Rehabilitation in adults with complex psychosis

Consultation on draft guideline - Stakeholder comments table
20/12/2019 – 05/02/2020

Stakeholder	Document	Page No	Line No	Comments	Developer's response
British Association for Behavioural & Cognitive Psych otherapies	Guideline	General	General	It is key to define clearly the professional training required for Psychologists appropriate to the role for Rehabilitation services for psychosis and complex mental health. Rehabilitation Psychologists clearly require to be trained to Doctoral level in Clinical Psychology given the training background and experience required for working with complex cases where the evidence base is limited and formulation driven interventions are required. Additionally neuropsychological assessment skills are key to rehabilitation role as well as the requirement to work across the MDT where staff support/ reflective practice should be key to role along with teaching, training, research and quality improvement requirements.	Thank you for your comment. It is not within the remit of NICE guidelines to recommend the requirements for professional training.
British Association for Behavioural & Cognitive Psych otherapies	Guideline	General	General	In relation to the above comments there are many roles and requirements of Rehabilitation services mentioned throughout the guideline that are best provisioned by specific professions. So e.g. with reference to Clinical Psychology, roles involving, case formulation, Reflective Practice as well as provision of psychological Therapies would fall within the remit of Clinical Psychology. Whilst there may be some overlap (e.g. appropriately trained mental health professionals in other professions may be able to provide some aspects of this role with supervision) it would make it much clearer for commissioners to see the roles and remit of each profession clearly mapped in this guideline such that coherent decisions could be made regarding relative professional resource allocations (see further comments below)	Thank you for your comment. Investigating which roles would be most effective at delivering the recommendations made in the guideline was not identified as a priority at scoping. As such we are not able recommend any specific role types.

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British Association for Behavioural & Cognitive Psychotherapies	Guideline	General	General	In connection with the comments above it is important to specify resource required per head of Rehabilitation population, e.g. per head of inpatient population what would be the desired level of resource required for each specialty? This kind of detail is crucial for commissioners	Thank you for your comment. Your comments will be considered by NICE where relevant support activity is being planned. However resourcing is outside of NICE's remit.
British Association for Behavioural & Cognitive Psychotherapies	Guideline	General	General	Suggested research recommendations are very limited in scope. Whilst cost effectiveness is important, there are many unknown areas in complex psychosis e.g. mechanisms related to the aetiology and maintenance of enduring problems in psychosis and improving associated psychological therapies. If commissioners are to consider research as part of the package for Rehabilitation services, appropriately trained and skilled individuals with combined research and clinical backgrounds should be identified as key to resource.	Thank you for your comment. The research recommendations made in the guideline were determined by the areas of uncertainty and variation that were investigated by guideline and hence do not cover every aspect of rehabilitation in complex psychosis.
British Association for Behavioural & Cognitive Psychotherapies	Guideline	010	004	In relation to the section 1.4, Improving Access, please be aware of the recent BABCP & NHSE BAME Positive Practice Guide for Improving Access to Psychological Therapies. This may be useful to refer to in relation to practical strategies which can enable better therapeutic practice: http://www.babcp.com/files/About/BAME/IAPT-BAME-PPG-2019.pdf	Thank you for your comment. Unfortunately we are not able to cross reference to non-NICE guidance in the recommendations.
British Association for Psychopharmacology	Guideline	General	General	The phrase "people with complex psychosis and other related mental health conditions" is used several times in the document. However this phase does not have a clear diagnostic meaning, In the glossary, this phrase is said to include "schizophrenia, bipolar disorder, psychotic depression, delusional disorders and schizoaffective disorder". This is such a broad selection of diagnoses that it becomes meaningless and potentially dangerous to make pharmacological recommendations encompassing all these diagnostic groups. The evidence base is founded	Thank you for your comment. We have made amendments to the recommendations in section 1.9 of the guideline to make it clear which conditions a particular augmentation strategy is indicated for.

				on the principle that pharmacological treatments are trialled on patients with specific diagnoses and any guidelines making recommendations for pharmacological treatment should therefore specify for which condition(s) a particular treatment is indicated. Tor example the recommendation to augment clozapine with antidepressants may be helpful in psychotic depression but may well be contra-indicated in patients with bipolar. We would recommend that where pharmacological recommendations are made, they should be diagnostically specific.	
British Association for Psychopharmacology	Guideline	004	003	Recommendation 1.1.1The criteria for eligibility for rehab should include the fact that the NICE guidelines for the person's condition (eg schizophrenia) have been followed but the patients has still not recovered. Patients should have a thorough review of their treatment, and referred to specialist services for a second opinion as appropriate.	Thank you for your comment. We think the concept of following the recommendations in the NICE guideline for the person's condition but that the person still has not recovered is adequately conveyed by using the phrase 'have treatment resistant symptoms'. Including this as one of the eligibility criteria for accessing rehabilitation could have the undesired effect of people not being offered rehabilitation soon enough.
British Association for Psychopharmacology	Guideline	013	017	Recommendation 1.5.11We suggest altering the first bullet point to read "people who need treatment in a highly specialist or tertiary unit, including people with psychosis and brain injury, or psychosis and autism spectrum disorder, and amending the second bullet point to read ""people who have a clear clinical or legal requirement to receive treatment outside their home area"	Thank you for your comment. We have not adopted your suggested wording for the first bullet as the committee agreed that citing the population first was clearer. We have made your suggested change to the second bullet point.
British Association for Psychopharmacology	Guideline	014	018	Recommendation 1.6.2Another bullet point should be added: moving towards self-management and self-administration of medication	Thank you for your comment. We have added moving towards self management of medication to the bullet points.

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British Association for Psychopharmacology	Guideline	025	012	Recommendation 1.9.5include referral to specialist services for non-response to treatment despite following NICE guidelines	Thank you for your comment. Rehabilitation services would be the specialist service for non-response to treatment despite following NICE guidelines, therefore the recommendations in this guideline would be followed.
British Association for Psychopharmacology	Guideline	026	004	Recommendation 1.9.8"Seek specialist advice if needed, for example from a specialist mental health pharmacist" : change to "A psychiatrist specialising in treatment resistance and/or a specialist MH pharmacist. Consider referral to relevant specialist services, eg for treatment resistant psychosis, mood disorders, personality disorder as appropriate".	Thank you for your comment. We have amended recommendation 1.9.9 to include another psychiatrist specialising in treatment resistance. We have amended recommendation 1.9.19 to 'Consider referring for a second opinion from a relevant specialist when treating people whose symptoms have not responded well to standard treatment'.
British Association for Psychopharmacology	Guideline	026	004	Recommendation 1.9.8Clozapine dose should be optimised prior to augmentation	Thank you for your comment. We have made this change.
British Association for Psychopharmacology	Guideline	026	004	Recommendation 1.9.8The guidelines name aripiprazole specifically but there is no evidence that this is more effective as an augmentation than other antipsychotics. Aripiprazole augmentation has some evidence in reducing weight gain and sedation and is most often used in this context.	Thank you for your comment. As documented in the rationale and impact section, the committee specifically mentioned aripiprazole as an example while recommending augmentation with antipsychotics. This was because amisulpride is more commonly prescribed than aripiprazole, but the evidence did not show a change in psychosis symptoms following amisulpride, while there was some evidence regarding the effectiveness of aripiprazole in reducing total psychosis symptoms.
British Association for Psychopharmacology	Guideline	026	004	Recommendation 1.9.8The recommendation to add a mood stabiliser does not appear to be evidence based. While there is evidence that mood stabilisation can be effective in patients with a mood disorder or schizoaffective disorder, the recommendation as written seems to imply	Thank you for your comment. We have amended the recommendation to clarify that augmentation with a mood stabiliser would be for psychosis with significant affective symptoms.

				that this should also be recommended in schizophrenia but we aware not aware of any evidence for such a practice. We consider that this recommendation should be withdrawn.	
British Association for Psychopharmacology	Guideline	026	004	Recommendation 1.9.8Similarly, the recommendation to add an antidepressant to clozapine would only be indicated if the person suffered from depression, and could risk precipitating mania in patients with schizoaffective or bipolar disorder. Some SSRIs, eg fluvoxaminem have dangerous drug-drug interactions with clozapine. We consider that this recommendation should be withdrawn.	Thank you for your comment. We have amended the recommendation to clarify that augmentation with an antidepressant would be if there are significant depressive symptoms in addition to the psychotic condition. Recommendation 1.9.11 specifies the need to take into account drug interactions and side effects when using multiple medicines. We have added the example of mania to this recommendation.
British Association for Psychopharmacology	Guideline	026	004	Recommendation 1.9.8 For people with complex psychosis and related severe mental health conditions whose symptoms have not responded adequately to clozapine alone, consider options such as augmenting clozapine with: an antipsychotic, for example aripiprazole and/ora mood stabiliser and/oran antidepressant Comment: The evidence base supporting pharmacological clozapine-augmentation strategies is inconsistent and weak. There is no mention that the nature of the medication used to augment clozapine treatment will rather depend on the clinical indication (i.e. target symptoms and/or behaviour). Further, there is no justification provided for selecting aripiprazole as an example of an antipsychotic medication to be used to augment clozapine treatment.This recommendation further notes that the clinician should, 'Seek specialist advice if needed, for example from a specialist mental health pharmacist.' Comment: While a specialist mental health pharmacist should be a member of a mental health team, surely	Thank you for your comment. We have amended recommendation 1.9.9 to clarify that what is used to augment clozapine treatment depends on the clinical indication. As documented in the rationale and impact section, the committee specifically mentioned aripiprazole as an example while recommending augmentation with antipsychotics. This was because amisulpride is more commonly prescribed than aripiprazole, but the evidence did not show a change in psychosis symptoms following amisulpride, while there was some evidence regarding the effectiveness of aripiprazole in reducing total psychosis symptoms.

				rehabilitation psychiatrists should have the relevant expertise for these prescribing decisions.	
British Association for Psychopharmacology	Guideline	026	012	Recommendation 1.9.9There is a recommendation that if combination anti-psychotic treatment is used, prescribers should consider 2 antipsychotics with different receptor-binding profiles. This could be interpreted as a recommendation to prescribe antipsychotic polypharmacy. With the exception of clozapine augmentation, the evidence base does not support antipsychotic polypharmacy. We recommend instead that antipsychotic polypharmacy is specifically recommended against.	Thank you for your comment. We have deleted the recommendation about antipsychotic polypharmacy.
British Association for Psychopharmacology	Guideline	026	012	Recommendation 1.9.9 If combination treatment is used, consider 2 antipsychotics with different receptor-binding profiles.Comment: There is no evidence that any particular combination of antipsychotic medications is superior to monotherapy.	Thank you for your comment. We have deleted the recommendation about antipsychotic polypharmacy.

