs and SGAs is not reflecting the complexity of the working mechanisms of these drugs, most of which have a	Thank you for drawing attention to this. We agree and feel this is reflected throughout the guideline,

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	s					‘rich’ pharmacology: chlorpromazine, an FGA, for example poses clear sedation and metabolic risks, while aripiprazole, an SGA, much less. Also, greater sensitivity to adverse events in this age group is not limited to the side effects typical of SGAs, with younger patients treated with FGAs showing a much increased risk of extra-pyramidal symptoms compared to adults (Keepers 1983). We suggest to mostly avoid generalisations, in favour of clearly stating which drugs, or sub-group of drugs, are most likely to cause a particular adverse event, without too much regard for classes, as actually suggested on page 215 of the guidelines (‘choosing the most appropriate drug and formulation for an individual may be more important than the drug group (FGA or SGA)’). **Ref:** Keepers GA, Clappison VJ, Casey DE. Initial anticholinergic prophylaxis for neuroleptic-induced extrapyramidal syndromes. Archives of General Psychiatry 1983 Oct;40(10):1113-7.	(see Chapter 7, p 201, second paragraph).
SH	Bristol-Myers Squibb and Otsuka Pharmaceutical s	7	Full	19	18-26	We believe the summary of the ‘landmark study’ from Correll et al., 2008, on page 19 is not as accurate as could be: ‘This revealed high prevalence and rapid onset (within 12 weeks) of weight gain and metabolic disturbances. Changes were dose related with risperidone, whereas only adverse metabolic effects were dose related with olanzapine, and no dose relationship was observed with aripiprazole and quetiapine.’ This gives the impression that both quetiapine and aripiprazole were associated with weight gain and metabolic disturbances, and that this was dose-independent, while in fact aripiprazole was not associated with metabolic disturbances at all, only weight gain (indeed in a dose-independent manner), as acknowledged in the original publication (‘Metabolic baseline-to-end-point	Thank you for your comment. We agree with your comment and have made changes accordingly.

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						changes were not significant with aripiprazole or in the untreated comparison group.')	
SH	Bristol-Myers Squibb and Otsuka Pharmaceuticals	8	Full	259	1	We do not believe that integrating the Haas 2009 study here is the most appropriate choice: the choice of a tenfold lower dosage was merely used as a control, given the reluctance to use a placebo, as stated by the authors in the text of the article. We do appreciate that considering this article in the section of the guidelines comparing pharmacological treatments to placebo will probably result in under-estimating the side effects associated with risperidone, as the difference of the therapeutic dose with the pseudo-placebo dose is likely to be smaller than with a real placebo, but feel that if kept at the place where it is now, it artificially gives the impression that increasing the dose of risperidone will result in much more favourable results in terms of efficacy, which is generally not very clear with other antipsychotics, as noted in the rest of the guidelines, and which probably cannot be concluded from this study with clearly sub-therapeutic drug levels in one arm.	Thank you for your comment, however the GDG considered the lower dose of risperidone used in this study to not be comparable to a placebo and therefore feels it has been incorporated into the most appropriate section. Efficacy and side effect outcomes have therefore been reported for each treatment group in the Haas et al. (2009) trial, as with all other comparisons in the other included trials in this section, i.e. in a transparent way, setting out the findings for each dose, for each drug. Furthermore, the GDG believe the context of the quality of the evidence has been clearly reported in section 7.3.7, in which it has been stated: "no robust conclusions can be drawn regarding antipsychotic medication in the treatment of the acute episode in children and young people with psychosis or schizophrenia" and therefore the GDG believe the specific results

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							associated with the Haas et al. (2009) trial could not be said to be over or under estimated.
SH	Bristol-Myers Squibb and Otsuka Pharmaceuticals	9	Full	281	2	We are of the opinion that if available, Z-scores should also be presented next to weight gain and BMI increase, as in children and adolescents followed-up for 6 or 12 months, weight gain accompanying natural body growth is to be expected.	Thank you for your comment, however we believe the data presented is sufficient and in-line with NICE methods for guideline development.
SH	CNWL NHS Trust					Vocational services for people with severe mental health problems: Commissioning Guidance. (Department of Health/Department for Work and Pensions. London) Department of Work and Pensions (2009) Realising Ambitions: Better Employment Support for people with a mental health condition. (DWP. London) 10.Centre for Mental Health (February 2009) Briefing Paper 37: Doing What Works, Individual Placement and Support into Employment (Centre for Mental Health. London) 14. Bond GR, Kukla M, Impact of Follow Along Support on Job Tenure in the Individual Placement and Support Model. Journal of Nervous and Mental Disease, March 2011 – Volumne 199 – Issue 3 – pp 150-155	Thank you for drawing attention to this. These recommendations were drawn from the adult guideline for Schizophrenia and we are currently considering new evidence in an update of this guideline. When the children's guideline is reviewed for update, this may be considered.
SH	CNWL NHS Trust	1	NICE guideline	21	6	"assessments in early intervention in psychosis services are multidisciplinary". Please add what you consider to be the essential staff mix for this team. Otherwise this will be interpreted in some team by a junior doctor and a nurse and nothing more. I would like to see other professions suggested e.g. OTs, pharmacists, support workers, staff to assist with work placements/training. Etc	Thank you for your comment. The standard term that we use is healthcare professional unless there are very good reasons to be specific – for example, prescribing of controlled drugs, some particular role within the NHS (eg the coordinating role and gatekeeping role

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							of GPs), or some other statutory duty which rests with a particular professional group (eg social work roles). We are not concerned with professional roles per se, but with interventions and care being delivered by hcps with the relevant competencies and experience. Which profession provides care is beyond the scope of this guideline.
SH	CNWL NHS Trust	2	NICE	26	16	Currently reads “The choice of antipsychotic medication should be made by the parents or carers of younger children, or jointly with the young person and their parents or carers, and healthcare professionals.“ Please partially delete so that it reads: “The choice of antipsychotic medication should be made jointly with the young person and their parents or carers, and healthcare professionals.“	Thank you for your comment, but we are distinguishing here between younger children, and older children who may be Gillick competent. In some circumstances when the child is very young, and antipsychotic medication is deemed to be the most suitable treatment, the decision may need to be made between the healthcare provider and the parents/carers alone.
SH	CNWL NHS Trust	3	NICE	27	vario us	Please add some text about offering appropriate formulations to younger children e.g. orodispersible or liquids, rather than language as formulation may be a further barrier in some younger people.	Thank you for your comment; however we cannot make recommendations about specific formulations without an evidence base to link them to.

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SH	CNWL NHS Trust	4	NICE	33	1	Typo in reference number "1.3.243"	Thank you for pointing this out, we have corrected the section number.
SH	CNWL NHS Trust	5	NICE	38	15	Please change "high potency" to "typical"	Thank you for your comment, however the GDG feel the words 'high potency' should remain and no change has been made.
SH	CNWL NHS Trust	6	NICE	38	vario us	Please refer the reader to the Guidelines on Violence, as this is a very brief section and we need a lot more added e.g. post RT Psychical heath monitoring.	Thank you for your comment; however the NICE guideline on Violence is a guideline regarding adults and would therefore not be appropriate to refer to.
SH	CNWL NHS Trust	7	NICE	42	4	Typo in reference number "1.3.243" Please add text emphasising the enormous importance of adherence to medicines and reference to all the data that demonstrates increased relapse rates and poorer outcomes with poor adherence. There should also be mention of the role of clozapine and depots – it feels like an omission not to comment on their potential place (as is done in the "Adult" schizophrenia guidance).	Thank you, 1.3.243 has been corrected. We have also noted your comments, but some aspects, e.g. adherence to medicines, remain outside the scope of the guideline. This is a guideline for children and young people, so depots are not referred to as they are only used for adults.
SH	CNWL NHS Trust	8	NICE	30	5-6	Please delete. It is inconsistent to specifically address the advice to give about one drug (which is highly unlikely to be used) and then not equally give advice about all other equally serious concerns relating to other named medicines.	Thank you for your comment. This recommendation comes from a previous guideline and as there is a Product Licence for this drug to be used in children, the GDG have decided to keep the recommendation as it

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							stands.
SH	CNWL NHS Trust	9	NICE Full	148-190		There is lack of review of the value of activities, occupations and occupational therapy in the psychological interventions section - which focus on Arts therapies, CBT and Family interventions, while there is very little evidence re RCTs in this area there is qualitative research, Brown, J. (2011). 'Talking about life after early psychosis: The impact on occupational performance'. *The Canadian Journal of Occupational Therapy,* 78**,** 156-163. Brown, W. & Niki, K. (2007). Recovering mental health in Scotland. Report on narrative investigation of mental health recovery. ed. Glasgow: Scottish Recovery Network. Byrne, R., Davies, L. & Morrison, A. P. (2011). 'Priorities and preferences for the outcomes of treatment of psychosis: A service users perspectives'. *Psychosis,* 2**,** 210-217. Cook, S. & Chambers, E. (2009). 'What hinders people with psychotic conditions doing what they want in their daily lives.'. *British Journal of Occupational Therapy,* 72**,** 238-248. Kupra, T., Woodside, H. & Pocock, K. (2010). 'Activity and social participation in the period following first episode psychosis and implications for occupational There is also negligible reference to the Recovery approach	Thank you for your comment and the references provided. We agree that these are important aspects. However, we did not identify evidence in children and young people andthe references suggested are adult studies and therefore outside the scope of this guideline. In regards to your comment on Recovery, we believe that this is covered in section 1.8 (Promoting recovery and providing possible future care in secondary care).
SH	CNWL NHS Trust	10	NICE	43	1.6.18	There is no mention of the evidence based Individual Placement and Support Model which is	Thank you for drawing attention to this. These

