National Institute for Health and Care Excellence

Psychosis and schizophrenia in adults (update)

Guideline Consultation Table

20 August – 1 October 2013

Unique comment ID (internal use only)	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
133	Association for Family Therapy and Systemic Practice in the UK	1	FULL	General		This response is submitted by AFT, the Association for Family Therapy and Systemic Practice (www.aft.org.uk). AFT is committed to supporting developments in practice, research, training and delivery of high quality therapeutic services for families and other caring groups, and is the UK's leading organisation for professionals working systemically with individuals, couples, families and other networks of care across the lifespan. AFT's membership is multi-disciplinary and includes Family and Systemic Psychotherapists (aka family therapists), clinical psychologists, psychiatrists, GPs, nurses, social workers, teachers, occupational therapists, health visitors and others committed to developing their systemic practice skills and understandings.	Thank you for your interest in the guideline.
134	Association for Family Therapy and Systemic Practice in the UK	2	FULL	24	41	The implication seems in the text that genetic risk is substantial due to 'many genes, each of which makes a small contribution.' This seems to imply truth when it is still only speculation, and adds bias to the medical model.	Thank you for your comment. We do not agree that the text implies a medical model. Please see the subsequent paragraph in the same section (2.1.8) which makes it quite clear that the majority of people who develop schizophrenia do not have a relative with schizophrenia we think this is a balanced presentation of what we currently know of the causes of psychosis and schizophrenia.
135	Association for Family Therapy and Systemic Practice in the UK	3	FULL	29	18	Regarding definition of carer, I (TS) would like to add: there may be times when the service user does not define the family member as a carer, but the family member defines themselves as carer in that they regard themselves as emotionally close and a provider of support even if they are not living with the service user. This apparent contradiction can be confusing for the mental health team, and they may consequently exclude the family member in the wishes of the service user, leaving the family excluded from the process and unsupported. There is need for clearer guidelines in such cases.	Thank you for your comment. You raise very important issues; these are dealt with in the chapter on carer's experience, which makes recommendations to directly address this specific issue.
136	Association for Family Therapy and Systemic Practice in the UK	4	FULL	108	36	Clear definition of who a carer is would be helpful, for instance close member of family not necessarily living with the service user and not necessarily next of kin, yet having a close supportive role during times of good and ill health.	Thank you for your comment. The section you refer to is a recommendation. We do not routinely add in definitions of terms in recommendation. However, a definition of a carer is available in the introduction of the chapter and we have amended it to reflect your comments. See section 4.1.
137	Association for Family Therapy and Systemic Practice in the UK	5	FULL	109	8	When the service user has refused to allow information to be shared with the carer, mental health services have few guidelines on how to support family members whilst maintaining confidentiality, thus depriving carers of support and overlooking an opportunity to work therapeutically with families and services users in conflict. Greater guidelines are needed to assist staff in supporting families without breaching confidentiality even if the	Thank you for your comment. We recognise this is a very difficult area and believe recommendations in the full guideline 4.6.1.4 (NICE guideline recommendation 1.1.5.4) covers your concerns.

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						service user has not given permission.	
138	Association for Family Therapy and Systemic Practice in the UK	6	FULL	276	30	This description of Family Interventions is too narrow and marginalises systemic psychotherapy theory and practice. For example, the one year Family Interventions in Psychosis training I (TS) run for an NHS Trust is a synthesis of systemic practice and psychosocial interventions, with an emphasis on psychotherapeutic tools of engaging the whole family drawn from systemic family therapy. Narrative therapy interventions, solution-focused techniques and other systemic therapy interventions are applied to the Family Intervention work, as well as trauma models, interactive behavioural cycles, and collaborative practice drawn from Peter Fraenkel's work with multi-stressed families. This is just one example, in Sussex, of Family Intervention trainings across the country, which are much broader in psychotherapeutic scope than the text suggests.	Thank you for your comment. Psychological interventions were not part of the scope and accordingly this section was not open for consultation.
139	Association for Family Therapy and Systemic Practice in the UK	7	FULL	279	15	Regarding the paucity of information on training: where the profession of the therapist carrying out Family Interventions is named as clinical psychologist, it is not clear whether that person is also dual trained as systemic family therapist. Many psychologists have an additional systemic training of 2 to 4 years, but are employed solely as psychologists. Thus the systemic training is being utilised but not acknowledged. Is this the case here?	Thank you for your comment. Psychological interventions were not part of the scope and accordingly this section was not open for consultation.
140	Association for Family Therapy and Systemic Practice in the UK	8	FULL	296	2	AFT agrees that the training and competencies warrant further research. Failure to understand the training and competencies needed by the Family Interventions practitioner threatens to minimise the skills required to deliver Family Interventions, and also marginalises Systemic Family Psychotherapists, who have a huge body of knowledge and experience in working with families.	Thank you for your comment. Psychological interventions were not part of the scope and accordingly this section was not open for consultation.
141	Association for Family Therapy and Systemic Practice in the UK	9	FULL	298	20	Clarity would be useful for staff when the family is asking for Family Intervention but the service user is refusing.	Thank you for your comment. Psychological interventions were not part of the scope and accordingly this section was not open for consultation.
142	Association for Family Therapy and Systemic Practice in the UK	10	FULL	324	32	AFT would add to this recommendation, that professionals not only have an appropriate level of competence in delivering the intervention, but in the case of Family Interventions, that level of competence should be measured for instance by a family therapy qualification or Family Interventions course.	Thank you for your comment. Psychological interventions were not part of the scope for this 2014 update and this section of the full guideline was not open for stakeholder consultation.
143	Association for Family Therapy and Systemic Practice in the UK	11	FULL	324	34	Supervision shoud be provided in the case of Family Interventions by a systemic family psychotherapist.	Thank you for your comment. Psychological interventions were not part of the scope for this 2014 update and this section of the full guideline was not open for stakeholder consultation.
144	Association for Family Therapy and Systemic Practice in the UK	12	NICE	General		AFT stresses the importance of whole family interventions at first episode psychosis, subsequent acute episodes and recovery. It is widely acknowledged that relatives and other supporters of people with mental health problems should be included in their care. Whole-family interventions and partnership working with carers and families is now central to secondary care UK mental health policies and clinical practice guidelines. However, for many families/ carers this remains an aspiration rather than a reality. Frank Burback, Roger Stanbridge and colleagues at The Somerset Partnership NHS Foundation Trust have developed family focused mental health practice as well as specialist family interventions (FI)	Thank you for your comment. Family interventions were not part of the review in this 2014 update. The references will be put forward for the next update evaluation.

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						for people with a diagnosis of psychosis, and Family Therapy clinics for those with complex and severe needs. The specialist family intervention services plus widespread high-quality trainings for mental health staff create a 'triangle of care' with service users and their families, and have resulted in widespread adoption of systemically informed, 'whole-family' practice. Trainings integrate CBT and systemic therapy. Practitioners are supported by on-going consultation and supervision led by Family and Systemic Psychotherapists. As Burbach et al highlight, systemic family therapy skills and understandings are crucial to supporting practitioners in effective delivery of integrative family intervention models. 'We would argue that our integrated approach offers significant advantages over a purely psycho-educational one, in that the systemic (interactional) view of causality as circular enables a non-blaming exploration and resolution of family dynamics which may be maintaining problems. This non-linear view of causality is combined with a postmodern therapeutic stance which enables an integration of the various FI models within a more open, collaborative therapeutic relationship (Burbach and Stanbridge 2001). Therapy based on these concepts is particularly valued by families who have used our service (Stanbridge el al 2003) and therapists trained in Somerset have found it much easier to engage families than clinicians trained in more prescriptive psycho-educational family intervention models (Bailey, Burbach and Lea 2003).' from: Frank Burbach, John Carter, Jane Carter and Matthew Carter (2007) Chapter Five: Assertive Outreach and Family Work, from Changing Outcomes in Psychosis: Collaborative Cases from Practitioners, Users and Carers. edited by Velleman, Davis, Smith and Drage, Blackwell Press. Bailey, R., Burbach, F.R. and Lea, S. (2003) The Ability of Staff Trained in Family Interventions to Implement the Approach in Routine Clinical Practice. Journal of Mental Health, 12: 131-141. Burbach, F.R. and Stanbridge, R.I. (2001) Creating Collaborative Therapeutic Relationships with Families Affected by Psychosis. Paper presented at the International Society for the Psychological Treatments of Schizophrenia and other Psychoses Conference, University of Reading, 13-14 September Stanbridge R.I., Burbach, F.R., Lucas, A.S. & Carter, K. (2003) A study of families' satisfaction with a family interventions in psychosis service in Somerset. Journal of Family Therapy, 25: 181-204.	
145	Association for Family Therapy and Systemic Practice in the UK	13	NICE	22	1.3.4.1	Treatment options: AFT requests the GDG consider the treatment principles and outcomes of the Open Dialogue approach, developed by JaakkoSeikkula and colleagues in Western Lapland, Finland. This family and network approach aims at treating people in their homes. The treatment involves the social network of the person with a diagnosis of psychosis, and starts within 24 hours after contact. Responsibility for the treatment process rests with the same team in inpatient and outpatient settings. The aim is to	Thank you for your comment. There were no RCTs of the Open Dialogue Approach that could be used in these reviews. The Seikkula trial is not a RCT and did not meet inclusion criteria for this review.

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						generate dialogue with the family and network to find words for the experiences that occur when psychotic symptoms exist. In a 5 year follow-up study, 85% of patients returned to their studies or full time employment; more than 80% were living without any psychotic experiences. This was reached with minimum use of psychotic medication and, in 2/3 cases, no psychotic medication at all. Jaakko, S et al (2006) Five-year experience of first-episode nonaffective psychosis in open-dialogue approach: Treatment principles,follow-up outcomes, and two case studies', Psychotherapy Research, 16: 2, 214	
346	British Association for Psychopharmacology	1	FULL	26	11	The discussion of the dopamine hypothesis is twenty years out of date. In particular it does not mention the now well established in vivo imaging findings of elevated dopamine function in schizophrenia, linked to symptoms, present in the prodrome and linked to onset of psychosis.	Thank you for your comments. The evidence you cite is not proof of the dopamine hypothesis and there is a great deal of contradictory evidence surrounding the aetiology of schizophrenia and psychosis in general. This uncertainty is reflected in the section to which you refer, particularly regarding the dopamine hypothesis.
347	British Association for Psychopharmacology	2	FULL	26	11	The discussion of the mode of action of antipsychotics it is factually wrong- antipsychotics do not block dopamine release. In addition it does not discuss their well established specificity to dopamine receptors- including in vivo findings in first episode patients that clearly link response to D2/3 receptor blockade.	Thank you very much. This is an error which has been changed
348	British Association for Psychopharmacology	3	FULL	26	11	There is no discussion of the glutamate hypothesis. As a leading hypothesis and more established than some of the other hypotheses discussed we recommend this is discussed.	Thank you for your comment. This introductory chapter is intended to cover the epidemiology and manifestations of psychosis and schizophrenia and to introduce the reader to background information in preparation for reading the chapters on evidence. The section on possible causes refers to the main areas that have been proposed. The so called glutamate hypothesis is barely known by the vast majority of people who work in mental health and so was omitted for reasons of space and clarity.
349	British Association for Psychopharmacology	4	FULL	30	27 on	This section reverts to an unnecessary and partly inaccurate comparison of first and second-generation antipsychotic that is not consistent with chapter 10.	Thank you very much, we have altered the last sentence to reflect your comment. Please see paragraph 3, section 2.5.2 of the full guideline.
350	British Association for Psychopharmacology	5	FULL	31	15 on	The discussion of long-term outcomes with and without antipsychotic treatment is grossly unbalanced and neglects the complexities. Specifically it cites one non-significant open, non-randomised study that has no comparator group (placebo or antipsychotic) and does not refer at all to the large number of randomised placebo-controlled studies and meta-analyses of these (egLeucht et al Lancet 2012; Kishimoto et al 2013). This imbalance is very mis-leading. The authors of the cited study call it exploratory and are appropriately cautious, calling for a trial. The complexities of this issue are not discussed at all. The issue is dealt with much better in chapter 10- it would be better to remove this section in preference to chapter 10.	Thank you for your comment. We have added to this section to address this imbalance but feel that it is an important discussion that needs to be included in the introduction.
96	British Medical Association	1	NICE	18	1.2.1	We agree.	Thank you.
97	British Medical Association	2	NICE	20	1.3.1	We agree.	Thank you.
98	British Medical Association	3	NICE	20	1.3.2.1	We are not sure why a GP with specialist psychiatric training could not start antipsychotic medication when a patient presents with mild	The guideline aims to raise standards and to ensure that the use of antipsychotics is strictly limited to those who have been formally

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						psychotic symptoms. It is currently very difficult to consult a psychiatrist by phone and to involve a community mental health team may take several days after faxing the referral form, which would delay the process.	diagnosed with psychosis. Although some GPs will be able to distinguish between someone in a prodromal state from someone in the early phases of psychosis, they still need to be referred to secondary care for assessment and treatment. In an emergency, liaison with a psychiatrist is essential and offering antipsychotics before they are seen would be best after they have discussed the presentation, not before.
99	British Medical Association	4	NICE	33	1.5.3	We agree; there are some good ideas here for improving care.	Thank you very much for your comment.
100	British Medical Association	5	NICE	General	-	In summary, this is a useful review.	Thank you.
352	British Psychological Society	1	FULL	General		The Society welcomes the addition of 'psychosis'. However the concept still seems rather reified. – at some points there is an implication that an illness 'does things' to people rather than there being a need to understand why people have certain experiences and feelings, and what can help. An example would be on page 3 – 'a major psychiatric disorder that alters a person's perception, thoughts, mood and behaviour'.	Thank you for your comment. This section has been amended to reflect your point.
353	British Psychological Society	2	NICE	20	1.3.1.1	The Society welcomes the inclusion of a recommendation that early intervention in psychosis be made available to all people with a first episode or presentation of psychosis.	Thank you.
354	British Psychological Society	3	NICE	20	1.3.1	The Society believes that assessment may take some time and it is worth engaging somebody in order to access good quality information. We would suggest that it is worth advising on how trauma and PTSD should be assessed. We would also recommend the inclusion of any caregivers, and information sharing preferences and also whether the person is a parent and support for children is required.	Thank you for your comment. The guideline development group agree that assessment will take time. There was very little evidence about the treatment or the assessment of trauma in people with psychosis and schizophrenia; hence reference was made to the PTSD guideline in the absence of more specific evidence. See recommendation in section 1.1.5 in the NICE guideline for carers and information sharing.
355	British Psychological Society	4	NICE	8	13	Where the affective psychoses are distinguished from schizophrenia spectrum psychosis, it would be helpful to be clearer in noting the potential for diagnostic uncertainty. In these cases, we would recommend the need to use clinical judgement in determining the most appropriate interventions.	Thank you for your comment. Diagnosis was not part of this 2014 update.
356	British Psychological Society	5	NICE	11		We are concerned that it appears to be assumed that all service users will find medication helpful in first episode, whereas this is not the case.	Thank you for your comment. This recommendation needs to be read in the context of the rest of the guideline. In Section 1.3.6, the guideline makes it clear that treatment with antipsychotics should be considered as an 'explicit individual therapeutic trial', and that the drug may need to be stopped or changed if side effects are intolerable. The evidence shows that antipsychotic medication combined with a psychological intervention is the most effective course of action for a first episode, and while it is to be expected that people should be offered both, whether they choose to take up both will be an individual preference.
357	British Psychological Society	6	NICE	15	1.1.3	The Society welcomes the attention to physical health and monitoring of physical health.	Thank you.
358	British Psychological Society	7	NICE	19	1.2.3.2	The Society welcomes the recommendation not to offer medication preventatively as timely.	Thank you.
359	British Psychological Society	8	NICE	22	1.3.4.2	We welcome the advice to offer psychological intervention to those not wishing to take medication. However, the wording 'advise that psychological interventions are more effective when delivered in conjunction with antipsychotic medication' is overly restrictive.	Thank you. The GDG chose this wording carefully, so that there is an option, but the service user understands the evidence that, done in combination with medication, CBT/FI appear to be more effective. If/when better evidence emerges that psychological treatments are

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						Although RCTs show this to be the case on average, it should be acknowledged that this may not be the case for all service users depending on their specific circumstances and needs. We would recommend inserting the phrase 'under certain conditions'. This point also applies to communication with service users about other issues.	effective alone, we would change this. But if the evidence continues to suggest that combining drugs and psychological interventions has the best results, this offer based on preference will remain.
360	British Psychological Society	9	NICE	24	1.3.6.3	The Society strongly endorses the recommendation that 'Treatment with antipsychotic medication should be considered an explicit individual therapeutic trial '. We welcome this as. Indeed we believe that were medication used in this way, the quality of mental health services would be significantly improved.	Thank you very much for your comment.
361	British Psychological Society	10	NICE	38	2.1-2.5	The Society welcomes the research recommendations.	Thank you
362	British Psychological Society	11	NICE	27	6	We would welcome a clearer distinction in relation to the difference between the formulation arising from routine psychiatric assessment and a psychological formulation. This distinction is not widely understood in services.	Thank you for your comment. This recommendation was not open for public consultation. In the NICE guideline please read the "Recommendation wording in guideline updates" section for more information on which recommendations stakeholders are allowed to comment on.
363	British Psychological Society	12	FULL	199	21	The Society welcomes recognition of the benefits of peer support. However, it is perhaps unnecessarily harsh on professional staff who work in the teams which in recent times have specialised in reaching those hard to engage i.e. assertive outreach teams. There is no research cited to support the statement that "assertive attempts to re-engage patients are perceived as harassing".	Thank you for your comment. The guideline development group considered the potentially negative impact this statement could have so it has been removed from the full guideline.
364	British Psychological Society	13	FULL	226-325	All	We believe that the guideline is missing any review of other up-and-coming approaches and especially ACT and mindfulness. There are now enough studies to at least warrant a review. Four RCTs of ACT for psychosis are quoted in the new book "ACT and Mindfulness for Psychosis" – pg 7: Bach & Hayes (2002), Gaudiano& Herbert (2006), Shawyer et al (2012), White (2011). Evaluations of mindfulness other than Chadwick et al (2005, 2009). The Society believes that, based on the evidence now available, ACT offers a viable alternative to the traditional CBT model of therapy for psychosis: ACT's therapy goals of promoting acceptance, psychological flexibility and valued living are appropriate to the often long term nature of psychosis, fit well with a recovery framework, and represent a helpful shift from a more traditional approach in which symptom elimination would be viewed as the key criteria for measuring treatment effectiveness. Reference: Bach, P., & Hayes, S.C. (2002). The use of acceptance and commitment therapy to prevent the rehospitalisation of psychotic patients: A randomized controlled trial. Journal of Consulting and Clinical Psychology, 70, 1129-1139. Chadwick, P. (2005). Mindfulness groups for people with psychosis. Behavioral and Cognitive Psychotherapy, 33, 351-359. Chadwick, P., Hughes, S., Russell, D., Russell, I., &Dagnan, D. (2009). Mindfulness groups for distressing voices and paranoia: A replication and randomized feasibility trial. Behavioural and Cognitive Psyhchotherapy, 37, 403-412.	Thank you for your comment. Psychological interventions were not part of the scope for this 2014 update. When NICE conduct a review to assess the need for a future update, this will be taken into consideration.

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						Gaudiano, B.A., & Herbert, J.D. (2006). Acute treatment of inpatients with psychotic symptoms using acceptance and commitment therapy: Pilot results. Behaviour Research and Therapy, 44, 415-437. Shawyer, F., Farhall, J., Mackinnon, A., Trauer, T., Sims, E., Ratcliffe, K., Larner, C., Thomas, N., Castle, D., Mullen, P., &Copolov, D. (2012) A randomised controlled trial of acceptance-based cognitive behavioural therapy for command hallucinations in psychotic disorders. Behaviour Research and Therapy, 50, 110-121 White, R.G., Gumley, A.I., McTaggart, J., Rattrie, L., McConville, D., Cleare, S, et al. (2011). A feasibility study of Acceptance and Commitment Therapy for emotional dysfunction following psychosis. Behaviour Research and Therapy, 49, 901–907.	
365	British Psychological Society	14	FULL	260	2	The Society believes that some reference to the likely need for some adaptation for particular groups is needed, such as people with a learning disability. For example, an additional recommendation such as:	Thank you for your comment. Psychological interventions were not part of the scope and accordingly this section was not open for consultation.
366	British Psychological Society	15	FULL	260	2	The Society would welcome further clarification on whether 'planned' sessions mean those 16 sessions are attended or offered. Some reference to what would be considered an adequate "dose" is also needed.	Thank you for your comment. Psychological interventions were not part of the scope and accordingly this section was not open for consultation.
367	British Psychological Society	16	FULL	260	4	The Society would welcome the inclusion of 'formulation-driven' or 'individually formulated' somewhere as well as the recommendation to follow a manual. Reference should be made to CBTp not simply being CBT for psychosis but for any other difficulties, which may be secondary to psychosis or may be co-morbid (for example, anxiety, depression, OCD, PTSD).This should be made explicit or otherwise state that trials have not been held of 'CBT for anxiety in people with psychosis' and that this is needed.	Thank you for your comment. Psychological interventions were not part of the scope and accordingly this section was not open for consultation.
368	British Psychological Society	17	FULL	260	21	We believe that there is a need for research into the efficacy of CBT for co-morbid difficulties in the context of psychosis; for example, OCD, PTSD, depression, anxiety, substance misuse, personality traits, anger. Clients with psychosis are usually excluded from research trials on 'CBT for …. Any of the above'.	Thank you for your comment. Psychological interventions were not part of the scope and accordingly this section was not open for consultation.
369	British Psychological Society	18	FULL	318	11	The Society would suggest adding two more recent reference Read &Bentall (2012) and Steel (2011). Read, John and Bentall, Richard P. (2012). Negative childhood experiences and mental health: theoretical, clinical and primary prevention implications. British Journal of Psychiatry, 200:89-91, DOI: 10.1192/bjp.bp.111.096727 Steel, C. (2011). The relationship between trauma and psychosis: a CBT perspective. Available online: http://www.ukpts.co.uk/site/assets/Steel-UKPTS-Oxford-2011.pdf	Thank you for your comment. We have added these references to the section.
370	British Psychological Society	19	FULL	319	1-20	It is worth noting that the research on PTSD is secondary to psychotic episodes and/or hospital admissions. See Morrison et al's (2003) review for discussion and references. Reference: Morrison, A. P., Frame, L., & Larkin, W. (2003). Relationships between trauma and psychosis: A review and integration. The	Thank you very much for your references.

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						British Journal of Clinical Psychology, 42, 331–351. doi:10.1348/014466503322528892.	
371	British Psychological Society	20	FULL	320	18-34	It would be helpful to distinguish between working with people with trauma histories (where the history is often incorporated into a psychological formulation of their psychosis and other distressing experiences) and people with psychosis who also meet the criteria for PTSD such as having flashbacks. Standard CBTp involves work with trauma histories, but it is not clear what the evidence is for trauma-focused CBT where they meet PTSD criteria. The Society is concerned that the review therefore fails to acknowledge a lot of trials of relevance to lines 39-41 (table 86), because a lot of CBTp does address the 'psychological management of trauma'.	We were tasked with evaluating the benefits and harms of psychosocial interventions which aim to manage trauma in a population with a diagnosis of psychosis and schizophrenia. The cause of the trauma (trauma histories or PTSD for example) was not a reason to exclude any trials. We have included any trials that meet the inclusion criteria set-out in Table 86, i.e. psychological interventions which aim to manage trauma for people with psychosis and schizophrenia. A review of CBT for psychosis is included in the psychological interventions chapter. We did not update this chapter in this 2014 update and accordingly this section was not open for consultation.
372	British Psychological Society	21	FULL	321	5	We would suggest the inclusion feasibility RCT (De Bont et al. 2013).The results of this feasibility trial suggest that PTSD patients with co-morbid psychotic disorders benefit from trauma-focused treatment approaches such as PE and EMDR. It would also be valuable to include the pilot study (van den Berg & van der Gaag, 2012). This is a current multi-site RCT in the Netherlands looking at the effect of treatment of posttraumatic stress disorder in people with a lifetime psychotic disorder. The treatment of PTSD has a positive effect on auditory verbal hallucinations, delusions, anxiety symptoms, depression symptoms, and self-esteem. EMDR can be applied to this group of patients without adapting the treatment protocol or delaying treatment by preceding it with stabilising interventions. References: de Bont, Paul A.J.M., van Minnen, Agnes .& de Jongh, Ad (in press, 2013). Treating PTSD in Patients With Psychosis: A Within-Group Controlled Feasibility Study Examining the Efficacy and Safety of Evidence-Based PE and EMDR Protocols. Behavior Therapy. Available online: www.sciencedirect.com van den Berg, D. P., & van der Gaag, M. (2012). Treating trauma in psychosis with EMDR: A pilot study. Journal of Behavior Therapy and Experimental Psychiatry, 43(1), 664–671. doi:10.1016/j.jbtep.2011.09.011	Thank you for the references however after June 2013 we are unable to accept publications in press. The reference will be kept and when NICE next update on psychological interventions in psychosis and schizophrenia this reference will be reviewed.
373	British Psychological Society	22	FULL	324	17	The Society recommends that this is revised to be more specific and state that someone with training in PTSD in Psychosis is needed and make reference of the potential need to adapt work for people with psychosis.	Thank you for your comment. There was just one trial for people with PTSD & psychosis. Whilst your comment has face validity, we do not have any evidence that suggests that people who have had a psychosis and develop PTSD need to be treated differently to people who have PTSD in the absence of a psychosis. We have made a research recommendation which we hope will clarify this issue.
374	British Psychological Society	23	FULL	507	28	It is worth noting that the current level of service provision in many areas means that it is not possible for all people with an established diagnosis of schizophrenia to have a joint care plan between	Thank you for your comment. Our recommendations are based on clinical evidence and expert guideline development group consensus. We understand that the resources are limited and