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British Association for Psychopharmacology	Guideline	026	014	Recommendation 1.9.10The use of therapeutic plasma levels in non-clozapine anti-psychotics is of little value other than to assess adherence. We would only recommend plasma levels are taken in patients on clozapine or where non-adherence or toxicity is suspected	Thank you for your comment. We have made a change to justify monitoring for other drugs as well as clozapine.
British Association for Psychopharmacology	Guideline	026	014	Recommendation 1.9.10 Optimise the dosage (as tolerated) of medicines used in the management of complex psychosis (see recommendations 1.9.1 and 1.9.8) according to the BNF and therapeutic plasma levels in the first instance. Comment: Checking plasma clozapine levels is a reasonable approach if the illness has shown insufficient response, as there is an identified plasma clozapine level required to ensure an adequate trial. But otherwise, the value of plasma level information for other antipsychotic medications to inform clinical management is questionable.	Thank you for your comment. We have made a change to justify monitoring for other drugs as well as clozapine.
British Association for Psychopharmacology	Guideline	027	001	Recommendation 1.9.11"Only use multiple medicines, or doses above BNF or summary of product characteristics limits, to treat complex psychosis". This should be modified to read "multiple medicines in the same class"	Thank you for your comment. We have not made this change as the committee are keen to encourage minimal numbers of medications from all classes.
British Association for Psychopharmacology	Guideline	027	001	Recommendation 1.9.11 Only use multiple medicines, or doses above BNF or summary of product characteristics limits, to treat complex psychosis: • if this is agreed and documented at a meeting with a multidisciplinary team and the person (and their family, carer or advocate, as appropriate) • as a limited therapeutic trial, returning to conventional dosages or monotherapy after 3 months, unless the clinical benefits of higher doses or combined therapy clearly outweigh the risks • if the medicines are being used to treat specific symptoms (for example, positive and negative symptoms) Comment: With regard to	Thank you for your comment. We have changed the 3rd bullet point to clarify that you should only consider multiple medicines if the medicines are being used to treat specific symptoms that are disabling/distressing.

				the last bullet point, it could be argued that for a treatment-refractory, complex psychotic illness, the 'specific symptoms' that might warrant a trial of 'multiple medicines' or high dosage would need to be clear and persistent target symptoms that were disabling, intolerable or distressing. To describe them only as positive or negative symptoms seems rather too vague.	
British Association for Psychopharmacology	Guideline	027	015	Recommendation 1.9.12If pharmacological treatment is not successful, consider referring to a second opinion from a relevant specialist service eg specialists in psychosis, mood disorder, personality disorder etc as relevant	Thank you for your comment. It is within the competence of a mental health rehabilitation service to carry out a full medication review to inform reduction or stopping of medicine. Therefore we have not made the change you suggest. Recommendation 1.9.19 has been amended to include consideration of a referral to a specialist service for a second opinion
British Association for Psychopharmacology	Guideline	027	015	Recommendation 1.9.12The decision to discontinue antipsychotic medication is highly complex and requires a very thorough review of treatment and careful planning. There is also a lack of evidence to guide this practice. In our experience, discontinuation of antipsychotics, even in specialist settings, frequently leads to relapse and often failure of the placement with a return to acute inpatient care, and the inclusion of this recommendation in the guidelines is likely to lead to adverse outcomes for patients in our view. We suggest adding "If pharmacological treatment is not successful, consider referring for a second opinion from a specialist service for treatment resistant psychosis". If the panel still feel that the option to discontinue antipsychotics must be included in the guidelines, we suggest it should be recommended only after a second opinion, if possible from a service	Thank you for your comment. It is within the competence of a mental health rehabilitation service to carry out a full medication review to inform reduction or stopping of medicine. Therefore we have not made the change you suggest.

				specialising in the person's condition, and in the context of a carefully formulated care plan.	
British Association for Psychopharmacology	Guideline	027	015	Recommendation 1.9.12The recommendation: "be cautious when reducing doses, because people with complex psychosis and related severe mental health conditions may have been on medicines for many years" is not a clear recommendation in our opinion.	Thank you for your comment. We have amended the recommendation to make it clearer.
British Association for Psychopharmacology	Guideline	027	025	Recommendation 1.9.14 Monitor drug levels to check adherence and guide dosing: • at least annually and as needed for clozapine and mood stabilising anti-epileptic medicinesComment: There is very little evidence for benefit with mood stabilisers such as valproate in 'complex psychosis and related severe mental health conditions' and little value in conducting routine plasma levels as there do not seem to be any clinically useful dose-response or dose-toxicity relationships for valproate, at least in patients with epilepsy (Scottish Intercollegiate Guidelines Network. Diagnosis and management of epilepsy in adults. Edinburgh: SIGN; 2013).	Thank you for your comment. We have amended the recommendation to clarify that augmentation with a mood stabiliser would be for psychosis with significant affective symptoms. We have made a change to justify monitoring for other drugs as well as clozapine.
British Association for Psychopharmacology	Guideline	028	001	Recommendation 1.9.15 Consider monitoring prolactin levels annually if the person is taking a medicine that raises prolactin, and more regularly if they have symptoms.Comment: Elevation of plasma prolactin is a known effect of many antipsychotic medications, so the value of routine monitoring is uncertain, certainly in males. If a woman with a complex psychosis is planning a pregnancy, and taking an antipsychotic medication with the	Thank you for your comment. People with complex psychosis do not always report side effects. For example men with high prolactin levels may be experiencing side effects (e.g. lactation) and not report it. Therefore the committee recommended monitoring of prolactin levels should be considered.

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				potential to elevate plasma prolactin, then the serum prolactin level should be checked, 'More regular monitoring' is recommended for patients 'if they have symptoms', but if this refers to signs and symptoms of hyperprolactinaemia, it would be helpful to be more specific about their nature.	
British Association for Psychopharmacology	Guideline	028	014	Recommendation 1.9.19if symptoms persist despite following the NICE guideline on medicine optimisation, consider referring to a second opinion from a specialist service.	Thank you for your comment. Recommendation 1.9.19 has been amended to include consideration of a referral to a specialist service for a second opinion.
British Association for Psychopharmacology	Guideline	029	016	Recommendation 1.10.3Specify that the medical team should have primary responsibility for coordinating and monitoring physical healthcare.	Thank you for your comment. The medical members of the rehabilitation team will be heavily involved in monitoring and co-ordinating physical healthcare. However this will also be relevant to the whole team.
British Association for Psychopharmacology	Guideline	030	022	Recommendation 1.10.7Under the smoking section the issue of smoking effects on antipsychotic levels should be highlighted	Thank you for your comment. We have added an extra recommendation to be aware of the potential significant impact of reducing cigarette smoking on the metabolism of other drugs, particularly clozapine.
British Association for Psychopharmacology	Guideline	031	019	Recommendation 1.10.13Full blood count and U&E should also be checked at least annuallty	Thank you for your comment. Full blood count and renal function tests have been added to the annual physical health check.
British Association for Psychopharmacology	Guideline	044	017	Add "and National level"	Thank you for your comment. We have not made this change as commissioning at a national level would effectively be an out of area placement - something the guideline is trying to reduce.

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British Association of Art Therapists	Guideline	014 - 015	General	Great to see recommendation of recovery-orientated practice, also p. 15 supported decision-making and p. 15-16 staff competencies.	Thank you for your comment and your support of our recommendations.
British Association of Art Therapists	Guideline	011	003 - 012	Why are arts therapists not included in recommended MDTs for inpatient and community rehab services? The NICE guidelines for psychosis and schizophrenia recommend offering arts therapies (see also comment 8 below). Art therapists work in rehabilitation and arguably should be included in the recommended MDT. They have also worked with severe and enduring mental health conditions for many years. Arts therapists who have training placement experience in these services can forge an alliance even when a person finds it difficult to communicate verbally.	Thank you for your comment. We have amended recommendation 1.5.1 to clarify that the multidisciplinary teams should comprise a range of professionals including the roles specified in the bulleted list. This list is not meant to be exhaustive.
British Association of Art Therapists	Guideline	018	006 - 030	Good to see assessment is comprehensive. However, it should also include experience of racism and race/ethnicity-related discrimination where the person belongs to an ethnic minority. Staff may need training to improve their cultural competency. One recent study reported that a project enabled work with members of UK African Caribbean communities to culturally adapt family intervention but it required funding, and it seems unlikely to happen without it (Edge, D., and Grey, P., 2018). An assets-based approach to co-producing a culturally adapted family intervention (CaFI) with African Caribbeans diagnosed with schizophrenia and their families. Ethnicity and Disease, 28, Suppl. 2, 485-492. Also, staff may need training in trauma-informed approaches in order to enquire sensitively about past or current psychological trauma. Failing to address trauma, abuse and racism may hamper people's recovery, leading to increased on-going costs, but it needs skilled and sensitive assessments and therapeutic work.	Thank you for your comment. Experience of racism and race/ethnicity-related discrimination would be covered when taking a social history, as recommended in 1.7.1. Trauma is covered when taking a psychological and psychosocial history. We have added trauma informed care to the examples of psychological informed approaches that staff may need to be trained in (recommendation 1.9.8). Recommendation 1.6.11 is to ensure that staff have training and competence in delivering non-discriminatory practice and attend appropriate diversity training. Edge 2018 was excluded from our qualitative evidence review about barriers to access to rehabilitation because the study was not related to access to mental health rehabilitation services.