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						internationally considered the most effective at supporting people with mental health problems to access paid employment. The model has been successfully implemented across the UK. Please refer to the following references: Waghorn and Lloyd: The importance of Vocation in recovery for young people with psychiatric disabilities. British Journal of Occupational Therapy. Becker, Haiyi, McHugo, Halliday, Martinez 2006. What predicts supported employment programme outcomes. MH Journal Vol 42, No 3,June 2006. Becker, Swanson, Bond, Merren Evidenced Based Support Employment Manual 2008, Dartmouth Psychiatric Research Centre, Waghorn and Lloyd: The Importance of vocation in recovery for young people with psychiatric disabilities, Birtish Journal of Occupational Therapy. Domminy and Butcher: Does paid work produce positive social capital returns for people with severe and enduring mental health conditions, IPS Services, South Downs Housing Mental Health and Social Inclusion, Vol 16 Issue 1 (2012) Department of Health and Department for Work and Pensions (2006	recommendations were drawn from the adult guideline for Schizophrenia and we are currently considering new evidence in an update of this guideline. When the children's guideline is reviewed for update, this may be considered.
SH	College of Mental Health Pharmacy		Full	302	2	The College fully supports the provision of information about potential benefits and side effects of antipsychotics and is of the view that the Guideline should specify that WRITTEN information in age appropriate form e.g. pictorial is provided. This information should be validated and reviewed on a regular basis	Thank you for your comment; we believe that this is covered in the guideline, see recommendations 4.6.3.2 and 4.6.3.3.
SH	College of Mental Health Pharmacy	2	Full	302	28	See note above about provision of written information	Thank you for your comment. We believe that this is covered in the guideline, see

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							recommendations 4.6.3.3 and 4.6.3.4.
SH	College of Mental Health Pharmacy	3	Full	304	1	The College fully supports this recommendation to record the reason for dosages above the BNF etc. The College would like to see the recommendation go further than this and advise that the Recommendations in the Royal College of Psychiatrists Consensus statement on High dose Antipsychotics 2006 (summarised in BNF section 4.2) are also included	Thank you for your comment. The GDG have discussed this issue but came to the conclusion that the recommendation is adequate as it stands, as it references BNF.
SH	College of Mental Health Pharmacy	4	Full		11	The College fully supports this recommendation Evidence from Prescribing Observatory for Mental Health Audits show that PRN medication is one of the most common reasons for prescribing higher than BNF doses of antipsychotics	Thank you, noted.
SH	Community Links	1	Full	10	4	Not giving a positive message about psychological interventions .It is worth illustrating offering choice of interventions can be very important if we are to encourage engagement with mental health teams, especially for those who are making a clear decision about not wanting to take medication. We would appreciate more emphasis on the challenges of engagement and how choice may be a way to facilitate this.	Thank you for your comments. The GDG reviewed the evidence for psychological interventions systematically and recommended the provision of these interventions on this basis. The GDG emphasise and highlight patient choice regarding the type of treatment chosen. However, patient choice does not mean that non-evidence based forms of an intervention should be used.
SH	Community Links	2	Full	11	12	If in all situations secondary services were to be responsible for physical monitoring it would be a limited approach to adopt. In our Early Intervention service model we have promoted positive continued involvement of primary care	Thank you for your comments, we agree and believe this is covered elsewhere (see recommendation 4.6.12.2,

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						and GPs whilst we are working with young people, and this may include where appropriate monitoring anti psychotic medication in the first year. Where a GP is seeing the young person regularly this may be the most practical arrangement, and the secondary service can be available for laison.It is also our philosophy to discourage over involvement with secondary services when not required with less problematic presentations.	4.6.12.5 and 4.6.12.7.
SH	Community Links	3	Full	11	21	We felt there should be more emphasis about the importance of age appropriate services, and a point made about adult acute wards not being an ideal option.	Thank you for your comment, we believe this is covered in the guideline (e.g. recommendation 4.6.10.1, 4.6.1.1, 4.6.2.4 and 4.6.10.2)
SH	Community Links	4	Full	14	5	No discussion about transitional services and their role in ensuring young people do not lose contact with mental health services.	Thank you for your comment. We believe this is covered in recommendation 4.6.5.
SH	Community Links	5	Full	19	12	There is no recognition that third sector may be the health care provider (as is the case with Leeds early intervention in psychosis that we provide), or working in partnership with the statutory services to deliver NHS commissioned services.This is not reflective of the changing health economy.	Thank you for your comment; however we believe that recommendations 4.6.4.5 and 4.6.4.6 recognise the role of the third sector.
SH	Community Links	6	Full	35	5	Lack of detail about what is meant here by Social skills training, it would be important to consider social recovery needs, especially as disruption and delays in social development is often a key issue.	Thank you, but we cannot find a mention of social skills training in the section you are referring to so we are unable to respond to your comment.
SH	Department of Health		Full	Gene ral		Thank you for the opportunity to comment on the draft for the above clinical guideline. **I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.**	Thank you for your comment.

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SH	Eli Lilly and Co Ltd	1	Full	General		Thank you for giving us the opportunity to comment. We have reviewed the guideline and have no comments to make at this time.	Thank you, noted.
SH	Greater Manchester West Mental Health Services NHS Foundation Trust	1	Full	General		I would like to comment about the inappropriateness of using the term "schizophrenia". There is a raft of evidence to conclude that the concept is out-dated, invalid, stigmatising and of little clinical utility. There is a growing body of professional opinion that we should abandon this label in relation to adults, so it is particularly disappointing that the term is still being used in future guidance about children and young people.	Thank you for your comment. We believe that we have covered this in section 2.6 'Language and stigma'.
SH	Greater Manchester West Mental Health Services NHS Foundation Trust	1	FULL	306	10-15	By including the TA213 this seems to suggest the guidelines agree that Risperidone should be the first-line antipsychotic in 15-17 years. However this seems to contradict the rest of the guideline where no particular antipsychotic seems to be favoured over another as first-line.	Thank you for your comments. The recommendations made in TA213 have been included, verbatim, into this guideline as per NICE processes. This was also validated when NICE reviewed this guidance.
SH	ISPS-UK		Full	28	6-9	Once again, we would welcome further strengthening and development of the important point made here, that responses to the young person's psychosis have to be conditioned by awareness of the possibly distinctive priorities of this age group. Often the young person is facing all the developmental tasks of adolescence (and the stresses associated with these may have played a significant part in triggering the psychosis, as Harrop & Trower (2003) suggest) at the same time as contending with the difficulties arising from their psychosis. Often, a successful psychological intervention may need to be as	Thank you for your comment. To address your concerns, we have added the sentence: 'This includes addressing the normal developmental tasks of adolescence with young people and their families as well as managing a psychotic disorder.' in section 2.7.

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						concerned with enabling progression in the young person's relationships within their family, and with facilitating appropriate and manageable independence, as it is with symptoms of psychosis. In such cases it would be helpful to state that this needs incorporating within psychological and psychosocial interventions generally, not confined within the family interventions * Harrop C & Trower P (2003) Why Does Schizophrenia Develop at Late Adolescence? Wiley-Blackwell	
SH	ISPS-UK	1	Full	22	10-13	Although the importance of trauma in a significant proportion of cases of psychosis is acknowledged here, it does not feature substantially elsewhere in the guideline, and barely at all in the brief version. We would welcome reinforcement of this point. For example, to the comment that trauma history should be routinely included within assessment could be added an explicit recommendation that psychological interventions offered should be appropriately adapted to take account of previous trauma (eg, as described by *Kingdon & Turkington, 2008), and that this is among the competencies needed by workers in this field. Perhaps in the brief version a further bullet point at 1.3.27 such as: [CBT should] *be sensitive to any trauma that may have increased the young person's vulnerability to psychosis*. A short statement of this sort might help counter any tendency to make a false distinction between 'true psychosis' on the one hand, and psychosis arising from trauma on the other (**Desai et al, 2012). Similarly, at 1.3.30 in the brief version a further bullet point would be helpful, to the effect that healthcare professionals delivering psychological interventions should *be aware of possible earlier trauma as a feature of some cases, and use this to*	Thank you for your comment. We believe this is covered in the full guideline, see recommendation 4.6.7.1 and section 6.1.1. In regards to the NICE guideline, the GDG agree that trauma is not adequately reflected and have therefore amended recommendation 1.3.3 to include *'history of trauma'*.