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						primary and secondary care. It The guideline implies that all people with psychosis should be referred to secondary care, however, the recent Joint Commissioning Panel for Mental Health guidelines for community health services provide guidance about whether a person with psychosis could be seen in primary care alone, since secondary care is a limited resource and should be reserved for people with complex social needs and/or high risk.	therefore a variety of teams and crisis houses were considered. Please see recommendations in section 1.4.1 of the NICE guideline.
375	British Psychological Society	24	FULL	507	33	The Society recommends that carers should not only be offered an assessment of their needs but also the relevant support to meet these needs and offered follow up to ensure these needs have been met.	Thank you for your comment. The GDG were very committed in reviewing the needs of carers and went a long way in reviewing the available evidence. Recommendations were formed based on this evidence and expert opinion, please see the carers chapter for more information.
376	British Psychological Society	25	FULL	508	15-44	The Society welcomes the implication that a referral to secondary care may not always be necessary, although this is stated implicitly and tentatively. Factors that may be used to indicate that referral to secondary care is appropriate are: a) Complexity, and by this we mean someone being very unwell and having a range of social needs that primary care cannot meet. b) Risk - Many of the points mentioned in this section about medication and side effects could be managed by the GP, with support/consultation from secondary care. There needs to be more of this and reference to primary care needing training to better support people with psychosis.	Thank you for your comment. The GDG have recognised your concern and an extra bullet point has been added to reflect the risks of neglecting the complex social needs. Please see section 12.2.3 in the full guideline.
377	British Psychological Society	26	FULL	510-513	All	We would recommend that a reference to the recovery model and its influence in recent years is included. Greater emphasis should also be made on personalised care and service-user driven outcomes.	Thank you for your comment. The recovery model is a philosophy which is important in informing an evidence-based approach to interventions and the service users' views. Unfortunately, we could not find a recent reference to the use of the recovery model in current practice. However, the GDG believe that the principles of the recovery model are of paramount importance and considered this when deciding on critical outcomes for the reviews of interventions and services. For example, in the reviews of non-acute community care and alternatives to acute admission (sections 12.3 & 12.4), we list amongst the critical outcomes 'satisfaction with services', 'quality of life' 'social functioning' and 'employment and education'. These are all outcomes which are service-user driven. We also discuss the importance of service user preference and choice in section 12.3.6 & 12.4.5 (linking evidenced to recommendations) as well as include this aspect in the recommendations.
378	British Psychological Society	27	FULL	513	34	The Society believes that clients should not have to be referred to secondary care just to access psychological treatments. These should be made available in primary care; for example, SMI-IAPT initiatives.	Thank you for your comment. The guideline development group agreed to expand the sentence to include specialist psychological treatments for psychosis. See section12.2.4, third to last paragraph for the addition.
379	British Psychological Society	28	FULL	534	13	The Society is concerned that this ignores two critical differences between Assertive Outreach (Assertive Community Treatment or Assertive Outreach and Intensive Case Management.) 1 AO emphasises a team approach, ICM does not. 2 ICM is a poorly defined model, whereas ACT is very well defined. The terms ACT and ICM are used interchangeably in the document, although the text does not cite any evidence that ACT and ICM are equivalent. The Cochrane review (Dieterich et al,	Thank you for your comment. Assertive Community Treatment (ACT) and Intensive Case Management (ICM) are approaches to caring for people with severe mental illness (typically schizophrenia or bipolar disorder) who require intensive community support and have frequent admissions. The approaches are similar: both use an assertive outreach model of care (i.e. persisting with service users who are not engaging) and both specify that practitioners should carry limited caseloads. ACT and ICM have been around for at least

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						2010) may assert an equivalency between these two models, but there is a lack of evidence to support this. When AO and ICM are compared as different models, the evidence for ICM is weaker (e.g. Cochrane review, 1998). Conflating the two models then simply weakens the evidence for AO. It would be more helpful to look at evidence for clearly defined models, rather than conflating different models. Reference: Dieterich M, Irving CB, Park B, Marshall M. (2010). Intensive case management for severe mental illness. Cochrane Database of Systematic Reviews (10):CD007906.	four decades, during which time ACT has become increasingly precisely defined, but has also become less distinct from ICM, as case managers have increasingly adopted a team based approach and other elements of the ACT model. With time the distinction between these models has been lost. The introduction to ICM has been modified at length to explain the complexity behind this situation and to justify the GDGs decision to combine the two interventions. Please see section 12.3.5 on the full guideline.
380	British Psychological Society	29	FULL	534	26	We believe that these definitions are unhelpful when attempting to make this comparison. The only difference given between ICM and non-ICM is caseload size. But since one is defined as up to and including 20, whereas the other is defined as over 20 people, the difference between services compared could just be a single additional case. This lack of clear difference perhaps accounts for the weak results reported on p 542.	Thank you for your comment.If one is going to make a division on the basis of caseload size then it is necessary to choose a cut-off point. To some extent this will be an arbitrary process. We chose a caseload of 20 because this is somewhat higher than most guidelines for ICM, ACT and indeed EIS teams (which tend to specify caseloads of 1:10 to 1:15, but considerably lower than the caseloads seen in low intensity case management services, which tend to me around 1:30. In theory it is possible that had we chosen a slightly different cut-off, the mix of studies would be slightly different - but in practice the distribution of studies is bipolar - i.e. the great majority of ICM studies are well below 20 and the non-ICM studies are well above. Moving the cut-off slightly has therefore little impact. We actually looked at caseload size as a co-variable in our meta-regression if ICM studies, including ACT. It did not have any impact on outcome. I think it is therefore highly improbable that slight changes to the cut off point of 20 would have any impact on the apparent lack of difference between ICM and other non-intensive case management services.
381	British Psychological Society	30	FULL	547	8	We suggest that it would be appropriate to add a caveat to the failure to find a large effect on duration of hospitalisation in the UK. This has already been explained by context (For example, Stefan Priebe et all, 2009). The already low bed numbers in the UK make it difficult for any services to reduce them significantly. An international comparison shows admissions in countries with comparatively high bed numbers, or when beds are cut as teams are established. In the UK there are probably more appropriate means to investigate effectiveness; for example, recovery outcomes. Reference: Priebe, S., Katsakou, C., Amos, T., Leese, M., Morriss, R., Rose, D., Wykes, T., and Yeeles, K. (2009) - Patients' views and readmissions 1 year after involuntary hospitalisation – The British Journal of Psychiatry, 194, 49-54.	Thank you for your comment. We agree that this is important to note. However, the section you refer to is the clinical evidence summary, which has to reflect the clinical evidence. We have however added the reference you suggest to the 'linking evidence to recommendations section' (see section 12.3.6) which is a more contextualised discussion of the evidence.
382	British Psychological Society	31	FULL	551	18-22	The Society believes that the smaller caseloads are a significant factor in the success of EIS. EIS care coordinators see their clients regularly (often 1-2 times/week), which contributes significantly to recovery and also allows better monitoring of signs of relapse, to prevent it earlier. EIS staff are usually more psychologically minded and/or trained in low-intensity psychological interventions (but not high intensity 'CBT or FI') This improves the overall care.	Thank you for your comment. The GDG were in agreement that there were better outcomes when the case loads where lower and there was more time to conduct the treatment. An addition has been made to section 12.3.6.

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383	British Psychological Society	32	FULL	552	23	On the previous page, the critical outcomes for ICM do not include symptom reduction. This seems appropriate, so it is not clear why the discussion about trade-off refers so much to symptoms. The Society would therefore welcome greater emphasis on the assessment of effectiveness in terms of recovery; for example, quality of life and functioning.	Thank you for your comment. As you state the critical outcomes were effectiveness in terms of recovery and thus the primary focus in this section is on those outcomes. However, as a secondary consideration, we were also tasked with showing that ICM did not have harmful effects on symptoms and thus state so using these as secondary outcomes. Secondary outcomes are listed in the full review protocol in appendix 6.
384	British Psychological Society	33	FULL	554	15	There is a lack of distinction between ICM and AO which is unhelpful, given that in the UK in recent times assertive outreach teams have been focused on those with poor engagement and high desirability.	The review of Assertive Outreach for access and engagement is in section 6.2.4 of the access and engagement to service-level interventions chapter.
385	British Psychological Society	34	FULL	554	30	We believe that there are significant service implications with this. We would recommend that clarification is made regarding whether EI is considered to be the most appropriate service or whether it is about extending the EI care package in an appropriate setting.	Thank you for your comment. The GDG reviewed the evidence for the effectiveness for EIS and came to the view that EIS should be available for people with 1st episode psychosis whatever their age or DUP. There was no evidence providing "an EI care package" in any other setting. We therefore can't recommend what you are suggesting. However, there is good evidence that some of the ingredients of EI services, namely family interventions and CBT for psychosis do have a positive effect in other settings other than EIS. These were therefore recommended in any setting.
386	British Psychological Society	35	FULL	555	16	There are often difficulties at the interface between mental health services and learning disability services (e.g. Royal College of Psychiatry, 2012, p.8), which can negatively affect the quality of care provided to people with a learning disability. We would therefore recommend the inclusion an additional explicit reference to the commissioning of clear arrangements between mental health and learning disability services (as recommended by the Joint Commissioning Panel for Mental Health, 2013, p.14) to ensure that people with a learning disability can access appropriate services for psychosis and schizophrenia. For example: "12.3.7.9 Commissioners should ensure there is clarity over how services are to be provided to people a learning disability, so that there is a clear pathway for them to follow. Disputes over eligibility criteria between mental health and learning disability services should not delay access to treatment." References: Joint Commissioning Panel for Mental Health (2013) - Guidance for commissioners of mental health services for people with learning disabilities http://www.jcpmh.info/wp-content/uploads/jcpmh-learningdisabilities-guide.pdf Royal College of Psychiatrists' Faculty of Psychiatry of Intellectual Disability (2012) People with learning disability and mental health, behavioural or forensic problems: the role of in-patient services http://www.rcpsych.ac.uk/pdf/FR%20ID%2003%20for%20website.pdf	Thank you for your comment. This is a very important issue which may lead to Quality Statements but it also requires specific attention. This will be reviewed in the Learning Disabilities and Challenging Behaviour guideline which is due for publication in March 2015.
387	British Psychological Society	36	FULL	580	1	The Society would recommends that specific reference to the need for clear commissioning arrangements as to how crisis resolution and home treatment teams can be accessed by people with a learning disability be made. For example: "12.4.6.1 Consider crisis resolution and home treatment teams as a first-line treatment to support people with psychosis or schizophrenia during an acute	Thank you for your comment. How to access treatments for people with learning disabilities may well be covered in a new guideline mental health problems and people with learning disabilities.

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						episode in the community if the severity of the episode, or the level of risk to self or others, exceeds the capacity of the early intervention in psychosis services or other community teams to effectively manage it. Commissioners should ensure there is clarity over how these services are to be provided to people a learning disability, so that there is a clear pathway for them to follow. Disputes over eligibility criteria between mental health and learning disability services should not delay access to treatment."	
90	Carers Trust	1	FULL	27	27	Our comments are as follows: the discussion of a therapeutic alliance between service user, professional and carer appears to directly reference the Triangle of Care (http://professionals.carers.org/health/articles/triangle-of-care,6802,PR.html) including this clearly as a recommendation will enable the therapeutic alliance being more easily embedded.	Thank you. Your comment refers to the introductory chapter. The introductory chapter can't include recommendations as these are all located in the evidence chapter. However, we have included a reference to the Triangle of Care in this section
91	Carers Trust	2	FULL	General		The health economics evidence omits two key areas: the carer contribution and the impact certain interventions will have on the carer's health. In particular models of ongoing community support (when a service user is in crisis) can have a significant and lasting impact which has its own health economic impact.	Thank you for your comment. However, the search of the health economic literature has not identified economic studies in this area. Nevertheless, in section 4.5 of the full guideline the GDG acknowledged that burden of care may last for many years, increase carer morbidity and stress, and that this will have economic consequences.
92	Carers Trust	3	FULL	67		Section 4 looks at individual interventions that can benefit carers however does not take into account the benefits of a carer inclusive service model – in particular the Triangle of Care as cited in Example 1.	Thank you for your comment. The GDG agreed to cite the Triangle of Care in the introduction, please see section 2.4 in the full guideline for the reference.
270	Central & North West London NHS Foundation Trust	1	NICE	15	1.1.3.3	· Suggest that readers refer to 'Brief interventions and referral for smoking cessation (PH1)' · Question the recommended use of Bupropion given risk of lowering seizure threshold	Thank you very much. The text has been amended to reference the PH guidance. We have also amended the recommendation regarding Bupropion and added the need for regular monitoring due to possible neuropsychiatric adverse effects.
271	Central & North West London NHS Foundation Trust	2	NICE	16	1.1.3.6	Suggest monitoring of "body mass" (presumably BMI?) elaborated to say: 'weight and waist or height measurement...to be monitored' - in order to be consistent with 1.3.6.1	Thank you for your comment, reference to 'body mass' has been changed to 'weight' in the NICE guideline recommendation 1.1.3.6.
272	Central & North West London NHS Foundation Trust	3	NICE	16	1.1.5.3	· Instead of 'positive outcomes and recovery': 'positive outcomes based on the principles of Recovery (defined)' · Add 'Information about the roles and contributions of different health professionals'	Thank you for your comment. The guideline development group agrees with your second point and has revised the recommendation accordingly. They did not agree with the first point because they felt that recovery was a distinct category.
273	Central & North West London NHS Foundation Trust	4	NICE	17	1.1.5.7	· Suggest change from 'have a positive recovery message' to 'based on the principles of hope and Recovery'.	Thank you for your comment; the recommendation has been revised to say 'have a positive message about recovery'.

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274	Central & North West London NHS Foundation Trust	5	NICE	18	1.1.6.2	· Which self-management programme is recommended and what should it contain	Thank you for your comment. Chapter 8 in the full guideline goes into detail as to how self management has been defined, and the different types of packages which fall under self management programmes, such as the Wellness Recovery Action Plan (WRAP), the Illness Management and Recovery (IMR) programme and the Social and Independent Living Skills (SILS). Again the components of self management programmes vary depending on the specific programme, whilst meeting the core purpose of self-management. Please see section 8.3 of the full guideline.
275	Central & North West London NHS Foundation Trust	6	NICE	18	1.1.6.3	· Suggest changing line 'building a social support' network to 'building a social and occupational support network'.	Thank you for your comment, but the guideline development group did not think it appropriate to add 'occupational' in this context.
276	Central & North West London NHS Foundation Trust	7	NICE	23	1.3.6.1	· Suggest including 'Before starting antipsychotic for any patient…' to indicate that baseline investigations are not only for those with early psychosis · Earlier point 1.3.3.1 refers to measuring weight and not waist circumference – should clinicians measure both? · Not being able to complete these investigations (e.g. due to patient refusal) should not contraindicate treatment.	Thank you for your comment. The guideline development group felt that antipsychotics should not be offered to people at high risk of developing psychosis. If however you are asking about those who have an established psychosis and initiating a new treatment then the guideline group would support the same baseline investigations. In regards to your second point, the following justification explains in detail why the guideline development group have recommended checking for weight, waist circumference and fasting blood glucose and HBA1c. Blood glucose measurement reflects the state of glucose regulation at the moment of sampling, whereas HbA1c is an indirect measurement of glucose regulation based on the incorporation of glucose during Haemeaglobin synthesis – and reflects an averaged-out picture of glucose regulation over the three months prior to the sampling. Occasionally (and dangerously) people on antipsychotics will develop diabetes aggressively (typically following initiation) – in these individuals HbA1c may be normal even though their blood glucose could be rapidly climbing. Moreover by stopping the antipsychotic the diabetes can be reversed – emphasising the importance of clinical awareness and use of blood glucose to detect this dangerous and potentially reversible state The particular value of HbA1c is as a longer term measure of gradual shift in someone who was moving along a slower path (typically) towards type 2 diabetes. It is true that monitoring fasting blood glucose on a regular basis could detect shifts but the problem in practice is often that routine fasting measures can be difficult to achieve – whereas for HbA1c it does not matter whether fasting or not – so it is the ideal method of spotting a gradual shift in glucose regulation over time and is convenient and reliable Waist circumference - the critical issue here is that the development of central obesity (best measured by an increase in waist circumference) is the most important driver of metabolic syndrome with its attendant risks for developing CVD and diabetes. For instance if change in weight was the only measure used it will fail to

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							discriminate between alterations in body composition (ie lean muscle or fat). If a patient refuses to have these assessments this is not a contraindication to treatment, it is a matter for clinical judgement.
277	Central & North West London NHS Foundation Trust	8	NICE	25	1.3.6.4	· Suggest that secondary care team maintain responsibility for prescribing but that physical health care is shared responsibility at all times.	Thank you for your comment. These recommendations were written as a result of discussions within the guideline development group (GDG) regarding good practice by the GDG. There is also a wealth of evidence that the current primary/ secondary interface is not effective for this aspect of care (e.g. typified by findings of the National Audit of Schizophrenia). We acknowledge that monitoring physical health is appropriate given the side effects of medication and this was the basis for recommending that the initiator of prescribing should take responsibility for assessing the adverse effects through effective and systematic monitoring. We did arrive at a GDG consensus that there should be clearer allocation of responsibility for monitoring what are after all primarily adverse effects of medications in the first treatment phase to the treating psychiatric practitioner/service, and that this responsibility would normally transfer to primary care after 12 months. The recommendations are quite explicit about which parameters should be measured and how they should be recorded.
278	Central & North West London NHS Foundation Trust	9	NICE	26	1.3.6.9	This is incorrect. Regular combined antipsychotics are used 'as augmentation strategies with clozapine in treatment resistant cases'.	Thank you for your comment. The evidence for this recommendation was not reviewed however the wording is regular combined antipsychotics, which suggests that combination treatment is not routine.
279	Central & North West London NHS Foundation Trust	10	NICE	28	1.4.1.3	· Given that 'acute day care, crisis houses and other facilities' are less available now – what alternatives are there; and what should these facilities incorporate as a minimum	Thank you. The recommendation describes those we have reviewed, while accepting there may be other alternatives, such as respite, staying with relatives, or being supported in a hostel, for example. Without reviewing others (there were no trials of the others) we wouldn't be able to say what 'minimum' facilities they should incorporate.
280	Central & North West London NHS Foundation Trust	11	NICE	28	1.4.1.5	· Many ICM/AOT teams are now disbanding	Thank you. The recommendations are based on the evidence. Although some services have shut ACT/ICM, many have not. The evidence does support their use when preventing drop out from services is a priority.
281	Central & North West London NHS Foundation Trust	12	NICE	28	1.4.1.6	· Currently says "if hospital admission is unavoidable, ensure that the setting is right for the persons' age and level of vulnerability." Suggest adding "and gender as well as level of security required to safely deliver care."	Thank you for your comment; the guideline development group has added gender. Level of security will be a matter for local determination.
282	Central & North West London NHS Foundation Trust	13	NICE	29	1.4.2.1	· Suggest deletion of oral in 'offer: - oral antipsychotic medication in conjunction with…' · Suggest that psychological interventions are offered with caveat 'if appropriate' in acute psychosis.	Thank you. Drug and psychological interventions were not reviewed for this 2014 update and cannot therefore be changed in their meaning. The previous update was quite clear that oral antipsychotics should be the mainstay of treatment and that psychological treatments (FI and CBT) should be offered to all people with schizophrenia.
283	Central & North West London NHS Foundation Trust	14	NICE	29	1.4.3.1	· Suggest change wording from 'offer oral antipsychotic medication or review existing medication' to 'offer antipsychotic medication and review existing medication' · Suggest add text to refer the readers back to the required	Thank you. Drug and psychological interventions were not reviewed for this 2014 update and cannot therefore be changed in their meaning. The previous update was quite clear that oral antipsychotics should be the mainstay of treatment and that

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						tests specified in 1.3.6.1	psychological treatments (FI and CBT) should be offered to all people with schizophrenia.
284	Central & North West London NHS Foundation Trust	15	NICE	33	1.5.3.2	· Responsibility for physical health care and health checks is unclear – 'a copy of the results should be sent to the [secondary care team]; is this not always the case, not just after transfer? Also, should not physical health care and checks remain joint responsibility throughout treatment?	Thank you for your comment, but the guideline development group thinks that this recommendation is clear.
285	Central & North West London NHS Foundation Trust	16	NICE	General		We welcome the new recommendations· In support of supported employment and peer support· The inclusion of occupational activity in management· Research recommendations in terms of peer support; those who do not wish to take medication; and discontinuing/reducing medicine.	Thank you.
286	Central & North West London NHS Foundation Trust	17	NICE	General		Agree with the definition of psychosis	Thank you.
176	College of Mental Health Pharmacy	1	NICE	General		The Guideline does not have line numbers, so the locations of comments will be identified using paragraph numbers.	Thank you.
177	College of Mental Health Pharmacy	2	NICE	4	5	The word 'Recovery' needs to be defined. For the majority of people affected by schizophrenia It does not mean being free of the illness, which is what 'recovery' is usually taken to mean. Without a clear definition, this may create unrealistic expectations among both health professionals and patients and their carers. In addition, although reference is made to recovery, the overall tone of the guideline is lacking in clinical optimism and therapeutic ambition. The strong impression is that schizophrenia is something to be contained or managed; the idea of recovery is considered to be laudable but largely unrealistic. There needs to be a much stronger emphasis on recovery rather than management as the goal of treatment.	Thank you for your comments. The introduction to the NICE guideline has limited space and it is, therefore, succinct/brief. In the full guideline, the 2nd chapter goes into the disorder and its impact, as well as theories and much more background. In the full guideline we are able to expand on a range of related issues, such as recovery, much more effectively. In the introduction for the NICE guideline the term recovery has the same meaning as it would in other health contexts and doesn't, therefore, need defining.
178	College of Mental Health Pharmacy	3	NICE	4	5	The word 'compensate' suggests that people affected by schizophrenia are able to adjust to their condition and are able to live a normal or near-normal life. Like 'recovery' (above) unless 'compensate' is clearly defined it is likely to create unrealistic expectations.	Thank you. The language used in the introduction is plain English and the GDG did not think this needed defining.
179	College of Mental Health Pharmacy	4	NICE	15	1.1.3.3	The recommendation to offer bupropion to aid smoking cessation is made as a strong recommendation. However, the bupropion SPC section 'Special Warnings and Precautions' contains specific warnings about the co-prescription of bupropion with antipsychotics and the potential for neuropsychiatric reactions including the emergence of psychotic symptoms. In addition, bupropion is a potent inhibitor of the hepatic p450 2D6 enzyme and may significantly increase plasma levels of some commonly prescribed antipsychotics such as risperidone. This recommendation should be revised from 'offer' to 'consider', with information about the risks of prescribing bupropion for patients with psychotic illnesses who may be taking antipsychotic medicines.	Thank you for your comment. We have amended the recommendation regarding Bupropion and added the need for regular monitoring due to possible neuropsychiatric adverse effects.
180	College of Mental Health Pharmacy	5	NICE	16	1.1.5.1	The care plan should be reviewed annually with the carer.	Thank you for your comment. The recommendation has been revised to state that the care plan should be reviewed annually.
181	College of Mental Health Pharmacy	6	NICE	17	1.1.5.5	Add 'or if there is evidence that information is not being shared effectively between services, for example, between specialist	Thank you for your comment. However this recommendation is about information sharing between service users and carers,

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						services and GPs.'	therefore the guideline development group have not changed the recommendation as you have suggested.
182	College of Mental Health Pharmacy	7	NICE	17	1.1.5.7	This recommendation is too vague. It should be made clear that ad-hoc interventions are unlikely to be effective, and that educational interventions should follow a clearly-defined structured programme and be delivered by people who have been trained and have skills in that role.	Thank you for your comment. The GDG discussed this at length and felt the recommendation should remain as it is as it is consistent with the evidence reviewed.
183	College of Mental Health Pharmacy	8	NICE	18	1.1.6.3	What is missing here is any mention of the importance of validation of the experience of the person with schizophrenia. Sufferers do not think in terms of 'symptoms' and need to be supported in integrating their own frames of reference with those of health professionals. They also need information about the outcomes of different treatments and the likely outcomes of doing nothing or of poor adherence to treatment regimens.	Thank you. This guideline will be taken in conjunction with the Guideline and QS on Service user Experience in Adult Mental Health which recommends a very patient-centred approach to care, including full provision of information about the disorder, its treatment, services, access, the benefits of treatment and any downsides/side effects to treatment.
184	College of Mental Health Pharmacy	9	NICE	18	1.2.1.1	The early signs of a first episode of schizophrenia are likely to include non-specific negative symptoms such as social withdrawal, isolation and deteriorating self-care. Psychotic symptoms usually arise much later in the prodrome. These early signs are the ones that should be emphasised here if early referrals are to be made.	Thank you for your comment. The guideline development group agree that behaviour should be checked for along with other experiences suggestive of possible psychosis. See NICE recommendation 1.2.1.1 for the addition.
185	College of Mental Health Pharmacy	10	NICE	19	1.2.4.1	Monitoring should be put in place whether or not treatment is offered or accepted, is successful or unsuccessful.	Thank you for your comment. The guideline group do not agree that monitoring should be put in place in all circumstances. Monitoring should be selective; if the treatment is successful, monitoring is unlikely to be worthwhile. Furthermore the GDG didn't agree that you should monitor people who don't accept monitoring.
186	College of Mental Health Pharmacy	11	NICE	19	1.2.4.2	It is not clear whether the patient should be included in the GP's SMI register. If not, how feasible will it be for the GP to continue monitoring?	Thank you for your comment. If a person has psychosis/schizophrenia, the GP should include them in their SMI register, whether they are being seen by secondary care or not.
187	College of Mental Health Pharmacy	12	NICE	20	1.3.1.4	If the patient is still unwell after 3 years, the advantages of continuing with the early intervention service (which has thus far failed to obtain an improvement) are unlikely to be significant. The emphasis at this point should be on good communication and maintaining continuity of care while responsibility for the patient's care is transferred to a team whose primary role and expertise is in continuing care.	Thank you for your comment. This recommendation was purely evidence based. EIS reduce relapse rates, decrease symptoms, improve quality of life and are preferred to standard community treatment. These effects are lost 12 months after leaving EIS. The recommendation is perfectly in-line with the evidence.
188	College of Mental Health Pharmacy	13	NICE	20	1.3.3.1	The success of psychological interventions often depends on pharmacological treatment to stabilise the patient's mental state. Pharmacological treatment for most patients is crucial, as is the involvement of a health professional with expertise (as opposed to a basic working knowledge) in pharmacological treatments - ie a specialist mental health pharmacist. Specialist mental health pharmacists should be added specifically to the list of health professionals who should be involved.	Thank you. We don't usually refer to specific professionals unless only one type of professional is required, for example when diagnosing psychosis a psychiatrist needs to be directly involved. Mental health pharmacists are very important in the MDT in mental health, but a psychiatrist would also have in-depth knowledge of drug treatments, side effects etc.
189	College of Mental Health Pharmacy	14	NICE	23	1.3.4.3	The NICE guideline for Bipolar Disorder (CG 38) is out of date. It should no longer be recommended as an authoritative guide to clinical practice. A more up to date guideline would be the British Association for Psychopharmacology Guideline 2009.	Thank you for your comment; the Bipolar Disorder guideline is currently being updated and will be referenced when it is published.
190	College of Mental Health Pharmacy	15	NICE	23	1.3.5.1	a. Generally this section should be made more specific about the adverse events that should be discussed and how information should be presented. It is essential that the benefits of treatment be emphasised – and agreed – with the patient before any discussion	Thank you for your comment. Antipsychotics were not reviewed in this 2014 update, while some recommendations were amended, pharmacological interventions for first episode and subsequent acute episodes were not reviewed. The references will be kept to inform

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						of adverse effects. Comparative information about adverse effects between drugs should be available in a simple format. eg: Name of adverse effect, what it is like to experience it, and how different antipsychotics compare in their liabilities to induce it.b. There should be a statement that, apart from clozapine, there is little evidence to demonstrate important differences in efficacy between first- and second-generation antipsychotics. However, there is strong evidence for differences in adverse effect profiles, particularly those adverse effects that are mediated by dopamine blockade – antipsychotic-induced movement disorders and elevation of serum prolactin. There should be an unambiguous statement that the avoidance of adverse effects (as far as is possible) is a priority and both a clinical and an ethical responsibility for all health professionals involved in the care of an individual patient.c. There should be an explicit statement here that the acquisition cost of an antipsychotic is NOT a primary consideration in choosing an antipsychotic for an individual patient. Clinical need (eg. for clozapine), the avoidance of adverse effects, the maintenance of good physical health and a patient's willingness to take an antipsychotic medicine are all of much greater importance.d. Metabolic: All the variables of metabolic disease should be included eg. hypertensione. Extrapyramidal: add 'Parkinsonism'f. Cardiovascular: This is not an area on which patients can be expected to make an informed decision. Many health professionals do not themselves fully understand the clinical importance of prolongation of the cardiac QT interval. The implication here is that a patient could, in theory, give 'informed' consent to an ill-informed clinical decision. QT prolongation should be a consideration in weighing treatment options before they are presented to the patient. If a patient would be put at risk by QT prolongation or is already on another medicine that causes QT prolongation then such an option should not be offered.g. Hormonal: elevation of plasma prolactin is the only problem of note	the next update.
191	College of Mental Health Pharmacy	16	NICE	23	1.3.6.1	Obtaining an accurate record of nutrition is likely to be extremely difficult if a patient is acutely psychotic.	Thank you for your comment. The GDG understand the difficulties however this should be dealt with on an individual basis by the health practitioner.
192	College of Mental Health Pharmacy	17	NICE	24	1.3.6.3	· 'Discuss and record the side effects that the person is most willing to tolerate.' Change 'willing' to 'Unwilling' · 'Record the indications and expected benefits . . .' o It would be useful for a proforma to be developed for this to create a systematic approach and consistency between patients, health professionals, services and over time. · 'Justify and record reasons for dosages outside the range given in the BNF or SPC.' Change to: o Record the expected benefits and potential risks of doses outside the range given in the BNF or SPC and the expected time for an improvement in symptoms and appearance of adverse effects. o Implement appropriate monitoring and safety measures (eg.	Overall this chapter was not open for consultation as pharmacological interventions were not reviewed. However, new recommendations have been added (see page 430, where there is an explanation for this). Where recommendations end '2009, amended 2014', the evidence has not been reviewed but changes have been made to the wording that have altered the meaning (for example, because of equalities issues or a change in the availability of drugs, or incorporated guidance has been updated). Further explanations of the reasons for the changes are given in appendix A of the NICE guideline. For purposes of transparency the 'new' and 'amended' recommendations were not shaded in grey so that stakeholders could see the changes made to the full guideline.