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British Association of Art Therapists	Guideline	021	010 - 012	It is good to see this recommendation: "Rehabilitation services should develop a culture that promotes activities to improve daily living skills as highly as other interventions (for example, medicines)." Not so easy to see how medication can be prevented from overshadowing other things, as it has done for many years despite previous calls from RCP and NICE for change. It seems unlikely to change without funding for change management and/or staff training to increase confidence in enacting truly shared decision-making about medication rather than acting in a risk-averse manner (Morant, N., Kaminskiy, E., and Ramon, S. (2015). Shared decision making for psychiatric medication management: beyond the micro-social. *Health Expectations.* doi: 10.1111/hex.12392)	Thank you for your comment and your support of our recommendations. We are not able to specify how these recommendations are put into practice, along with any funding required to do so, as this will be a matter for local implementation. Morant 2015 was not included as evidence in the guideline because it is an expert review about decision making for psychiatric medication in general rather than for complex psychosis and related conditions.
British Association of Art Therapists	Guideline	028	018 - 021	Good to see recommendation that medication adherence may be promoted by "avoiding complex medicine regimes and polypharmacy wherever possible". However, the recommendation just above, for services to promote medication adherence, seems likely to reinforce the existing tendency of promoting adherence rather than listening when people are finding medication unpleasant or unhelpful, and it ignores the risks attached to medications themselves.	Thank you for your comment. The recommendations in the NICE guideline on medicines adherence aim to try and address the issues that you raise. As such we think it is sensible to cross refer to them.
British Association of Art Therapists	Guideline	043	001 - 002	Not clear how the committee came to the view that there was no need for additional resources to deliver the recommendations. The recommendations include training staff in recovery-orientated principles and recognition that some services are not delivering this to a sufficient degree (P. 42 lines 16-19). Where and how will this training take place? Cultural competency is another likely training need.	Thank you for your comment. This text relates to the resource implications of recommendation 1.2.1 which does not mention training. Therefore we have not made any changes to it.

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British Association of Art Therapists	Guideline	064	015 - 020	This comment is about the statement: "In the committee's experience, some people in rehabilitation services are not able to engage with CBT. The committee discussed the importance of providing additional psychological interventions but could not recommend a specific intervention because of the lack of evidence. Instead they recommended possible interventions to consider and emphasised that these should be based on psychological assessment, formulation and consideration of each person's preferences." This statement ignores increasing evidence for art therapy, with three randomised controlled trials showing positive results. Montag et al. (2014) was carried out with people starting as inpatients, with continuation offered following discharge. Both per protocol and ITT analyses showed positive results up to six months after the intervention. If art therapy is not offered, this reduces choice and potentially reduces the possibility of recovery, especially for people who have difficulty engaging with purely verbal therapy: Green, B.L., Wehling, C., & Talsky, G.J. (1987). Group art therapy as an adjunct to treatment for chronic outpatients. Hospital and Community Psychiatry, 38, 988-991. [No doi]Montag, C., Haase, L., Seidel, D., Bayer, M., Gallinat, J., Herrmann, U., & Dannecker, K. (2014). A pilot RCT of psychodynamic group art therapy for patients in acute psychotic episodes: Feasibility, impact on symptoms and mentalising capacity. PLOS ONE, 9 (11), e112348. doi: 10.1371/journal.pone.0112348Richardson, P., Jones, K., Evans, C., Stevens, P., & Rowe, A. (2007). Exploratory RCT of art therapy as an adjunctive treatment in schizophrenia. Journal of Mental Health, 16, 483–491. doi: 10.1080/09638230701483111The MATISSE trial (Crawford et al. 2012), which had a null result with community-based art therapy, suffered from very low	Thank you for your comment. The guideline included a review question which aimed to identify what principles should guide adjustments to standard treatments in the management of underlying psychosis in people using rehabilitation services. This question investigated the effectiveness of interventions for treatment of refractory psychosis resistant to standard treatment and looked at adjustments to psychological interventions, modifications of CBT and modifications of family interventions. No evidence was identified on adjustments to art therapy made for the rehabilitation population and so we are not able to make any recommendations in this area. The MATISSE trial (Crawford 2012, Patterson 2013) was included as evidence in the review about interventions to improve interpersonal and social skills (see recommendations 1.8.4 to 1.8.5 and evidence report L). Our evidence review considered art therapy for interpersonal & social skills in people with complex psychosis and related conditions rather than as a treatment for the positive or negative symptoms of schizophrenia. For this reason, Green 1987, Montag 2014 and Richardson 2007 were not included as evidence. Holtum 2014 was a critique of the MATISSE trial and while it was not included as evidence, the committee were aware of the criticisms of the trial when they discussed the evidence.

				attendance at both intervention and active control conditions, meaning art therapy as such was not tested. It is well known that many people who have been in the mental health system for several years with a schizophrenia diagnosis (the majority of MATISSE participants) have difficulty travelling and getting out without assistance, and this was not taken into account in the trial. The low attendance may have been because at the time it was done, people diagnosed with schizophrenia were generally poorly served (Schizophrenia Commission. 2012), which in turn may have been partly because, or accentuated by it being carried out in a period of heightened austerity (different from when Richardson et al., 2007 occurred, and different from the contextual conditions for Montag et al., 2014). A subsequent detailed qualitative study of MATISSE participants reported that people who did commit to art therapy often overcame great difficulty to attend (Patterson, Borschmann & Waller, 2013). A detailed critique based on the Medical Research Council recommendations for evaluations of complex interventions can be found in Holttum and Huet, 2014). Crawford, M. J., Killaspy, H., Barnes, T. R., Barrett, F., Byford, S., Clayton, K., . . .Waller, D. (2012). Group art therapy as an adjunctive treatment for people with schizophrenia: Multicentre pragmatic randomised trial. BMJ, 344, e846. doi:10.1136/bmj.e846Holttum, S., & Huet, V. (2014). The MATISSE trial - a critique: Does art therapy really have nothing to offer people with a diagnosis of schizophrenia. Sage Open, 2014, 4. https://doi.org/10.1177/2158244014532930 Schizophrenia Commission. 2012. The abandoned illness. London: Rethink. https://www.rethink.org/media/2303/tsc_main_report_14_nov.pdf)Patterson, S., Borschmann, R., & Waller, D.E.	

				(2013). Considering referral to art therapy: responses to referral and experiences of participants in a randomised controlled trial. International Journal of Art Therapy, 18, 2-9. doi: 10.1080/17454832.2012.738425	
British Association of Art Therapists	Guideline	064	022 - 024	The following statement seems problematic: “Despite the lack of evidence from trials, the committee decided that the option of providing all staff with skills in delivering [low intensity psychological] interventions should be considered in rehabilitation settings.” This seems problematic considering that another intervention with greater supporting evidence (art therapy) is not seen as important at all. Added to the art therapy trials, the qualitative evidence alluded to in the 2014 NICE guideline on psychosis and schizophrenia suggested that many service users valued creative activities. These may not be adequately provided by people other than arts therapists, most of whom are trained in both creative fields and specialist therapy skills. The potential impact of favouring poorly evidenced low intensity psychological interventions by minimally trained staff is that they may be used in ways that are far from therapeutic, especially when services are insufficiently resourced. This may result in more people continuing to have prolonged disability, and feeling the need to fight the system rather than work with it, which will end up costing more.	Thank you for your comment. The guideline included a review question which aimed to identify what principles should guide adjustments to standard treatments in the management of underlying psychosis in people using rehabilitation services. This question investigated the effectiveness of interventions for treatment of refractory psychosis resistant to standard treatment and looked at adjustments to psychological interventions, modifications of CBT and modifications of family interventions. No evidence was identified on adjustments to standard art therapy as a therapy for the symptoms of treatment resistant complex psychosis and so we are not able to make any recommendations in this area. The committee considered evidence about art therapy for interpersonal and social skills. They recommended structured group activities (recommendation 1.8.4) and agreed that group art therapy could be one of these activities.

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British Association of Art Therapists	Guideline	6E+07	007 - 030028 - 030001 - 006	We agree with the need for universal staff competencies. However, p. 57 lines 28-30 and p. 58 lines 1-6 seem to play down the need to resource staff training, by alluding to the 'down-the-line' benefits to service users reducing costs in the longer term. The problem with this is that already stretched services are not going to find the resources to implement new training in the hope of this later benefit. Central government needs to step up and provide this. If the belief really is that it saves money, then it should be given up-front funding. The statement p. 58 lines 5-6 is especially questionable: "But these recommendations are derived from other NICE guidance so should reflect current practice." Where is the evidence that this is what is in fact happening in practice?	Thank you for your comment. We have stated that the recommendations on staff competences may have a resource impact where services do not currently provide training. It is not within the remit of the guideline to provide funding for the recommendations - this will be a matter for local implementation. Recommendations in other NICE guidance should be being implemented.
Care Quality Commission – MH in Rehabilitation Project Group	Guideline	001	004, 005, 006	We are concerned about the restrictive, very defined nature of the guidance. Rehabilitation in mental health spans many health conditions and not just complex psychosis and related severe mental health conditions. The title of this guidance strongly leans towards inpatient rehabilitation; it may exclude a large population of providers who care for those outside of this diagnosis within inpatient rehabilitation and also within community rehabilitation settings. We would like to suggest that guidance be considered for rehabilitation services across the wider mental health sector.	Thank you for your comment. As specified in the scope, this guideline focusses on people with complex psychosis. Those with other mental health conditions are outside the scope of this guideline and we are not able to make recommendations on their rehabilitation. However, we have made changes at the start of the guideline to be clear that senior rehabilitation practitioners can also provide advice to services outside the rehabilitation pathway on appropriate treatment and support, including specialist placements and tailored support packages, for people with other primary mental health diagnoses or neurodevelopmental conditions.
Care Quality Commission – MH in Rehabilitation Project Group	Guideline	011	003	We are concerned that some key clinicians have been omitted from the make-up of the multi-disciplinary team (MDT) – we seek to include Speech and Language Therapist (SALT) and physiotherapist into the list at this section.	Thank you for your comment. Speech and Language Therapists have been added to the list of specialties that the MDT should have access to.