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						inform their understanding of the young person's experience of psychotic symptoms. Kingdon D & Turkington D (2008) *Cognitive Behaviour Therapy for Psychosis.* Guilford Press	
SH	Lancashire Care NHS Foundation Trust	1	NICE version	Gene ral		We thought it was user friendly and easy to follow	Thank you for your comment.
SH	Lancashire Care NHS Foundation Trust	2	NICE version	Gene ral		We didn't think it could be changed to better promote equality of opportunity	Thank you for your comment.
SH	Lancashire Care NHS Foundation Trust	3	NICE version	Appe ndix B		This is very handy	Thank you for your comment.
SH	Lancashire Care NHS Foundation Trust	4	NICE Version	P41		Psych therapies, IAPT for SMI might have an impact on our ability to deliver these? It'll increase pressure on Psychological therapists / waiting times.	Thank you for your comment – we agree the implications of psychological therapies will need to be carefully considered by service managers and commissioners.
SH	Neonatal and Paediatric Pharmacists Group (NPPG)	1	NICE Full	45 295		The Full Guideline notes on p 295 that there is a paucity of data and what is available is low quality evidence. We would therefore consider a research recommendation on pharmacological interventions to be justified. Given the fact that most antipsychotic medications are noted not to have a marketing authorisation for use in children and young people, a research recommendation to identify appropriate doses of	Thank you for your suggestion, but we believe this is covered in the other research recommendations (see research recommendation 2.4, and 2.5)

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						antipsychotic medicines in children and young people may be justified.	
SH	NHS Direct			General		NHS Direct welcome the guideline and have no comments on the content as part of the consultation.	Thank you for your comment.
SH	NHS Sheffield		NICE version	28 39 And general observations	1.3.17 1.6	Also, I think there is an issue that managing C+YP with psychosis has usually been a secondary care role. People have often been kept in services long term unless they have defaulted, or a practice has a particular interest in mental health. The monitoring requirements are significant, and may therefore represent a significant transfer of work into GP without any resource. Some of it may be covered by QOF. This comment isn't a "jobsworth" one, but sometimes following people up requires quite a lot of outreach and resource, and these younger patients are a priority because of the need to reduce long term morbidity.	Thank you for your comment.
SH	NHS Sheffield		NICE version	27 28 And general observations	1.3.16 1.3.17	Also, good practice and good prescribing changes, and as the summary acknowledges, these drugs have significant side-effects. It will be hard for GPs to keep up to date enough around modern neuroleptics, and if some of the planned research dictates, we may move away from these medications a bit in the future.	Thank you for your comment. The GDG agree and have added a recommendation to clarify that GPs should not start antipsychotic medication in children or young people except in conjunction with a consultant psychiatrist, see new recommendation 1.3.2
SH	NHS Sheffield		NICE version	20 And general observatio	1.1.23	So there needs to be very good detail and also realistic expectations around discharge planning and follow up with support and advice - ie some thought on what it means on the ground and not just on paper, and an appreciation that not all GPs may have the mental health experience of GPs who may be involved in guidelines, commissioning	Thank you for your comment. We would like to draw your attention to the reference to the Department of Health's 'Transition: getting it right for young people' in the

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				ns		etc.	'Person-centred care' section of the NICE guideline.
SH	NHS Sheffield		NICE	22 32	1.3.2 1.4.1	Reads well and was informative. I wonder if the side-effects need to be highlighted more. In particular, young people find certain side-effects difficult and may stop meds because of them - lack of energy, weight gain and sexual dysfunction (whether in a relationship or not). If this isn't sensitively explored, compliance may be less and not all practitioners may be as aware as others - does it need to be clearer in the summary? It is mentioned but not flagged up as much as I suspect would be helpful.	Thank you for your comment, however, the GDG believe this is covered adequately in 1.3.14 and 1.3.17.
SH	Nottinghamshire Healthcare NHS Trust	1	Full	27	2	Suggest routine urine drug testing given high prevalence of comorbid substance use in young people presenting with psychotic symptoms. Young people may not routinely disclose their substance misuse and parents/carers may be unaware of it. It is also important to know about the presence of substance misuse prior to starting treatment with antipsychotic medication in view of the potential for interactions between prescribed and illicit medication	Thank you for your comment. Biological or physical tests for substance use may be useful in the assessment, treatment and management of substance misuse for adults and young people with psychosis – however; this should first be agreed with the person as part of their care plan. On that basis, the GDG do not agree that biological or physical tests should be used in routine screening for substance misuse to children and young people presenting with psychotic symptoms.
SH	Nottinghamshire	2	Full	27	2	Should we be asking that all patients have a full	Thank you, we agree with

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	Healthcare NHS Trust					physical examination undertaken by their GP	your comment and believe this is covered in recommendations 4.6.12.1 - 4.6.12.5.
SH	RCGP	1	Full	32	7	The choice of anti-psychotic is indeed guided by side-effect profile. The SGA Amisulpiride on balance confers a good balance of efficacy and reduced side-effect profile. It has less weight gain and drowsiness compared to others such as Olanzapine and Quetiapine, though it has raised prolactin as its main problem which may not be relevant in children and young people.	Thank you for your comments. However, the GDG do not agree with your comment that raised prolactin levels is not a problem in children and young people as it is associated with a range of adverse clinical features all relevatn to this age group. These can include amenorrhea, oligomenorrhea, anovu-latory cycles, galactorrhea, breast pain, breast enlargement, gynecomastia and increased risk of breast cancer. Long-term hyperprolactinemia may also lead to delayed pu-berty, primary amenorrhea, short stature, infertility, and osteopenia and/or osteopo-rosis.
SH	RCGP	2	Full	27	10	Stigma amongst clinicians against patients with mental health problems is widespread particularly in primary care. Labelling often occurs with the use of terms such as “that Schizophrenic” patient thereby dehumanising the patient. However part of this stigmatisation is justified as these patients can be unkempt and behave in ways not accepted as the norm in society. Diagnostic overshadowing often happens with physical symptoms and	Thank you for your comments. We believe this is covered in section 2.6 ‘Language and stigma’.

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						complaints wrongly attributed to the primary mental health disorder. The stigma attributed to psychosis is worse in patients from certain ethnic minorities as they are wrongly seen as violent or aggressive so these patients have a double jeopardy.	
SH	RCGP	3	Full	17	17	The term psychosis should also incorporate the ICD 10 code of Acute and transient Psychosis or Brief Psychotic episode under DSM 1V. Such diagnoses are often overlooked in the UK and Psychotic patients are often wrongly labelled Schizophrenic simple because the latter diagnoses are not commonly recognised in the UK. These "Brief Psychotic" episodes confer a good prognosis.	Thank you for your comment. Although an important issue, we do not aim to cover differential diagnosis, as it is outside its scope.
SH	RCN	1		gene ral		We have no comments to submit at this stage.	Noted.
SH	Roche Products Ltd.	1	NICE version	18	1.1.1 9	We recommend that health and social care professionals should also have competence in explaining what patients can expect from their treatment. We believe that when patients and their carers fully understand the expected effects (both in terms of efficacy as well as side effects) of the treatment options offered, their engagement in treatment will be improved. Therefore we recommend an additional bullet is added to this section stating: *'explaining the expected effects of the various treatment options available'*.	Thank you for your comment. We agree but believe this is already reflected in the guideline elsewhere (e.g. 1.1.11-1.1.15).
SH	Roche Products Ltd.	2	NICE version	20	1.2.1	We recommend that further detail is provided to explain 'other experiences suggestive of possible psychosis' to enable referring physicians to better identify situations where a psychotic episode may be about to occur. The current wording does not emphasise 'negative' symptoms, common in the prodromal phase, which may be missed or wrongly attributed to depression or 'adolescent behaviour'.	Thank you for your comment, however the GDG consider this to be covered in the Introduction.

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SH	Roche Products Ltd.	3	NICE version	21	1.2.3	It would be helpful if the guideline were more comprehensive in its description of the types of symptoms that should be monitored. We believe that symptoms are well described on page 3 in the first paragraph of the introduction to this guideline. Paragraph 1.2.3 could potentially refer to this.	Thank you for your comment. The GDG discussed this but came to the conclusion that the description of symptoms has been provided in the most appropriate place in the guideline and that it wasn't necessary to repeat this information.
SH	Roche Products Ltd.	4	NICE version	27	1.3.1 4	Before starting antipsychotic medication, we would recommend a baseline assessment of symptoms is made using the 'Positive and Negative Syndrome Scale' (PANSS). Capturing this assessment at baseline will provide an objective assessment of symptoms which can be evaluated further as treatment progresses.	Thank you for your comment, however we do not agree that PANSS should be used at assessments as it is a research tool.
SH	Roche Products Ltd.	5	NICE version	29	1.3.1 7	We recommend that the 'ability to attend school or other social activities' is also monitored regularly throughout treatment given its relevance to social function, learning, and routine activities.	Thank you for your comment, however this recommendation is specifically about monitoring antipsychotic medication. The child or young person's social and educational functioning are covered by other recommendations (1.1.5 and 1.8.12-1.8.15).
SH	Royal College of Paediatrics and Child Health	1	NICE version	Gene ral	Gene ral	This guideline is extremely helpful. Particularly with respect to the recommendation that the primary care make appropriate referral to the CAMHS team once the symptoms are identified.	Thank you for your comment.
SH	Royal College of Psychiatrists	1	Full	17	32	Despite the tone of this, evidence exists to suggest that more medical formulations may be less stigmatising e.g., Journal of Nervous & Mental Disease: November 2004 - Volume 192 - Issue 11 - pp 734-744	The page and line number provided do not match the comment, however the GDG feel that the issue of stigma is well covered in section 2.6.