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						regular blood pressure monitoring or ECG). Monitor closely for adverse effects. If, after the pre-specified time, no improvement is obtained, reduce the dose to within SPC limits and consider changing to an alternative treatment.	
193	College of Mental Health Pharmacy	18	NICE	24	1.3.6.4	It is not efficacy that should be monitored. Efficacy is something that is measured in controlled clinical trials. What is meant here is response to treatment.	Thank you. You are correct please see NICE recommendation 1.3.6.4
194	College of Mental Health Pharmacy	19	NICE	25	1.3.6.4	· Weight. If there is significant weight gain, this should be monitored more frequently – suggest every 3 months. · Waist circumference should be monitored more frequently than annually if there is significant weight gain – suggest every 3 months · Fasting glucose etc. Should be monitored more frequently with medicines well-known to cause metabolic problems (eg. olanzapine & clozapine.) Suggest 3 monthly, especially if there is significant weight gain. · Adherence. There is evidence that health professionals are unable accurately to assess adherence. Adherence should be assessed using a formal instrument such as the Drug Attitude Inventory (DAI). Professionals need training in using the DAI and services should have policies in place regarding what should be done in the event of poor adherence. · Overall physical health. In drugs well-known to cause elevation of plasma prolactin, (eg all first-generation antipsychotics, and some second-generation drugs like amisulpride and risperidone) monitor plasma prolactin levels at 1 month, 3 months and 1 year then annually. There is evidence of causal links between elevated prolactin levels and loss of bone mineral density and/or breast cancer. If prolactin levels are significantly above the upper limit of normal implement bone scanning and educate patients in how to conduct self-examination for breast lumps. Ensure that breast examination is part of the annual health check.	Thank you for your comment. In regards to the frequency of the monitoring the guideline development group(GDG) acknowledged that people with first episode psychosis or schizophrenia may require more regular monitoring but this may not be necessary to all first episode psychosis. The GDG therefore agreed that the physical health checks should happen at least once a year and further monitoring should be at the discretion of the professionals.
195	College of Mental Health Pharmacy	20	NICE	28	1.4.1.1	'Consider crisis resolution and home treatment teams as a first-line treatment to support people with psychosis or schizophrenia . . .' Change 'treatment' to 'service'.	Thank you for your comment; the guideline development group has made the change you have suggested.
196	College of Mental Health Pharmacy	21	NICE	28	1.4.1.5	'Consider intensive case management for people with psychosis or schizophrenia who are likely to disengage from treatment.' Change to: 'services or treatment'.	Thank you for your comment; the guideline development group has made this change.
197	College of Mental Health Pharmacy	22	NICE	32	1.5.1.1	Engagement and risk management should have equal emphasis	Thank you. EIS services place a greater emphasis on engagement; hence the extension of this 'principle' to services for people with more established schizophrenia.
198	College of Mental Health Pharmacy	23	NICE	32	1.5.1.2	'Review antipsychotic medication annually . . .' · At least annually. More frequently if adverse effects emerge which do not necessarily cause physical distress (eg. metabolic effects, raised prolactin).	Thank you for your comment. The guideline development group went a long way to review the evidence and to set best practice recommendations in the ultimate aim to improve the physical health and to promote recovery for people with psychosis and schizophrenia. These recommendations are best practice points and clinicians are to use their clinical judgement as to whether monitoring should be more or less regular.
199	College of Mental Health Pharmacy	24	NICE	39	2.2	The section on research is missing an important opportunity to highlight the need for research into interventions to support	Thank you for your comment. Whilst the guideline development group(GDG) agree that your suggestions for interventions to

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						adherence with antipsychotic medicines. Suggestions: · The effect of structured educational programmes for patients and carers · The use of depot antipsychotics in real-world settings in patients selected according to systematically identified risk of poor adherence	support adherence with antipsychotic medicines could be useful, reviewing the evidence for such adherence-focused interventions was not in the scope of the 2014 update, and therefore the GDG are not certain as to whether such research has not been conducted since the 2009 guideline.
338	College of Occupational Therapists	1	FULL	11	26- 27	Occupational therapy was also represented in the guideline development group and should be mentioned here.	Thank you for your comment. This has been added to the full guideline
339	College of Occupational Therapists	2	FULL	228	6-17	Behavioural activation is also used in mental health services and does not appear on this list.	Thank you for your comment. Psychological interventions were not part of the scope and accordingly this section was not open for consultation.
340	College of Occupational Therapists	3	FULL	248	18	It is interesting that the guidelines include research evidence of occupational therapists delivering CBT. While there is a role for the profession here, it is disappointing that the only direct mention to occupational therapists is in relation to CBT rather than in relation to our expertise in activity and occupation.	Thank you for your comment. Psychological interventions were not part of the scope and accordingly this section was not open for consultation.
341	College of Occupational Therapists	4	FULL	514	20-23	It is excellent that the domains of MDT assessment still include activities of daily living, occupation and leisure but (see point above) there is no mention of the expertise that occupational therapists bring to these specific areas.	Thank you for your comment. Although NICE recommendations do not usually specify individual roles, the guideline development group have recognised the important role of occupational therapists and have made sure they are represented in the full guideline, see the introductions in Chapter 12, EIS and CMHTs for the addition.
342	College of Occupational Therapists	5	FULL	530	2	While it is excellent that occupational therapists are mentioned as part of CMHTs, they are also established in Early Intervention Services, Intensive Case Management and Home Treatment Teams and this should also be recognised within these guidelines.	Thank you for your comment. Occupational therapists play an important role in all the services listed. However, other than in the introduction for CMHT the guideline only spells out certain professionals in the EIS introduction, so occupational therapists have been added there.
343	College of Occupational Therapists	6	FULL	581		It is extremely valuable to include this chapter on vocational rehabilitation with the useful summary of the research evidence in this area. However, in line with previous comments, we would have expected to see some mention of the occupational therapy role that is key in promoting these opportunities to service users.	Thank you for your comment. The following sentence has been added to the introduction of the Vocational Rehabilitation chapter: "Assessment and interventions relating to vocational rehabilitation may be offered by occupational therapists and specialist employment advisors. To aid speed of access and a link to other clinical interventions, the person providing employment interventions is based in the clinical multidisciplinary team."
344	College of Occupational Therapists	7	FULL	638/639		All the vocational recommendations are valuable and ones that the College would support.	Thank you
345	College of Occupational Therapists	8	FULL	General		The College of Occupational Therapists is disappointed that there is no section for occupational therapy as we have a growing evidence base in this area. For example: Hoshi J, Yotsumoto K, TatsumiE, Tanaka C, Mori T, Hashimoto T (2013) Subject-chosen activities in occupational therapy for the improvement of psychiatric symptoms of inpatients with chronic schizophrenia: a controlled trial. Clinical Rehabilitation,27(7), 638-645. Foruzandeh N, Parvin N (2013) Occupational therapy for inpatients with chronic schizophrenia: a pilot randomised controlled trial. Japan Journal of Nursing Science, 10(1),136-141.	Thank you for your comment. Occupational therapy is an important part of therapy for people with psychosis and schizophrenia and an occupational therapist was recruited to be an integral part of the guideline development group (GDG) to advise on the overall development of the guideline however occupational therapy in itself was not part of this 2014 update.
200	Department of Health		FULL	Genera		I wish to confirm that the Department of Health has no substantive	Thank you for your consideration

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				I		comments to make, regarding this consultation.	
389	Expert reviewer 1	1	FULL	general		I found this an extremely valuable addition to the previous guideline, generally well written and easy to follow. However, I thought the recommendations were somewhat too brief and practice may be better influenced and improved by giving a little more detail on how best practice can be achieved.I thought the good practice examples were useful, succinct and likely to lead to improved practice. Need to ensure all good practice examples are reiterated in the recommendations.Use of quotations from qualitative studies generally appeared very well chosen to illustrate points made.	Thank you for taking the time to review this guideline. The GDG take implementation very seriously when drafting recommendations. However, they must also balance providing detail with providing clear and uncomplicated recommendations. The GDG believe the correct balance between detail and clarity has been achieved to ensure that the reader can successfully implement the recommendations into practice. Furthermore, NICE provide a range of implementation tools to support moving from evidence-based guidance into practice. Lastly, it is unfortunately not NICE style to give best practice examples in recommendations.
390	Expert reviewer 1	2	FULL	69	17	Could the 'Triangle of Care' also be referenced here?	Thank you for your comment. The GDG agreed to cite the Triangle of Care in the introduction, please see section 2.4 in the full guideline for the reference.
391	Expert reviewer 1	3	FULL	82	3-4	Good see it clearly stated that information needs to be neither too much nor too little, timely and tailored to meet specific needs. Add this to recommendation 4.6.1.3?	Thank you, we agree this would be a valuable addition to support the recommendation further, the following line was added to full guideline rec 4.6.1.3 (NICE rec 1.1.5.3) to say ..." When providing information, support the carer if necessary."
392	Expert reviewer 1	4	FULL	82	9	Very good point	Thank you
393	Expert reviewer 1	5	FULL	82	18	I don't understand the term 'emotional distance'; I am also unclear whether 'emotional distance' is desirable or not	Thank you. This term has been removed and the meaning of the term spelt out.
394	Expert reviewer 1	6	FULL	82	24-25	Is there a recommendation from this point?	Thank you for your comment. There isn't a recommendation from "valuing the identity and experience of the carer. However, there are recommendations which address "sharing decision making and involvement, providing clear and comprehensible information; and access to health services".
395	Expert reviewer 1	7	FULL	82	31-36	Is there any evidence yet about whether information provided as an educational course, in a setting such as a Recovery College, can overcome isolation and improve understanding	Thank you for your comment. No such evidence was found in our review.
396	Expert reviewer 1	8	FULL	83	29-30	I don't understand 'so as to minimise interfering with caring responsibilities'.	Thank you for your comment. This has been clarified.
397	Expert reviewer 1	9	FULL	84	16-18	Is there any more that can be said about how this can be offered, bearing in mind that an initial response to becoming a carer is often denial.	Thank you for your comment. You raise some very important points, however the section to which you refer to is a summary of the evidence gained from qualitative studies about carers views and experiences. We can't add to that evidence. We have nevertheless used the evidence to form recommendations in chapter 4, section 4.6 where we do address the issues you raise.
398	Expert reviewer 1	10	FULL	84	19-41	As above in point 7, is there any advice about where to deliver the 'group' and whether it is best described as a 'group' or a 'course'. If so, add this to recommendations.	Thank you for your comment. The papers refer to the intervention as an 'education group', 'group psychoeducation',or just 'psychoeducation' . The evidence showed that the 'group' aspect was valued by carers as it provided an avenue for sharing experiences with other carers. This section is an evidence summary and thus we can only refer to the terminology used in the included studies. Regarding where to deliver the 'group' only one of the included studies briefly includes some carer quotes about the location of the group. Some carers in that study suggested a central location and different times of the day would be appropriate to ease access and increase choice. Some carers also believed that a home-based

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							programme was inconvenient and had a negative impact on other family members. These themes were only found in one included study and were not supported or discussed in the other studies. However, we have added a brief description of these views.
399	Expert reviewer 1	11	FULL	85	15	Add reference to explain acronym	Thank you for your comment. After inspection the guideline development group preferred not to single one charity out above the others, even if it is one of the better known carer support groups. The reference to Grippers has been removed.
400	Expert reviewer 1	12	FULL	85	21-30	Thematic synthesis very clearly worded and useful.	Thank you
401	Expert reviewer 1	13	FULL	85	30	Is there anything known for secure services?	Thank you for your comment. Secure services were not reviewed in this 2014 update.
402	Expert reviewer 1	14	FULL	87	15-18	I think this description section is rather too brief. Is facilitated self-help another phrase that could also be used as a means of promoting an understanding of bibliotherapy?	Thank you for your comment. We have clarified the overall definition by changing the name of category to 'Self-help interventions'. The components and method regarding the delivery of self-help were briefly and clearly stated. This was to ensure we could include in the review any studies which met criteria for self-help. 'Self-help' is a broader category of interventions that would include bibliotherapy and is more widely recognised than bibliotherapy'. The included study evaluating 'problem solving bibliotherapy' also refers to the intervention as a 'self-help therapy in book form'
403	Expert reviewer 1	15	FULL	104-105	19-8	Very useful information to help managers think about delivery costs and value for money.	Thank you
404	Expert reviewer 1	16	FULL	105	33	Should read 'identify' not 'identity'.	Thank you. This has been amended.
405	Expert reviewer 1	17	FULL	106	7-15	Is there any guidance about who is best placed to sign-post carers to a group and/or how to advertise the group?	Thank you for your comment. There was no direct evidence to support this.
406	Expert reviewer 1	18	FULL	106	32-33	I found that I had to read this sentence many times to capture its meaning	Thank you for your comment. This sentence is redundant and has been deleted.
407	Expert reviewer 1	19	FULL	106	35-36	This is an important point – I think it could be expanded to make the point more clearly. That a toolkit is used alongside (not an alternative to) healthcare professionals input could be added to the recommendations.	Thank you for your comment. We don't recommend the toolkit as the evidence was insufficient to do so.
408	Expert reviewer 1	20	FULL	108	16-17	Is it possible to add guidance about when psycho-education is best delivered within the context of family intervention and when not. In my experience psycho-education often provides the means to engage families in further family work, so if it appears that family intervention may be useful it is generally best not to provide psycho-education outside the family intervention framework.	Thank you for your comment. The guideline development group agrees and has clarified in section 4.5 [Linking Evidence to Recommendations for chapter 4] that consideration should be given to assessing the appropriate timing for psychoeducation offered on an individual basis.
409	Expert reviewer 1	21	FULL	108	27-29	Could the context for delivery also be included/	Thank you for your comment. The guideline development group considered contextualising the carer recommendations but opted not to do so on the grounds that carer interventions should be available in any context and should not be specific to any situation or location.
410	Expert reviewer 1	22	FULL	109		Could there be some recommendations for further research included here?	Thank you for your comment. A research recommendation has been drafted, investigating the benefits of a family intervention combined with a carer intervention compared to a family intervention alone. See chapter 4, section 4.6.2 for the new research recommendation
426	Expert reviewer 2	1	FULL	18	1	"Worldwide, it has been estimated that schizophrenia falls into the	Thank you for your comment. This has been changed to reflect that

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						top ten medical 1 disorders causing disability (World Health Organization, 1990)." Check this because 2004 and 2010 WHO updates are available and I think schizophrenia has changed in the ranking.	schizophrenia falls into the top 15 medical disorders, please see section 2.1.3, of the full guideline for this change and reference
427	Expert reviewer 2	2	FULL	19	30+	DSM5 may also be worth citing, as they aim to simplify diagnosis somewhat.	The DSM is produced by the American Psychiatric Association and although it is widely used in research, especially in the USA, it does not have universal/ international application. The introduction chapter 2, describes clearly what we have included in psychosis. We do nevertheless reference ICD10, which does have international application.
428	Expert reviewer 2	3	FULL	20	39	"Males with schizophrenia die 20 years earlier and 39 females 15 years earlier than the general population (Wahlbeck et al., 2011)." These estimates from Sweden and Findland and Denmark may be on the high side; some studies suggest 10-15 years; worth double checking	Thank you for your comment. This is an accurate quote derived from the Wahlbeck et al study, which the group felt is relevant to the European situation.
429	Expert reviewer 2	4	FULL	20	40	"About a third of premature deaths arise from suicide and accidents but most are accounted for by physical disorders (Brown et al., 2010;Saha et al., 2007)," I don't think this is correct; a number of recent studies show 13%-15% deaths from "unnatural causes" Please double check this literature (can supply some) because your figure is double	Thank you for your comment. The guideline development group agree that this reference is now out of date. The reference has been changed to reflect this.
430	Expert reviewer 2	5	FULL	20	44	"which include CVD, 42 metabolic disorders such as diabetes mellitus, chronic obstructive pulmonary 43 disease, certain cancers and infectious disorders such as HIV, hepatitis C and 44 tuberculosis (Leucht et al., 2007)." You haven't mentioned cardiovascular disease (and stroke) the number one cause!! Although it does appear on the following page	Thank you for your comment. Cardiovascular disease is included in the list. However, for clarity we have included a list of cardiovascular disorders in this section.
431	Expert reviewer 2	6	FULL	23	2	"Nasrallah 2 commented that 'Neither old antipsychotics, such as haloperidol, nor metabolically 3 "benign" atypicals, such as ziprasidone, are exceptions' (Nasrallah, 2011)." Comment doesn't sit well with style of NICE doc	Thank you for your comment. This has been amended.
432	Expert reviewer 2	7	FULL	23	15	"Because first episode psychosis often commences when a person is in their late teens 15 and 20s (Kirkbride et al., 2006) " I recommend mentioning weight gain is higher in those with low baseline weight	Thank you for your comment. This has been added to the section. See section 2.1.6 in the full guideline.
433	Expert reviewer 2	8	FULL	23	33	"smoking rates fell in the general population from 39% in 1980 to 25% in 2004," Smoking is now under 20% in the general popn	Thank you. This has been amended. See section 2.1.6 in the full guideline.
434	Expert reviewer 2	9	FULL	23	33	"miss out on effective prevention of a potent cause of premature death from CVD" 6 studies show low rates of smoking cessation advice given in schizophrenia	Thank you for your comment. The text in the full guideline has been amended. See section 2.1.6 in the full guideline.
425	Expert reviewer 2	10	FULL	33		I would advise that the guidelines be changed in line with comments above	Thank you for your comment.
435	Expert reviewer 2	10	FULL	37	32	Re inequalities….mention health inequalities….ie unequal receipt of medical treatment, eg Mitchell et al, 2010.	Thank you for your comment. Addressing health inequalities is mentioned in this paragraph. The aim is to emphasise legal duties relating to the Equality Act 2010.
436	Expert reviewer 2	11	FULL	39	18	Coordination of physical healthcare…suggest to comment on	Thank you very much. The introduction chapter of the full guideline

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						responsibility. That is, responsibility is shared etc. (it is raised later in 7.2.8.5)	is not intended to make recommendations. The important recommendation as you have already pointed out is at the end of chapter 7. This recommendation is also in the NICE guideline, whereas the introductory chapter will not be.
437	Expert reviewer 2	12	FULL	131	5	"However, at 52 weeks' follow-up, 5 CBT significantly reduced transition to psychosis (moderate quality evidence)." Please state by how much. This is controversial area.	The effect size has been updated. Further statistical information concerning the outcome can be found in table 33.
438	Expert reviewer 2	13	FULL	170	25	"established schizophrenia taking antipsychotics can, by the age of 38, be identified"... Age is pretty irrelevant here; a red herring. Children develop pre-diabetes is maintained on atypical.	Thank you for your comment. The reference to age has been removed.
439	Expert reviewer 2	14	FULL	172	2	You need to consider the most intensive behavioural programme study: just published DaumitG.L., Dickerson F.B., Wang N.-Y., et al.NEngl J Med 2013; 368:1594-1602. I believe this also has 18 month effects, but your review stops at 6months	Thank you for your comment. As you state, we do include this paper. However, we have included all follow-up points and don't just use 6 month data. Although data is reported at 18 months, the duration of the intervention was 6 months. Therefore, follow-up is defined as 12 month. Therefore, we have reported outcomes at the end of intervention (6 months post-randomisation), up to 6 month follow-up (12 months post-randomisation); and 7-12 month follow-up (18 months post-randomisation). Table 45 shows the length of follow-up for the studies include in the review.
440	Expert reviewer 2	15	FULL	186	7	Mention pre-diabetes rather than diabetes alone?	Thank you for your comment. The guideline development group agreed to make reference to the NICE pathway for diabetes which includes pre-diabetes. See NICE recommendation 1.1.3.2 for the change.
441	Expert reviewer 2	16	FULL	197	22	"Do not offer varenicline for smoking cessation to people with psychosis and 22 schizophrenia because of the increased risk of adverse neuropsychiatric 23 symptoms." Whilst I agree with your caution, your caution is too extreme,varenicline can be prescribed under close supervision and should not be removed as an option. I would recommend: "Offvarenicline for smoking cessation with caution to people with psychosis and schizophrenia because of the increased risk of adverse neuropsychiatric symptoms."	Thank you for your comment. We have amended the recommendations to reflect your comment.
442	Expert reviewer 2	17	FULL	197	25	"Identify people with psychosis or schizophrenia who smoke, have high blood pressure, abnormal lipid levels or increased waist measurement, or 26 are physically inactive," grammatical error	This is a recommendation has been amended please see NICE recommendation 1.5.3.3
443	Expert reviewer 2	18	FULL	251	2	Effect of CBT, this is also a controversial area, I think it should be divided into effects short, medium and long term	Thank you for your comment. Psychological interventions were not part of the scope and accordingly this section was not open for consultation.
416	Expert reviewer 3	1	FULL	170	22	Weight gain and hypertriglyceridaemia are the cardiometabolic changes that occur the most quickly, not glucose and hypercholesterolaemia which tend to change more slowly	Thank you for your comment. The text has been amended to reflect your accurate suggestion, see chapter 7 section 7.2
417	Expert reviewer 3	2	FULL	171	2-3	It may be worth mentioning at this point that out-patient programmes seemed more effective than in-patient	Thank you for your comment. This has been added
418	Expert reviewer 3	3	FULL	172	3	While I appreciate that there may limits placed on the type of	Thank you for your comment. We acknowledge there are different