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Care Quality Commission – MH in Rehabilitation Project Group	Guideline	011	013	We are concerned that a key role has been omitted from the make-up of the MDT – we seek to include education services in this section.	Thank you for your comment. We have amended recommendation 1.5.1 to clarify that the multidisciplinary teams should comprise a range of professionals including the roles specified in the bulleted list. This list is not meant to be exhaustive.
Care Quality Commission – MH in Rehabilitation Project Group	Guideline	027	011	Consideration to be given to include the use of a side-effect assessment tool to monitor side effects.	Thank you for your comment. Tools to monitor side effects were not identified as a priority at scoping and so we are not able to make any recommendations in this area.
Care Quality Commission – MH in Rehabilitation Project Group	Guideline	027	020	If treatment is being reduced or discontinued, we would recommend the inclusion of a guidance note that the care plan should be revised to include the change in treatment.	Thank you for your comment. Revising the care plan would be encompassed by 'agreed and documented'.
Care Quality Commission – MH in Rehabilitation Project Group	Guideline	028	011	We recommend the inclusion of education of the patient, family or carer on the risks of using non-prescription substances.	Thank you for your comment. This issue is not specific to rehabilitation for people with complex psychosis and so was not prioritised for investigation. As such we have not appraised the evidence in this area and are unable to make recommendations.
Care Quality Commission – MH in Rehabilitation Project Group	Guideline	028	011	We recommend that inclusion of a service level agreement between the provider of rehabilitation services and the local GP, who assumes lead responsibility for the person's physical health needs, is in place. We see this as essential where regular blood monitoring is required for particular medications.	Thank you for your comment. We have added service level agreements to recommendation 1.3.16. We have also recommended that local protocols are put in place and that GPs keep a list of patients with psychosis (see recommendation 1.10.1)

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Care Quality Commission – MH in Rehabilitation Project Group	Guideline	030	025	We recommend the inclusion of key clinical professionals such as dietitians, physiotherapists and nutritionists.In addition to this section, we recommend the guidance makes reference to and includes statements regarding the use of up to date technology available for monitoring physical health, such as digital wearables.	Thank you for your comment. These professionals have been added to the list of specialists that the MDT needs to have access to. Technologies for monitoring physical health were not prioritised for investigation when the committee agreed the PICOs for the review questions and so we are not able to make any recommendations in this area.
Care Quality Commission – MH in Rehabilitation Project Group	Guideline	031	030	In comparing the list in the guidance at section 1.7.3, we recommend the list is identical and the same physical health checks are carried out as at the initial physical health assessment.	Thank you for your comment. The initial assessment and the annual assessment. have different purposes. The initial assessment provides a much more detailed physical health review to detect co-morbidities and establish baselines. Lead responsibility for this initial assessment is with the Rehabilitation service. The annual review focusses on protecting those individuals on the SMI register against obesity, premature cardiovascular disease and type 2 diabetes. Lead responsibility for this sits with primary care and aligns with the QOF. Therefore the lists of tests are not meant to be identical and we have not made this change.
Care Quality Commission – MH in Rehabilitation Project Group	Guideline	004	008, 009, 010, 011	Recommendations We are concerned about the restrictive nature of limiting the group of people who should be offered a rehabilitation service. We believe rehabilitation should be made available to anyone with potential to fulfil their rehabilitation goals and objectives, in a variety of settings. This section excludes those in supported accommodation, those living at home with a care package, inpatient services where community packages have broken down, or any other inpatient setting where rehabilitation is active. There is no mention of stepped care model of rehabilitation. We suggest this guidance be expanded to include all types of rehabilitation services or to design a complementary matched guidance for other rehabilitation services that are not inpatient 'beds' based.	Thank you for your comment. Recommendation 1.1.1 is focussed on those people who are likely not to have been offered a rehabilitation service as indicated by the groups in the bullet points. However, we have made amendments to make clear that a rehabilitation service should be offered to a wider group of people than just those in inpatient rehabilitation. The rehabilitation pathway recommended in the guideline is effectively a stepped care model. However the committee were at pains to emphasise that although the pathway aims to support people to move from higher to lower supported settings, there is flexibility for people to join the pathway at different points and move up as well as down the pathway. Stepped care is often interpreted in a more linear fashion.

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Care Quality Commission – MH in Rehabilitation Project Group	Guideline	006	020	The Lead Commissioner We are concerned that the guidance reinforces the view that a health and social care commissioner has overall lead of commissioning rehabilitation services. It is often a delegated responsibility. We would suggest an addition to the guidance of the types of roles the Lead Commissioner could be i.e. a definition of the lead commissioner.	Thank you for your comment. The committee think that the lead commissioner should be a commissioner as they are appointed to have an overview of what is being commissioned. Delegation can happen at the point of provision of components of the rehabilitation pathway.
Central and North West London NHS Foundation Trust	Guideline	General	General	I have been through the NICE guidance and tend to agree with it. We are actually doing the majority already, the only things that really stood out is they saying Rehabilitation should be joint funded by Health and Social Care, but currently with our CNWL Boroughs it is all Health funded. The other thing they are saying there should be Rehab Community Teams which CNWL has been moving against and the Rehab service should also be responsible for overseeing all out of area patients. With these two I kind of agree they are probably right.	Thank you for your comment and support of the guideline recommendations. We have amended our recommendations on rehabilitation in the community to make it clearer what their role is.
Centre for Mental Health/Equally Well UK	Guideline	029	006	Physical health care section (Section 1.10) It should be noted that there was no expert on physical healthcare in this population on the committee, nor an evidence review of physical health care needs and interventions for this group. These seem significant omissions.	Thank you for your comment. The committee had input from a member with expertise in physical healthcare when agreeing the recommendations. People with complex psychosis have difficulties accessing routine physical healthcare, therefore the focus of the question the guideline investigated was about the process by which they can access routine physical healthcare. Specific interventions for specific conditions are covered by existing site specific NICE guidance and have been cross referred to (see recommendation 1.10.18).

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Centre for Mental Health/Equally Well UK	Guideline	029	006	Physical health care section (Section 1.10) The recommendations in this section relate to process rather than clinical care. There is no comment on the management of obesity (for example) in people with severe mental illness, despite the publication of WHO guidance on this topic. WHO guidance and other meta-analyses/systematic reviews are available that discuss the clinical management of this group and should be included as a separate evidence review.	Thank you for your comment. People with complex psychosis have difficulties accessing routine physical healthcare, therefore the focus of the question the guideline investigated was about the process by which they can access routine physical healthcare. Specific interventions for specific conditions are covered by existing site specific NICE guidance and have been cross referred to (see recommendation 1.10.18).
Centre for Mental Health/Equally Well UK	Guideline	029	016	Recommendation 1.10.3The in-patient rehab team should work with EITHER primary care OR secondary care services. In some situations, primary care staff may be unable to attend patients who are in-patients (current BMA advice on medical responsibility). An alternative needs to be planned with secondary care providers.	Thank you for your comment. We have deleted the text 'working collaboratively with primary care' from the recommendation.
Centre for Mental Health/Equally Well UK	Guideline	029	021	Recommendation 1.10.4this recommendation is unclear. What sort of healthcare professional, and what sort of training is intended? Is their role a management responsibility or a clinical task?	Thank you for your comment. We have amended recommendation 1.10.4. to be clearer who the nominated professional could be.
Centre for Mental Health/Equally Well UK	Guideline	031	007	Recommendation 1.10.10Flu vaccination: Whilst in-patients should be offered flu vaccination (as recommended here), it is irrational not to make the same offer to community patients with a complex severe mental illness. Practically, since so many also have other co-existing morbidities such as diabetes, cardiovascular, or respiratory disease, some in the community can be offered protection against influenza. Offering this protection to all with a severe mental health problem would seem to fall into the "good practice guidance" advice.	Thank you for your comment. In line with NG103, we have included people who have a co-morbid physical disorder (such as chronic respiratory disease, chronic heart disease and diabetes) that means they are more likely to develop potentially serious complications from flu in the recommendation.

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Centre for Mental Health/Equally Well UK	Guideline	031	019	Recommendation 1.10.13Physical health check: a) In both this section, and 1.7.3 (initial health check) there is no recommendation to check full blood count to exclude anaemia etc. This should be included. b) the initial heath check recommends checking prolactin (if indicated). Prolactin should be checked at subsequent health checks as well, as medication may have been changed, and prolactin is an independent factor for cardiovascular risk. Since cardiovascular risk is raised in this group, all potential factors should be included. c) Cardiovascular risk assessment should be undertaken at least annually using a recommended cardiovascular risk tool/algorithm such as QRISK3 (https://qrisk.org/three/) which includes both severe mental illness and anti-psychotic medications as risk factors. d) Primary care training does not include the assessment of movement disorders related to anti-psychotic medication – the main thrust of this recommendation. It may be that whilst assessment of movement disorders is important, it may not be the primary care physician who is best placed to deliver this particular assessment.	Thank you for your comment. Full blood count and renal function tests have been added to the annual physical health check. Monitoring of prolactin levels is already covered by recommendation 1.9.15. We did not look at the evidence for the effectiveness of cardiovascular risk tools and so are not able to recommend QRISK3. Recommendation 1.10.18 cross-refers to CG181, which has recommendations about cardiovascular risk assessment that are appropriate for the population in this guideline. Assessment of movement disorders would be undertaken by the rehabilitation team.
Centre for Mental Health/Equally Well UK	Guideline	032	016	Recommendation 1.10.17This recommendation would benefit from having hyperlinks to the relevant NICE guidelines for early identification and management of specific conditions, e.g. COPD, CVD, hypertension. etc.	Thank you for your comment. We have made this change.
College of Mental Health Pharmacy (CMHP)	Guideline	028 030	011 – 013 022	Whilst we support smoking cessation , we would like to point out that : a) stopping or reducing smoking can affect blood plasma levels of certain psychotropic medication. For example, clozapine, an antipsychotic prescribed in treatment resistant schizophrenia, can be increased even to toxic levels if the patient stops smoking. b) some stop-smoking medications, for example varenicline, can cause	Thank you for your comment. We have added an extra recommendation to be aware of the potential significant impact of reducing cigarette smoking on the metabolism of other drugs, particularly clozapine.