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						Maybe a rephrase?	
SH	Royal College of Psychiatrists	2	Full	21	39	“simplistic” seems inappropriately pejorative here, particularly as conditions like 22q11 suggest that some single genes impact on some cases of schizophrenia.	Thank you for your comment. We agree with your comment and have amended the sentence to read *‘...the notion’* instead of ‘...*the rather simplistic notion’.*
SH	Royal College of Psychiatrists	3	Full	22	44	It might be worth having a discussion of Multiple Complex Developmental Disorder (MCDD) here. See doi: 10.1097/CHI.0b013e31818b1c63	Thank you for your comment. Although an increased risk for schizophrenia later on in life has been described in children with MCDD, studies of samples of children with schizophrenia have not identified MCDD as a precursor. It would therefore seem inappropriate to mention MCDD here.
SH	Royal College of Psychiatrists	4	Full	24	3	As well as PDDs, there is a specific profile of neuromotor, receptive language, cognition difficulties with emotional problems and interpersonal difficulties (arch gen psych 2002 May;59(5):449-56.)	Thank you for your comment, however the reference you provided does not refer to co-morbidity in childhood or adolescent schizophrenia but to precursors of adult schizophrenia. It is therefore not of relevance here.
SH	Royal College of Psychiatrists	5	Full	24	20	MCDD is a high risk group for schizophrenia development, but this is written like it isn’t.	Thank you for your comment. This section discusses differential diagnosis, not precursors of schizophrenia. However, to address your concern and to make this

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							point clearer, we have added the following sentence to paragraph 2.4.1: 'Whilst the long term risk for the development of schizophrenia is increased in these children, the majority will not develop the disorder in the short term.'
SH	Royal College of Psychiatrists	6	Full	26	21	The distinction between personal and public stigma should be mentioned here. Personal stigma tends to be lower, but public stigma is less likely to impede health-seeking behaviours while the possible confusion arising from a "normalising" account of subjectively strange experiences in order to avoid stigma should also be mentioned.	Thank you for your comment and for the provided reference. Although interesting, the paper referred to examines stigma in undergraduate students, which is not likely to be directly comparable to a UK patient population of children and young people with experience of psychosis.
SH	Royal College of Psychiatrists	7	Full	27	2	It may also be important to emphasise that young people will receive a positive response to help-seeking from the outset (Aust NZ J Psych 2006, Vol. 40, No. 1 , Pages 51-54)	Thank you for your comment. To address your point, we have added line in section 2.6, line 26 to say that a positive response from professionals is one way to reduce stigma.
SH	Royal College of Psychiatrists	8	Full	28	4	However, some cultures may find medicalization de-stigmatising (see comment 1 above)	Thank you for your comment. We believe that the section of text you refer to does not take a position, but merely points out that diagnostic label can cause distress.
SH	Royal College of	9	Full	29	8	Should comorbidity be mentioned here too?	Thank you for your

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	Psychiatrists						comment. We agree and have added a bullet point here on co-morbidity.
SH	Royal College of Psychiatrists	10	Full	35	45	While changes in body habitus are significant across the board, metabolic changes are more idiosyncratic (JAMA. 2009;302(16):1765-1773) with Olanzapine carrying more risk for e.g., diabetes (Neuropsychopharmacology (2010) 35, 1997–2004). 3-6 monthly blood tests could significantly reduce compliance, and I'm wondering whether the blanket recommendation should be nuanced to allow judgement in relation to the drug/dose being used, and impact on habitus, while stressing the need to review cardiovascular health and diabetic risk.	Thank you for your comment. The GDG have considered your suggestion, but feel that this addition will not improve the recommendation and therefore no changes have been made.
SH	Royal College of Psychiatrists	11	Full	37	35	I'm at a loss here. NICE could easily advise precisely what investigations/actions should be taken, and don't understand why they haven't. Local services will then be incentivised to overcome the barriers mentioned.	Thank you for your comment. This section is an introduction. Please refer to the recommendations for guidance on investigations and actions to be taken.
SH	Royal College of Psychiatrists	12	Full	38	25	There does seem to be very little evidence-based information on education and schizophrenia. Should this be mentioned?	Thank you, we agree that the evidence here is very limited and we relied on the expert opinion of the GDG to address this issue. The fact that the evidence is limited has been described in sections 8.62 and 8.7.
SH	Royal College of Psychiatrists	13	Full	76	40	It's not pointed out that GPs do refer many such patients to CAMHS, so it may be more sensible to improve detection within CAMHS e.g., by posting EIP workers there (which could also help their training)	Thank you for your comment, but we have defined the role of CAMHS and EIP services in section 4.5 and in recommendation 1.3.1.
SH	Royal College of Psychiatrists	14	Full	78	35	See my earlier comments about stigma: the kind of stigma, and the person/culture being	Thank you, we note your point but this section came

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						considered, are all important variables.	out of a topic group discussion and is not based on a literature review.
SH	Royal College of Psychiatrists	15	Full	81	1.1.6	Suggest something needed about "developmentally appropriate adjustments and readjustments with age"	Thank you for your comment, we have amended 1.1.6 to include this suggestion.
SH	Royal College of Psychiatrists	16	Full	84	1.1.16	This would need to be breached in some rare child protection circumstances	Thanks you for your comment; however this is covered in recommendation 1.1.3 of the NICE guideline and recommendation 4.6.1.3 of the full guideline.
SH	Royal College of Psychiatrists	17	Full	94	1.3.4	Shouldn't this include the child comorbidities e.g., autism and those mentioned at comment 3 & 4 above?	Thank you for your comment. The assessment of neurodevelopmental co-morbidities is covered in recommendation 1.3.4 (NICE Guideline). 1.3.5 relates to episodic conditions (depression, anxiety, substance misuse) that may emerge and change during the early phase of the disorder and its treatment. In regards to 'comment 3 and 4 above', see our response to comments no. 96 and 97.
SH	Royal College of Psychiatrists	18	Full	95	1.6.7	Should there be specific blood chemistry or BMI cutoffs requiring review?	Thank you for your comment. The GDG have discussed your suggestion but concluded this is guided by a clinical decision at this point.
SH	Royal College of	19	Full	100	10	An "either/or" approach should be accompanied by	Thank you for your

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	Psychiatrists					a recommendation that local services should have a specific local protocol to ensure rapid response	comment, however the GDG disagree this would be necessary.
SH	Royal College of Psychiatrists	20	Full	101	7	“trained and competent” needs operationalizing, particularly for social care professionals.	Thank you for your comment, professionals should be competent to treat and care for children and young people with psychosis and schizophrenia. Although important, the other issues you raise are outside the scope and need to be determined at a local level.
SH	Royal College of Psychiatrists	21	Full	107	4	See earlier comments about comorbidity	Thank you for your comment, but we feel that we have described ‘co-existing neurodevelopmental conditions’. See comments no 96, 97 and 101 in regards to our responses to your earlier comments.
SH	Royal College of Psychiatrists in Wales					*Implementation Guidance*, to address the problems of accessing psychological therapies, however, there is no specific mention of children and young people. The Mental Health (Wales) Measure is a Law set down by Welsh Government that includes a legislative framework for ‘Care & Treatment Plans’ in secondary mental health care. This replaces and has similarities in function to CPA in England. Clinicians, Service users and families in Wales will be familiar with and working within this framework and not CPA. There is a separate Special Education Needs Code of Practice for Wales.	Thank you for your comment. We agree and have acknowledged this by adding a foot note to the full guideline (see footnote 1, section 2.5).

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						http://wales.gov.uk/docs/dcells/publications/120705sencodeofpracticeen.pdf Wales has the same Mental Health Act but a different Code of Practice. Wales does not have EIP services. There are one or two partial services only. There is a Welsh government 'intelligent target' around Early Intervention in Psychosis and an acceptance of the need to introduce different and better ways of working with first episode psychosis but no plans for new monies or a national PIG for EIS. Some acknowledgement of this difference will be required in the Guidance.	
SH	Royal College of Psychiatrists in Wales	1	Full	Gene ral		This is a good and clear document and will be very useful in clinical practice. As the NICE guidance is for England & Wales it is vital that where reference is made in the document to the relevant legislative and policy frameworks, that the equivalent frameworks in Wales are also cited and referenced. It will be more difficult for clinicians in Wales to make effective use of the NICE Guidance with NHS providers of services and multi-agency partners if it does not appear explicitly relevant to the Welsh policy and legislative framework. This is also extremely important for the young people and families in Wales who receive information on services that reflect the policy context in Wales. The key factors in the draft that Welsh Government policy pertain to : Different NSF for children & young people, different guidance re transition age. CAMHS in Wales is expected to serve up to 18 years from April 2012. Services remain variable. No IAPT for children & young people in Wales. Local Health Boards provide for the delivery of psychological therapies across the clinical	Noted. We agree and have added foot notes to both guidelines.

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						spectrum and delivery of these services differs across Wales; it is at best patchy and at worst failing. The Welsh Government has recognised this and in May produced guidance, *Psychological Therapies in Wales, Policy*	
SH	Royal College of Psychiatrists in Wales	2	Full	29	15	Again, the Early Intervention Process has not been introduced in Wales.	Thank you for your comment. We agree and have acknowledged this by adding a foot note to the full guideline (see footnote 1, section 2.5).
SH	Royal College of Psychiatrists in Wales	3	Full	33	4	The guidance does not reference the position in Wales regarding the organisation of services as we have no EIP services. Same key issues but different NHS context.	Thank you for your comment. We agree and have acknowledged this by adding a foot note to the full guideline (see footnote 1, section 2.5).
SH	Royal College of Psychiatrists in Wales	4	Full	74	25	CPA is a policy that now applies to England only. In Wales we are required to prepare Care & Treatment Planning under the Mental Health (Wales) Measure 2010. However, CPA and C&TP have the same principals.	Thank you for your comment. We agree and have acknowledged this by adding a foot note to the full guideline (see footnote 1, section 2.5) and amending recommendation 4.6.12.5.
SH	Royal College of Psychiatrists in Wales	5	Full	111	20	In Wales, where there is no EIP, it is important that children remain in service for three years.	Thank you for your comment. We have amended recommendation 4.6.12.5 to acknowledge the differences in Wales and England. Please also see recommendation 4.6.13 which now includes 'Children and young people...should have access to that service for up to 3 years...'