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						evidence that can be reviewed about lifestyle interventions, considering only RCT data excludes a number of longer observational studies that suggest that lifestyle interventions can be of benefit in this patient group. This becomes important in the clinical evidence summary where it is stated that "As no longer-term data were available, the effects greater than 6 months are not known." They are known – for example I have published data on 8-yr follow-up but just not part of an RCT	views with regard to what constitutes the best available evidence when evaluating the effectiveness of interventions, but we do not believe there are currently agreed methods for combining randomised and non-randomised evidence to answer questions about interventions. Therefore, for a particular question, where there was RCT evidence, we focused on that evidence and did not search for non-randomised evidence. We set this method out in the review protocol before beginning the review, and do not believe it would be appropriate to change this approach after reviewing the evidence.
419	Expert reviewer 3	4	FULL	183	2	I am a co-author of the Winterbourne analysis (& also smoking CE analysis)	Thank you for your comment. The Vancouver style is used for references, as Sophia Winterbourne is the lead author of multiple only the first author is referenced.
420	Expert reviewer 3	5	FULL	184	15	Outside the field of psychosis, there is good evidence that increasing physical activity is beneficial for health even in the absence of weight change	Thank you. The text has been amended. The GDG agree that the main aims of a physical health and healthy eating intervention should be to improve health, reduce weight and improve quality of life. See chapter 7, section 7.2.7 for the change.
421	Expert reviewer 3	6	FULL	185	23	And prevention of diabetes	Thank you. We have made specific reference to preventing Type 2 Diabetes, NICE guidance, in recommendation 1.5. 3.3
422	Expert reviewer 3	7	FULL	186	8	I would prefer use of "glucose" rather than "sugar" because this is more accurate	Thank you for your comment. Reference to sugar will be changed to glucose throughout.
423	Expert reviewer 3	8	FULL	186	11	I would prefer use of "weight" rather than "mass" because this term is better understood. While annual monitoring is fine for people who are well established on treatment, it is too infrequent for people with new onset psychosis or people with treatment changes. Most national and international guidelines recommend monitoring frequencies between 6 weeks and 3-4 months in this early treatment phase. (Personally I think 3-4 monthly is fine) If you do not want to be prescriptive, it may be worth suggesting "more frequent monitoring in the early treatment phase is needed"	Thank you for your comment, reference to 'body mass' has been changed to 'weight' in the NICE guideline recommendation 1.1.3.6. In regards to the frequency of the monitoring the GDG acknowledged that people with early onset of psychosis or schizophrenia may require more regular monitoring but this may not be necessary to all early onsets and for those with established schizophrenia. This recommendation applies to the care across all phases and therefore the physical health checks should happen at least once a year and further monitoring should be at the discretion of the professionals.
424	Expert reviewer 3	9	FULL	186	29	I would like to recommendation that cross references to the prevention of diabetes guideline for those at high risk of diabetes. This may encompass use of metformin for those who do not respond to lifestyle advice alone.	Thank you for your comment. Please see NICE recommendation 1.1.3.2 which will hopefully go a long way in identifying those who are at a high risk of diabetes.
411	Expert reviewer 4	1	FULL	506-515		Interface between primary and secondary care section of chapter 12 is clear, up-to date and recommendations seem well justified	Thank you
412	Expert reviewer 4	2	FULL	516-555		Non acute community mental health care section of chapter 12. – this section tackles a complex evidence base, analyses it clearly and synthesises the findings well, and provides a nuanced and well argued conclusion. The recommendations seem well evidenced and realistic	Thank you.
413	Expert reviewer 4	3	FULL	555-580		Alternatives to acute admission section of chapter 12 – this section I found less convincing. The evidence concerning CRHTTs is clear and the recommendation 12.4.6.1 is clearly justified. However the evidence reviewed concerning crisis houses (the data available from a single study was inconclusive) and acute day care (acute day care likely to be of longer duration; evidence inconclusive in terms of satisfaction) and the lack of robust economic evidence does not seem to justify the recommendation that crisis houses and	Thank you for your comment. The guideline development group (GDG) agree that the evidence for CRHTTs in reducing the need for hospital admission is clear. They also agree that the provision of crisis houses as an alternative place to stay at night is based on service user preference, especially as the evidence is lacking about their effectiveness as an independent intervention. Nevertheless, crisis houses, as an alternative to staying at home while continuing to receive care from a CRHTT seems sensible to the GDG. The

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						acute day care 'may be considered as alternatives'. The justification given is in large part service user preference and extending choice. However, NICE is generally rigorous in considering the full evidence base. In practice these can only be considered if the facilities are available in the health economy: they need to be commissioned and funded at a service level (and funding will only be available by replacing acute hospital care). Stronger evidence is therefore needed for including these service options as to be considered.	evidence for acute day care was better but it was agreed that it is less robust than the CRHTT. on the other hand, the GDG considered acute day care a viable alternative setting in which CRHTTs could continue their work while remaining at home, as no support could pose a risk for some Service Users. We have therefore amended the recommendations to reflect patient preference and the need for alternative sites for CRHTTs.
414	Expert reviewer 4	4	FULL	580	9-12	Rec 12.4.6.3 I do not understand how the evidence supports the recommendation that CRHTTS should be supported by acute day care or crisis houses. Typically they are supported by acute inpatient care and community teams. Is there evidence that suggests the CRHTTS are more effective when supported by crisis houses or acute day care?	Thank you for your comment. We are grateful that you brought this to our attention. Recommendation 12.4.6.3 has been omitted and recommendation 12.4.6.4 (current NICE recommendation 1.4.1.3) has been modified to make it clear that CRHTTs are the first line service for acute community treatment. We have clarified that when capacity of other services is exceeded, they are the single point of entry to other services. CRHTTs should be considered before admission to an inpatient unit to facilitate prompt discharge. We have more tentatively suggested that acute day care facilities can also be considered if preferred by the service user (and as an additional service to the work of the CRHTT) in order to facilitate choice, and for those who may not have the support needed during the day at a point of crisis.
415	Expert reviewer 4	5	FULL	580	13-16	Rec 12.4.6.4 This recommendation appears to place the evidence for CRHTTs, crisis houses and acute day care as an alternative to hospital admission on an equal footing. This does not seem to me to be correct based on the evidence presented.	Thank you. The recommendation has been redrafted in light of your comment, please see NICE recommendation 1.4.1.4: "Consider acute community treatment within crisis resolution and home treatment teams before admission to an inpatient unit and as a means to enable timely discharge from inpatient units. In addition, acute day care facilities or crisis houses may be considered if available. [new 2014]"
351	Faculty of Forensic and Legal Medicine of the Royal College of Physicians	1	NICE	20	1.3.1.2	Early Intervention Teams should accept referrals from healthcare providers working in other settings. In the prodromal stage of psychosis young people can present to agencies such as Police Custody Healthcare Teams due to offending behaviour related to deteriorating mental health	Thank you. Police Custody Healthcare Teams were outside the scope. Moreover, the guideline does not limit who can refer to an EIS. The prodromal phase is addressed in the section on preventing psychosis. All the trials underpinning the prodromal phase are based on people who are treatment seeking, not on people in the criminal justice system (unless they are asking for help).
151	International Society for the Psychological and Social Approaches to Psychosis - UK branch	1	NICE	1	Title	We very much welcome the change in name of the guideline's subject to 'Psychosis and Schizophrenia' rather than just 'Schizophrenia'	Thank you.
152	International Society for the Psychological and Social Approaches to Psychosis - UK branch	2	NICE	6	Final line of page	We think the cross-referencing here and throughout to the recommendations in Service user experience in adult mental health significantly strengthens the guideline	Thank you.
153	International Society for the Psychological and Social Approaches to Psychosis - UK branch	3	NICE	14	1.1.1.1	Reinstate deleted para from 2009 Guideline. The wording of this para crucially sets the standard for implementation of the Guideline and cross reference cannot be relied on.	Thank you for your comment. The recommendation from the 2009 guideline has been reinstated as you have suggested.
154	International Society for the Psychological and	4	NICE	14	1.1.2.1	Reinstate deleted opening phrase and first 3 bullet points. Reason as per 1.	Thank you for your comment. The recommendation from the previous *Schizophrenia* guideline has been superseded by the

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	Social Approaches to Psychosis - UK branch						*Service User Experience in Adult Mental Health* guideline. The guideline development group has added an introductory paragraph to direct readers to that guideline.
155	International Society for the Psychological and Social Approaches to Psychosis - UK branch	5	NICE	18 (no line numbers given in NICE guideline	1.2.1.1.	The first part of this bullet point suggests that both distress AND decline in function are required. Could consideration please be given to instead requiring distress OR decline in function. For some individuals their distress lessens as a delusional belief strengthens, and where there is a manic element to the presentation, distress is rarely a feature. Conversely, should not a person who is distressed by their experiences and beliefs be referred even if they are continuing to function? This criterion is also out of lines with the frequently used PANSS criteria for defining psychosis.	Thank you for your comment. The guideline development group drafted the recommendation which is linked to the evidence base and it therefore does not warrant changing to 'OR'. Furthermore, PANSS is not used for transient symptoms.
156	International Society for the Psychological and Social Approaches to Psychosis - UK branch	6	NICE	21	1.3.3.1	What is the evidence that a traditional full physical examination adds anything to a detailed enquiry for symptoms, and blood tests? A traditional full physical examination is a highly impractical recommendation for community patients who see psychiatrists whose skills in physical examination are likely to be limited, and whose GPs are often reluctant to carry this out. It is also intrusive and not necessarily helpful to the therapeutic alliance. It therefore seems particularly important to be clear about the evidence for doing this in a first presentation of psychotic symptoms.	Thank you for your comments. We agree that undertaking a physical examination for people in their first episode of psychosis should be handled with great sensitivity, as one would do for someone in an acute confusional state or with other organic brain syndrome. To not undertake a physical exam for someone with psychosis, who has greater physical health risks than someone who has never had a psychosis, would be unjustifiable.
157	International Society for the Psychological and Social Approaches to Psychosis - UK branch	7	NICE	21	1.3.3.2	Why is only trauma being considered when research also indicates that other types of adversity are very relevant (eg bereavement, victimisation experiences, etc)? The guideline also seems to imply that relevant trauma will always be the kind of trauma that would merit a diagnosis of PTSD (ie, catastrophic, life-threatening), whereas research indicates that a much wider range of trauma is relevant. Many study protocols of CBT for trauma specifically exclude people with psychosis, so it is very unclear how far this research applies to people with psychosis. It therefore seems inappropriate to recommend these treatments to people experiencing psychosis, (though of course they should be considered, and of course addressing the impact of trauma is absolutely crucial.) Models for treatment of complex PTSD may be more appropriate.	Thank you for your comments. The psychological treatment of trauma was in the scope, whereas bereavement was outside the scope. For the section on trauma, we were keen to determine if there was any evidence to guide practitioners about the treatment of the effects of trauma for people with psychosis. We searched for trial data specifically addressing the treatment of PTSD/trauma in people with psychosis and found very little. The GDGs view, therefore, was that, in the absence of evidence to the contrary, people with psychosis and trauma should have access to the same treatment and help that other people have access to.
158	International Society for the Psychological and Social Approaches to Psychosis - UK branch	8	NICE	22	1.3.3.4	We want to comment on the phrase 'psychiatric and psychological formulation' . What is meant by a psychiatric formulation? Surely a good psychiatric formulation should encompass psychological matters if the formulation is truly biopsychosocial? Is this phrase intended to imply that the psychiatrist would be offering one formulation and the psychologist another? If so, we think this is extremely unhelpful – patients need their teams to offer shared understanding, not potentially conflicting perspective.	Thank you for your comment. The guideline development group feels that it needs to be stated that the formulation is psychiatric and psychological. In the context of this guideline a psychiatric perspective would be required in order to reach a description of the wide range of factors involved in the predisposition to, onset of and maintenance of the psychosis or schizophrenia, as defined by the Royal College of Psychiatrists' curriculum for Specialist Core Training in Psychiatry (2010), and moreover some service users find a formulation based on psychiatric diagnoses helpful, and a useful way of explaining their experiences to others.
159	International Society for the Psychological and Social Approaches to Psychosis - UK branch	9	NICE	22 and 23	1.3.4.1-1.3.5.1	Given the recent Cochrane review of antipsychotic medication in first episode, the apparently excellent results in services which do not routinely use antipsychotics (egSeikkula 2012), and the uncertainty about long term benefit, should the guideline not be	Thank you for your comment. In this recommendation, we also refer to recommendation 1.3.5.1 which recommends discussing the benefits and possible side effects of pharmaceutical interventions with the service user. We believe this addresses your concern.

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						recommending that benefits and uncertainties about medication be discussed with the patient to allow them to make an informed decision.	
160	International Society for the Psychological and Social Approaches to Psychosis - UK branch	10	NICE	23	1.3.6.1	What is the evidence / argument for doing both HBA1c and fasting glucose? What is the argument for adding waist circumference.	Thank you for your comment. The following justification explains in detail why the guideline development group have recommended checking for weight, waist circumference and fasting blood glucose and HBA1c. Blood glucose measurement reflects the state of glucose regulation at the moment of sampling, whereas HbA1c is an indirect measurement of glucose regulation based on the incorporation of glucose during Haemeaglobin synthesis – and reflects an averaged-out picture of glucose regulation over the three months prior to the sampling. Occasionally (and dangerously) people on antipsychotics will develop diabetes aggressively (typically following initiation) – in these individuals HbA1c may be normal even though their blood glucose could be rapidly climbing. Moreover by stopping the antipsychotic the diabetes can be reversed – emphasising the importance of clinical awareness and use of blood glucose to detect this dangerous and potentially reversible state The particular value of HbA1c is as a longer term measure of gradual shift in someone who was moving along a slower path (typically) towards type 2 diabetes. It is true that monitoring fasting blood glucose on a regular basis could detect shifts but the problem in practice is often that routine fasting measures can be difficult to achieve – whereas for HbA1c it does not matter whether fasting or not – so it is the ideal method of spotting a gradual shift in glucose regulation over time and is convenient and reliable Waist circumference - the critical issue here is that the development of central obesity (best measured by an increase in waist circumference) is the most important driver of metabolic syndrome with its attendant risks for developing CVD and diabetes. For instance if change in weight was the only measure used it will fail to discriminate between alterations in body composition (ie lean muscle or fat). Quoting from the Prof Marc De Hert "*Psychiatrists should monitor and record the Body Mass Index (BMI) and waist circumference of every patient at each clinic visit regardless of the type of antipsychotic drug they have been prescribed; patients should also be encouraged to monitor and record their own weight. Waist circumference, which is simple and inexpensive to measure, is a better predictor than BMI of systolic blood pressure, HDL cholesterol and triglyceride levels*". Ref De Hert, M.; Detraux, J.; van Winkel, R.; Yu, W.; Correll, C. U., Metabolic and cardiovascular adverse effects associated with antipsychotic drugs. *Nat Rev Endocrinol***2012,** *8* (2), 114-26.
161	International Society for the Psychological and	11	NICE	23	1.3.5.1 and or	Added extra bullet point about rebound consequences of stopping taking medication	Thank you for your comment. As the evidence was not reviewed, further changes to the pharmacological recommendations are not

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	Social Approaches to Psychosis - UK branch				1.3.6.3		possible.
162	International Society for the Psychological and Social Approaches to Psychosis - UK branch	12	NICE	23	1.3.5.1 and or 1.3.6.3	Add extra bullet point about how to find advice if patient wishes to stop taking medication	Thank you. Recommendations 1.4.6.3-5 all address stopping medication and how to do this. The guideline development group didn't review medication or its discontinuation for this 2014 update, so we are unable to alter this.
163	International Society for the Psychological and Social Approaches to Psychosis - UK branch	13	NICE	24	1.3.6.3	We think the second bullet point is inappropriate. It is obviously important to discuss with the patient the 'indications and expected benefits and risks of oral antipsychotic medication, and the expected time for a change in symptoms and appearance of side effects' and many patients may value having this in writing. However to record them would be simply to record standard information available in product characteristics, textbooks etc, and to do this in case notes would use time which might be far better used for discussion with the patient.	Thank you for your comment. Where recommendations end '2009, amended 2014', as the one to which you refer does, the evidence has not been reviewed but changes have been made to the wording that have altered the meaning (for example, because of equalities issues or a change in the availability of drugs, or incorporated guidance has been updated). Further explanations of the reasons for the changes are given in appendix A of the NICE guideline. For purposes of transparency the 'new' and 'amended' recommendations were not shaded in grey so that stakeholders could see the changes made to the full guideline.
164	International Society for the Psychological and Social Approaches to Psychosis - UK branch	14	NICE	32	1.4.6.3.	Please see comment 6 above. Given the Wunderink (2013) study, the basis for this recommendation seems much less clear than indicated here.	This recommendation was not open for public consultation. In the NICE guideline please read the "Recommendation wording in guideline updates" section for more information on which recommendations stakeholders are allowed to comment on.
165	International Society for the Psychological and Social Approaches to Psychosis - UK branch	15	NICE	38	2.1	Re-write, the proposed wording is so critical it devalues Section 1.1.6. Experience in the community shows that there is a strong need for this support.	Thank you for your comment. The guideline development group disagree – weak evidence for clinical practice recommendations and the need to make a strong research recommendation are not incompatible.
166	International Society for the Psychological and Social Approaches to Psychosis - UK branch	16	NICE	39	2.2	Delete last sentence on this page or re-word. Reason as per Item 4	Thank you for your comment. We assume you are referring to the sentence that states that there is little evidence for the interventions without medication. The guideline group felt this was the whole point of the research recommendation as there have been no methodologically robust studies conducted.
167	International Society for the Psychological and Social Approaches to Psychosis - UK branch	17	FULL	198 (Does not tally with Table of Contents page numbering)	Whole section	We think the greatly increased attention to peer-provided and self-managed interventions is helpful and useful. What is missing from the guideline is any review of other up-and-coming approaches and especially ACT and mindfulness. There are now enough studies to at least warrant a review. Four RCTs of ACT for psychosis are quoted in the new book "ACT and Mindfulness for Psychosis" – pg 7: Bach & Hayes (2002), Gaudiano& Herbert (2006), Shawyer et al (2012), White (2011).	Thank you for your comment. A review on psychological interventions was outside the scope of the 2013 update. NICE will conduct a review to assess the needs of future updates. This will be taken into consideration.
168	International Society for the Psychological and Social Approaches to Psychosis - UK branch	18	FULL	226-325	All	Despite being a relatively new development, there is emerging evidence that Mindfulness- Based Cognitive Therapy is useful for people with psychosis within both inpatient and community settings. There have been a number of small randomised controlled trials and feasibility studies (Alvaro, et al. 2012; Chadwick et al, 2009; Chadwick et al; 2005; Langer et al., 2012; van der Valk et al., 2013). In addition there are a number of qualitative studies (Abba et al., 2008; Ashcroft et al, 2012; Dennick et al., 2013; Ellett, 2013; May et al., 2012; Taylor et al., 2009). There are a number of studies describing how to use mindfulness-based cognitive	Thank you for your comment. Psychological interventions were not part of the scope for this 2014 update and accordingly was not open for consultation

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						therapies with people who experience psychosis (Bardy-Linder et al., 2013; Jacobsen et al, 2011; Davis et al., 2007; York, 2007) as well as a book of how to deliver this therapy to people with psychosis (Morris et al., 2013; Chadwick, 2006). A recent meta-analysis of 209 studies of mindfulness-based therapy (Khoury et al., August 2013b) concluded that MBT is an effective treatment for a variety of psychological problems, and is especially effective for reducing anxiety, depression, and stress. Current NICE Guidelines for Schizophrenia encourage the treatment of mood disorders as well as the psychosis. A second recent meta-analysis about to be published (Khoury et al., October 2013a) concluded that mindfulness interventions are moderately effective in treating negative symptoms and can be useful adjunct to pharmacotherapy; however, more research is warranted to identify the most effective elements of mindfulness interventions. There is an opportunity here to decrease the time taken from research to everyday service provision that NICE should seize whole heartedly, otherwise another five years will pass before this work will become recommended. This therapy is relatively low cost and with suitably trained staff highly effective. At the very least NICE Guidelines for Psychosis and Schizophrenia in Adults (2014) should state that there is very good emerging evidence that mindfulness-based cognitive therapy is an effective component of psychological treatment and should be considered.	
169	International Society for the Psychological and Social Approaches to Psychosis - UK branch	19	FULL	269	28-30	The description provided of psychodynamic therapy would apply only to certain forms of psychodynamic therapy, in particular the suggestion that 'therapists maintain a degree of opacity in order to allow transference to emerge'. Many therapists would regard it as important to avoid encouraging negative transference in people who experience psychosis, and would actively discourage this, including through avoiding opacity. Thus this definition gives a misleading impression of psychodynamic therapy. The definition offered on page 299 seems much more appropriate. But this also suggests that supportive varieties of psychodynamic therapy might be more appropriately considered in the counselling and psychotherapy section.	Thank you for your comment. Psychological interventions were not part of the scope and accordingly this section was not open for consultation.
170	International Society for the Psychological and Social Approaches to Psychosis - UK branch	20	FULL	318	11	Add more recent reference Read &Bentall (2012). Read, John and Bentall, Richard P. (2012). Negative childhood experiences and mental health: theoretical, clinical and primary prevention implications. British Journal of Psychiatry, 200:89-91, DOI: 10.1192/bjp.bp.111.096727	Thank you for your comment. We have added this reference to the section.
171	International Society for the Psychological and Social Approaches to Psychosis - UK branch	21	FULL	318	11	Add more recent reference Steel (2011). Steel, Craig (2011). The relationship between trauma and psychosis: a CBT perspective. Available online: http://www.ukpts.co.uk/site/assets/Steel-UKPTS-Oxford-2011.pdf	Thank you for your comment. We have added this reference to the section.
172	International Society for the Psychological and Social Approaches to Psychosis - UK branch	22	FULL	325	5	Include feasibility RCT (De Bont et al. 2013).The results of this feasibility trial suggest that PTSD patients with co-morbid psychotic disorders benefit from trauma-focused treatment approaches such as PE and EMDR. de Bont, Paul A.J.M., van Minnen, Agnes .& de Jongh, Ad (in press, 2013). Treating PTSD in Patients With	Thank you for your comment. The guideline development group agreed that these are important psychological therapies; if there is evidence to suggest that these could potentially make a difference to the established recommendations, then these will undergo due review in the future.

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						Psychosis: A Within-Group Controlled Feasibility Study Examining the Efficacy and Safety of Evidence-Based PE and EMDR Protocols. Behavior Therapy. Available online: www.sciencedirect.com Include pilot study (van den Berg & van der Gaag, 2012). Treatment of PTSD has a positive effect on auditory verbal hallucinations, delusions, anxiety symptoms, depression symptoms, and self-esteem. EMDR can be applied to this group of patients without adapting the treatment protocol or delaying treatment by preceding it with stabilizing interventions. van den Berg, D. P., & van der Gaag, M. (2012). Treating trauma in psychosis with EMDR: A pilot study.Journal of Behavior Therapy and Experimental Psychiatry, 43(1), 664–671. doi:10.1016/j.jbtep.2011.09.011 Current multi-site RCT in the Netherlands looking at the effect of treatment of posttraumatic stress disorder in people with a lifetime psychotic disorder. Research led by Professor Mark van der Gaag. Due to be completed in November 2013. Research question: Are Eye Movement Desensitization and Reprocessing (EMDR) and Prolonged Exposure (PE) effective in treating posttraumatic stress disorder compared to waiting list in people with lifetime psychotic disorders? doi 10.1186/ISRCTN79584912	
173	International Society for the Psychological and Social Approaches to Psychosis - UK branch	23	FULL	504	Whole section	**We could find no reference in this section to the whole-team Open Dialogue Approach, used with striking success in Finland (Seikkula et al, 2011, *Psychosis*, 3) – we see this as a major omission.**	Thank you for your comment. There were no RCTs of the Open Dialogue Approach that could be used in these reviews. The Seikkula trial is not a RCT and did not meet inclusion criteria for this section.
174	International Society for the Psychological and Social Approaches to Psychosis - UK branch	24	FULL	General		It is frequently a problem for EIP practitioners that certain pattern of psychotic experiences meet service criteria for diagnoses of psychosis (eg based on PANSS) but are deemed not 'true' psychosis as their underlying cause is believed to be traumatic or psychological or related to personality in some way. Related to this many EIPs use criteria for defining psychosis NOS which cast the net more widely than do more traditional approaches. It would be helpful if the guidance could address this by eg. - Commenting on criteria for provision of FEP services. - More clearly acknowledging that most diagnoses of psychosis, and all diagnoses of schizophrenia are descriptive in nature, and based on meeting criteria for the presence of a certain pattern of symptoms, not on their presumed underlying cause. - Considering the issue of whether research on effectiveness of antipsychotics applies to people who meet the lower threshold EIP definitions of psychosis but not of specific psychotic disorders.	The guideline makes no assumptions about the aetiology of psychosis. It is purely about the interventions and services to help and treat people with psychosis and schizophrenia. In addition, you should note that we have not updated the chapter on pharmacology. We have updated the psychology, only in the area of the treatment of trauma, you will find this in chapter 9, section 9.11. In the section on service provision, we looked at the evidence for early intervention services which are specifically for people with first episode psychosis or at least in the early years of psychosis. We continue to recommend that anyone should have access to these services who meet these criteria (early psychosis) but of any age of onset.
175	International Society for the Psychological and Social Approaches to Psychosis - UK branch	25	FULL	General		We understand that the revision is strictly limited, and does not intend to update recommendations concerning psychological interventions per se. However, it is striking how dated the 2009 guidelines are now looking in the light of developments in psychological interventions since then, notably concerning: 3rd wave CBT, including mindfulness; Supportive psychodynamic approaches developed specifically for psychosis (Rosenbaum et al, 2012, Psychiatry 75(4); The Open Dialogue approach (Seikkula, 2011, Psychosis, 3)	NICE conduct an evidence review every 2 years to assess whether the guideline warrants an update. Thank you for your comment and reference.