				psychiatric side-effects such as depression, anxiety, hallucinations, suicidal ideation, and aggression.	
College of Mental Health Pharmacy (CMHP)	Guideline	011	013	We recommend that this statement is changed to specialist mental health pharmacists	Thank you for your comment. We have made this change.
College of Mental Health Pharmacy (CMHP)	Guideline	018	008 - 010	We recommend that a comprehensive Medicines Reconciliation at time of entering the rehab services should be included here, with clear documentation about a) the medication plan- which medicines are to be continued /stopped/reviewed with relevant monitoring tests completed and due dates for upcoming tests b) who will be prescribing medication: some medicines are prescribed by the GP but others are prescribed by secondary care e.g. clozapine c) which pharmacy/pharmacies will be dispensing and supplying each of the medicines	Thank you for your comment. We have added medicines reconciliation to recommendation 1.7.2. The documentation you suggest would be included in the care plan, as specified in recommendation 1.7.7.
College of Mental Health Pharmacy (CMHP)	Guideline	019, 027, 031	013, 027, 029	Females of child bearing age who are prescribed Valproate (an anti-epileptic medication) must be provided with adequate support in line with the MHRA advice regarding Pregnancy Prevention Programme and a risk acknowledgment form completed https://www.gov.uk/drug-safety-update/valproate-pregnancy-prevention-programme-actions-required-now-from-gps-specialists-and-dispensers	Thank you for your comment. We have clarified in the text that valproate must not be used in women of childbearing potential, unless other options are unsuitable and the pregnancy prevention programme is in place. We have also specified that the MHRA safety advice on valproate use by women and girls should be followed.

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College of Mental Health Pharmacy (CMHP)	Guideline	021	009	We feel that support with medication-taking so that service users can live independently should be included here. One such example is self-medication programmes. However, it is mentioned much further along the document on p28, lines 23-26. The objective of self-medication programmes is to educate patients about their medicines and give them increasing responsibility for taking medication unsupervised. This is often initiated during in-patient stay or on rehabilitation units but needs monitoring in the community. Self-medication is an important part of the rehabilitation process- it significantly reduces the burden to social services of care packages for administration of medication and forms an important part of a rehabilitation programme which improves the chances of successful outcome through the increased chances of independent living.	Thank you for your comment. Self management of medications was an important outcome in this review question (see evidence review K: interventions to improve activities of daily living). We did not find any randomised trials of relevant interventions reporting self-management of medications specifically in patients with complex psychosis undergoing rehabilitation and so cannot make any recommendations on this issue. However we have made recommendations on self management of medications in the context of adjustments to standard treatments (see recommendations 1.9.22 and 1.9.23).
College of Mental Health Pharmacy (CMHP)	Guideline	025 - 028	001 – 003, 023 - 026	We recommend that NICE would consider adding a statement about a discussion between the service-user and a specialist mental health pharmacist about psychotropic medication. Research has shown that patient-education about medication with a shared decision making approach can improve medication-adherence and hence overall health outcomes. Furthermore, we would recommend that NICE might also include a statement about providing service-users with patient-friendly format of information about medication to help them make a valuable contribution to their own care. This can be through either printed information or directing them to online resources	Thank you for your comment. The concept of shared decision making is inherent throughout the guideline and specifically referenced in recommendation 1.9.2, which relates to all treatments. We do not think it is necessary to say this again for the pharmacological treatments. We have already cross referenced the NICE recommendations about shared decision making which contain details about tailoring the format of information.
College of Mental Health Pharmacy (CMHP)	Guideline	026	010 - 011	We welcome this statement, thank you.	Thank you for your comment.

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College of Mental Health Pharmacy (CMHP)	Guideline	027	021 - 022	We suggest that a copy of the agreed treatment plan should also be given to the person and their carer(s)	Thank you for your comment. This would be encompassed by the bullet 'agreed and documented at a meeting with a multidisciplinary team and the person'. Recommendation 1.7.12 also requires that care plans are shared with the person which should ensure they receive a copy.
East London NHS Foundation Trust	Guideline	029 - 030	006 - onwards	Section 1.10There is a lack of clarity regarding monitoring of physical health. Psychosis and schizophrenia in adults: prevention and management CG178 recommends that The secondary care team should maintain responsibility for monitoring service users' physical health and the effects of antipsychotic medication for at least the first 12 months or until the person's condition has stabilised, whichever is longer. Thereafter, the responsibility for this monitoring may be transferred to primary care under shared care arrangements. Whereas 1.10.2 in this guideline states For people having community rehabilitation, GPs should assume lead responsibility for the person's physical health needs, including health checks and treatment of physical health conditions, working collaboratively with the community mental health rehabilitation team and other services as relevant.We are also not clear how the role of the healthcare professional coordinating physical healthcare would differ from a Care Coordinator who would usually take on this role and refer to the doctors within the team or the GP as needed.	Thank you for your comment. People with complex psychosis are likely to have been under the care of secondary mental health services for over 12 months. Therefore the recommendations in section 1.10 are in keeping with those in GC178. Recommendations 1.10.4 and 1.10.5 have been amended for clarity. The new wording means that a care coordinator could take on the role of the nominated professional.
East London NHS Foundation Trust	Guideline	010	001 - 003	Recommendation 1.3.16This should include involvement of Home Treatment Team where appropriate and consultation with local supported accommodation providers.	Thank you for your comment. Different localities have different set-ups, some of which have home treatment teams and others have an entirely different service. Therefore, the guideline has not specified how this should be delivered to allow flexibility. The responsible team would be specified in the local protocol.

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East London NHS Foundation Trust	Guideline	011	001	Section 1.5 StaffingWithin out community rehabilitation team our compliance with mandatory training is high. We promote and encourage CPD activities across all members of our team. We have an excellent level of staff retention. Our highest turnover tends to be among support workers who gain experience and go on to higher skilled appointments.	Thank you for your comment and providing this information about your community rehabilitation team.
East London NHS Foundation Trust	Guideline	011	017	Recommendation 1.5.3Our role in the housing panel means that we can have direct input into the accommodation being commissioned and keep an overview of the available options as well as gaps in the system. We have been involved in the tendering process for new providers by invite from the London Borough of Hackney who recognise that our clinical input is a vital part of commissioning the correct provision for service users under the care of Rehab teams and across the broader system.	Thank you for your comment and providing this information about your involvement in the housing panel.
East London NHS Foundation Trust	Guideline	012	008 - 021	Recommendation 1.5.7 The community rehabilitation team should play a key role in rehabilitation services supporting the patient at the centre at a local neighbourhood level. They should provide care in the community as well as in-reach work with local acute wards – meeting with patients who might benefit from referral to the community team, joint working with community recovery teams where appropriate, partnership working with local accommodation providers and consultation with local commissioners around the supported accommodation landscape. It should be the role of the community team to advocate for patients with complex psychosis, in particular in helping them to maintain and build local connections and avoid out of area placements which may lead to increased social isolation.	Thank you for your comment. We agree, and have amended the recommendation to be more specific about the need for in-reach work.

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East London NHS Foundation Trust	Guideline	012	027	Recommendation 1.5.9For example involving advocacy services at an early stage where appropriate.	Thank you for your comment. Recommendation 1.5.9 already includes a cross reference to the NICE guideline on decision making and mental capacity so we do not think further detail needs to be added to the recommendation itself.
East London NHS Foundation Trust	Guideline	012, 051	001 – 007, 009 - 027	Recommendation 1.5.5. On page 51 the report acknowledges the lack of evidence around 'characteristics of effective highly specialist or longer-term high-dependency inpatient services'. It highlights the reality that some people spend many years with a poor quality of life in such units which is a concern of the CQC. We share this concern and feel that the recommendations in guideline 1.5.5 are without an evidence base. The research recommendation which links to this recommendation covers costs effectiveness and clinical effectiveness. We would suggest that economic modelling could provide some evidence on costs and use of tools such as Dialog+, use of medication/prescribing, level of activity and independence in activities of daily living could provide some evidence on clinical effectiveness. In terms of cost we are confident that long term out of area placements are not cost effective when compared to community based rehab within supported accommodation. Furthermore the research question fails to include patient recorded outcome measures or patient satisfaction measures.	Thank you for your comment. As documented in the rationale and impact section of the guideline, the evidence showed that rehabilitation units with an expected maximum length of stay were associated with better quality of care. Further information about the committees' discussion of this evidence can be found in evidence review F: required components of an effective rehabilitation pathway. The committee noted that there was limited evidence available on longer-term high-dependency units and consequently made a recommendation for further research. It will be interesting to see what the conclusions of this research are once it has been conducted. Whilst the research recommendation doesn't specify patient reported outcome measures, we would envisage that any such study would seek to capture patient reported outcomes for measuring effectiveness.
East London NHS Foundation Trust	Guideline	013	001 - 015	We would add that supported accommodation setting should also continue to support people who would like to live in their own home to continue planning this. As we have stated above, recognising that there are people within rehabilitation services whose circumstances and ambitions can change. Having consistent access to local authority independent housing through for example a mental health quota is a positive way to support this. Data about how	Thank you for your comment. As the purpose of supported accommodation is to enable people to achieve the highest possible level of independence, which would include living in their own home, we have not made your suggested change.