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SH	Royal College of Psychiatrists in Wales	6	Full	147	21	Again, there is no IAPT programme for children and young people in Wales.	Thank you for your comment. We agree and have acknowledged this by adding a foot note to the full guideline (see footnote 1, section 2.5).
SH	Royal College of Psychiatrists in Wales	7	Full	321	28	In Wales we have a separate Code of Practice for children with SEN. The Welsh Government is proposing a new Additional Needs (AN) Code of Practice to supersede the SEN CoP, to address issues of quality assurance, and to set out clear responsibilities.	Noted. We agree and have added foot notes to both guidelines.
SH	Royal College of Psychiatrists in Wales	8	Full	323	1	Regarding young people over 16 years frequently out of education on presentation or who have had gaps in education consequent to psychosis and wish to return. More emphasis could be placed on returning to education, as well as training and work, to 6th form or FE College. It would be helpful to reference FE Colleges because Mental Health Services can make very useful links with local FE for post 16s. There are examples of excellent support.	Thank you for your comment. We believe the importance of continued education, training and work has been covered adequately by recommendation 1.1.5 and also 1.8.12 – 1.8.15. Providing guidance to education organizations is beyond the scope of this guideline.
SH	SWYPFT	1	Full	14	17	'Schizophrenia' is defined in the opening paragraph but then the term psychosis is introduced without explanation, which could be misleading (the explanation is provided later on page 27, line 25.	Thank you for your comment. We have defined psychosis in the 1st paragraph and made other changes to make it clear that 'psychosis' is used as a shorthand term for psychotic disorder – which has a broader definition in contrast to more narrowly defined schizophrenia.
SH	SWYPFT	2	Full	17	34	Although the guidelines recognise that each person will present differently, practice shows us that there is such wide variation between patients	Thank you for your comment. The GDG believes that section 2.6,

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						given a Schizophrenia diagnosis that the term is often redundant (especially for this age group). We know from 10 years of EIP practice that a willingness to work with 'diagnostic uncertainty', taking a symptom/experience based approach instead, is key to effective EIP work for this age group. Evidence cited such as Jarbin (2003) only tells us that people given this diagnosis are likely to still have this diagnosis a few years later. It does not address the lack of specificity.	'Language and stigma' covers this, as well as section 2.1.5.
SH	SWYPFT	3	Full	105	25	Re service transitions: could the guidance give minimum standards for the time scale that this should happen (specific circumstances notwithstanding)? I think this can often be done in a planned way but far too quickly.	Thank you for your comment, but specifying a minimum time scale for service transitions is a matter for local implementation.
SH	SWYPFT	4	Full	156	6	Re: psychological therapy: There is not enough research evidence to specify that manualised CBT should be offered to the exclusion of other similar approaches. The evidence we have points to the value of some key components, such as collaborative formulation, use of diagrams, homework etc. which can be effectively provided within other therapeutic modalities, such as MBT, CAT, ACT. There is a risk that by being so specific, we stifle innovation and creativity.	Thank you, we agree that the evidence on psychological therapies is limited however CBT has the largest amount of evidence available amongst all psychological therapies. In the absence of evidence, the GDG can not recommend MBT, CAT or ACT.
SH	SWYPFT	5	Full	166	11	In current practice, a significant amount of CBT interventions are provided by non-therapist team members who have training in PSI (under the supervision of qualified practitioners). Examples include CBT formulations, exposure plans for anxiety, weighing up evidence for paranoia. This 'lower level' CBT should be taken into account, rather than simply focussing on the provision of formal 1:1 CBT.	Thank you for your comment. We have assessed all available evidence but not found any evidence to make recommendations for 'lower level' CBT.
SH	SWYPFT	6	Full	167	28	It doesn't make sense to me to specify that a	Thank you for drawing

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						therapy manual with proven efficacy must be used and then suggest modifying it (therefore making it not evidence-based)	attention to this. However, evidence for this recommendation comes from the adult guideline and the adaptation of this recommendation focussed on making it suitable to children and young people. The manual itself has not been adapted.
SH	Thorn Steering Group Queens University Belfast	1		Gene ral		The Thorn Steering Group (TSG) welcome this eagerly awaited NICE consultation on: psychosis and schizophrenia in young people. It is against this background that we would like to draw particular attention to the following points:	Noted.
SH	Thorn Steering Group Queens University Belfast	2		Gene ral		The labelling is confusing and there is lack of clarity on definitions. Schizophrenia appears to be the dominant descriptor of choice, (psychosis frequently being relegated to brackets). There is no explicit evidence of placing either term within an understandable framework of vulnerability and resilience. We believe more use of terms such as vulnerability, stress and resilience could reduce the stigma associatedwith these illnesses.	Thank you for your comment, however the GDG believe this is covered in section 2.6 'Language and stigma'.
SH	Thorn Steering Group Queens University Belfast	3		Gene ral		The language used is very illness and disability focused e.g. impairment (mild, severe), chronic, 'minority of cases making a full recovery'. This language use shows: a lack of shared understanding of psychosis/schizophrenia; of the impact of illness; and the experience of living with the illness from the young person and family perspective.	Thank you for your comment; we have redrafted parts of the introduction to address some of the points you have raised regarding the language used. However, we feel that we have accurately described the evidence for schizophrenia as a whole in young people, which does show

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							generally a poor outcome and high level of impairment for early onset schizophrenia.
SH	Thorn Steering Group Queens University Belfast	4		General		The use of terms such as negative and positive symptoms could be potentially frightening to the young person and their family. The TSG would consider the use of these terms within the guideline to be part premature/part unnecessary. A biopsychosocial approach to psychosis and schizophrenia would use terms such as resilience (vulnerability), worrying thoughts (anxiety); unusual thoughts (delusions); hearing voices, unusual sounds (hallucinations). There is no attempt throughout the guideline to present a person-centred lexicon of words and phrases that maximises optimism and minimises distress for the young person and their family.	Thank you for your comment. We agree that the language around the concepts of schizophrenia and psychosis can be alienating and marginalising, a subject which we have addressed in section 2.6 on 'Language and stigma'. We have ensured that such language does not permeate the rest of the guideline. We would also direct you to the 'Information for the Public' online booklet (currently in development), which is a version of the guideline intended for children and young people and their parents and carers, which explains any medical language and seeks to frame psychosis and schizophrenia in the way that you have suggested.
SH	Thorn Steering Group Queens University Belfast	5		General		Although the document covers a wide range of issues relevant to best practice in treatment we would particularly like to draw attention to the following:	Thank you for your comment.
SH	Thorn Steering Group Queens University	6		General		Psychosocial interventions appear to be mistakenly equated with CBT and Family Interventions alone, with CBT being given the	Thank you for your comment. The systematic literature search

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	Belfast					greater visibility.	conducted, included a range of psychological and psychosocial interventions (please see protocol for eligibility criteria) and the guideline provides recommendations based on the best available evidence identified. We therefore recommend arts therapies in additions to CBT and family intervention, with the strongest evidence being for the latter two interventions, because this reflects the best evidence available.
SH	Thorn Steering Group Queens University Belfast	7		Gene ral		Working with families (family interventions) is presented as if it would be significantly different to a practitioner working with any family. There are core skills that all practitioners require when engaging with families beginning with sensitivity, empathy and respect. Family Interventions should not be confuses with family therapy. A family who is coming to terms with a diagnosis of psychosis/schizophrenia does not require Family Therapy (ever).	Thank you for your comment. The GDG agree and any references to family therapy has been removed and replaced with family interventions.
SH	Thorn Steering Group Queens University Belfast	8		Gene ral		There are suggestions to not recommend some approaches without sufficient explanation as to why these are not acceptable. For example Compliance Therapy is not recommended as an intervention, yet Motivational Interviewing which is the central component of Compliance/Adherence Therapy has extensive positive research to support its use in behaviour change (such as ambivalence about taking medication), and would	Thank you for your comment. We identified no evidence for compliance therapy and were therefore not able to make any recommendations about its use or to make any recommendations against its use.