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204	Janssen	1	FULL	15-17		Janssen believes that although a low threshold referral system may be simpler and preferable it is not sustainable in the medium to long term; whereas, educational programmes lead to increased skill, competency and responsibility. Expensive secondary care services and their resources (which are becoming scarcer) should be utilised for the right patient at the right time of their illness and not be a replacement for educating primary care service providers to manage less severe patients. Additionally, Janssen believes that there needs to be a more defined patient profile to support secondary care to discharge patients back to primary care and for primary care to accept them.	Thank you. The inclusion of people at high risk of psychosis is important because the people in this category are distressed, impaired, symptomatic and in need of help. It also appears that intervening with these high risk groups may well reduce transition to psychosis. The GDG thought it important to address the needs of this group as well as the need of those with established psychosis and the people with diagnosed schizophrenia.
205	Janssen	2	FULL	35	23&24	Primary Care Liaison teams: Janssen believes that the emphasis on, and role of these teams, should be more clearly defined and highlighted as a mechanism to support stable patients transitioning into primary care as previously stated in NICE CG82.	Thank you for your comment. The introduction is just that and not an evaluation of the evidence. Our review of service level interventions found no evidence for us to make a recommendation on primary care liaison teams.
206	Janssen	3	FULL	35	34 onwards	Janssen believes that greater emphasis should be placed on patients achieving recovery earlier in their illness to minimise the social and personal disadvantages. Recovery is more likely to be achieved when patients are in the early stages of their illness and have a higher level of functioning. A greater focus on earlier recovery may have a positive impact on the number of patients with schizophrenia in employment and meaningful vocational activities.	Thank you. In the NICE guideline we have a specific section on promoting recovery which is given great prominence. This includes an emphasis on many of the principles of recovery and recommendations around supported employment. In addition our recommendations on early interventions emphasise the need to provide comprehensive treatments and services as early as possible so as to aid an early recovery.
207	Janssen	4	FULL	36	24	We agree that there is variance in the reported level of unemployment for people with schizophrenia, and would suggest that NICE considers the range cited in the Work Foundation Report on employment in schizophrenia, which is between 8 and 15%.	Thank you for your comment. The figures in this section are related to people with severe mental illness not just schizophrenia. However if you look at section 2.1.3 Impairment and Disability, in the full guideline, the rates of people with schizophrenia who are out of employment have been reported.
208	Janssen	5	FULL	36	35	We would agree with the points raised in the preceding paragraph and we would also ask the committee to examine the evidence for individual placement support (IPS) in delivering successful employment for people with schizophrenia. A paper by Rinaldiet al. (2011) in The Psychiatrist entitled "Increasing the employment rate for people with longer-term mental health problems", claims that in 2003, the employment rate for longer-term service users was 10.9% and by 2006 this had risen significantly to 20.5% ($x2 = 8.60$, d.f. = 1, $P<0.0003$) following implementation of IPS. Figure 2 shows that the same effect was found for longer-term service users with a diagnosis of schizophrenia: in 2003 the employment rate was 7.8% and this rose to 15.9% in 2006 ($x2 = 10.2$, d.f. = 1, $P<0.001$). This change was largely affected by the introduction of an IPS model in that time period. (http://pb.rcpsych.org/content/35/9/339.full)	Thank you we did review IPS in the chapter on vocational rehabilitation.
209	Janssen	6	FULL	37	27-31	We would agree with NICE, that to ensure that young people receive adequate support to remain in, or achieve employment, is a key goal for the health system; we would ask NICE to examine the evidence for Individual Placement Support (IPS) for people who have lived with schizophrenia for a number or years. In the paper by Rinaldi*et al* (2011)(cited above) the implementation of IPS demonstrated that rates of improvement in employment were seen in patients with an average age of 42.8years.	Thank you for your comment. Evidence for IPS is considered in the chapter 13, Vocational Rehabilitation in the full guideline, in section 13.2.1 we have made it clearer that supported employment is referred to as IPS.
210	Janssen	7	FULL	38	14-39	Janssen believes that there is an inconsistency in terms of which	Thank you for your comment. We have strengthened and expanded

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						patients are accepted back into primary care as per NICE guidelines CG82. Patients on Long Acting Injectable (LAI) therapies are less likely to be accepted by primary care and therefore do not have access to the same physical health monitoring and ongoing support/intervention that patients on oral medication have. Janssen believes that all patients should be given the best available care and the transfer to primary care should always be an option irrespective of initiating therapy. Recommendations by NICE explicitly state the need for primary care to accept stable patients regardless of their medication route and that provision for administering LAI in primary care should be made.	the recommendations regarding physical health and monitoring the effects of medication both in primary and secondary care. Please see chapter 7 of the full guideline.
211	Janssen	8	FULL	38	14-39 (General)	Janssen believes that NICE should provide a framework/template for transitioning stable patients back into primary care. This framework should explicitly outline roles, responsibilities (including the defining the process and requirements for delivering LAI in Primary Care) and routes to re-access secondary care. The template should include guidance on physical health monitoring expectations in line with QOF.	Thank you for your comment. We make a range of recommendations regarding primary and secondary care, including physical health, and transition between primary and secondary care in both directions. See the NICE guideline recommendations, section 1.5 Promoting Recovery and Possible Future Care.
212	Janssen	9	FULL	39	General	Janssen believes that GPs need to have an increased understanding/training and be able to monitor the mental health wellbeing of stable patients as well as the physical health monitoring. This should include understanding of medications and prescribing in schizophrenic patients and a rapid access route for specialist input. Additionally, Janssen recognises the need for improved physical health monitoring and intervention in secondary care and believe that a national CQUIN aligned to the QOF indicators for physical health in serious mental health would drive a consistent approach to physical health and wellbeing across the care pathway and an improvement in the outcomes for this.	Thank you for your comment. Please see the NICE guideline recommendations in section 1.5.3 Monitoring physical health in primary care. We agree with Janssens comment.
213	Janssen	10	FULL	144	34	We propose a change of wording to the statement which reads - "[i]n addition, some antipsychotics may be associated with clinically significant side effects." In the studies referenced, there was no difference with regard to side effects for risperidone compared with placebo.	The SPC list many possible undesirable effects. See:- http://www.medicines.org.uk/emc/medicine/9939/SPC/RISPERDAL+CONSTA+25%2c+37.5+and+50+mg+powder+and+solvent+for+prolonged-release+suspension+for+intramuscular+injection/#UNDESIRABLE_EFFECTS Referring to the trials included in this review, in the Phillips 2009 trial although there was no significant difference between groups in adverse effects, a larger proportion of the risperidone group had an increase in weight (30.0 % vs. 9.1 % and 6.7 %). This was not statistically significant although the difference in numbers could be clinically meaningful. The lack of statistical significant difference between the risperidone group and control groups is not surprising considering the dose of risperidone was reduced when adverse effects were observed. Therefore, we cannot state there were no adverse effects observed. McGorry 2002 states that in the risperidone group: '…neuroleptic adverse effects (minor rigidity in 1 patient and mild

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							sedation in 3 patients, relieved in all 4 cases by dose reduction). The paper does not provide any further information about attrition in the intervention and control arms and the differences between groups. Therefore, the GDG came to the view that in the absence of any evidence of beneficial effect, and the fact that all antipsychotic are associated with significant harm, it was important to recommend not using antipsychotics in this context. Furthermore, the GDG have considered revising the text but decided not to as the text reflects the overall evidence we have.
214	Janssen	11	FULL	145	2-3	We do not feel that the evidence presented for *all* antipsychotics showing harm and which outweigh the benefits in this population. Harm was not seen with risperidone. We suggest rewording; "Moreover, adverse events, specifically weight gain, were evident with some antipsychotics (olanzapine) and risk of this would outweigh the benefits in this population."	The SPC list many possible undesirable effects. See:- http://www.medicines.org.uk/emc/medicine/9939/SPC/RISPERDAL+CONSTA+25%2c+37.5+and+50+mg+powder+and+solvent+for+prolonged-release+suspension+for+intramuscular+injection/#UNDESIRABLE_EFFECTS Referring to the trials included in this review, in the Phillips 2009 trial although there was no significant difference between groups in adverse effects, a larger proportion of the risperidone group had an increase in weight (30.0 % vs. 9.1 % and 6.7 %). This was not statistically significant although the difference in numbers could be clinically meaningful. The lack of statistical significant difference between the risperidone group and control groups is not surprising considering the dose of risperidone was reduced when adverse effects were observed. Therefore, we cannot state there were no adverse effects observed. McGorry 2002 states that in the risperidone group: '…neuroleptic adverse effects (minor rigidity in 1 patient and mild sedation in 3 patients, relieved in all 4 cases by dose reduction). The paper does not provide any further information about attrition in the intervention and control arms and the differences between groups. Therefore, the GDG came to the view that in the absence of any evidence of beneficial effect, and the fact that all antipsychotic are associated with significant harm, it was important to recommend not using antipsychotics in this context. Furthermore, the GDG have considered revising the text but decided not to as the text reflects the overall evidence we have.
215	Janssen	12	FULL	145	31	Comments as above for line 2; the statements regarding weight gain and potential for type-2 diabetes, cardiovascular disease and irreversible brain changes have not been shown with all antipsychotics, and not shown in the studies presented in the proposed guideline. We suggest rewording this section to reflect	Thank you for your comment. The GDG think all antipsychotics have significant risks, no antipsychotics have ever been shown to be risk free.

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						this. Whilst at this time there may be no evidence of benefit, there is no evidence of harm to this extent with all antipsychotics.	
216	Janssen	13	FULL	187	General	Sect.7.3 Janssen believes that primary care is more equipped and experienced in interventions for smoking cessation and therefore highlights that all stable schizophrenic patients should be offered the opportunity to transition back to primary care in order that they receive the appropriate physical health monitoring and interventions, resulting in reduced risk for patients and positively impacting on the premature mortality rates for patients with schizophrenia.	Thank you for your comment. The guideline already supports a return to primary care for those who wish to and are stable. The guideline also placed an increased emphasis on primary care's role in the management of physical health problems and improving health.
217	Janssen	14	FULL	410	32	In line with recent international guidelines, (Canadian Guidelines 2013[1]), we propose that second generation LAIs are offered as an option for treatment during all phases of illness. There is evidence to show that LAIs are as effective as oral antipsychotics, and may improve rates of remission, as well as decrease the risk of relapse and hospitalisation. (Leucht 2011[2], Tiihonen 2011[3]). There is also evidence to show that some LAI antipsychotics (risperidone LAI) are effective in relapse prevention when used in early onset schizophrenia, and patients may achieve remission.[4] References: 1.Malla A et al. Can J Psychiatry 2013;58(5 Suppl 1):30S–35S2.Leucht C et al. Schiz Res 2011; 127 (1-3):83-92 3. Tiihonen J et al. American Journal Of Psychiatry 168 (6), P.603-609. 4Emsley R et al. J ClinPsychopharmacol 2008; 28:210–213.	Thank you for your comment, long acting injections were outside of the scope's remit for this 2014 update and accordingly this section was not open for consultation.
218	Janssen	15	FULL	581	10-11	We would acknowledge that there is variance in the reported level of unemployment for people with schizophrenia, we would request that NICE considers the range cited in the Work Foundation Report on employment in schizophrenia, which is between 8 and 15%.	Thank you for your comment. This has changed.
219	Janssen	16	FULL	581	38-40	We agree with the comments around stigma and discrimination and lack of integrated employment support in mainstream services all contributing to the current unemployment figure for people with schizophrenia. We would also like the GDC to consider the lack of tangible incentives for NHS commissioners to encourage providers to deliver integrated employment support (through mechanisms like CCGOIS or CQUIN) as a contributing factor to the low levels of employment for people with lived experience of schizophrenia.	Thank you for your comment. This is a very serious issue but which is beyond NICE's remit.
220	Janssen	17	FULL	582	5-9	We would like the GDC to consider citing IPS explicitly as a model of employment support with the most evidence base as well as back to work and in work support.	Thank you for your comment. The definition for supported employment has been updated to reflect that supported employment is referred to as IPS. Please see the full guideline, chapter 13, section 13.2.1, Definition and aim of intervention.
228	Lundbeck UK and Otsuka Pharmaceuticals (JOINT SUBMISSION)	1	NICE	General		NICE version – please note that we have limited our response to the 61 page NICE version rather than the 698 page 'Full' draft documentLundbeck and Otsuka welcome the opportunity to provide a joint response to NICE in respect of this consultation on the draft guideline. Both Lundbeck and Otsuka have a rich heritage in improving the lives of those suffering with diseases of the central nervous system. We are currently working in partnership in the area of psychiatry and neuroscience and are in the latter stages of developing a maintenance treatment for schizophrenia in adults.	Thank you for reviewing the NICE guideline.
229	Lundbeck UK and Otsuka Pharmaceuticals (JOINT SUBMISSION)	2	NICE	12	1	The definition of "other" side effects should explicitly refer to sedation in addition to "unpleasant subjective experiences". Among patients with schizophrenia, medication side effects are highly	Thank you. The issue of adherence is a very important issue. The GDG would agree that side effects are a major contributing factor to poor adherence. The guideline makes it quite plain that the choice of

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						prevalent and associated with medication non-adherence. Cognitive effects such as sedation can increase the rate of non-adherence (Bhanji 2004). In terms of impact on health services, non-adherence is significantly associated with increased healthcare resource use. Difficulties with the administration and tolerability of antipsychotic treatments are key contributing factors to poor adherence resulting in increased relapse rates and hospitalisations.Prevention, identification, and effective management of medication-induced side effects are important to maximize adherence and reduce health resource use in schizophrenia (DiBonaventura 2012). When considering ways to improve adherence with medication, it is important to take into account the many reasons why patients may avoid, or stop, taking their medication. For first episode psychosis, the impact of side effects and tolerability should be acknowledged when the service user and healthcare professional are making a choice of medication. Side effects such as sedation can increase the rate of non-adherence (Bhanji 2004) and poor tolerability of current treatments is a significant cause of non-adherence (DiBonaventura 2012). References Bhanji, NH et al 'A review of compliance, depot intramuscular antipsychotics and the new long-acting injectable atypical antipsychotic risperidone in schizophrenia.' EurNeuropsychopharmacol. 2004 Mar;14(2):87-92, 2004 DiBonaventura M, et al 'A patient perspective of the impact of medication side effects on adherence: results of a cross-sectional nationwide survey of patients with schizophrenia', BMC Psychiatry 2012, 12:20, 2012	antipsychotic should be a collaborative approach having informed the service user about key side effects associated with different drugs. However, we have not reviewed strategies to improve adherence for this guideline, nor did we review specific drugs and their side effects for this 2014 update as it was outside of the scope.
230	Lundbeck UK and Otsuka Pharmaceuticals (JOINT SUBMISSION)	3	NICE	12	19	We would recommend that the frequency of physical health monitoring for people with psychosis or schizophrenia should be increased to every six months rather than annually, as is currently proposed in this draft. This is for the following reasons: People with serious mental illness have significantly worse physical health outcomes than the rest of the population (Department of Health, 2011). People with schizophrenia and psychosis die on average 15 to 20 years earlier than the general population (Schizophrenia Commission, 2012). In particular, people with schizophrenia who develop cancer are three times more likely to die than those in the general population with cancer and are twice as likely to die from heart disease as the general population (Schizophrenia Commission, 2012). These are costly conditions which place an additional burden on the NHS. It is vital that people with schizophrenia are able to access high quality treatment, care and support – for both their physical and mental health problems – as early as possible after diagnosis. For example, the National Schizophrenia Audit 2012 has reported that monitoring of cardiometabolic risk factors in people with schizophrenia, particularly weight gain, is extremely poor, with only 29% of people receiving a fully comprehensive assessment of risk	Thank you for your comment. The GDG agreed with what you said and as a result have set out a number of recommendations for baseline investigations and ongoing monitoring, see section 1.3.6 . However, they judged that after this, an annual health check is sufficient.

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						factors. Increasing the frequency of physical health monitoring for people with schizophrenia and psychosis could help earlier and more effective interventions and alleviate the burden of schizophrenia on patients and the NHS. Successful treatment early in the course of the disease is important, for example, Harrison (2001) indicated that the percentage of time spent experiencing psychotic symptoms in the first two years is the strongest predictor of long-term symptoms and disability. References Department of Health, No Health Without Mental Health: a cross-government mental health outcomes strategy for people of all ages, February 2011 The Schizophrenia Commission, The abandoned illness: a report from the Schizophrenia Commission, 2012 National Audit of Schizophrenia, Report of the National Audit of Schizophrenia 2012, December 2012 Harrison G, et al. Recovery from psychotic illness: a 15- and 25-year international follow-up study Br J Psychiatry. 2001;178(6):506-517	
231	Lundbeck UK and Otsuka Pharmaceuticals (JOINT SUBMISSION)	4	NICE	16	4-7	We welcome the addition of paragraph 1.1.3.6 but would recommend that the frequency of physical health monitoring for people with psychosis or schizophrenia should be increased to every six months rather than annually. (Please see response 3 above)	Thank you for your comment. In regards to the frequency of the monitoring the GDG acknowledged that people with early onset of psychosis or schizophrenia may require more regular monitoring but this may not be necessary to all early onsets and for those with established schizophrenia. This recommendation applies to the care across all phases and therefore the physical health checks should happen at least once a year and further monitoring should be at the discretion of the professionals.
232	Lundbeck UK and Otsuka Pharmaceuticals (JOINT SUBMISSION)	5	NICE	18	1.1.6.3	We welcome the addition of paragraph 1.1.6.3, and in particular, the recognition that peer support and self-management programmes should include information and advice about preventing relapse (lines 13-14). This addition could be strengthened by an explicit reference to the importance of peer support in helping people's compliance with their treatment regime to help prevent relapse. People whose symptoms are not controlled effectively or who do not adhere to treatment experience high rates of relapse and hospitalisation. For example, around 80% of people with schizophrenia will relapse within five years of a treated first episode – this is partly through discontinuing their medication (Robinson et al. 1999).Casiero et al. 2012 concluded that non-adherence to medication is the biggest predictive factor of relapse after a first episode of psychosis. Recent research suggests that over three quarters (77%) of patients diagnosed with schizophrenia that are prescribed medication deviate from their treatment recommendations (Gibson 2013). This study suggests that 29% of patients are intentionally non-adherent to their treatment regime and 71% are unintentionally non-adherent (Gibson 2013). Poor adherence among patients to their treatment for	Thank you for your comment and the references. The guideline development reviewed the evidence to check whether peer support helps people's compliance with their treatment regime to help prevent relapse but unfortunately there was insufficient evidence to support such a recommendation.

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						schizophrenia is a major risk factor of relapse, which results in increased mortality. Non-adherence to medication results in an increased relapse risk of up to five times that of adherent patients (Leucht, 2006). People with schizophrenia can suffer from a 'revolving door' of treatment and relapse. Relapse is a major driver of cost in schizophrenia, mainly due to hospitalisation. A study in the UK found costs for relapsed patients were over four times higher than for non-relapsed patients (£8,218 compared with £1,899 over a six month period) (Almond, 2004). A clearer focus on helping patients' adherence could make a significant contribution to preventing many relapses for people with schizophrenia. In practical terms, improving adherence and preventing relapse could be achieved through helping to ensure the NHS provides clear written (online and hard copy) and oral information to people with schizophrenia (and their carers). Such information could cover: · Side effects of medication (as these can increase the rate of non-adherence (Bhanji 2004)) · Different means of administration of treatment · Clinical perspectives on the advantages or disadvantages of different formulations of medication e.g. tablets, solutions, short-acting depots or long-acting injections (LAI) References Robinson D G et al. 'Predictors of relapse following response from a first episode of schizophrenia or schizoaffective disorder', Archives of General Psychiatry, 56, 241–247, 1999 Gibson et al. 'Understanding treatment non-adherence in schizophrenia and bipolar disorder: a survey of what service users do and why', BMC Psychiatry 2013, 13:153 Leucht, 'Epidemiology, clinical consequences, and psychosocial treatment of non-adherence in schizophrenia',JClin Psychiatry, 2006;67 Suppl5:3-8 Almond, S et al, 'Relapse in schizophrenia: costs, clinical outcomes and quality of life' The British Journal of Psychiatry (2004) 184: 346-351 Bhanji, NH et al 'A review of compliance, depot intramuscular antipsychotics and the new long-acting injectable atypical antipsychotic risperidone in schizophrenia', EurNeuropsychopharmacol. 2004 Mar;14(2):87-92, 2004 Casiero et al. 'Predicting relapse after a first episode of non-affective psychosis: A three-year follow-up study' Journal of Psychiatric Research, 46 (2012) 1099-1105	
233	Lundbeck UK and Otsuka Pharmaceuticals (JOINT SUBMISSION)	6	NICE	22	9-14	In amended paragraph 1.3.3.4, we recommend that a care plan is written following an assessment of the patient's physical health in addition to an assessment based on a psychiatric and psychological formulation, as is currently drafted. An assessment of physical health in this context is an important part of care planning because people with schizophrenia often suffer from other conditions. For example:	Thank you. Please see NICE recommendation 1.3.3.4 for the amended recommendation.

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						· Prevalence of type 2 diabetes is two to three times higher for people with schizophrenia than in the general population · People with schizophrenia who develop cancer are three times more likely to die than those in the general population with cancer · People with severe mental illness are twice as likely to die from heart disease as the general population (Schizophrenia Commission, 2012). Physical assessment, for example, for a patient's predisposition to a condition such as diabetes, may help inform decisions about the most appropriate treatment for each patient. References The Schizophrenia Commission, The abandoned illness: a report from the Schizophrenia Commission, 2012	
234	Lundbeck UK and Otsuka Pharmaceuticals (JOINT SUBMISSION)	7	NICE	22	17-18	Paragraph 1.3.4.1 currently refers to people with first episode psychosis being offered oral antipsychotic medication in conjunction with psychological interventions; however, we believe that it should be made explicit that antipsychotic medication is available in different formulations, as tablets, a solution, a short-acting depot, as a long-acting injection (LAI). It can take some time to find the optimum or most suitable medication for each person, in terms of effectiveness and side effects to suit individual circumstance (Rethink Mental Illness, 2013). It is important that this guideline reflects the range of treatments available. Rethink Mental Illness, Schizophrenia – Treatments, accessed on 19 September 2013 via: http://www.rethink.org/diagnosis-treatment/conditions/schizophrenia/treatments	Thank you. We did not review drug treatments for this 2014 update. We have simplified some of the recommendations, including this one. The guideline does make reference to using oral preparations as the mainstay and to use depots when covert adherence is a problem, although this hasn't been updated, the GDG were content with the range of preparations referred to in the guideline.
235	Lundbeck UK and Otsuka Pharmaceuticals (JOINT SUBMISSION)	8	NICE	23	1.3.5.1	In respect of choice of antipsychotic medication, the definition of "other" side effects should explicitly refer to sedation in addition to "unpleasant subjective experiences" as is currently drafted in paragraph 1.3.5.1. This is because difficulties with the administration and tolerability of oral antipsychotic treatments are key contributing factors to poor adherence resulting in increased relapse rates and hospitalisations. Side effects such as sedation can increase the rate of non-adherence (Bhanji 2004). Please see response 2 above for further supporting arguments and references. References Bhanji, NH et al 'A review of compliance, depot intramuscular antipsychotics and the new long-acting injectable atypical antipsychotic risperidone in schizophrenia.' EurNeuropsychopharmacol. 2004 Mar;14(2):87-92, 2004	Thank you for your comment. Pharmacological interventions were not reviewed in the 2014 guideline update. The references provided will be kept and when the evidence is re-reviewed to assess whether another update is necessary these references will be very helpful.
236	Lundbeck UK and Otsuka Pharmaceuticals (JOINT SUBMISSION)	9	NICE	29	1.4.3.1	In paragraph 1.4.3.1 the reference to medication should reflect the full range of treatments available to patients following an acute exacerbation. Informed patient choice should be a central principle in ensuring that people with psychosis or schizophrenia have a positive experience of care. We believe that it should be made explicit that antipsychotic medication is available in different	Thank you for your comment. Where recommendations end [2009, amended 2014], the evidence has not been reviewed but changes have been made to the recommendation wording that change the meaning (for example, because of equalities duties or a change in the availability of drugs, or incorporated guidance has been updated). Explanations of the reasons for the changes are given in

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						formulations, as tablets, a solution, a short-acting depot, as a long-acting injection (LAI).Shared decision-making is based on sharing information and agreeing jointly the best treatment plan to enable patients to achieve their personal goals. The provision of high quality information underpins the principle of patient choice, which is enshrined in the NHS Constitution (Department of Health, 2013). Timely and accurate information on treatment and care options is a vital part of supporting people to feel in control, and empowering them to make informed decisions about treatment. When patients and clinicians make a joint decision, both are more likely to adhere to their treatment plan (Gray, 2009).Non-adherence to medication is the most common cause of relapse for people with schizophrenia (National Audit of Schizophrenia, 2012). A patient-centred approach to care has a positive effect on medication adherence – when patients and clinicians make a joint decision, both are more likely to adhere to the treatment plan (Gray, 2009).· It is vital that people are fully supported in decision-making about their treatment. The National Schizophrenia Audit has reported that many people with schizophrenia feel they are not provided with information about their medication in a suitably understandable form. Only 62% reported that the information was in a form they could properly understand. Further, they did not always feel sufficiently involved in the final decision about which medication they should take. While clinical staff reported that they thought they had involved people with schizophrenia in their choice of medication in 62% of cases, only 41% of people with schizophrenia felt their views were taken into account (National Audit of Schizophrenia, 2012).ReferencesNational Audit of Schizophrenia, Report of the National Audit of Schizophrenia 2012, December 2012Gray R et al, 'Antipsychotic long-acting injections in clinical practice: medication management and patient choice', British Journal of Psychiatry, 2009Department of Health, The NHS Constitution for England, March 2013	appendix A of the NICE guideline.
237	Lundbeck UK and Otsuka Pharmaceuticals (JOINT SUBMISSION)	10	NICE	32	24-25	The recommendation in paragraph 1.5.1.2 for an annual review of antipsychotic medication should be a minimum. Recent research suggests that over three quarters (77%) of patients diagnosed with schizophrenia that are prescribed medication deviate from their treatment recommendations (Gibson 2013). This study suggests that 29% of patients, are intentionally non-adherent to their treatment regimen and 71% are unintentionally non-adherent (Gibson 2013). Frequent reviews to assess adherence, benefits and side effects would represent a patient-centric approach. References Gibson et al. 'Understanding treatment non-adherence in schizophrenia and bipolar disorder: a survey of what service users do and why', BMC Psychiatry 2013, 13:153	Thank you for your comment. The guideline development group went a long way to review the evidence and to set best practice recommendations in the ultimate aim to improve the physical health and to promote recovery for people with psychosis and schizophrenia. These recommendations are best practice points and clinicians should be trusted to use their judgement as to whether monitoring should be more or less regular.
238	Lundbeck UK and OtsukaPharmaceuticals (JOINT SUBMISSION)	11	NICE	33	13	We would recommend that the frequency of physical health monitoring in primary care for people with psychosis or schizophrenia should be increased to every six months rather than	Thank you for your comment. The guideline development group went a long way to review the evidence and to set best practice recommendations in the ultimate aim to improve the physical health

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						annually, as is currently proposed in paragraph 1.5.3.2. Please see response 3 (p.12, l19 above for further supporting arguments and references.	and to promote recovery for people with psychosis and schizophrenia. These recommendations are best practice points and clinicians should be trusted to use their judgement as to whether monitoring should be more or less regular.
245	NHS Direct	1	FULL	General		None comments on this guideline as part of the consultation.	Thank you
444	NHS England	1	FULL	General	General	The guidelines name should be for schizophrenia and related psychosis as the introduction makes clear this is what you actually meant	Thank you, the guideline is not solely about schizophrenia and related psychosis it is about the management of any psychosis before a more specific diagnosis has been made, for example schizophrenia or bipolar. It is also about the treatment of schizophrenia and psychosis (in other words when the diagnosis has been made). When a diagnosis of bipolar disorder has been made, for someone who has developed a psychosis, their management has been covered in the bipolar guideline. We have amended the NICE guideline introduction to reflect this.
445	NHS England	2	FULL	General	General	CBT for people at risk of early stages of psychosis should not be "Offer" but at most "Consider". Recent research and summary of research in Archives General Psychiatry 2013 shows the actual rate of transition to psychosis is much lower than first thought: about 15% in a year and maybe 30% by 5 years. Also NNT in a meta analysis is 20+. Given these factors it seems unlikley CBT will be cost effective. The cost implications are huge as this is a heterogenous group with mostly other mental health problems than psychosis	Thank you for your comment. We acknowledge that most people do not transition to psychosis as well agree with your concerns regarding unnecessary exposure to interventions. We also acknowledge that this is a co-morbid group. This is discussed in section 5.7 of the full guideline. The GDG took these issues into consideration when formulating recommendations. However, there was evidence in a meta-analysis of randomised controlled trials (the best available evidence) that CBT did have a significant benefit over supportive counselling in reducing the likelihood of transitioning to psychosis. The GDG therefore believe that the recommendation is appropriate.
446	NHS England	3	FULL	General	General	How can you still recommend CBT when Cocharenmea -analysis 2012 and Lynch et al 2010 in Psychological Medicine showed NO SIGNIFICANT difference with supportive counselling and befriending? This is an unscientific recommendation. You should recommned Psychotherapy and ask for more research on Befriending	Thank you for your comment. We are unsure which CBT recommendation you are referring to. If you are referring to the recommendations in section 9.4, this section was not a part of the scope for the current 2014 update. When NICE conduct a review to assess the need for a future update, any new evidence will be taken into consideration. We think you may be referring to this section due to the Lynch** paper you reference. This review included adults (not adolescents or elderly people) meeting diagnostic criteria for schizophrenia, major depressive disorder, or bipolar disorder. We are not clear which Cochrane meta-analysis you are referring to without a reference. If you are referring to the recommendations regarding CBT for an 'at risk' population (sections 5.5 & 5.8 of the full guideline), our review of the evidence does support CBT over supportive counselling. The GDG thus believe this recommendation is appropriate. ** We assume you are referring to the following: Lynch, Laws & McKenna (2010) Cognitive behavioural therapy for major psychiatric disorder: does it really work? A meta-analytical review of well-controlled trials, 40, 9-24.