				many such homes are available in each borough for people to step down into from supported settings is another key element in determining the supported accommodation pathway and why people may get stuck at certain points.	
East London NHS Foundation Trust	Guideline	013	028 - 031	Recommendation 1.5.13Where out of area placements are in place we are concerned that an interval of 6 months between reviews is not frequent enough and invites the potential for people to stay longer than might be necessary. If there is no incentive for the out-of-area placement provider to transfer the person back either to an equivalent local service or a step-down service with their locality the placement may be unnecessarily extended.	Thank you for your comment. Currently the requirement for out of area placements is an annual review, so the recommendation for a review at 6 months will increase the frequency compared with current practice. The committee were mindful of the need to balance between what is ideal and what is feasible in terms of resources and so have not made any changes to this frequency.
East London NHS Foundation Trust	Guideline	022	026 - 028	Recommendation 1.8.8We would emphasise that these opportunities are based within the community both for inpatients and people living in the community. For example when our patients are inpatients (on acute wards) where possible we encourage them to maintain their community based activities and links to their supported accommodation/community care givers. Obviously when people are in out of area placements this is much more of a challenge.	Thank you for your comment. We agree - all the recommendations in this section are about engagement in community activities, including leisure, education and work (as indicated by the subheading).
East London NHS Foundation Trust	Guideline	032	025	Recommendation 1.10.17Treatment for physical health disorders should be offered in primary care (or secondary physical healthcare). In the community, all service users should have access to a GP and it is important that there is no confusion over who is providing treatment. This is particularly important for example in treatment for diabetes where duplication of prescribing could be very dangerous. Is there a reason why this only states 'ideally in primary care'?	Thank you for your comment. We agree but some patients will not engage with primary care and some people are in in-patient settings where they do not have access to a GP. This is why we have said treatment should be offered in line with NICE guidance, ideally in primary care.

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East London NHS Foundation Trust	Guideline	041	011 - 014	Is the implication that people with recurrent admissions or extended stays in acute inpatient units require inpatient rehabilitation? We would argue that a review of placement (either supported placement or package of care), management of symptoms and review of care plan is the priority and higher support in the community if needed. We accept that some patients will have recurrent admissions or extended stays but the priority should still be to maintain a placement within the local community, rather than on an inpatient unit or in an out of area placement. This should be led by a well-staffed community rehabilitation team. Where there is a tenancy in place all efforts should be made to protect this if it is likely that the person could be supported to maintain this. This may involve a significant package of care which would still be more patient centred and cost-effective than inpatient rehabilitation.	Thank you for your comment. The text is not intended to imply that people with recurrent admissions or extended stays in acute inpatient units require inpatient rehabilitation. As the text says, these groups are indicative of people with treatment-resistant symptoms and functional impairments. Recommendation 1.1.1 clarifies that it is these people who should be offered a rehabilitation service as it is the view of the committee that they are often overlooked.
East London NHS Foundation Trust	Guideline	044	014 - 017	We are very concerned about regional level commissioning. How would this differ to out of area placement? Depending on the size of the region, patients could feel just as disconnected from their local community and carers and families would potentially have to travel as far as in the case of an out of area placement. If funding was concentrated in a community model using acute inpatient beds when required (as we currently operate in City and Hackney) regional commissioning would not be needed.	Thank you for your comment. This recommendation is in line with national policy on reducing out-of-area placements. The guideline is recommending working at regional not national level.
East London NHS Foundation Trust	Guideline	046	020 - 023	We believe this is essential for a successful placement, not optional. We cannot foresee any reason why someone would not be able to visit the placement they are expected to live in (unless if it is a temporary/emergency placement) and it is important that people make informed choices about where they live.	Thank you for your comment. This text describes the evidence that was identified in this area, it is not a recommendation. The recommendation about having opportunities to visit potential supported accommodation before moving in (recommendation 1.3.13) makes it clear that this should happen.

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East London NHS Foundation Trust	Guideline	048	002 - 009	Again, where there is a strong supported accommodation offering there are more opportunities for developing home titration protocols using Home Treatment Team and with on-site staff. Clozapine titration should always be an option where it is safe to provide this.	Thank you for your comment. This text describes the committees' deliberations when making the recommendations. Thank you for your support of this recommendation.
East London NHS Foundation Trust	Guideline	005	003 - 005	Section 1.2We believe that any Rehabilitation service should be centred around a strong community rehabilitation team, with adequate provision of supported accommodation. This would constitute a well resourced multidisciplinary team working in partnership with local authority commissioners and accommodation providers. We do not agree that it is necessary to have a range of inpatient rehabilitation settings and in fact we believe that focusing a rehabilitation service around medium and long stay inpatient episodes can be damaging. The negative effects of hospital admission are well documented: institutionalization and dependency; distress from enforced social proximity to others, or from separation from friends and family; harm from other patients or staff; loss of employment or housing tenure; the development of unhelpful coping strategies; stigma. (Community alternatives to inpatient admissions in psychiatry, Brynmor Lloyd-Evans and Sonia Johnson World Psychiatry. 2019 Feb; 18(1): 31–32). Other issues associated with admissions include institutionalisation and dependency; intense social contact exacerbating acute psychosis; the development of paranoid delusions involving staff; the opportunities to learn inappropriate behaviours from other patients; injury from patient-patient aggression; paradoxical loneliness through separation from social networks; loss of community tenure; loss of job; welfare benefit problems; despair and depression from seeing damaged and acutely ill others; stigmatization in the community of origin; and the	Thank you for your comment. Based on feedback from stakeholders, we have amended the recommendations to make it clearer that: • each locality should have a defined rehabilitation pathway, which is part of the comprehensive local mental healthcare system • this pathway should have access to a range of service components in different settings, to provide the appropriate rehabilitative treatment and support that people need to facilitate their recovery and allow them to progress from high support settings to more independent settings • a local needs assessment will need to be conducted to determine which service components are required for the local population as this is likely to vary from one area to another. • The rehabilitation services need to be provided as locally as possible but that some service components can be shared across areas The committee thought it likely that different levels of support would be needed to enable people's full recovery, wherever they are living in both community and inpatient settings but that the results of the needs assessment will determine exactly which services are needed and where for the local population.

				acquisition of drug taking or other substance use habits or contacts. The prevention of these complications requires assessment, supervision,support and active management. A conceptual model of the aims and functions of acuteinpatient psychiatry LEN BOWERS, ROB CHAPLIN, ALAN QUIRK, & PAUL LELLIOTT Journal of Mental Health,August 2009; 18(4): 316–325.Notwithstanding the challenges faced in some localities, we believe that the ambition should be for community based rehabilitation, investing the funds spent on long-stay provision and out of area placements to build local provision of support and accommodation.	Lloyd-Evans 2019 was not included as evidence because it is an expert review and not focused on rehabilitation. Bowers 2009 was not included as evidence because it focuses on acute inpatient care rather than rehabilitation.
East London NHS Foundation Trust	Guideline	005	011 - 012	Section 1.3As evidence to support the comments above we have been sharing our own experience from City & Hackney (part of East London NHS Foundation Trust) with wider stakeholders including Royal College of Psychiatrists and the Rehab Get It Right First Time work stream. As a local system we do not have any inpatient rehabilitation beds, out of area rehabilitation beds, private hospital bed use for adults with mental health problems and extremely low use of acute ECR beds (for many years). Alongside this we maintain a lower than the England average length of stay on acute wards (City & Hackney currently under 15 days). Without seeing data from other local systems comparing acute and rehab bed use it is very difficult to conclude that having inpatient rehab beds is associated with lower or more efficient or effective use of acute mental health beds. We are concerned that the assertion that inpatient rehab beds should be part of the local pathway is not appropriate and is not supported by the evidence.We	Thank you for your comment and providing this information about the experience of East London NHS Foundation Trust. Based on feedback from stakeholders, we have amended the recommendations to make it clearer that: • each locality should have a defined rehabilitation pathway, which is part of the comprehensive local mental healthcare system • this pathway should have access to a range of service components in different settings, to provide the appropriate rehabilitative treatment and support that people need to facilitate their recovery and allow them to progress from high support settings to more independent settings • a local needs assessment will need to be conducted to determine which service components are required for the local population as this is likely to vary from one area to another.

				are an MDT based in the community with a mix of medical, nursing, social work, OT, psychology and support worker time. The work we do is in the context of integrated mental health and social care with East London Foundation Trust managing the budget for CCG complex care and the mental health supported accommodation budget for London Borough of Hackney. Our rehab service is unusual in that we do not have any inpatient rehab beds in our Trust (London Boroughs of City & Hackney, Tower Hamlets and Newham) and through working closely with clinical colleagues, the local authority and accommodation providers we are able to support people within the community who might otherwise become long stay patients on inpatient units. This model relies heavily on the strength of our relationships with other agencies and the assertive approach we use in trying to find the right fit for individual patients in terms of their accommodation and broader care. We believe that this promotes independence through allowing people to be supported to live within the local community.	• The rehabilitation services need to be provided as locally as possible but that some service components can be shared across areas The committee thought it likely that different levels of support would be needed to enable people's full recovery, wherever they are living in both community and inpatient settings but that the results of the needs assessment will determine exactly which services are needed and where for the local population.
East London NHS Foundation Trust	Guideline	050	018 - 027	1.5.3We would suggest that the size of accommodation is less relevant than the staffing provision, skill mix and quality of the physical environment. If a large supported accommodation setting is not well staffed there is potential for those with negative symptoms or social isolation to become vulnerable. However, if the provision is well staffed the setting may provide something similar to general needs accommodation allowing service users to build confidence and gain independence.	Thank you for your comment. The evidence appraised for this guideline showed that providing rehabilitation in smaller facilities was of benefit to service users and so we have recommended this. Recommendations 1.5.1 and 1.5.2 specify the appropriate staffing for rehabilitation facilities.
East London NHS Foundation Trust	Guideline	008	007	Recommendation 1.3.10In our experience co-working is not always required if there is a comprehensive handover. There are occasions when we feel it is more appropriate to do a direct transfer to make things clear for the service	Thank you for your comment. We have amended recommendation 1.3.12 to make clear that direct transfer may be appropriate in some situations.

				user. There may also be limitations to this where Trusts use out of area placements.	
East London NHS Foundation Trust	Guideline	008	010 - 014	Local rehabilitation panel – this could be a local community rehab team – see above, in City & Hackney the community rehabilitation and recovery team works with the housing panel, acute wards and community teams to provide support and advice on discharge, transfer and accommodation step-down.	Thank you for your comment. We agree that the local rehabilitation panel would include local rehabilitation practitioners.