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						be a requisite for all practitioners working with young people with psychosis/schizophrenia.	
SH	Thorn Steering Group Queens University Belfast	9		Gene ral		The role of the Vulnerability-Stress (diathesis-stress) model/hypothesis to reduce distress for the young person and their family and enhance optimistic outcomes needs to be a foundation of the therapeutic approach to treatment. The V-S model also links very naturally with Keeping well (preventing relapse).	Thank you for your comment, however the guideline is primarily concerned with evaluating the safety and efficacy of interventions rather than the foundations of the various therapeutic approaches.
SH	Thorn Steering Group Queens University Belfast	10		Gene ral		What is also essential is incorporation the use of a Normalising Rationale approach to help develop understandability of the person's psychosis by placing their experiences in the context of their life-course of the person's. Both the V-S and use of a normalizing Rationale can help to reduce the stigmas of labels such as psychosis/schizophrenia.	Thank you for your comment. We agree and believe that the importance of a 'normalising environment' has been adequately addressed by the guideline (see recommendation 6.5.13.3 of the full guideline and recommendation 1.3.28 of the NICE guideline).
SH	Thorn Steering Group Queens University Belfast	11		Gene ral		There needs to be more emphasis on the awareness, knowledge and skills that should be developed through education programmes, this should be very specific in relation to all practitioners and all specialities. There seems to be very little written regarding the education teachers will receive to ensure they are qualified to take on the role of identifying early signs of vulnerability in young people.	Thank you for drawing attention to this. We have noted your comments, but some aspects, e.g. education specifications for teachers, remain outside the scope of the guideline.
SH	Thorn Steering Group Queens	12		Gene ral		The increased vulnerability of this group to poorer physical health has been presented as a 'fait	Thank you for your comments. The GDG feel

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	University Belfast					accompli', and is a very worrying expectation to create. There needs to be more emphasis on promoting health and awareness of the higher risk to certain conditions, with a clear strategic plan on how to maintain health. This will also be supported by therapeutic prescribing of medication, it must be stressed that all practitioners are aware of the basics of pharmacodynamics and pharmacokinetics and be confident to assess for side-effects and adverse effects of prescribed medications.	these issues have been adequately covered in the guideline (see recommendations 1.3.4-1.3.6, 1.3.14- 1.3.18, 1.3.21 and 1.3.25). In regards to your concern around prescribing medication, we have added a new recommendation 1.3.2.
SH	University of Glamorgan: Faculty of Health Sport & Science		NICE version	3	2	Issue of style / format: following word 'affect' place word 'mood' in brackets. Rationale – presume this is aimed at practitioners. Doc gives bracketed definition of hallucinations (line 5) delusions (line 6) and negative symptoms (line 7) so why not 'affect'? Alternatively would not practitioners be expected to understand these terms and others that might beg definition elsewhere in doc. Is 'glossary of terms' required / desired?	Thank you for your suggestion, we have changed the word 'affect' to 'mood' in the NICE guideline. Otherwise we feel that the terminology used has been explained where needed.
SH	University of Glamorgan: Faculty of Health Sport & Science		NICE version	3	23	After' affective' add the word 'disorder such as'. Remove brackets.	Thank you for your comment; this section has been redrafted.
SH	University of Glamorgan: Faculty of Health Sport & Science		NICE version	3	27	Prior to word' treatment 'add 'recognition'.	Thank you for your comment, we have made this change.
SH	University of Glamorgan: Faculty of Health Sport & Science		Full	9	26	With regard to 'referral to a consultant psychiatrist' could this be to another professional with the appropriate level of training and experience, e.g. consultant nurse.	Thank you for your comment, however the GDG disagrees that a referral of this kind should be made to a consultant nurse as well as a consultant psychiatrist.

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							They do however agree that a referral can be made to a specialist mental health service - rather than a specific psychiatrist (either in CAMHS or an early intervention in psychosis service), but the service must include a consultant psychiatrist with training in child and adolescent mental health. Recommendation 1.3.1 in the NICE guideline has been adjusted to reflect this.
SH	University of Glamorgan: Faculty of Health Sport & Science			13	18 8-20	Need to add in Mental Health Measure (Wales) 2010. Training identified as important and therefore appropriate training should be made available and accessible for practitioners to develop the required level of competence.	Thank you for your comment. We have made reference to the MHM (Wales) on pages 36 and 37 in the full guideline. In regards to your second comment, we believe this is a matter for local implementation.
SH	University of Glamorgan: Faculty of Health Sport & Science			20	3-6	In order to achieve identified guidance clear transitional arrangements / protocols should be in place and also good links with youth mental health services where these exist	Thank you for your comment. We also believe clear transitional arrangements should be in place and believe this has been addressed in recommendation 1.1.24
SH	University of Glamorgan: Faculty of Health Sport & Science			21	7	Remove word ‘considerable’.	Thank you for your comment, we have made this change

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SH	University of Glamorgan: Faculty of Health Sport & Science			21	9	This assessment could also take place bay an appropriately skilled expert of a different discipline e.g. nursing / psychology	Thank you for your comment. The GDG have discussed this issue and feel that this is partly covered in recommendation 1.3.4. Further, we have amended recommendation 1.3.1 to make it clear that referral could be to a service which has access to a consultant psychiatrist, rather than to a specific individual.
SH	University of Glamorgan: Faculty of Health Sport & Science			22	20	This assessment could also take place by an appropriately skilled expert of a different discipline e.g. nursing / psychology	Thank you for your comment. The GDG have discussed this issue and feel that this is partly covered in recommendation 1.3.4. Further, we have amended recommendation 1.3.1 to make it clear that referral could be to a service which has access to a consultant psychiatrist, rather than to a specific individual.
SH	University of Glamorgan: Faculty of Health Sport & Science			24	2-14	This guidance should also be in accordance with local protocols and legislation e.g. MHM Wales and required care and treatment plans.	Thank you for your comment, we believe this has been covered in recommendation 1.7.5. and on pp.36-7 of the full guideline.
SH	University of Glamorgan: Faculty of Health Sport & Science			35	12	Definition of what constitutes a crisis requires explanation and also local definitions of this may vary, e.g. Wales where definitions exist for emergency urgent and routine referrals in Camhs	Thank you for your comment, but precisely because definitions of the term ‘crisis’ may vary, the GDG deems that this would be a matter for

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							clinical judgement.
SH	University of Glamorgan: Faculty of Health Sport & Science			37	16-21	Current educational policies will only provide education within a hospital setting to children & young people who have be admitted for longer than a specified timeframe.	Thank you for highlighting this issue. However, addressing current educational policies is beyond the scope of this guideline.
SH	University of Glamorgan: Faculty of Health Sport & Science			38 38	20 22	Following word 'tranquilisation' add 'and/or restraint'. As above	Thank you for your comment, we have made this change to recommendation 1.5.14 as you have suggested.
SH	University of Glamorgan: Faculty of Health Sport & Science			40	8	Points or areas not covered: CPA mentioned. Being reconfigured in Wales in line with Mental Health Measure (Wales) 2010. Implications of this to CPA (Wales) for children / young people, e.g. different documentation. Where CPA mentioned include recognition of latter? Further despite 'suicide' explicitly mentioned pg. 48, line 28 in relation to general prevalence of significance, there appears to be no referral to related guidance / advice in the doc.	Thank you for your comment.We agree and have added "...or, if in Wales, Care and Treatment Plans (C&TP)" where CPA is mentioned. In regards to your comment on suicide, we believe this is covered in recommendations 1.5.15 and 1.7.7.
SH	University of Glamorgan: Faculty of Health Sport & Science			41	5-8	To advise that somebody should remain in a service for 3 years whatever their age of entry is too rigid as they may be more appropriately placed in a different service.	Thank you for drawing attention to this. We have changed recommendation 1.8.1 to '...have access to that service for up to 3 years whatever the age of onset of psychosis or schizophrenia.'
SH	University of Glamorgan: Faculty of Health Sport &	10	NICE	43	19-21	This needs to be made explicit that this liaison should be done with consent.	Thank you for your comment, we have changed recommendations 1.8.12 and 1.8.13 to make

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	Science						this clear.
SH	University of Glamorgan: Faculty of Health Sport & Science	11	General Comments			No mention of The Legal Aspects of the Care and Treatment of Children and Young People with Mental Disorder. NICE Guidance ‘ Self Harm’ recommended at 1.4.27 in relation to ‘Rapid tranquilisation and restraint. Why explicitly here and not for example in section ‘ Referral in crisis’?	Thank you for your comments. ‘The Legal Aspects of the Care and Treatment of Children and Young People with Mental Disorder’ is not referred to as we feel that the same areas (admission to hospital, decision making in relation to admission and treatment, consent and discharge), are covered in the guideline (see the Introduction, the section ‘Person-centred care’, ‘Transfer and discharge’, and in recommendations 1.1.18, 1.4.4, 1.5.1, 1.5.3, 1.5.6, 1.5.8 and 1.5.11 of the NICE guideline). Referring to the document you mention in the guideline would also be outside the remit of NICE processes. In relation to your second comment, we agree and have moved the recommendation referring to the NICE Guidance on Self Harm to the ‘Referral in crisis’ section.
SH	Welsh Government		Full	General		This is a good and clear document & will be very useful in clinical practice. The evidence review and guidance recommendations on psychological therapies, medication & physical monitoring are	Thank you for your comment. We agree and have acknowledged this by adding foot notes to the full

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						clear and very welcome. As the NICE guidance is for England & Wales it is vital that where reference is made in the document to the relevant legislative and policy frameworks, that the equivalent frameworks in Wales are also cited and referenced. It will be more difficult for clinicians in Wales to make effective use of the NICE Guidance with NHS providers of services and multi-agency partners if it does not appear explicitly relevant to the Welsh policy and legislative framework. This is also extremely important for the young people and families in Wales who receive information on services that reflect the policy context in Wales. The key factors in the draft that Welsh Government policy pertain to : Different NSF for children & young people, different guidance re transition age. CAMHS in Wales expected to serve up to 18 years from April 2012. Services remain variable. No IAPT for children & young people in Wales Mental Health (Wales) Measure is a Law set down by Welsh Government that includes a legislative framework for 'Care & Treatment Plans' in secondary mental health care. This replaces and has similarities in function to	guideline (see footnotes 1, 2, 3, 46,107 on pages 27, 35, 158 and 347, respectively). We have also added "...or, if in Wales, Care and Treatment Plans (C&TP)" where CPA is mentioned.).
SH	Welsh Government					CPA in England. Clinicians, Service users and families in Wales will be familiar with and working within this framework and not CPA. There is a separate Special Education Needs Code of Practice for Wales. Reference needed. Wales has same Mental Health Act but different Code of Practice. Wales does not have EIP services. There are one or two partial services only. There is a Welsh government 'intelligent target' around Early Intervention in Psychosis and an acceptance of the need to introduce different and better ways of	Thank you, see the response provided in the comment above.