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447	NHS England	4	FULL	General	General	We are concerned that there is no mention of reproductive issues in this guideline. Peak incidence of schizophrenia is in the reproductive years. Pregnancy, childbirth and childrearing can have adverse effects on the mother's mental health. The illness and its indirect effects as well as medication can have adverse effects on the developing foetus, infant and child[1] They are more likely to have unplanned pregnancies[2] Antipsychotic and mood stabilising drugs can have adverse developmental and metabolic effects. They have lower rates of antenatal care, higher rates of preterm delivery and poorer obstetric outcomes[3.] Relapse of maternal illness, particularly following[4,5] stopping medication is common in postpartum year and up to 60% of children are removed into care of Social Services by 2 years. Mention should therefore be made of need for contraception, pre pregnancy counselling and collaborative management of these high risk pregnancies with maternity services6,7,8. 1. GentileS.Schizophr Bull 2010;36(3):518-44. 2. Matevosyan N. Sexual Disabil 2009;27(2):109-18. 3. Howard LM. Eur J ObstetGynecolReprodBiol 2005;119(1):3-10.Munk-Olsen T, et al. Arch Gen Psychiatry 2009;66(2):189-95. 4. Harlow BL, et al. Arch Gen Psychiatry 2007;64(1):42-8. 5. Munk-Olsen T, et al. Arch Gen Psychiatry 2009;66(2):189-95. 6. CEMD. The Eighth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom Br J of Obstetrics and Gynaecology, Vol 118, Sup 1 7. NICE. Guidelines on Antenatal and Postnatal Mental Health: London: DoH, 2007 Scottish Intercollegiate Guidelines Network (SIGN) Management of perinatal mood disorders. Edinburgh: SIGN 2012	Thank you for your comment. NICE and The National Collaborating Centre for Mental Health (NCCMH) is currently updating the guideline on Antenatal and Postnatal Mental Health (CG45), where these issues will be addressed.
448	Public Health England	1	FULL	110		Section 5.1 Preventing PsychosisWouldrecommend stronger focus on building mental resilience within communities as a means of supporting the general mental wellbeing of communities. People who may be at risk of developing Psychosis or Schizophrenia would benefit from this as a member of that community. Enhanced mental awareness within communities would also benefit people who have Psychosis and Schizophrenia as communities could be more understanding. .	Thank you for your comment. We agree this would be of value to recommend and would have done so if there was an evidence base for it, unfortunately none was found.
449	Public Health England	2	FULL	170-173		Section 7.2 / 7.3 Physical wellbeing Welcome the focus on the physical wellbeing of people with Psychosis and Schizophrenia. The focus on smoking cessation, alcohol use, diet & exercise and treatment of high blood pressure particularly important. Focusing on the weight gain following prescribing of anti psychotic medication also very important. The uptake of national public health programmes (cancer, non cancer, vaccination and NHS Health Checks) by people with Psychosis and Schizophrenia needs monitoring.	Thank you
450	Public Health England	3	FULL	331		Section 10.2 Anti psychotics The effects of weight gain for some anti psychotic medication requires additional focus. The prescribing of anti psychotics should be accompanied by active advice and	Thank you for your comment. Pharmacological interventions were not part of the scope for this 2014 update and this section of the full guideline was not open for stakeholder consultation.

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						support in managing the potential for weight gain.	
241	Roche Products	1	NICE	18	1.1.6.3	We would recommend that the 3rd bullet be amended to read 'identifying and managing both positive and negative symptoms'. As this section deals with peer support and self-management programmes, we feel patients should be well informed in the management of the full range of symptoms that they should be aware of, particularly as patients who experience negative symptoms may be less inclined to seek medical support.	Thank you for your comment. The GDG did not feel it was necessary to specify this in the recommendation.
242	Roche Products	2	NICE	18	1.2.1.1	Patients who are at risk of psychosis may experience a decline in social functioning (i.e. appropriately engaging in conversation) or they may withdraw from social circumstances. To highlight this risk, we would recommend that the first sentence be modified to read: 'If a person is distressed, has a decline in social functioning or withdrawal…'	Thank you for your comment. The guideline development group felt your suggestion is implicit in the recommendation and did not feel there was enough reason to change the recommendation.
243	Roche Products	3	NICE	19	1.2.4.1	This section suggests that on-going monitoring of symptoms, impairment and disruption is recommended for patients who have not been diagnosed with psychosis, but who continue to display symptoms. Could NICE make a recommendation on the tools / checklists that are available to assist with this review to ensure health care professionals are utilising a recommended method for assessment?	We have not reviewed different tools or checklists and so we cannot recommend one or another. However, we will be able to refer to the tools used in the research in the implementation material that will support this guideline.
244	Roche Products	4	NICE	32	1.5.1.1	The range of symptoms a patient may experience will vary and the treatments need to be adjusted accordingly to address these symptoms. We would suggest the 2nd bullet be modified as follows: 'be competent to provide all interventions offered and be cognisant of using the appropriate treatment for the symptoms experienced'.	Thank you for your comment. The GDG carefully considered this recommendation and felt an extension of the 2nd bullet point was unnecessary.
146	Royal College of General Practitioners	1	FULL	General		The definition of Psychosis does not include the term Acute and transient psychosis or Brief psychotic episode as per DSM IV.	The DSM is produced by the American Psychiatric Association and although it is widely used in research, especially in the USA, it does not have universal/ international application. The introduction chapter 2, describes clearly what we have included in psychosis. We do nevertheless reference ICD10, which does have international application.
147	Royal College of General Practitioners	2	FULL	General		The terms Psychosis and Schizophrenia are often loosely used interchangeably which is not correct and accurate	The new title for this guideline, psychosis and schizophrenia, reflects the real clinical situation in which many people are diagnosed first as having a psychosis, before a more specific diagnosis of either schizophrenia or bipolar disorder is considered. Psychosis is a broader term encompassing a range of different conditions. In terms of the research used within the guideline some trials are specifically with people with schizophrenia, whereas a number of trials are with mixed psychotic diagnoses. In the updated sections of the guideline, 'psychosis or schizophrenia' has been used to refer to all people who are covered by the updated guidance, apart from where we mean people with a specific diagnosis of schizophrenia. The terminology in the sections of the guideline that have not been updated has not changed because the remit of the previous guidelines was 'schizophrenia'.
148	Royal College of General Practitioners	3	FULL	General		There is mention of Family therapy which should be relevant to patients with High Expressed Emotions (Critical comments, hostility and over involvement)	Thank you, we agree. It is relevant.

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149	Royal College of General Practitioners	4	FULL	General		There is mention of when Psychosis starts in young adulthood but from my research this is at the age of 21	Thank you. We are not entirely sure we understand the point that you are trying to make. The epidemiology, including age of onset, is dealt with in the introduction chapter of the full guideline.
150	Royal College of General Practitioners	5	FULL	General		Amisulpiride as an atypical antipsychotic has showed considerable efficacy with reduced weight gain compared with Olanzapine and Risperidone. It is also less sedating than Quetiapine but admittedly has raised prolactin as a problem. Abilify in theory had the least side-effects but in practice has reduced efficacy compared to Olanzapine	Thank you for your comments. Pharmacological interventions were not part of the 2013 guideline update.
221	Royal College of Nursing	1	FULL	General	General	The Royal College of Nursing welcomes proposals to update this guidance.	Thank you
222	Royal College of Nursing	2	FULL	2-3		There is only one nurse on the group and no representative of community nurses who form the bulk of people working with schizophrenia in modern psychiatry.	Thank you. We agree with you that community psychiatric nurses form the backbone of the mental health workforce and are a very important part of the multi disciplinary team. We do advertise for membership to the GDG but we are always limited by those who apply. Nevertheless we think the GDG was balanced with a good multi disciplinary membership.
223	Royal College of Nursing	3	FULL	12	9-13	Would this also cover Dept of Work and Pensions who commission assessment of benefits claims?	Thank you for your comment. A fourth bullet point has been added to ensure a wider representation for whom this guideline is intended for, please see section 1.2.2.
224	Royal College of Nursing	4	FULL	29	34	Not sure that "may" should not be "will"	Thank you for your comment. The text has been amended accordingly.
225	Royal College of Nursing	5	FULL	374	21	Could not see anywhere in this section a recommendation that injectable anti-psychotic drugs should be placed in same category as other long term drugs for example ones for diabetes so that patients are exempt from paying. This would be helpful.	Thank you for your comment. Pharmacological interventions were not part of the scope for this 2014 update and this section of the full guideline was not open for stakeholder consultation.
226	Royal College of Nursing	6	FULL	516	1-5	This should already be happening under current legislation and rules.	Thank you for your comment. The GDG wish to retain this recommendation from the 2002 guideline and 2009 update.
227	Royal College of Nursing	7	FULL	569	8	This section needs to consider day hospital provision in rural areas where in some areas there are non-existent and / or lack of public transport which means that patients cannot access the ones in large cities.	Thank you. This is the issue for all provision of health services. Many rural areas don't have easy access to hospitals including day hospitals. Moreover, the community based interventions also pose a problem in rural areas especially where you need to cover large areas.
249	Royal College of Psychiatrists - General Adult faculty, and the Perinatal faculty	1	FULL	General		The guideline provides a good overall update and most of the content and recommendations are welcome.	Thank you
250	Royal College of Psychiatrists - General Adult faculty, and the Perinatal faculty	2	NICE	18	1.2.1.2	With regard to the following recommendation, 'refer them for assessment without delay to a specialist mental health service or an early intervention in psychosis service because they may be at increased risk of developing psychosis. [new 2014]':What is the evidence for this recommendation? The guideline does not adequately consider the harm of inappropriate referrals	Thank you for your comment. The full guideline contains all the evidence and the interpretation of the evidence by the guideline development group. Where necessary the GDG have made consensus based recommendations. As for NICE recommendation 1.2.1.1, this is a complex recommendation derived from different types evidence: 1. Primary evidence

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							2. Meta-analysis 3. GDG consensus
251	Royal College of Psychiatrists - General Adult faculty, and the Perinatal faculty	3	NICE	23	1.3.6.1	There was a big response to the addition of the consideration of waist circumference, fasting blood sugar and HbA1c, particularly how valuable and feasible this would be. However the emphasis on early and close monitoring of physical health is very welcome. One respondent had looked at the HBA1C and fasting glucose issue in the consultation and publication of "Clozapine physical health monitoring standards" which was published for Scotland via the Chief Medical Officer for Scotland, Prof Harry Burns. This publication recommended the use of fasting glucose, although admitted that for some this is more difficult logistically.	Thank you for your comment. The following justification explains in detail why the guideline development group have recommended checking for weight, waist circumference and fasting blood glucose and HBA1c. Blood glucose measurement reflects the state of glucose regulation at the moment of sampling, whereas HbA1c is an indirect measurement of glucose regulation based on the incorporation of glucose during Haemeaglobin synthesis – and reflects an averaged-out picture of glucose regulation over the three months prior to the sampling. Occasionally (and dangerously) people on antipsychotics will develop diabetes aggressively (typically following initiation) – in these individuals HbA1c may be normal even though their blood glucose could be rapidly climbing. Moreover by stopping the antipsychotic the diabetes can be reversed – emphasising the importance of clinical awareness and use of blood glucose to detect this dangerous and potentially reversible state The particular value of HbA1c is as a longer term measure of gradual shift in someone who was moving along a slower path (typically) towards type 2 diabetes. It is true that monitoring fasting blood glucose on a regular basis could detect shifts but the problem in practice is often that routine fasting measures can be difficult to achieve – whereas for HbA1c it does not matter whether fasting or not – so it is the ideal method of spotting a gradual shift in glucose regulation over time and is convenient and reliable Waist circumference - the critical issue here is that the development of central obesity (best measured by an increase in waist circumference) is the most important driver of metabolic syndrome with its attendant risks for developing CVD and diabetes. For instance if change in weight was the only measure used it will fail to discriminate between alterations in body composition (ie lean muscle or fat). Quoting from the Prof Marc De Hert "*Psychiatrists should monitor and record the Body Mass Index (BMI) and waist circumference of every patient at each clinic visit regardless of the type of antipsychotic drug they have been prescribed; patients should also be encouraged to monitor and record their own weight. Waist circumference, which is simple and inexpensive to measure, is a better predictor than BMI of systolic blood pressure, HDL cholesterol and triglyceride levels*". Ref De Hert, M.; Detraux, J.; van Winkel, R.; Yu, W.; Correll, C. U., Metabolic and cardiovascular adverse effects associated with antipsychotic drugs. *Nat Rev Endocrinol***2012,** *8* (2), 114-26.
252	Royal College of Psychiatrists - General Adult faculty, and the	4	FULL	23		With regard to monitoring physical health, this is welcomed considering the side-effects of medication. However some respondents felt that Primary Care should still have a role in this.	Thank you for your comment. We cannot locate the section on page 23 in the full guideline that you refer too. However, this seems to be directed at recommendations (e.g. 1.3.6 and 1.5.3.2). These

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	Perinatal faculty					One respondent suggested that physical health monitoring should be recorded in care plans/notes, (such as weight, BMI, BP, ECG and Bloods) as per NAS audit.	recommendations were written as a result of GDG consensus. There is also a wealth of evidence that the current primary/ secondary interface is not effective for this aspect of care (e.g. typified by findings of the National Audit of Schizophrenia). We acknowledge that monitoring physical health is appropriate given the side effects of medication and this was the basis for recommending that the initiator of prescribing should take responsibility for assessing the adverse effects through effective and systematic monitoring. We did arrive at a GDG consensus that there should be clearer allocation of responsibility for monitoring what are after all primarily adverse effects of medications in the first treatment phase to the treating psychiatric practitioner/service, and that this responsibility would normally transfer to primary care after 12 months. The recommendations are quite explicit about which parameters should be measured and how they should be recorded.
253	Royal College of Psychiatrists - General Adult faculty, and the Perinatal faculty	5	FULL	23		The recommendations on activity and employment are very welcome.	Thank you
254	Royal College of Psychiatrists - General Adult faculty, and the Perinatal faculty	6	FULL	General		Although there are four text references to cannabis in the full guideline document as a potential risk factor, there is no mention of this at all in the NICE Guideline (the shorter version which is the one that people will read). Although there remains clinical debate around its aetiological role, respondents felt that their experiences in clinical practice concords with the evidence suggesting it is a factor both in aetiological terms for some patients and in terms of worsening prognosis once psychosis is established. There should be at least some reference to the potential detrimental effects of cannabis within the shorter version, and a clearer discussion of the emerging evidence would be worth considering within the full version.	Thank you for your comment. There's a NICE guideline on Psychosis and Co-existing Substance Misuse (CG120) which does deal with cannabis. This guideline, however, makes no assumptions about aetiology and is devoted to treatments and services.
255	Royal College of Psychiatrists - General Adult faculty, and the Perinatal faculty	7	FULL	General	Combined anti-psychotic treatment	In clinical practice this is often used, and monitored using High Dose Anti-psychotic monitoring. I also aware of practice of using Aripiprazole to help reduce weight gain with other anti-psychotics as well as try to treat negative symptoms. Should the wording be changed 'not be used in regular treatment of patients with Schizophrenia'?	Thank you we are not updating this section on drug treatments. We have looked at weight gain including behaviour and dietary interventions but we did not look at the use of medication in this context as it was outside of the scope and accordingly was not open for consultation.
256	Royal College of Psychiatrists - General Adult faculty, and the Perinatal faculty	8	FULL	General		Should change of smoking status should be considered i.e. nicotine reduces the available anti-psychotic levels in the bloods (or conversely caffeine increases anti-psychotic blood levels) therefore patients may then require higher than normal doses of anti-psychotics.	Thank you for your comment however the evidence relating to antipsychotics has not been reviewed.
257	Royal College of Psychiatrists - General Adult faculty, and the Perinatal faculty	9	NICE	18	1.2.1.1	The first part of this bullet point suggests that both distress AND decline in function are required. Could consideration please be given to instead requiring distress OR decline in function. For some individuals their distress lessens as a delusional belief strengthens, and where there is a manic element to the presentation, distress is rarely a feature. Conversely, should not a person who is distressed by their experiences and beliefs be referred even if they are continuing to	Thank you for your comment. The guideline development group drafted the recommendation which is linked to the evidence base and it therefore does not warrant changing to 'OR'. Furthermore, PANSS is not used for transient symptoms.

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						function? This criterion is also out of lines with the frequently used PANSS criteria for defining psychosis.	
258	Royal College of Psychiatrists - General Adult faculty, and the Perinatal faculty	10	NICE			Why is only trauma being considered, when research also indicates that other types of adversity are very relevant, e.g. bereavement, victimisation experiences etc? The guideline also seems to imply that relevant trauma will always be the kind of trauma that would merit a diagnosis of PTSD (i.e. catastrophic, life-threatening), whereas research indicates that a much wider range of trauma is relevant.	Thank you for your comments. The psychological treatment of trauma was in the scope, whereas bereavement was outside the scope. For the section on trauma, we were keen to determine if there was any evidence to guide practitioners about the treatment of the effects of trauma for people with psychosis. We searched for trial data specifically addressing the treatment of PTSD/trauma in people with psychosis and found very little. The GDGs view, therefore, was that, in the absence of evidence to the contrary, people with psychosis and trauma should have access to the same treatment and help that other people have access to.
259	Royal College of Psychiatrists - General Adult faculty, and the Perinatal faculty	11	NICE			Many study protocols of CBT for trauma specifically exclude people with psychosis, so it is very unclear how far this research applies to people with psychosis. It therefore seems inappropriate to recommend these treatments to people experiencing psychosis, (though of course they should be considered, and of course addressing the impact of trauma is absolutely crucial.) Models for treatment of complex PTSD may be more appropriate.	Thank you for your comments. We searched for trial data specifically addressing the treatment of PTSD/trauma in people with psychosis and found very little. The GDGs view, therefore, was that, in the absence of evidence to the contrary, people with psychosis and trauma should have access to the same treatment and help that other people have access to.
260	Royal College of Psychiatrists - General Adult faculty, and the Perinatal faculty	12	NICE	21	1.3.3.1	What is the evidence that a traditional full physical examination adds anything to a detailed enquiry for symptoms, and blood tests? A traditional full physical examination is a highly impractical recommendation for community patients who see psychiatrists whose skills in physical examination are likely to be limited, and whose GPs are often reluctant to carry this out. It is also intrusive and not necessarily helpful to the therapeutic alliance. It therefore seems particularly important to be clear about the evidence for doing this in a first presentation of psychotic symptoms.	Thank you for your comments. We agree that undertaking a physical examination for people in their first episode of psychosis should be handled with great sensitivity, as one would do for someone in an acute confusional state or with other organic brain syndrome. To not undertake a physical exam for someone with psychosis, who has greater physical health risks than someone who has never had a psychosis, would be unjustifiable.
261	Royal College of Psychiatrists - General Adult faculty, and the Perinatal faculty	13	NICE	22	1.3.3.4	Regarding the phrase 'psychiatric and psychological formulation', what is meant by a psychiatric formulation? Surely a good psychiatric formulation should encompass psychological matters if the formulation is truly biopsychosocial? Is this phrase intended to imply that the psychiatrist would be offering one formulation and the psychologist another? If so, I think this is extremely unhelpful – patients need their teams to offer shared understanding, not a potentially conflicting perspective.	Thank you for your comment. The guideline development group feels that it needs to be stated that the formulation is psychiatric and psychological. In the context of this guideline a psychiatric perspective would be required in order to reach a description of the wide range of factors involved in the predisposition to, onset of and maintenance of the psychosis or schizophrenia, as defined by the Royal College of Psychiatrists' curriculum for Specialist Core Training in Psychiatry (2010), and moreover some service users find a formulation based on psychiatric diagnoses helpful, and a useful way of explaining their experiences to others.
262	Royal College of Psychiatrists - General Adult faculty, and the Perinatal faculty	14	NICE	22	1.3.4.1	Given the recent Cochrane review of antipsychotic medication in first episode, the apparently excellent results in services which do not routinely use antipsychotics (e.g. Seikkula 2012), and the uncertainty about long term benefit, should the guideline not be recommending that benefits and uncertainties about medication be discussed with the patient to allow them to make an informed decision.	Thank you for your comment. In this recommendation, we also refer to recommendation 1.3.5.1 which recommends discussing the benefits and possible side effects of pharmaceutical interventions with the service user. We believe this addresses your concern.
263	Royal College of Psychiatrists - General Adult faculty, and the Perinatal faculty	15	NICE	24	1.3.6.3	Some respondents feel that the second bullet point is inappropriate. It is obviously important to discuss with the patient the 'indications and expected benefits and risks of oral antipsychotic medication, and the expected time for a change in symptoms and appearance	Thank you. The notes are not just a legal record of treatments and side effects, they are also a record of the agreement made with the service user. The record should say, in advance, the rationale for giving a drug (including the service users preferences), and the

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						of side effects' and many patients may value having this in writing. However to record them would be simply to record standard information available in product characteristics, textbooks etc, and to do this in case notes would use time which might be far better used for discussion with the patient.	expected period for improvement, side effects etc. The service user now has pretty much full access to notes, so this is so that the service user can see why this is being prescribed and the expected effects at the start.
264	Royal College of Psychiatrists - General Adult faculty, and the Perinatal faculty	16	NICE	32	1.4.6.3	Please see comment 14 above. Given the Wunderink (2013) study, the basis for this recommendation seems much less clear than indicated here.	This recommendation was not open for public consultation. In the NICE guideline please read the "Recommendation wording in guideline updates" section for more information on which recommendations stakeholders are allowed to comment on.
265	Royal College of Psychiatrists - General Adult faculty, and the Perinatal faculty	17	FULL	269	28-30	The description provided of psychodynamic therapy would apply only to certain forms of psychodynamic therapy, in particular the suggestion that 'therapists maintain a degree of opacity in order to allow transference to emerge'. Many therapists would regard it as important to avoid encouraging negative transference in people who experience psychosis, and would actively discourage this, including through avoiding opacity. Thus this definition gives a misleading impression of psychodynamic therapy. The definition offered on page 299 seems much more appropriate. But this also suggests that supportive varieties of psychodynamic therapy might be more appropriately considered in the counselling and psychotherapy section.	Thank you for your comment. Psychological interventions were not part of the scope and accordingly this section was not open for consultation.
266	Royal College of Psychiatrists - General Adult faculty, and the Perinatal faculty	18	FULL	General		What are the reasons for not considering two relevant controlled studies of psychodynamic therapy? Karon Rosenbaum 2012	Thank you for your comment, the psychological and psychosocial chapter has not been updated; the trials you mention will be reviewed in the next update review undertaken by NICE.
267	Royal College of Psychiatrists - General Adult faculty, and the Perinatal faculty	19	FULL	General		It is frequently a problem for EIP practitioners that certain patterns of psychotic experiences meet service criteria for diagnoses of psychosis (e.g. based on PANSS) but are deemed not 'true' psychosis as their underlying cause is believed to be traumatic or psychological or related to personality in some way. Related to this many EIPs use criteria for defining psychosis NOS which cast the net more widely than do more traditional approaches. It would be helpful if the guidance could address this by e.g. - Commenting on criteria for provision of FEP services. - More clearly acknowledging that most diagnoses of psychosis and all diagnoses of schizophrenia are descriptive in nature, and based on meeting criteria for the presence of a certain pattern of symptoms, not on their presumed underlying cause. - Considering the issue of whether research on effectiveness of antipsychotics applies to people who meet the lower threshold EIP definitions of psychosis but not of specific psychotic disorders.	The guideline makes no assumptions about the aetiology of psychosis. It is purely about the interventions and services to help and treat people with psychosis and schizophrenia. In addition, you should note that we have not updated the chapter on pharmacology. We have updated the psychology, only in the area of the treatment of trauma, you will find this in chapter 9, section 9.11. In the section on service provision, we looked at the evidence for early intervention services which are specifically for people with first episode psychosis or at least in the early years of psychosis. We continue to recommend that anyone should have access to these services who meet these criteria (early psychosis) but of any age of onset.
268	Royal College of Psychiatrists - General Adult faculty, and the Perinatal faculty	20	FULL	General		Equality of opportunity: There is no mention of the need for particular consideration of schizophrenia in relation to childbearing. Peak incidence for schizophrenia occurs within the reproductive years. Women of childbearing potential who have schizophrenia may be on treatments which have adverse foetal effects or which are associated with metabolic changes that may complicate pregnancy. They are more likely to have unplanned and unwanted pregnancies (Matevosyan, 2009). Women with schizophrenia	Thank you for your comment. The references will be sent to the Antenatal and Postnatal Mental Health guideline development group who are currently updating the guideline. The group have already discussed these equality issues and women of child bearing age offered any medication in relation to their mental health will be included in the review.