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East London NHS Foundation Trust	Guideline	General	General	We have made some general comments below to the overall approach of the guidelines. We are concerned it is service-led and not patient-led. We struggled to hear the patient voice within the writing around service delivery. It is clear that there is a considerable lack of an evidence base in many areas which is obviously a challenge. We felt that in the absence of evidence the guideline relies on the current system and doesn't take account of the change of direction that health services are taking (for example around neighbourhood model of care delivery) and the negative outcomes of long-stay inpatient care. The overall approach of these guidelines perpetuates siloes – many of the principles outlined apply to ALL mental health services and not specifically rehabilitation. With the move towards place based health and social care this separation feels inappropriate and out of keeping with the direction of services. Although integration is mentioned the actual guidelines do not reflect this approach in any way. Especially when there is no agreed understanding of what the difference is between someone who 'qualifies' for rehabilitation versus the very large number of people with complex psychosis who may well require the same sort of approaches as people who end up in rehabilitation services. This heterogeneity is not addressed at all which is particularly perplexing when there is a large national programme of collecting rehabilitation service data (Get it Right First Time) – whilst that process is also not without its challenges it seems a missed opportunity not to connect with that work in the absence of evidence from the literature. Large parts of the guidance such as regarding physical health apply to all people with severe mental illness and do not take account of the all the work done over the last decade to ensure that physical healthcare is everyone's business and not something the GP holds	Thank you for your comment. Whilst the guideline does start with recommendations on how services should be configured, we do not think that this means it is not patient led. The recommendations on service delivery have been developed based on the available evidence of the effectiveness of different rehabilitation services for people with complex psychosis. Based on feedback from stakeholders, we have amended the recommendations to make it clearer that: • each locality should have a defined rehabilitation pathway, which is part of the comprehensive local mental healthcare system • this pathway should have access to a range of service components in different settings, to provide the appropriate rehabilitative treatment and support that people need to facilitate their recovery and allow them to progress from high support settings to more independent settings • a local needs assessment will need to be conducted to determine which service components are required for the local population as this is likely to vary from one area to another. • The rehabilitation services need to be provided as locally as possible but that some service components can be shared across areas The committee thought it likely that different levels of support would be needed to enable people's full recovery, wherever they are living in both community and inpatient settings but that the results of the needs assessment will determine exactly which services are needed and where for the local population.

				separately. The continual separation of rehabilitation work from the core work of adult psychiatry is at best reductive and at worst counter-productive at a time when we are supposed to be developing a local systems approach to all health and social care. We are concerned about the way acute adult mental health services are portrayed in the guidance. There is no evidence that being on an acute adult mental health ward is any more or less detrimental to people than a rehabilitation ward. In addition the guidance talks about the expense of acute adult mental health wards – rehabilitation wards certainly do not cost less than an acute ward so this is incorrect. Another aspect of this is no acknowledgement that many rehabilitation services actually manage people with complex personality disorder/ trauma – especially inpatient rehabilitation services. Is this NICE guidance about services or clinical evidence? How can we separate the needs of people with all psychosis from the more severely affected group? Length of stay on wards are mentioned throughout the document (up to two years for community p.34 line 10, around one year for high dependency p.35 line 7, over three years for highly specialist p.35 line 17) and these are not evidence based at all. We are moving to outcomes based lengths of stay in community supported accommodation settings and feel that that is more relevant than actual length of stay – and it is not clear how having a maximum length of stay would mitigate institutionalisation or how it would be delivered in practice.We have made a number of specific comments below.	The guideline states that the overarching principles of rehabilitation (recommendation 1.2.1) are that rehabilitation services should provide a recovery orientated approach that ensures individualised, person-centred care through collaborative working and shared decision making. There are further recommendations about how to achieve this from section 1.6 onwards. We do not agree that the guideline perpetuates silos. There are numerous recommendations to ensure an integrated, whole system approach is taken by those commissioning rehabilitation services (recommendation 1.3.1) and that services are provided as a flexible pathway to enable people's recovery and social inclusion, whilst taking account of the fact that some people will fluctuate in their support needs (recommendations 1.3.7, 1.3.10, 1.3.11, 1.3.12). We have also added a recommendation about senior rehabilitation practitioners providing advice to other services outside the rehabilitation pathway for people with other primary mental health diagnoses. Most importantly we emphasise that rehabilitation services should be embedded within a comprehensive local mental health service. The committee were aware of the work GIRFT are doing on improving rehabilitation services and the Lead for the GIRFT programme was a member of the committee. We agree that physical health is everyone's business. Recommendation 1.3.16 aims to ensure that practitioners in primary care, secondary physical care and rehabilitation services work collaboratively and flexibly, drawing together

					the necessary expertise and capacity to manage physical health conditions. Recommendation 1.5.6 covers what the CMHRT should do, which includes liaising with the person's GP about their physical healthcare. Recommendations 1.10.4 and 1.10.5 detail the process to ensure good liaison between rehabilitation services and primary and secondary care. As specified in the scope, this guideline focusses on people with complex psychosis and related severe mental health conditions. Many will have comorbidities which may include complex trauma/personality disorder. However, those who have experienced trauma or who have personality disorder as a primary diagnosis are outside the scope of this guideline. The guideline has not examined the evidence base for these conditions as there is existing NICE guidance for the specialist care required for antisocial personality disorder, borderline personality disorder and post-traumatic stress disorder. Unfortunately we have not been able to identify where in the guideline we say that rehabilitation admissions are less costly than acute admissions. To address the issues raised by stakeholders we have made the following amendments to the guideline: • included an introductory statement to clarify which group this guideline covers • made changes at the start of the guideline to be clear that senior rehabilitation practitioners can also provide advice to services outside the rehabilitation pathway on appropriate treatment and support, including specialist placements and tailored support packages, for people

					with other primary mental health diagnoses or neurodevelopmental conditions. • emphasised the mental health comorbidities that may make rehabilitation more complex, including linking to relevant existing NICE guidelines (such as those on personality disorder). • added trauma informed care to the examples of psychological informed approaches that staff may need to be trained in (recommendation 1.9.8). added trauma informed care to the examples of psychological informed approaches that staff may need to be trained in (recommendation 1.9.8). In addition, experience of trauma and systematic assessment for comorbidities is included in the initial assessment (recommendation 1.7.2). We have amended the definition of complex psychosis to make it clearer who the guideline covers. The guideline recommendations were drawn from the evidence reviews that identified that local specialist rehabilitation services are effective for people with complex psychosis. In addition, the evidence showed that where local rehabilitation services are not in place, people with complex psychosis are at risk of being treated in out-of-area placements and of having lengthier inpatient stays than may be necessary, leading to poor clinical outcomes and greater costs of care. The evidence showed that having an expected maximum length of stay in a rehabilitation service is associated with

					better quality care. This recommendation (1.5.11) was further qualified to ensure that there was flexibility in expected timeframes and that lengths of stay were not interpreted in absolute terms. Usual lengths of stay in inpatient rehabilitation services that are provided in the glossary are based on the reviewed evidence. We have addressed your specific comments below.

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East London NHS Foundation Trust	Guideline	General	General	Integrated pathwayThe success of our team relies heavily on our role within the wider system. The strength of our partnerships with other organisations is paramount. As a specialist team we receive referrals from all the locality teams in Hackney as well as the inpatient wards. We visit community teams on a regular basis to encourage referrals and take an assertive approach to supporting those teams with patients who have complex needs and find it hard to settle in a place. We believe that this helps to avoid admissions and plays an important role in maintaining a community based focus for rehabilitation and recovery.Our role in the housing panel includes hosting bi-monthly panel meetings which advises on appropriate placements for patients funded by the London Borough of Hackney (LBH) for mental health needs. We have attendance from the lead commissioner for LBH, the Deputy Borough Director and representatives from the main accommodation providers. Through this we have good relationships with those providers and maintain a 'live' knowledge of where there are placement vacancies. In addition to the panel itself, we provide a pre-panel discussion option so that care coordinators can discuss complex patients before presenting them which often results in a more useful discussion and aids swift decision making. We have had very positive feedback since introducing this from those using the pre-panel slots. We have a pro-active approach to improving the process by gathering feedback from care coordinators. We have an ongoing Quality Improvement project on the accommodation pathway which has led us to test a number of change ideas including refining the forms we request care coordinators to fill out for their patients and changing the way we record panel outcomes. The case management function of our community rehabilitation team means working closely with mental health clinical	Thank you for your comments and providing detailed information about how your team is integrated within the wider system. We have amended our recommendations on rehabilitation in the community to make it clearer what their role is.