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						working with first episode psychosis but no plans for new monies or a national PIG for EIS. Some acknowledgement of this difference will be required in the Guidance.	
SH	Welsh Government		Full	29	15	EIP not introduced in Wales	Noted. We have added a foot note to the full guideline to acknowledge this (see page 27, footnote 1).
SH	Welsh Government		Full	74	25	CPA England policy only. Care & treatment Planning re Mental Health Measure Wales. Same principals.	Noted. We agree and where CPA is mentioned we have added "...or, if in Wales, the care and treatment plans (C&TP) (see section 4.3.1, 'Tier 4' second paragraph."
SH	Welsh Government		Full	111	20	Important point to remain in service for 3 years even in absence of EIP service eg CAMHS (no EIP in Wales)	Thank you for your comment. .[This recommendation is only applicable to EIP services due to the current restrictions placed on length of time that can be spent in an EIP service. We do not feel that we need to make a similar recommendation for CAMHS]
SH	Welsh Government		Full	147	21	No IAPT for Children & ypin Wales	Thank you for your comment. We agree and have acknowledged this by adding foot notes to the full guideline (see footnote 46, page 158)
SH	Welsh		Full	321	28	Refer also to Wales Code Practice SEN	Thank you for your

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	Government						comment. We agree and have acknowledged this by adding foot notes to the full guideline (see footnote 107, page 347)
SH	Welsh Government		Full	323	1	YP above 16 years frequently out of education on presentation or have had gaps in education consequent to psychosis & wish to return. Refer to return to education aswell as training & work for those post compulsory age for education – 6th form or FE College. Helpful to reference FE Colleges as mh services can make very useful links with local FE for post 16s-some provide excellent support.	Thank you for your comment. Although an important issue, we do not aim to cover services in further education as it is outside the scope of this guideline.
SH	Welsh Government		Full	33	4	Does not reference Organisation of Services in Wales. Same key issues but different NHS context.	Thank you for your comment. We agree and have acknowledged this by adding foot notes to the full guideline when a specific service, not available in Wales, is mentioned.
SH	West London Mental Health NHS Trust	1a	Full	gene ral		Our comments are as follows main points – different diagnosis and comorbidity not addressed. Too many details on generic good CAMHS practice not needed, "do not treat with" would read better as "there is little evidence for routine use of etc". Measuring hip and waist circumference in relation to physical health will not go down well with service users. Overall, looks comprehensive, but looking for something on non schizophrenic auditory hallucinations. Exampl a girl seen last year who was having this experience, and in the end it seemed to be more about her other OCD symptoms....though the voices (of a pop band) were externalised and sometime hostile .....and there has been a recent article in BJPsych about how common AH are as a normal developmental phenomenon .	Thank you for your comments. Although differential diagnosis and co-morbidity are important issues, they are outside the scope of this guideline. In regards to changing the wording used in recommendations, we do not agree with being unspecific where we have enough evidence to recommend 'do not treat with', as it would go against the purpose of this guideline. The GDG (which includes

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						So could the guidance explore the issue of differential diagnosis....when to watch and wait?....it might be covered.......", more needed on relapse prevention - not desperately impressed. A lot of it is simply detailing good practice for CAMHS - don't discriminate, offer equal access to all, involve parents and other agencies surely we don't need guidelines to tell us that! The adult nice guidelines don't make so many assumptions that staff are incompetent.	service users and carers) have discussed the necessity of measuring hip and waist circumference in relation to physical health and disagree that this would not go down well with service users. Furthermore this is the preferred measure for predicting cardio-metabolic risk. It is expected that section 1.1,which outlines general principles of care, will be considered when implementing recommendation 1.3.15. Therefore no change has been made to the recommendation. Thank you for your comments regarding good practice for CAMHS.
SH	West London Mental Health NHS Trust	1b	Full	gene ral		Main Points No mention of co-morbidity there is a lot of that in CAMHS, young people with OCD, ASD, ADHD who also develop psychosis. Lots of "do not treat with" really not helpful as that would stop people from being offered treatment that would actually be beneficial for them better to say "little evidence for offering social skills so this should not be offered routinely" actually a young person with ASD and psychosis may really benefit from social skills training most guidelines are less categorical which is more helpful. Little about relapse prevention PIG guidance made much of relapse prevention,	Thank you for your comment, please see response given above. In addition and with regards to relapse prevention, the GDG feel that recommendation 1.3.6 – 1.3.8 adequately covers this issue.

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						working with young people to help them recognise their relapse signature and setting up a management plan to address any signs of relapse. Physical Health We cannot think of a single young person with psychosis who would be comfortable with the clinician measuring their waist or hips how inappropriate would that be if a male clinician was seeing a female patient? This exposes us to complaints, would be unpleasant and uncomfortable to patients and actually lower self esteem. Teenagers are really sensitive about weight gain. To have their abdomen measured in sessions would be really intrusive and many patients would refuse point blank. Did users actually contribute to this? Hopefully some of these concerns will be addressed otherwise it won't be well received	
SH	Worcestershire Health and Care NHS TRust	1	NICE guidance	gene ral		Our comments are as follows: I noted some omissions that I felt should have been mentioned: **Cognitive Remediation Therapy (CRT)** There is RCT evidence for the value of CRT to address cognitive impairments (see recent meta analysis by McGurk et al (2007) of 26 trials of CRT showing moderate effects on cognitive impairment, psychosocial functioning and a small effect size on symptoms where the effects were stronger in studies where CRT was part of a comprehensive rehabilitation programme and there is emerging RCT trial evidence showing that some 16-18 year olds can benefit from CRT (Wykes et al 2007) References: McGurk S Twamley E Sitzer et al (2007) A meta-	Thank you for drawing attention to this. The age of participants in the McGurk et al. (2007) review did not meet our eligibility criteria which is why it was not included. The Wykes et al. (2007) trial has already been included in the systematic review in the guideline.

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						analysis of Cognitive Remediation in Schizophrenia American Journal of Psychiatry 164, 1791-1802 Wykes T Newton E Landau S et al (2007) CRT for young early onset patients with schizophrenia An exploratory RCT Schizophrenia Research 94, 221—230	
SH	Worcestershire Health and Care NHS TRUST	2	NICE guidance	gene ral		**Individual Placement Support (IPS)** While there is a reference on page 44 1.6.20 to 'supported employment programmes' there was no specific mention of IPS. There have been seven studies of IPS with a first episode population, including two randomised controlled trials. These studies have consistently shown much improved educational and vocational outcomes (school, college, training or competitive employment) with employment rates significantly favouring people receiving IPS compared to those receiving treatment as usual. There is also good evidence for the value of an IPS approach over any other form of supported employment programme. I feel IPS should be named as the supported employment intervention of choice for young people with psychosis . Reference: Rinaldi et al (2010) First episode psychosis and employment: A review. International Review of Psychiatry, April 2010; 22(2): 148–162	Thank you for drawing attention to this study. We have already included the RCT conducted by Killackey et al. (2008) however the second study reviewed by Rinaldi et al. (2010) (Neuchterlein et al. 2008) did not meet the eligibility criteria for our review as we did not include conference abstracts. When the children's guideline is reviewed for update in the future, IPS may be considered.
SH	Worcestershire Health and Care NHS TRust	3	NICE guidance	25	1.35	In earlier references on page 25 1.35 to getting young people back into education and work I think it should clearly that any intervention to facilitate the return to education training or work should have **mainstream education and training and paid work as their ultimate goal** to avoid young people remaining in supported training or	Thank you for your comment, we have changed the recommendation to incorporate your suggestion, see recommendation 1.3.9.

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						sheltered work and never returning to open education or work settings	
SH	Worcestershire Health and Care NHS TRust	4	NICE guidance	gene ral		**Practical issues:** I noted there was no mention that I could find about addressing a) practical issues such as debt, homelessness, alcohol and substance misuse or addressing factors that may have contributed to onset such as bullying, relationships issues, early trauma, parental separation and divorce.	Thank you for drawing attention to this. We have noted your comments, but some aspects, e.g. debt, homelessness, alcohol, substance misuse and areas such as the impact of bullying etc remain outside the scope of the guideline.
SH	Worcestershire Health and Care NHS TRust	5	NICE guidance	gene ral		**Developmental transitions**: there was no mention or reference that I could find to facilitating developmentally appropriate transitions in relation to autonomy and independence which are key transitions to be supported in this age group	Thank you for your comments, but we feel this is already covered in the guideline, see section 1.1 and in particular in section 1.1.7
SH	Worcestershire Health and Care NHS TRust	6	NICE guidance	5	First line	EI services provide people aged **14-35 years** not 15-35 years to reflect national EI Policy. This is also consistent with page 9 1.2.1 where it states '14 years and over'	Thank you for your comment. We have corrected this sentence accordingly (see Introduction, second paragraph on page 5 of the NICE guideline)
SH	Worcestershire Health and Care NHS TRust	7	NICE guidance	9	1.2.1	Referral for possible psychosis there is no reference to At Risk Mental State (ARMS) criteria which identifies in addition to the presence of transient psychotic symptoms, evidence of distress and help-seeking or in the context of functional decline over the last 12 months	Thank you for your comment. We have amended recommendation 1.2.5 to address your comment.
SH	Worcestershire Health and Care NHS TRust	8	NICE guidance	9	1.3.1	I am unsure if access **to a consultant psychiatrist with training in child and adolescent mental health is** always realistic in EI services and perhaps the words 'ideally trained' should be added as many EI services have adult	Thank you for your comment. The GDG have discussed this issue and feel that this is partly covered in