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						should have access to information on sexual health, contraception and pregnancy planning. Once pregnant, they are less likely to engage with antenatal care and have more adverse outcomes of pregnancy (Howard, 2005). There is evidence for an increased risk of relapse of schizophrenia in the first postnatal year (Harlow et al, 2009; Munk-Olsen et al, 2009). Guidance should highlight that the adverse metabolic effects of some antipsychotics may increase risk of gestational diabetes mellitus, and that certain antipsychotics, such as clozapine, may not be compatible with breastfeeding (Gentile, 2010). · Gentile S. Schizophr Bull 2010; 36(3):518-44. · Harlow BL, et al. Arch Gen Psychiatry 2007; 64(1):42-8. · Howard LM. Eur J ObstetGynecolReprodBiol 2005; 119(1):3-10.Munk-Olsen T, et al. Arch Gen Psychiatry 2009; 66(2):189-95. · Matevosyan N. Sexual Disability 2009; 27(2):109-18. · Munk-Olsen T, et al. Arch Gen Psychiatry 2009;66(2):189- By not addressing, or at least signposting, such issues in this guideline, there is a risk that reproductive issues in schizophrenia are seen as the province of specialist services, and the needs of patients in general services, particularly those of childbearing potential, remaining unmet.	
269	Royal College of Psychiatrists - General Adult faculty, and the Perinatal faculty	21	FULL	Definition of Psychosis		Response of the Perinatal Section: In perinatal psychiatry the term Postpartum or Puerperal psychosis is a term that although not used in the current classification systems is still used commonly in clinical practice and particularly by women themselves - for example, the key patient group is called Action on Postpartum Psychosis (see, www.app-info.net). The evidence strongly supports this form of psychosis has a very close relationship with bipolar disorder rather than schizophrenia. The use of the term "psychosis and schizophrenia" in NICE guidance which deals predominantly with schizophrenia and related conditions gives a false impression to women given this diagnosis that psychosis equates to schizophrenia.	Thank you for your response. This guideline addresses the management of psychosis and schizophrenia in general terms for all adults. Although this is directly relevant to women diagnosed with psychosis or more specifically for those with schizophrenia we are currently updating the guideline on APMH which will specify all the modifications needed for the treatment of psychosis and schizophrenia in the perinatal period.
114	Sheffield Health and Social Care NHS Foundation Trust	1	FULL	General		Formatting requires attention - spaces between words appear to have been omitted in several sections	Thank you for your comment. There has been a formatting issue to which we have finally found the source. This is a compatibility issue between the Word 2007 version and Word 2010 Which we are resolving.
115	Sheffield Health and Social Care NHS Foundation Trust	2	FULL	328	34	Loading doses - Whilst I agree with the general statement that loading doses should not be used – for the sake of accuracy it should be noted that paliperidone depot (Xeplion) requires the use of loading doses in some circumstances.	Thank you for your comment. Pharmacological interventions were not part of the scope for this 2014 update and this section of the full guideline was not open for stakeholder consultation.
116	Sheffield Health and Social Care NHS Foundation Trust	3	FULL	327	33	"or" should read "for"	Thank you, this has been changed.
117	Sheffield Health and Social Care NHS Foundation Trust	4	FULL	338		Clinical evidence summary – Although the review by Leucht et al (Leucht S, Cipriani A, Spineli L, et al. Lancet 2013; http://dx.doi.org/10.1016/S0140-6736(13),) was published after the update review date – Given the importance of their finding the results of thjis review should be incorporated into the Guideline update. This recent review sheds further light on the question of	Thank you for your comment. Pharmacological interventions were not part of the scope for this 2014 update and this section of the full guideline was not open for stakeholder consultation.

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						relative efficacy and tolerability of antipsychotic drugs. Although the authors acknowledge the differences in efficacy between the antipsychotics they reviewed were relatively small, never the less, this review provides a reasonably sound basis for updating the NICE guideline conclusion there was little evidence of clinically significant differences in efficacy between oral antipsychotics (line 31) This section of the guideline should be updated to reflect the fact that there is now reasonable evidence to suggest that there may be some differences between antipsychotics in both efficacy and all cause discontinuation .	
118	Sheffield Health and Social Care NHS Foundation Trust	5	FULL	376	1	Please clarify which "guideline update" the new systematic search for RCTs related to depot antipsychotics was conducted	Thank you for your comment; this has now been clarified.
119	Sheffield Health and Social Care NHS Foundation Trust	6	FULL	377		Studies included – It would be helpful to explain why depot olanzapine and depot paliperidone were not included.(e.g see Drug Ther Bull. 2012 Sep;50(9):102-5) Overall I am not convinced that there is sufficient evidence to change to overall conclusions in relation to the place of depot and long acting treatments – but for the sake of completeness the guideline should acknowledge the availability of other SGA long acting antipsychotics that were licensed in the UK at the time of the guideline update review.	Thank you for your comment. Pharmacological interventions were not part of the scope for this 2014 update and this section of the full guideline was not open for stakeholder consultation.
120	Sheffield Health and Social Care NHS Foundation Trust	7	FULL	General		As this will be the third edition of the full guideline Use of terms such as "since publication of the previous guideline"…and "the GDG foccused on" for the avoidance of doubt please consider stating the date/version of the "previous guideline" and whether or not the refereance related to the current (i.e "third" edition) or the previous (i.e second or first edition)	Thank you for your comment. The guideline has been amended throughout to make it clear which edition is being referred to. Sections of the guideline where the evidence has not been updated since 2009 are marked by asterisks and the date (**2009**_**2009**). Sections where the evidence has not been updated since the 2002 are marked by asterisks and the date (**2002**-**2002**).
121	Sheffield Health and Social Care NHS Foundation Trust	8	FULL	380		Re Studies included – see comment 4 above – reference to Leucht S, Cipriani A, Spineli L, et al. Lancet 2013; http://dx.doi.org/10.1016/S0140-6736(13),) should also be included in this section as this adds further weight to the case against a simple dichotomous classification of antipsychotics . In particular this review does gives a strong indication that there are clinically significant differences between antipsychotic drugs – in contrast to the statement on line 8 page 388	Thank you for your comment. Pharmacological interventions were not part of the scope for this 2014 update and this section of the full guideline was not open for stakeholder consultation.
122	Sheffield Health and Social Care NHS Foundation Trust	9	FULL	410	36	Consider adding "relative efficacy" to the list	Thank you for your comment. Pharmacological interventions were not reviewed in the 2014 update however some of the recommendations have been updated to bring them in line with the recommendations from *Psychosis and Schizophrenia in Children and Young People*. This was considered necessary to avoid discrepancies between the child and adult guidelines, particularly regarding early intervention. Consequently new sections have been added to the evidence to recommendations section. In addition some recommendations from the 2009 guideline have been amended to improve the wording and structure with no important changes to the context and meaning of the recommendation. We are unable therefore to make any further amendments to the recommendation.

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123	Sheffield Health and Social Care NHS Foundation Trust	10	FULL	412	32	See comment 2 above re depot paliperidone	Thank you for your comment. Pharmacological interventions were not part of the scope for this 2014 update and this section of the full guideline was not open for stakeholder consultation.
124	Sheffield Health and Social Care NHS Foundation Trust	11	FULL	235	31	We question the Crawford Patterson (2007) idea that psychoanalytic approaches to arts therapies predominate in the UK. The UK arts therapies literature during the previous 30 year s and current practices show that an increasingly collaborative and open approach is used with these clients. The approach is based on careful preparatory work and adapted to the client's level of need and current understanding: a range of psychotherapeutic approaches, including cognitive, supportive psychotherapy and group work are used eclectically.	Thank you for your comment. Psychological interventions were not part of the scope and accordingly this section was not open for consultation.
125	Sheffield Health and Social Care NHS Foundation Trust	12	FULL	235	33-40	Over years of working alongside people with the diagnosis art therapists in the UK have been influenced by clients, multidisciplinary literature and research, and by colleagues. They have developed specific ways of working with differing client needs (Springham, 2012). The elements of an adapted art therapy approach for people who experience psychosis can reasonably be said to include the following. A. Clear communication with other colleagues involved in the client's care in sharing thinking about the problems faced by people with a diagnosis. Such communication often provides real-world insights into the client's living circumstances (Greenwood and Leyton, 1984; Molloy, 1984; Huet, 1997; Wood, 1997; 2001, Richardson et al, 2007). B. A meeting with clients in advance of art therapy. These preparatory meetings serve several important functions in aiding engagement and alliance (Sainsbury Centre, 1998). It can take some time to prepare and so engage group members, when they are vulnerable and possibly frightened (Wood, 1997b).C. A safe room in which to work without interruptions. Ideally it has art materials and if possible a computer and art books. The place of practice becomes recognised and internalised by the client and helps contribute to a clear frame and a place in which it is possible to be absorbed in art making (Goldsmith, 1986; Killick and Schaverien, 1997; Wood, 2000). The books and the computer provide links to culture and media that might inspire art making and provide a sense of connection to society D. The positive symptoms of psychosis fluctuate and are rarely continuous and so although a person's thinking might be under internal attack, they may move in and out of an ability to think even in one session. Clients can often compose themselves (and restore their capacity to think and communicate) when they compose an image. Although this ability to think may not initially be enduring, the experience of restored thinking can be reassuring and aid ideas about recovery. With this aspect of art making in mind, it often seems helpful to be directive and encouraging about art making (Molloy, 1984; Wood, 1992; Greenwood, 1997; Mahony, 2011; Wood, 2001).E. The same elements of psychotherapeutic work are present in work with these clients as with others. However, repeatedly art therapists speak and write about needing to take particular care in order not to add to existing anxieties	Thank you for your comment. Psychological interventions were not part of the scope and accordingly this section was not open for consultation.

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						(Killick, 1991; Greenwood, 1997; Huet, 1997; Danneker, 2013). Groups are carefully constructed (hence the initial preparatory meetings) so that there will more likelihood of group members being able to work together (Greenwood and Layton, 1987; Liebmann, 1990; Huet and Skaife, 1998). Also groups tend to be open with clients being able to join and leave at different stages, though it is important to maintain coherence in group membership. Such adaptations for client need mean that a supportive approach or even one of 'therapeutic care' (Papadopoulos, 2002) are the most appropriate (Wood, 2012). Greenwood summarises an approach born out of long experience and the literature '...the main shift in technique concerns the value placed on a therapeutic stance that is empathic and supportive rather than confrontational or focused on an interpretive stance' (Greenwood, 2012: 26). F. With these clients the therapeutic relationship and group dynamics develop over time, even though they may not be immediately apparent. Although a therapist may sometimes be aware of transference and group tensions, it mainly seems appropriate when clients are in the midst of frightening mental processes, to be informed by these issues without either acting upon or voicing them (Molloy, 1984; Wood, 2011). Greenwood at various points in her writing (between 1987 and 2012) indicates that the effectiveness of therapy is not related to intensity of transference, in effect she describes what is a 'side by side' approach which is close to the collaborative approach being advocated by the User Movement. Papers in art therapy that have been particular in describing this practice include those by the art therapist Helen Greenwood and the psychiatrist Geoff Layton 'An Out-Patient Art Therapy Group' (1987) and 'Taking the Piss' (1988). Liebmann's edited book Art Therapy in Practice (1990) also contains four chapters in which art therapists (Thornton; Skailes; Lewis; and Swainson) identify elements of their particular approach to working with people with these diagnoses. Katherine Killick (1991) asserts the need for a very specific approach during an acute psychosis. Wood (1992) describes work with people with a long history. The Schaverien and Killick book (1997) includes edited chapters describing the specific nature of art therapy for people in different phases of psychosis. Wood's historical account (1997, 2001) illustrates the development of this particular work in art therapy. Huet's paper (1997) assertively describes the need for adaptation in relation to these clients. The Skaife and Huet book (1998) includes several chapters that articulate the qualities of group art therapy for people with a diagnosis (Sarra; Deco; and Saotome).	
126	Sheffield Health and Social Care NHS Foundation Trust	13	FULL	236	5-15	The definitions of arts therapies used by NICE accord with the broad based approach described above and currently employed by arts therapists in the UK.	Thank you for your comment. Psychological interventions were not part of the scope and accordingly this section was not open for consultation.
127	Sheffield Health and Social Care NHS Foundation Trust	14	FULL	240	31-39	The definitions of arts therapies aims used by NICE accord with the broad based approach described above and currently employed by arts therapists in the UK.	Thank you for your comment. Psychological interventions were not part of the scope and accordingly this section was not open for consultation.

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128	Sheffield Health and Social Care NHS Foundation Trust	15	FULL	238	3-10	It would be helpful to further clarify (with research and clearly defined protocols) which aspects of the arts therapies improve the client's experience of negative symptoms.	Thank you for your comment. Psychological interventions were not part of the scope and accordingly this section was not open for consultation.
129	Sheffield Health and Social Care NHS Foundation Trust	16	FULL	239	8-10	Currently in 2013 the salary scale for the majority arts therapists nationally is from mid-point band 6 to the top of band 7. Only a small number of 8a posts remain for people with either significance additional responsibilities or for those working in forensic settings. This information can be verified with the professional associations.	Thank you for your comment. Psychological interventions were not part of the scope and accordingly this section was not open for consultation.
130	Sheffield Health and Social Care NHS Foundation Trust	17	FULL	241	8-10	For clients with 'continuing needs' the length of the work is a vexed question, economic pressures may lead to shorter work, but this needs careful consideration. Some briefer interventions may be helpful as part of a rolling system of care (Huet and Springham, 2010), but there are clearly times when brief work would be a false economy.	Thank you for your comment. Psychological interventions were not part of the scope and accordingly this section was not open for consultation.
131	Sheffield Health and Social Care NHS Foundation Trust	18	FULL	411	37	In support of the recommendation for systematic and regular monitoring consideration should be given to advising clinicians to monitor in line with the Lester protocol	Thank you for your comment. The Lester protocol has not been subject to a systematic trial. The important issue is to ensure monitoring covers the key issues outlined in the recommendations rather than using a particular tool, unless the tool has been validated.
132	Sheffield Health and Social Care NHS Foundation Trust	19	FULL	330	10	Also link with monitoring recommendation p411 – It is important to stress that the life threatening adverse reactions to clozapine are not limited to neutropenia and agranulocytosis. Regular monitoring of bowel functioning should also be included as a specific parameter for patients in receipt of clozapine.	Thank you for your comment. Pharmacological interventions were not part of the scope for this 2014 update and this section of the full guideline was not open for stakeholder consultation.
246	South West Yorkshire Partnership NHS Foundation Trust	1	FULL	General		The concept of 'psychosis' can be seen as an improvement on the schizophrenia concept; however I think that the definition of psychosis being used is problematic. The increased interest in or use of the term 'psychosis' in the last 10-15 years has been to get away from the problematic notion of 'schizohprenia' (due to the stigma, discrimination and conceptual/validity issues related to 'schizophrenia'), with related concepts like 'schizoaffective disorder' even more scientifically dubious and problematic. However the term 'psychosis' is not without its problems, as it upholds ideas of chronicity, deficit and dysfunction (Boyle, 2006) and has similar conceptual problems. I would prefer to see behavioural or phenomenological descriptions such as voices and visions. These would be more specific and valid, and less loaded than medical concepts like psychosis. Separate guidelines for voices and visions, compared to guidelines for 'apparently unusual beliefs/ideas' (or 'delusions' in psychiatric speak) would be a step forward. There has been an increasing number of studies that have investigated these as separate phenomena.	Thank you for your comment, however the guideline development group disagrees. While the group understands that diagnostic terms such as 'psychosis' are associated with stigma, they are important in guidelines in order to establish the populations in intervention trials and to define NHS resources.
247	South West Yorkshire Partnership NHS Foundation Trust	2	FULL	General		The psychologists in your working group are predominantly orientated towards CBT or family interventions. This appears to have biased the recommendations of what psychological approaches are considered.	Thank you for your comment. Except for trauma, psychological interventions were not in the scope as it did not warrant an update. The Guideline Development Group (GDG) was selected according to the skills and experience required for this 2014 update and we don't accept our GDG was biased. Furthermore GDG members were asked at the beginning of every meeting to disclose their invested interest; if the group identify a conflict of interest for a particular the member, that member would have been asked to step outside during

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							a particular discussion to protect against bias. Please see Appendix 2 for the Declarations of interest.
248	South West Yorkshire Partnership NHS Foundation Trust	3	FULL	General		You use the RCT (Randomised Control Trial) as the 'gold standard' of research. This is inappropriate/unhelpful to a lot of psychological research as it aims to take context out of the research process, whereas psychology is all about context (Boyle 2002). Due to the reliance on RCTs approaches with excellent evidence like the Open Dialogue approach (e.g. Seikkula et al 2006) are not recommended. The Open Dialogue approach has much better outcomes than anything the UK currently has to offer, and is much more recovery orientated.	Thank you for your comment. We acknowledge there are different views with regard to what constitutes the best available evidence when evaluating the effectiveness of interventions, but we do not believe there are currently agreed methods for combining randomised and non-randomised evidence to answer questions about interventions. Therefore, for a particular question, where there was RCT evidence, we focused on that evidence and did not search for non-randomised evidence. We set this method out in the review protocol before beginning the review, and do not believe it would be appropriate to change this approach after reviewing the evidence.
101	Southern Health Foundation Trust	1	NICE	general		We found the document well written, helpfully structured and clearly presented	Thank you.
102	Southern Health Foundation Trust	2	NICE	general		We welcome use of the term 'psychosis' rather than relying solely on diagnostic categories (esp as this is particularly problematic for schizophrenia)	Thank you.
103	Southern Health Foundation Trust	3	NICE	general		We welcome the clear expectation of recovery from psychosis	Thank you.
104	Southern Health Foundation Trust	4	NICE	general		Re psychological interventions – CBT and FI are recommended. Is the expectation that everyone is offered both?	Thank you for your comment. Yes, ideally both CBT and family intervention should be offered, depending on the person's personal circumstances.
105	Southern Health Foundation Trust	5	NICE	11	21	On p 11 (and elsewhere) The NICE PTSD guideline is recommended for people with trauma symptoms. Does this include cognitive reprocessing work in the context of current and possibly acute psychosis?	Thank you. With regard to the treatment of trauma/PTSD, we searched for trial data specifically addressing the treatment of PTSD/trauma in people with psychosis and found very little. The GDGs view, therefore, was that, in the absence of evidence to the contrary, people with psychosis and trauma should have access to the same treatment and help that other people have access to. We have been unable to make any recommendations relating to PTSD and psychosis, including cognitive reprocessing
106	Southern Health Foundation Trust	6	NICE	13	2	On p 13 (and elsewhere) We welcome the emphasis on educational and vocational needs and implications for services	Thank you for your comment.
107	Southern Health Foundation Trust	7	NICE	16	1.1.5	We welcome the detailed and specific guidance on carers' needs and implications for services	Thank you.
108	Southern Health Foundation Trust	8	NICE	21	1.3.3.2	We welcome the recognition of trauma in psychosis, and the need to assess trauma history and current symptoms, in EIP. We strongly suggest that this be included in guidance for people with psychosis in all services not just EIP	Thank you. The section on assessment should apply to all stages/services, including assessing for trauma/PTSD. In the NICE guideline, section 1.3.3, the words 'Early intervention services' have been removed to reflect this.
109	Southern Health Foundation Trust	9	NICE	26	1.3.7.1	We suggest that definition and examples of treatment manuals are included	Thank you for your comment. This recommendation was not open for public consultation. In the NICE guideline please read the "Recommendation wording in guideline updates" section for more information on which recommendations stakeholders are allowed to comment on.
110	Southern Health Foundation Trust	10	NICE	38	18	We welcome the research agenda and helpful structure of this section	Thank you
111	Southern Health	11	NICE	42	26	Low intensity interventions are likely to be key to effective service	Thank you for your comment. We have reviewed what can be termed

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	Foundation Trust					provision (accepting limited evidence to date). Where will these interventions be detailed?	as 'low intensity interventions'. Please see section 7.2 (behavioural interventions to promote physical activity and healthy eating), and chapter 8 (peer-provided and self-management interventions) in the full version of the guideline. However, some of these 'low intensity' interventions' by definition were not particularly low in intensity, offering the intervention from between 3 to 104 weeks to the service user. Therefore, we did not feel it was appropriate to use the term 'low intensity'. Furthermore, we also felt these interventions served different purposes and thus could not be reviewed in the same section or chapters.
112	Southern Health Foundation Trust	12	NICE	general		We strongly recommend that a companion audit tool be developed to ensure data quality of service audits, and increase likelihood of adherence to the guidelines	Thank you for your comment. This is an implementation issue which will be passed onto the implementation team.
113	Southern Health Foundation Trust	13	NICE	Ethnicity		Key references need inclusion: 1. Rathod et al. (2013) Cognitive behaviour therapy for psychosis can be adapted for minority ethnic groups: A randomised controlled trial. Schizophrenia Research,143(2-3):319-26. 2. Rathod, S., Phiri, P., Kingdon, D., Gobbi, M. Developing Culturally sensitive Cognitive behaviour therapy for Psychosis for Ethnic minority patients by Exploration and Incorporation of Service Users' and Health Professionals' Views and Opinions. Journal of behavioural and Cognitive Psychotherapies, 2010. 38; 511-33.	Thank you for your comment. It is not NICE style to add references to the introduction of the NICE guideline.
201	Teva UK	1	FULL	23	31	Suggest Add – bowel habits	Thank you for your comment. This comment does not make sense as its referring to the section on smoking. However, we do acknowledge bowel habits in the introduction of the full guideline; see section 2.1.6. The guideline group felt it was important to raise awareness that constipation is a health concern which should be acknowledged.
202	Teva UK	2	FULL	24	31	Suggest Add – GI symptoms and bowel habits. Most antipsychotics like clozapine, haloperidol, quetiapine and amisulpride list constipation as an adverse reaction and adding certain co-medications can worsen the symptoms.	Thank you, part of the guideline to which you have referred to doesn't say anything about antipsychotics or their side effects. We think you are commenting on a section on page 30. This is purely an introduction and is not an evidence based appraisal of the full range of side effects which appears later in the chapter on drugs. Please note that we have not updated this chapter in this 2014 update.
203	Teva UK	3	FULL	23	8	Suggest Add - individual antipsychotics may require a specific area of monitoring	Thank you for your comment. However our conclusion based on studies such as Eufest (Kahn 2007) along with systematic reviews such as the Foley & Morley (2011) and Alvarez-Jimanez(2008) was that adverse effects on weight gain and metabolic issues could occur with any antipsychotic medication.
93	The Association for Dance Movement Psychotherapy (UK)	1	FULL	236	17	Body psychotherapy is not one of the arts therapies; however, the manualised treatment used for key research in this area so far (Rohricht and colleagues) has been indistinguishable from Dance Movement Psychotherapy (DMP), which is one of the arts therapies. As a result, this body of evidence has been considered for Cochrane Systematic Reviews concerning the effects of DMP, including Xia and Grant (2009). The term DMP is used in the UK, but internationally the same practice is known as Dance Movement Therapy (DMT), and this is the term used for Cochrane Systematic Reviews – however, DMP would be a more appropriate term for	Thank you for your comment. Psychological interventions were not part of the scope and accordingly this section was not open for consultation.

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						NICE guidelines.	
94	The Association for Dance Movement Psychotherapy (UK)	2	FULL	239	34-37	We would contest that all of the studies you have considered included HPC registered practitioners. DMP is not included in HPC, and therefore the studies conducted in both body psychotherapy and in its broader definition of DMP will not have included HPC registered practitioners. The reason for this is historical, and in no way reflects any difference in standards. It would be more correct to say that all of the practitioners were registered with the relevant registering body, and name each of these (which in the case of DMP / body psychotherapy, is ADMP).	Thank you for your comment. Psychological interventions were not part of the scope and accordingly this section was not open for consultation.
95	The Association for Dance Movement Psychotherapy (UK)	3	FULL	240	25	9.3.8.2: We suggest that it is misleading to recommend that all arts therapists must be registered with HPC, given the point made above. We strongly suggest a rewording, to 'registered with the appropriate professional body'.	Thank you for your comment. Psychological interventions were not part of the scope and accordingly this section was not open for consultation.
287	The National THORN Steering Group	1	NICE	3	14-16	There should be a broader dimensional view of psychosis e.g. positive, negative, organisational, cognitive and affective. The current two dimensional presentation tends to create a very narrow perspective of understanding of the illness and equally importantly the impact of illness on the individual. Although negative symptoms can remain, recovery and its pace is unique to the individual and it would be important to emphasis that this is to be expected and therefore more emphasis should be stressed on wellbeing, keeping well and building resilience, rather than the current emphasis on a state of stalemate ' sometimes a number of –ve symptoms will remain'	Thank you for your comments. The introduction to the NICE guideline has limited space and it is, therefore, succinct/brief. In the full guideline, the 2nd chapter goes into the disorder and its impact, as well as theories and much more background. In the full guideline we are able to expand on a range of related issues, such as recovery, much more effectively.
288	The National THORN Steering Group	2	NICE	4	12	Impact on the individual, family, friends	Thank you for your comment. This observation is correct, the word 'individual' has been added to the sentence.
289	The National THORN Steering Group	3	NICE	4	24	Although negative symptoms can remain, recovery and its pace is unique to the individual and it would be important to emphasis that this is to be expected and therefore more emphasis should be stressed on wellbeing, keeping well and building resilience	Thank you. The introduction is to do just that: to introduce the reader to psychosis and schizophrenia. The recommendations follow on from this. We can't recommend well-being and resilience-building in this section. Had we found evidence for 'resilience-building', for example, this would have been recommended in the main part of the guidance.
290	The National THORN Steering Group	4	NICE	4	24	Therefore emphasis should focus on biopsychosocial engagement and intervention with the individual during this critical period.	Again, although the GDG would support an individualised approach, this is not the role of the introduction.
291	The National THORN Steering Group	5	NICE	4	25	Families are more than important they are an integral part of the recovery process.	Thank you but the guideline development group feel that the emphasis on families and carers is appropriate.
292	The National THORN Steering Group	6	NICE	5	9	Line on medication is very unclear, does not make sense	Thank you but this is standard NICE wording.
293	The National THORN Steering Group	7	NICE	11	4	Mental health prevention, appear to be jumping into illness related treatment very quickly. Public health promotion needs to be considered here especially in relation to the choices people make that increase their vulnerability to developing a psychosis e.g drugs and alcohol; abuse; stress; crime;	Thank you for your comment, this was not part of the scope. In addition, please note that this section is about the key recommendations simply listed, without any context and divorced from the care pathway that the guideline contains. It will, therefore, appear that we are 'jumping' into treatment very quickly. Also note that there is a guideline on psychosis and co-existing substance misuse (CG120).
294	The National THORN Steering Group	8	NICE	11	5	The strategies required at this stage are not CBT or FI, but engagement with the individual and their families; carrying out a collaborative assessment; using the vulnerability-stress framework	Thank you for your comment. These are key priorities as selected by the guideline development group. Section 1.2 sets out recommendations for referral and assessment for possible psychosis