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						consultant psychiatrists who have not done specialist training in child and adolescent mental health	recommendation 1.3.4. Further, we have amended recommendation 1.3.1 to make it clear referral should be to a service which has access to a consultant psychiatrist, rather than to a specific individual.
SH	Worcestershire Health and Care NHS TRust	9	NICE guidance	16	1.1.1 3	I think information materials should include '**self help and web based resource materials and sites'** particularly for this age group who tend to use the web as their main source of information	Thank you for your comment. We believe that this is covered by the phrase 'written information' which can include web based, written materials.
SH	Worcestershire Health and Care NHS TRust	10	NICE guidance	21	1.2.3 .	I do not feel it is appropriate to continue to monitor possible psychosis for up to 3 years in secondary care services If they have not made transition to full psychosis by 12 months Particularly when a research gap identified on page 46 si in relation to specificity of current ARMS criteria. I feel monitoring should be transferred back to primary care and the family after 12 months if the person has not made transition to full psychosis by this point.	Thank you for your comment. The GDG believe that the wording 'up to 3 years' gives room for flexibility, and does not mean that monitoring needs to continue in specialist services for 3 years.
SH	Worcestershire Health and Care NHS TRust	11	NICE guidance	32	1.3.2 9	I welcomed the identified responsibility to monitor access to and take up of psychological interventions which is typically low and this fits with the current focus of IAPT for SEMI	Thank you for your comment, noted.
SH	Worcestershire Health and Care NHS TRust	12	NICE guidance	36	1.4.1 4	It should include reference to an assessment with the parents about their capacity to continue to provide support while in crisis to their offspring	Thank you for your comment, but we feel this is covered by parts of

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						in the home setting	recommendation 1.5.2, ‘support a child or young person in crisis and their parents or carers in their home environment’, and in recommendation 1.5.3.
SH	Worcestershire Health and Care NHS TRust	13	NICE guidance	37	1.4.1 18	I think this **should include expectations about routine treatment interventions while in an acute setting, review processes and their frequency and a likely discharge date so the young person sees that the admission is not open ended and is being monitored and has an endpoint**.	Thank you for your comment. The GDG feels this is covered in section 1.5 (Referral in crisis and challenging behaviour) and 1.1.24 (Transfer and discharge).
SH	Worcestershire Health and Care NHS TRust	14	NICE guidance	41	1.6.8	I agree that young people should ideally ‘remain for 3 years’ with EI but also note this may not always be possible or appropriate. We have to be mindful of the need to appropriately titrate interventions to individual need (rather than ‘a one size fits all’ approach)where it is felt 3 years of intervention may not be required. We also need to be mindful of human rights and avoiding harassment if young people choose to end their involvement with EI prematurely!	Thank you for drawing attention to this. We have changed recommendation 1.5.9 to ‘...have access to that service for up to 3 years whatever the age of onset of psychosis or schizophrenia.’
						There is negligible reference to the Recovery approach	In regards to your comment on Recovery, we believe that this is covered in section 1.6 (Promoting recovery and providing possible future care).

These stakeholder were approached but did not comment;

ABPI Pharmaceutical Serious Mental Illness Initiative

Academy of Medical Royal Colleges

Action on Postpartum Psychosis

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Alder Hey Children's NHS Foundation Trust
Allocate Software PLC
Association for Family Therapy and Systemic Practice in the UK
Association for Psychoanalytic Psychotherapy in the NHS
Association of Anaesthetists of Great Britain and Ireland
Association of British Insurers
Association of Child Psychotherapists, the
Association of Directors of Childrens Services
Association of Professional Music Therapists
Astrazeneca UK Ltd
Autism West Midlands
Birmingham and Solihull Mental Health NHS Foundation Trust
Black Country Partnership Foundation Trust
Bolton Council
Bradford and Airedale Primary Care Trust
Bradford District Care Trust
British Association for Counselling and Psychotherapy
British Association for Music Therapy
British Association for Psychopharmacology
British Association of Behavioural and Cognitive Psychotherapies
British Association of Dramatherapists
British Association of Music Therapy
British Association of Psychodrama and Sociodrama
British Association of Social Workers
British Medical Association
British Medical Journal
British National Formulary

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British Paediatric Mental Health Group

British Psychodrama Association

British Psychological Society

Calderdale and Huddersfield NHS Trust

Camden and Islington NHS Foundation Trust

Camden Carers Centre

Camden Link

Capsulation PPS

Care Quality Commission (CQC)

Carers Trust
Cerebra

Children's Services Development Group

CIS' ters

Citizens Commission on Human Rights

College of Mental Health Pharmacists

College of Occupational Therapists

Commission for Social Care Inspection
Contact

Critical Psychiatry Network

Cumbria Partnership NHS Trust

Department for Communities and Local Government

Department for Education

Department of Health, Social Services and Public Safety - Northern Ireland

Dorset Primary Care Trust

Drinksense

East London NHS Foundation Trust

Edinburgh Carers Council

Eli Lilly and Company

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Equalities National Council
Faculty of Forensic and Legal Medicine
Faculty of Occupational Medicine
Fair Play for Children
Five Boroughs Partnership NHS Trust
Forum for Advancement in Psychological Intervention
Genus Pharmaceuticals Ltd
George Eliot Hospital NHS Trust
Glencare
Great Western Hospitals NHS Foundation Trust
Greater Manchester West Mental Health NHS Foundation Trust
Hafal
Hammersmith and Fulham Primary Care Trust
Hampshire Partnership NHS Trust
Health Protection Agency
Health Quality Improvement Partnership
Healthcare Improvement Scotland
Hertfordshire Partnership NHS Trust
Hindu Council UK
Humber NHS Foundation Trust
Inclusive Health
Information Centre for Health and Social Care
Janssen
Kent and Medway NHS and Social Care Partnership Trust
Lancashire LINk
Leeds and York Partnership Foundation Trust
Leeds Community Healthcare NHS Trust
Leicestershire Partnership NHS Trust

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Liverpool Community Health

Liverpool Primary Care Trust

London Respiratory Team

Lundbeck UK

Medicines and Healthcare products Regulatory Agency

Medicines for Children Research Network

Mental Health Foundation

Mild Professional Home Ltd

Mind Wise New Vision

Ministry of Defence

National Association for Gifted Children

National CAMHS Support Service

National Cancer Action Team

National Commissioning Group

National Deaf Child and Adolescent Unit

National Institute for Health Research Health Technology Assessment Programme

National Institute for Health Research

National Mental Health Development Unit

National Patient Safety Agency

National Public Health Service for Wales

National Treatment Agency for Substance Misuse

Neonatal & Paediatric Pharmacists Group

NHS Bath & North East Somerset

NHS Clinical Knowledge Summaries

NHS Connecting for Health

NHS Hertfordshire

NHS Islington

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NHS Milton Keynes
NHS Plus
NHS Warwickshire Primary Care Trust
North Essex Mental Health Partnership Trust
Northumberland, Tyne & Wear NHS Trust
Nottingham City Hospital
OTUSKA PHARMACEUTICALS
Oxford Health NHS Foundation Trust
Partneriaeth Prifysgol Abertawe
PERIGON Healthcare Ltd
Pfizer
Pharmametrics GmbH
PROGRESS
Public Health Wales NHS Trust
Renal Association
Rethink Mental Illness
Richmond Fellowship
Royal Berkshire NHS Foundation Trust
Royal College of Anaesthetists
Royal College of General Practitioners in Wales
Royal College of Midwives
Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics and Child Health , Gastroenetrology, Hepatology and Nutrition
Royal College of Physicians
Royal College of Psychiatrists in Scotland
Royal College of Radiologists
Royal College of Surgeons of England
Royal Pharmaceutical Society

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Royal Society of Medicine

Scottish Intercollegiate Guidelines Network

Sensory Integration Network

Sheffield Childrens Hospital

Sheffield Health and Social Care NHS Foundation Trust

Social Care Association

Social Care Institute for Excellence

Social Exclusion Task Force

Society for Existential Analysis

Solent NHS Trust

South Essex Partnership NHS Foundation Trust

South Staffordshire and Shropshire Healthcare NHS Foundation Trust

South Staffordshire Primary Care Trust

South West London and St George's Mental Health NHS Trust

St Andrews Healthcare

St Andrew's Hospital

St Mary's Hospital

St Mungo's

Surrey and Border Partnership Trust

Sussex Partnership NHS Foundation Trust

Sutton1in4 Network

TACT

Tees, Esk and Wear Valleys NHS Trust

Teva UK

The College of Social Work

The Rotherham NHS Foundation Trust

UK Clinical Pharmacy Association

United Kingdom Council for Psychotherapy

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University of Edinburgh

User Voice

Walsall Local Involvement Network

Welsh Scientific Advisory Committee

Western Cheshire Primary Care Trust

Western Health and Social Care Trust

Whitstone Head Educational

Wigan Council

Worcestershire Acute Hospitals Trust
York Hospitals NHS Foundation Trust

YoungMinds

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