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						to help make sense of what has been happening/leading up to the increase of poor mental wellbeing.	and at risk mental states.
295	The National THORN Steering Group	9	NICE	11	6	CBT appears to be recommended at a very early stage, the rationale for this needs to be made very explicit. Importance needs to be given to the separation of CBT and CBTp (CBT for psychosis) and they need to be clearly described.	Thank you for your comment. This section of the NICE guideline is the key recommendations, which are, as already described, removed from the context that appears in the NICE guideline later in the document. The trials that underpin the recommendations for CBT for the treatment of psychosis were reviewed in 2009, before the label CBTp had emerged. As we have not updated the section on CBT for psychosis in this 2014 update we cannot change this.
296	The National THORN Steering Group	10	NICE	11		Working with Family	Thank you for your comment. This recommendation needs to be read in the context of the rest of the guideline. Working with families and carers is covered in section 1.1.5.
297	The National THORN Steering Group	11	NICE	11	16	Very positive inclusion of first episode age range. Although the needs of an older person with a first presentation may be different and the needs may not be as apparent as the younger person, but they still require the skills of an EI team.	Thank you for your comment. The GDG agreed and does think recommendation 1.3.1.1 supports your point.
298	The National THORN Steering Group	12	NICE	11	17	Assessing for PTSD requires the practitioner to be very skilled and knowledgeable. When exploring trauma the person's risk of suicide increases and support for the individual and their family need to be considered before recommending this.	Thank you for your comment. This is covered by the PTSD guideline to which this recommendation refers.
299	The National THORN Steering Group	13	NICE	11	26	Pre-Rx baseline assessment is crucial. Ongoing review, with the inclusion of family is also essential. It is important that this would be an integral part of the care plan with the inclusion of sharing this information with the patient to encourage engagement in healthy life-style choices.	Thank you for your comment. This recommendation needs to be read in the context of the rest of the guideline. For example, baseline assessment is covered in recommendation 1.3.6.1, ongoing monitoring in recommendation 1.3.6.2, and sharing information with families and carers in section 1.1.5.
300	The National THORN Steering Group	14	NICE	12	7	CBT is not differentiated from CBTp; it also seems to be suggested as an intervention very early on. We would consider a psychological approach to understanding the distress is important, and this can be very effectively achieved through use of the Vulnerability-Stress framework. Any psychological approach must be complimented by a biosocial approach also	The trials that underpin the recommendations for CBT for the treatment of psychosis were reviewed in 2009, before the label CBTp had emerged. As we have not undated the section on CBT for psychosis we cannot change this. The whole guideline includes references to psychological formulation and treatment, and should be taken in conjunction with the NICE guideline on service user experience in Adult Mental Health which emphasises the need to engage and understand the service user in their own terms.
301	The National THORN Steering Group	15	NICE	12	17	There should be a clear pathway within the MD working which identifies responsibilities, actions and outcomes.	Thank you for your comment. This is a matter for local determination.
302	The National THORN Steering Group	16	NICE	13	5	Are we confident that the guideline is also capturing people who are perhaps not at this stage of recovery, those who require a more assertive outreach model to engage at a social and personal level influences by the impact of illness.	Thank you for your comment. This is just one recommendation from section 1.5 which covers promoting recovery and possible future care for people at various stages of recovery and a range of service-level, psychological and pharmacological interventions are recommended.
303	The National THORN Steering Group	17	NICE	15	1.1.3.3	There is an over-emphasis on pharmacological approaches to supporting behaviour change (smoking) There needs to be more about psychological interventions and accessing more creative ways of engaging people in making changes through use of motivational techniques.	Thank you for your comment. The Cochrane review used in the review of interventions for smoking reduction and cessation did not find any strong evidence of the effectiveness of psychological approaches. Tsoi DT, Porwal M, Webster AC. Interventions for smoking cessation and reduction in individuals with schizophrenia. Cochrane Database of Systematic Reviews. 2013;2.
304	The National THORN	18	NICE	16	1.1.5.3	Suggest using the Triangle of Care as a standard for a good	Thank you for your comment. The GDG agreed to cite the Triangle

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	Steering Group					practice guide.	of Care in the introduction of the full guideline, please see section 2.4 in the full guideline for the reference.
305	The National THORN Steering Group	19	NICE	17	1.1.5.6	Suggest the Triangle of care audit template as a guide to enhancing communication between everyone.	Thank you for your comment. The Triangle of care has not been specifically reviewed but the GDG agreed that it should be referenced in the introduction of the full guideline as a good practice point, please see section 2.4 of the full guideline.
306	The National THORN Steering Group	20	NICE	17	1.1.5.6	This needs to be more explicit, sometimes when the SU does not agree and yet the family remain an integral part of risk assessment and management e.g. exploitation; or becoming unwell, perhaps posing a risk to the family.	Thank you. The GDG have developed a whole section on carers. It is the GDG view that all the key areas are covered in the recommendations in 1.5.1 (1.5.1.1-1.5.1.7 inclusive). The carers on the guideline, who led the drafting of this section, were content that these recommendations covered all the bases.
307	The National THORN Steering Group	21	NICE	17	1.1.5.7.	This model must also ensure that it enhances information between MDT and Multi Agency Team, so information does not get lost.	Thank you for your comment. It is hard to relate your comment to NICE recommendation 1.1.5.7, we think this relates to the recommendation above 1.1.5.5. In this case this recommendation is about sharing information between service users and carers not between different services.
308	The National THORN Steering Group	22	NICE	18	1.1.6.2	Further explanation of what this manual might contain would be important. Which manual ? Is there a blue print?	Thank you for your comment. The manuals referred to are those that are used in the clinical trials. It is not usual practice to refer to these in the NICE guideline.
309	The National THORN Steering Group	23	NICE	18	1.1.6.3	Suggest positively reframe with emphasis on keeping well.	Thank you for your comment. The guideline development group do not agree that a change to the recommendation should be made on this account.
310	The National THORN Steering Group	24	NICE	18	1.2.1.1	Guideline needs to include how PC staff will receive CPD on recognising these very sophisticated signs, 'transient or attenuated psychotic symptoms'	Thank you for your comment. It is not within the remit of NICE guidelines to advise on CPD.
311	The National THORN Steering Group	25	NICE	18	1.2.2.1	Inter-change of language, you have used transient psychosis, attenuated symptoms and now at risk mental state. It would be important that these are very clearly described for all practitioners. Important to recognise that resources do not currently extend to this group of individuals and they are still not being captured properly/early frequently getting caught up in drugs, alcohol, prison, other services.	Thank you for your comment. The guideline development group feels that it has used the terminology precisely - transient (short lived) and attenuated (of less intensity) symptoms are distinct categories; 'at risk mental state' has been used as an over-arching term. The guideline development group has, however, now defined transient and attenuated psychotic symptoms in the introduction.
312	The National THORN Steering Group	26	NICE	19	1.2.3.1	What are the recommendation for CBT at this early stage? CBTp should be the recommended framework.	Thank you. There is a good evidence base for the use of CBT in preventing psychosis, as well as to reduce symptoms when a person has developed psychosis. The GDG decided to call both of these interventions 'CBT' so as not to give the impression that a different type of CBT should be used to prevent psychosis from that used to treat a diagnosed psychosis.
313	The National THORN Steering Group	27	NICE	19	1.2.4.1	A good idea, but requires tighter guidance.	Thank you for your comment.
314	The National THORN Steering Group	28	NICE	20	1.3.1.4.	Skills/competence of the EI practitioner must be commensurate with those outlined in the Schizophrenia Commission Report (The Abandoned Illness)	Thank you for your comment. The guideline development group were very much in support for the Schizophrenia Commission Report, however we are unable to uses sources which aren't evidence based to make recommendations.
315	The National THORN Steering Group	29	NICE	21	1.3.3.1	You have omitted from your list of practitioners who could carry out assessment, mental health nurses. MH nursing is the largest professional group throughout the NHS mental health services. Social Workers also appear to have been omitted. The strength of the assessment will be a collaborative/multi-disciplinary approach to gathering information and sharing formulations and treatment	The recommendation only specifies that the assessment should include a psychiatrist (for diagnostic reasons/drug treatments) and a psychologist or person with psychological therapy expertise (to assess for/offer psychological interventions). For many people, the latter will be a psychiatric nurse. Clearly the assessment needs to be a multidisciplinary one. In this context, spelling out all the

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						plans.	professional groups would be long-winded.
316	The National THORN Steering Group	30	NICE	21	1.3.3.2	See earlier comment on PTSD	Thank you for your comment. This is covered by the PTSD guideline (CG26) to which this recommendation refers.
317	The National THORN Steering Group	31	NICE	22	1.3.3.4	The care plan should reflect a biopsychosocial formulation	Thank you for your comment, but the guideline development group is of the view that 'psychological and psychiatric formulation' is sufficient.
318	The National THORN Steering Group	32	NICE	22	1.3.4.1	Psychosocial interventions within a V-S framework. CBT or CBTp, how will the practitioner be assessed?	Thank you for your comment. Although the recommendation to which you refer is classed as 'new', the evidence for psychological interventions was not updated for this guideline and was therefore the matter in question was not within the scope of the update and accordingly was not open for consultation.
319	The National THORN Steering Group	33	NICE	22	1.3.4.2	CBT/CBTp requires to be differentiated. CBTp does not appear at all in the guideline.	The trials that underpin the recommendations for CBT for the treatment of psychosis were reviewed in 2009, before the label CBTp had emerged. As we have not undated the section on CBT for psychosis we cannot change this. The whole guideline includes references to psychological formulation and treatment, and should be taken in conjunction with the NICE guideline on service user experience in Adult Mental Health which emphasises the need to engage and understand the service user in their own terms.
320	The National THORN Steering Group	34	NICE	26	1.3.7.1	Time limited CBT does not reflect an understanding of the impact of illness; however CBTp is based on the underlying theory of CBT, but reflects the pace and stage of illness;, this could mean five minutes a day/week over the course of the persons illness. Which manual is being recommended, is it one for CBTp? Quite a lot of descriptive jargon on CBT	Thank you for your comment. This recommendation was not open for public consultation. In the NICE guideline please read the "Recommendation wording in guideline updates" section for more information on which recommendations stakeholders are allowed to comment on.
321	The National THORN Steering Group	35	NICE	27	1.3.9.2	Very positive and welcome, but must clearly demonstrate the need to understand CBTp and not just CBT, and be able to provide this within a broader bio	Thank you for your comment. Psychological interventions for 1st episode and subsequent acute episodes were not reviewed for this 2014 update and this recommendation is therefore not open to public consultation.
322	The National THORN Steering Group	36	NICE	28	1.4.1.1	Treatment in the least restrictive environment is always welcomed; and the closer to home the better. However with the continuing emphasis on home treatment it would be important to consider the impact this is having on the household, including siblings.	Thank you for your comment. The guideline recognised the impact on carers and family members and have made several recommendations to address their needs.
323	The National THORN Steering Group	37	NICE	30	1.4.4.4	It wold be important that art therapies are extended to a broad view of the arts e.g. music, dance, singing, drama.	This recommendation was not open for public consultation. In the NICE guideline please read the "Recommendation wording in guideline updates" section for more information on which recommendations stakeholders are allowed to comment on.
324	The National THORN Steering Group	38	NICE	30	1.4.4.6	All practitioners should at a minimum level be able to reduce stress using the psychological strategies of the Vulnerability-Stress Framework and a Normalising Rationale. There is too much emphasis in CBT, with no consideration at all given to CBTp.	This recommendation was not open for public consultation. In the NICE guideline please read the "Recommendation wording in guideline updates" section for more information on which recommendations stakeholders are allowed to comment on.
325	The National THORN Steering Group	39	NICE	31	1.4.4.7	We should be offering motivational approaches e.g. motivational interviewing.	This recommendation was not open for public consultation. In the NICE guideline please read the "Recommendation wording in guideline updates" section for more information on which recommendations stakeholders are allowed to comment on.
326	The National THORN Steering Group	40	NICE	31	1.4.6.1	What is the rationale for this?	This recommendation was not open for public consultation. In the NICE guideline please read the "Recommendation wording in guideline updates" section for more information on which

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							recommendations stakeholders are allowed to comment on.
327	The National THORN Steering Group	41	NICE	32	1.4.6.2.	The evidence for this approach needs to be very clearly presented.	This recommendation was not open for public consultation. In the NICE guideline please read the "Recommendation wording in guideline updates" section for more information on which recommendations stakeholders are allowed to comment on.
328	The National THORN Steering Group	42	NICE	32	1.4.6.3	Should be positively re-framed to recovery and wellbeing language e.g.it will be important to continue taking your medication as prescribed to remaining well	This recommendation was not open for public consultation. In the NICE guideline please read the "Recommendation wording in guideline updates" section for more information on which recommendations stakeholders are allowed to comment on.
329	The National THORN Steering Group	43	NICE	32	1.5.1.1	The full range of treatments outlined in the document do not accurately reflect best practice. How will competence of the practitioner be assessed?	Thank you for your comment. NICE guidelines are best practice. Whilst we do routinely recommend that practitioners should be competent it is beyond the scope to recommend how competency should be assessed.
330	The National THORN Steering Group	44	NICE	33	1.5.2.1	How will the PH care staff demonstrate their competence in being able to manage this?3	Thank you. Primary Care professionals are competent to manage people who have had psychosis and schizophrenia but have recovered and wish to have their ongoing (maintenance) care in primary care. This is commonly done.
331	The National THORN Steering Group	45	NICE	33	1.5.3.2	Excellent, very important, however the execution of this needs to be very tightly managed.33	The GDG have made fairly extensive recommendations in significant detail about physical health.
332	The National THORN Steering Group	46	NICE	33	1.5.3.3	Values based motivational interviewing needs to be included as a treatment approach for behavioural change.	Thank you. It may be helpful, but we found no evidence for this.
333	The National THORN Steering Group	47	NICE	35	1.5.4.1	Please see previous comments on the psychological/CBT/CBTp strategy proposed.	This recommendation was not open for public consultation.
334	The National THORN Steering Group	48	NICE	35	1.5.4.2	Engage with families, offer support and understanding. The language used is too formulaic	This recommendation was not open for public consultation. In the NICE guideline please read the "Recommendation wording in guideline updates" section for more information on which recommendations stakeholders are allowed to comment on.
335	The National THORN Steering Group	49	NICE	38	1.5.8.2	There needs to be more explicit consideration given to the individuals who are significantly impacted by the illness by including physical, social and recreational recovery.	Thank you for your comment. Physical, social and recreational activities are covered throughout this guideline and in the Service User Experience Guideline (CG136).
336	The National THORN Steering Group	50	NICE	41	2.5	This requires very careful consideration before it even gets to the hypothesis testing stage.	Thank you for your comment. This has already been subject to a moderately sized Dutch trial and 7-year follow-up (Wunderink) , which showed very encouraging health benefits without costs in terms of severity of relapse or functioning. The GDG were very concerned about the major health consequences of early neuroleptic exposure, which as we report in the guideline, are evident weeks after first exposure to drugs. The committee, including the user and carer groups represented, felt it was vital to develop strategies to be able to target drugs to those who will benefit and not to those who can manage without them. Accordingly it was felt that a large scale replication of the Wunderink trial was vital, in a UK context. We have slightly altered the recommendation to reflect the focus on health gain to underline this important issue.
337	The National THORN Steering Group	51	NICE	42	2.5	Impact of trauma presented in very negative language, consider reframing. It would be important to include in any exploration the experience of psychosis in itself as being potentially traumatic.	Thank you for your comment. The sentence now reflects a more positive language.

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388	The Work Foundation	1	FULL	17	34	I just wanted to clarify that the 15% employment rate figure was not from us, but was taken from the Schizophrenia Commission report. (available here: http://www.schizophreniacommission.org.uk/) Also, 15% was the top rate of a range of 5-15%, with 8% identified as an 'average'. The 8% is likely more appropriate. Quote from TWF report: The Schizophrenia Commission report identified the employment rate of this group as being around 8 per cent in the UK, within a range of 5 -15 per cent, against a national UK employment rate of 71 per cent.	Thank you for your comment. The paper has been checked and the correct figures and citations have been added.
239	United Kingdom Council for Psychotherapy	1	NICE	30	1.4.4.6	Although counselling and supportive psychotherapy is not recommended routinely, we are pleased to see that the patient's choices can be respected and this can be offered if the patient prefers. This could be worded more clearly in the guidelines.	This recommendation was not open for public consultation. In the NICE guideline please read the "Recommendation wording in guideline updates" section for more information on which recommendations stakeholders are allowed to comment on.
240	United Kingdom Council for Psychotherapy	2	NICE	32	1.4.6.2	We consider the use of psychoanalytic and psychodynamic principles and other reflexive process principles as significant in supporting the understanding and awareness of health care staff and facilitating better decision making and interaction in patient care. We support the inclusion of this recommendation.	This recommendation was not open for public consultation. In the NICE guideline please read the "Recommendation wording in guideline updates" section for more information on which recommendations stakeholders are allowed to comment on.

These organisations were approached but did not respond:
2gether NHS Foundation Trust
5 Borough Partnership NHS Foundation Trust
ABPI Pharmaceutical Serious Mental Illness Initiative
Action on Postpartum Psychosis
Adverse Psychiatric Reactions Information Link
Advisory Committee for Community Dentistry
Afiya Trust
Alder Hey Children's NHS Foundation Trust
Allocate Software PLC
Association for Psychoanalytic Psychotherapy in the NHS
Association for Rational Emotive Behaviour Therapy
Association of Anaesthetists of Great Britain and Ireland
Association of British Insurers
Association of Dance Movement Therapy UK
Association of Professional Music Therapists
Association of Psychoanalytic Psychotherapy in the NHS
Association of Therapeutic Communities
Astrazeneca UK Ltd
Autism West Midlands
Autistic People Against Neuroleptic Abuse
Autonomy Self Help Group
Avon and Wiltshire Mental Health Partnership NHS Trust
Barnet Enfield and Haringey Mental Health Trust
Barnsley Primary Care Trust
Baxter Healthcare
BBOLMC

Beating Bowel Cancer
Berkshire Healthcare NHS Foundation Trust
Birmingham and Solihull Mental Health NHS Foundation Trust
Birmingham City Council
Birmingham Early Intervention Service
Black and Ethnic Minority Diabetes Association
Black Mental Health UK
Bradford District Care Trust
Breakspear Medical Group Ltd
Bristol-Myers Squibb Pharmaceuticals Ltd
British Association for Counselling and Psychotherapy
British Association for Music Therapy
British Association of Art Therapists
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 Confederation of Psychotherapists / Psychoanalytic Council
British Dietetic Association
British Medical Journal
British National Formulary
British Nuclear Cardiology Society
British Nuclear Medicine Society
British Paediatric Mental Health Group
British Psychodrama Association
Buckinghamshire County Council
Buckinghamshire Primary Care Trust
BUPA Foundation
Business Boosters Network CIC
Calderdale and Huddersfield NHS Trust
Calderdale Primary Care Trust
Calderstones Partnerships NHS Foundation Trust
Cambridge University Hospitals NHS Foundation Trust
Camden and Islington NHS Foundation Trust
Camden Carers Centre
Camden Link
Capsulation PPS
Capsulation PPS
Care Quality Commission (CQC)
Care Services Improvement Partnership
Centre for Mental Health Research
Chartered Physiotherapists in Mental Health
Chartered Society of Physiotherapy
Children's Commissioner for Wales
CIS' ters
Citizens Commission on Human Rights
Clarity Informatics Ltd
Cochrane Bone, Joint and Muscle Trauma Group
College of Mental Health Pharmacists
Commission for Social Care Inspection

Community Housing and Therapy
Community Links
Contact
Critical Psychiatry Network
Croydon Health Services NHS Trust
Croydon University Hospital
Cygnet Health Care
Cygnet Hospital Harrow
Department for Communities and Local Government
Department for Education
Department of Health, Social Services and Public Safety - Northern Ireland
Derbyshire Mental Health Services NHS Trust
Det Norske Veritas - NHSLA Schemes
Dorset Mental Health Forum
Dorset Primary Care Trust
Drinksense
East and North Hertfordshire NHS Trust
East London NHS Foundation Trust
East Midlands Specialised Commissioning Group
East Sussex County Council
Eastern Health and Social Services Board
Eli Lilly and Company
Empowerment Matters
Equalities National Council
ESyDoc
Ethical Medicines Industry Group
Faculty of Dental Surgery
Faculty of Public Health
Five Boroughs Partnership NHS Trust
Food for the Brain Foundation
Forensic Arts Therapies Advisory Group
Forum for Advancement in Psychological Intervention
Galil Medical
GE Healthcare
Genus Pharmaceuticals Ltd
George Eliot Hospital NHS Trust
Glencare
Gloucestershire LINk
Great Western Hospitals NHS Foundation Trust
Greater Manchester Neurosciences Network
Greater Manchester West Mental Health NHS Foundation Trust
Hafal - Wales
Hammersmith and Fulham Primary Care Trust
Hampshire Ambulance Service NHS Trust
Hampshire Partnership NHS Trust
Harrogate and District NHS Foundation Trust
Health Protection Agency
Health Quality Improvement Partnership
Healthcare Improvement Scotland
Hertfordshire Partnership NHS Trust
Herts Valleys Clinical Commissioning Group

Hindu Council UK
Hiraeth Services Ltd
Hockley Medical Practice
holistic stress management
Home Office
Humber NHS Foundation Trust
HywelDda Local Health Board
InferMed
Information Centre for Health and Social Care
Integrity Care Services Ltd.
Kent and Medway NHS and Social Care Partnership Trust
Lancashire Care NHS Foundation Trust
Lancashire LINk
Leeds and York Partnership Foundation Trust
Leeds Community Healthcare NHS Trust
Leeds Partnerships NHS Foundation Trust
Leeds Primary Care Trust (aka NHS Leeds)
Leicestershire Partnership NHS Trust
Lesbian, gay, bisexual and trans domestic abuse forum
Lilly UK
Lincolnshire County Council
LivabilityIcanho
Liverpool Primary Care Trust
Liverpool Women's NHS Foundation Trust
London Respiratory Team
Luton and Dunstable Hospital NHS Trust
Manchester Mental Health & Social Care Trust
Maternal Mental Health Alliance
Maternity and Health Links
Medicines and Healthcare products Regulatory Agency
Mental Health and Substance Use: dual diagnosis
Mental Health Foundation
Mental Health Group - British Dietetic Association
Mental Health Nurses Association
Mental Health Providers Forum
Meriden Family Programme
Mersey Care NHS Trust
MerzPharma
Mild Professional Home Ltd
Mind
Mind Wise New Vision
Mindfulness Centre of Excellence
Ministry of Defence
MSD Ltd
National Association for Gifted Children
National Cancer Action Team
National Clinical Guideline Centre
National Collaborating Centre for Cancer
National Collaborating Centre for Mental Health
National Collaborating Centre for Women's and Children's Health
National Hospital for Neurology & Neurosurgery

National Institute for Health Research Health Technology Assessment Programme
National Institute for Health Research
National Institute for Mental Health in England
National Patient Safety Agency
National Pharmacy Association
National Prescribing Centre
National Public Health Service for Wales
National Self-Harm Network
National Treatment Agency for Substance Misuse
Neonatal & Paediatric Pharmacists Group
NHS Barnsley Clinical Commissioning Group
NHS Bournemouth and Poole
NHS Clinical Knowledge Summaries
NHS Connecting for Health
NHS County Durham and Darlington
NHS Devon
NHS Improvement
NHS Kirklees
NHS Milton Keynes
NHS Plus
NHS Sefton
NHS Sheffield
NHS South Cheshire CCG
NHS Trafford
NHS Wakefield CCG
NHS Warwickshire North CCG
NHS Warwickshire Primary Care Trust
NICE technical lead
North East London Mental Health Trust
North Essex Mental Health Partnership Trust
North of England Commissioning Support
North Shrewsbury CMHT
North Staffordshire Combined Healthcare NHS Trust
North Yorkshire & York Primary Care Trust
Northumberland, Tyne & Wear NHS Trust
Nottingham City Council
Nottingham City Hospital
Nottingham Healthcare NHS Trust
Nottinghamshire Acute Trust
Nottinghamshire Healthcare NHS Trust
Novartis Pharmaceuticals
Oxford Health NHS Foundation Trust
Oxfordshire Clinical Commissioning Group
Oxleas NHS Foundation Trust
PartneriaethPrifysgolAbertawe
Partnerships in Care Ltd
PERIGON Healthcare Ltd
Pfizer
Pharmaceutical Schizophrenia Initiative
Pharmametrics GmbH
Pilgrim Projects

POhWER
Primary Care Pharmacists Association
Primrose Bank Medical Centre
Prospect PBS Training Ltd
Public Health Agency
Public Health Wales NHS Trust
Queen Mary University of London
Queen's University Belfast
Renal Association
Rethink - Accommodation Plus
Rethink Mental Illness
Richmond Fellowship
Roche Diagnostics
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
Royal College of Paediatrics and Child Health ,Gastroenetrology, Hepatology and Nutrition
Royal College of Pathologists
Royal College of Physicians
Royal College of Psychiatrists in Scotland
Royal College of Psychiatrists in Wales
Royal College of Radiologists
Royal College of Speech & Language Therapists
Royal College of Surgeons of England
Royal Pharmaceutical Society
Royal Society of Medicine
Sainsbury Centre for Mental Health
Salisbury NHS Foundation Trust
Sandwell and West Birmingham Hospitals NHS Trust
Sandwell Primary Care Trust
SANE
Sanofi
schizophreniawatch
Scottish Intercollegiate Guidelines Network
Servier Laboratories Ltd
Sheffield Mental Health NHS Trust
Sheffield Primary Care Trust
Sheffield Teaching Hospitals NHS Foundation Trust
SIFA Fireside
Skills for Care
Social Care Association
Social Care Institute for Excellence
Social Perspectives Network
Society for Existential Analysis
Somerset Partnership NHS Foundation Trust
South Asian Health Foundation
South Essex Partnership NHS Foundation Trust
South London &Maudsley NHS 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
Southampton City Council
Speak Out Against Psychiatry
St Andrews Healthcare
St Mary's Hospital
St Mungo's
Staffordshire Ambulance Service NHS Trust
Staffordshire and Stoke-on-trent NHS Partnerships
State Hospitals Board For Scotland, The
stockport clinical commissioning group
Surrey and Border Partnership Trust
Surrey Primary Care Trust
Sussex Partnership NHS Foundation Trust
Sutton1in4 Network
TACT
Takeda UK Ltd
Tees, Esk and Wear Valleys NHS Trust
Tees, Esk and Wear Valleys NHS Trust
The Association of the British Pharmaceutical Industry
The College of Social Work
The National LGB&T Partnership
The Patients Association
The Rotherham NHS Foundation Trust
The Samaritans
The Survivors Trust
Threshold
Together
Trident Care and Support
Trinity-Chiesi Pharmaceuticals
Tuke Centre, The
Turning Point
Unite / Mental Health Nurses Association
United Kingdom National External Quality Assessment Service
University Hospitals Birmingham
University of Edinburgh
Victim Support
Walsall Local Involvement Network
Welsh Government
West London Mental Health NHS Trust
Western Cheshire Primary Care Trust
Western Health and Social Care Trust
Western Sussex Hospitals NHS Trust
Westminster Local Involvement Network
Whitstone Head Educational
Wigan Council
Wiltshire Primary Care Trust
Worcestershire Acute Hospitals Trust
Worcestershire Health and Care NHS Trust
York Hospitals NHS Foundation Trust