				colleagues and supporting them with accommodation issues. These are usually patients who are not care coordinated by their locality team but for whom there may be complexities or challenges around their accommodation. As case managers we can arrange capacity assessments where needed, appointeeship applications and help to facilitate accommodation step-downs. We took on this role to reduce delay in appropriate move-ons that we had identified as part of placement reviews.	
East London NHS Foundation Trust	Question			Q1 - Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why.We believe that the draft guidelines appear to take a rigid view of what rehabilitation services look like which given the lack of evidence for most of it is inappropriate and risks disengagement from the guidance as a whole. We do not believe there is a single way of providing the rehabilitation function in a local system and each local system is greatly variable from the next. There are some really important principles that should be shared such as processes for managing out of area long term bed usage, how to work with local authorities and which interventions have evidence for efficacy in this group of people. However stating that inpatient rehabilitation wards must be a part of the local system is not backed by evidence and would be both challenging and inappropriate to implement. Mental health bed usage is a complex issue with many factors affecting it that will differ depending on the local context, strengths, challenges, workforce etc.	Thank you for your comment. Based on feedback from stakeholders, we have amended the recommendations to make it clearer that: • each locality should have a defined rehabilitation pathway, which is part of the comprehensive local mental healthcare system • this pathway should have access to a range of service components in different settings, to provide the appropriate rehabilitative treatment and support that people need to facilitate their recovery and allow them to progress from high support settings to more independent settings • a local needs assessment will need to be conducted to determine which service components are required for the local population as this is likely to vary from one area to another. • The rehabilitation services need to be provided as locally as possible but that some service components can be shared across areas The committee thought it likely that different levels of support would be needed to enable people's full recovery,

					wherever they are living in both community and inpatient settings but that the results of the needs assessment will determine exactly which services are needed and where for the local population. ,
East London NHS Foundation Trust	Question			Q2 Would implementation of any of the draft recommendations have significant cost implications?There is the possibility that if the guidance remains rigid about inpatient rehab beds being part of a local system that this would have cost implications and even if (as is stated) old wards could be repurposed and a new build would not be required we would ask where will staff come from to work on the wards? When systems are struggling already with recruitment there will be serious cost and recruitment implications. As we have expanded on below there is nothing about people with complex trauma/ personality disorder and how many of them occupy some of the long term bed use in rehab or rehab type wards, often out of area. Surely money released by bringing those people back to their home borough should be used for psychological resources, psychotherapy services and evidence based treatments such as mentalisation based therapy.	Thank you for your comment. Based on feedback from stakeholders, we have amended the recommendations to make it clearer that: • each locality should have a defined rehabilitation pathway, which is part of the comprehensive local mental healthcare system • this pathway should have access to a range of service components in different settings, to provide the appropriate rehabilitative treatment and support that people need to facilitate their recovery and allow them to progress from high support settings to more independent settings • a local needs assessment will need to be conducted to determine which service components are required for the local population as this is likely to vary from one area to another. • The rehabilitation services need to be provided as locally as possible but that some service components can be shared across areas The committee thought it likely that different levels of support would be needed to enable people's full recovery, wherever they are living in both community and inpatient settings but that the results of the needs assessment will determine exactly which services are needed and where for the local population.

					As specified in the scope, this guideline focusses on people with complex psychosis. Many will have comorbidities which may include complex trauma/personality disorder. However, those who have experienced trauma or who have personality disorder as a primary diagnosis are outside the scope of this guideline. These people require specialist input to ensure appropriate care, treatment and support and as this guideline has not examined the evidence base for rehabilitation for these conditions it would not be appropriate to make recommendations. In addition, there is existing NICE guidance on personality disorder. To address the issues raised by stakeholders we have made the following amendments to the guideline: • included an introductory statement to clarify which group this guideline covers • made changes at the start of the guideline to be clear that senior rehabilitation practitioners can also provide advice to services outside the rehabilitation pathway on appropriate treatment and support, including specialist placements and tailored support packages, for people with other primary mental health diagnoses or neurodevelopmental conditions. • emphasised the mental health comorbidities that may make rehabilitation more complex, including linking to relevant existing NICE guidelines (such as those on personality disorder). • added trauma informed care to the examples of psychological informed approaches that staff may need to be trained in (recommendation 1.9.8).

					In addition, experience of trauma and systematic assessment for comorbidities is included in the initial physical assessment (recommendation 1.7.2).
East London NHS Foundation Trust	Question			Q3 What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.)We have provided some information about our own services below in order to share good practice and offer a more balanced and heterogeneous approach to rehabilitation services. There are a number of other wider system measures that would be key in helping the system provide good enough rehabilitation services such as the number of people waiting on an acute mental health ward for a rehab ward, acute bed use in that local system and lengths of stay across all inpatient settings in a system.	Thank you for your comment and providing information about the services provided by East London NHS Foundation Trust.
Gloucestershire Health and Care NHS Foundation Trust	Guideline	010	001 - 003	Owing to the rigorous requirements relating to the starting/restarting of clozapine, there are a number of significant concerns relating to such a clinical decision occurring in the community. These may be relating to the level and type of community mental health service needed to deliver such a clinical plan. However, it may also relate to issues regarding the individual patient (such as other current medication being prescribed which might interact with the clozapine or physical health issues which might further exacerbate the side effects of the clozapine being started or restarted). In addition, in the circumstances of a patient being restarted on clozapine, there is a risk that they might suffer a relapse of their mental illness in such circumstances, which might make the restarting of the	Thank you for your comment. We agree that there needs to be stringent oversight in these situations. This is why recommendation 1.3.18 is that the lead commissioner needs to ensure there is a local protocol agreed. We have added to this recommendation that this protocol would be drawn up by, or in consultation with the community mental health services pharmacist and include all the relevant safety checks.

				clozapine more problematic and ultimately untenable in a community setting.	
Gloucestershire Health and Care NHS Foundation Trust	Guideline	016	004 - 008	The reference to “rehabilitation staff should establish and maintain non-judgemental collaborative relationships with patients” and support being available for “rehabilitation staff to acknowledge and manage any feelings of pessimism about people’s potential for recovery” could potentially be perceived as portraying staff in an unnecessarily critical light by the reader.	Thank you for your comment. The wording is not intended to be negative about staff, however it does reflect the reality of working with people with complex needs. Recent concerns about quality of care were strongly in the committee’s mind when making this recommendation.
Gloucestershire Health and Care NHS Foundation Trust	Guideline	018	004 & 005	Does the offer of a comprehensive needs assessment by a multidisciplinary team need to be ideally within 4 weeks of entering the rehabilitation service, as on occasions it may take longer than this to undertake?	Thank you for your comment. Within 4 weeks is the timeframe in which the needs assessment should happen. We appreciate that there may be circumstances where this is not possible but think that inserting the word 'ideally' would allow a greater degree of flexibility than is optimal.
Gloucestershire Health and Care NHS Foundation Trust	Guideline	026	004 - 009	There is clear guidance described elsewhere by NICE about patients who do not respond to clozapine alone. However, the description in point 1.9.8 appears insufficiently focussed and gives the reader limited guidance as to why they might consider using an additional antipsychotic and/or a mood stabiliser and/or an antidepressant. While not necessarily needing to repeat the information in the guidance documented elsewhere by NICE, point 1.9.8 would be more informative if at least some further guidance /explanation was given to the reader about this. Furthermore, the recommendation of augmenting of clozapine with another antipsychotic medication “for example aripiprazole” might risk placing too much emphasis on this one particular antipsychotic medication over alternative antipsychotic augmentation strategies for which there is some (though also limited) evidence base.	Thank you for your comment. We have amended recommendation 1.9.9 to clarify that augmentation is for those whose symptoms have not responded adequately to clozapine alone at an optimised dose. As documented in the rationale and impact section, the committee specifically mentioned aripiprazole as an example while recommending augmentation with antipsychotics. This was because amisulpride is more commonly prescribed than aripiprazole, but the evidence did not show a change in psychosis symptoms following amisulpride, while there was some evidence regarding the effectiveness of aripiprazole in reducing total psychosis symptoms.

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Gloucestershire Health and Care NHS Foundation Trust	Guideline	034	009 - 010	Suggestion that the expected length of stay in a community rehabilitation unit is “1 to 2 years” and not “around 2 years”. (Ref. Joint Commissioning Panel for Mental Health: Guidance for commissioners of rehabilitation services for people with complex mental health need (2016)).	Thank you for your comment. We have made your suggested change.
Gloucestershire Health and Care NHS Foundation Trust	Guideline	035	006 - 007	Suggestion that the expected length of stay in a high dependency (high support) inpatient rehabilitation is “up to 1 year” and not “around 1 year”. In addition, where a local rehabilitation pathway provides a high dependency unit or a community rehabilitation unit (rather than both), the expected length of stay may be up to 3 years. (Ref. Joint Commissioning Panel for Mental Health: Guidance for commissioners of rehabilitation services for people with complex mental health need (2016)).	Thank you for your comment. We have retained the wording 'around 1 year' to prevent any interpretation of overly prescriptive timeframes (i.e. that this is the maximum amount).
Gloucestershire Health and Care NHS Foundation Trust	Guideline	005	011 - 012	There is no reference to long term complex care units in the description of inpatient rehabilitation facilities in lines 11 and 12. (Long term complex care units are described in the Joint Commissioning Panel for Mental Health: Guidance for commissioners of rehabilitation services for people with complex mental health need (2016), which completes the description of the range of rehabilitation inpatient facilities required to provide a comprehensive whole system approach in this regard).	Thank you for your comment. Long term complex care units are encompassed by recommendation 1.3.6 (highly specialist rehabilitation units and longer-term high-dependency rehabilitation units). The 2016 guidance for commissioners of rehabilitation services for people with complex mental health needs was not included as evidence in its own right in the guideline – because it is a guidance document rather than a research study. However, its reference list was checked for relevant studies.
Gloucestershire Health and Care NHS Foundation Trust	Guideline	056	011 - 014	The statement that there was “qualitative evidence” that “staff sometimes lack optimism or are overly risk-averse about the prospect of rehabilitation for some people, and that this can negatively affect a person’s recovery”, might risk representing a detrimental impression of staff who work in a challenging area of mental health which requires	Thank you for your comment. Whilst we would not want to create a detrimental impression of staff who work in this challenging area, the purpose of this text is to describe the evidence that was identified. As this was what the evidence reported it would not be appropriate for us to moderate the language used.

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				taking a longer term view of the patient's recovery over time.	
Gloucestershire Health and Care NHS Foundation Trust	Guideline	006	001 - 002	There is no clear explanation as to why the extended stay in acute inpatient units is "for example longer than 60 days". It might be that this needs to perhaps be removed in order to reduce any confusion over this matter.	Thank you for your comment. For a local rehabilitation service needs assessment to be conducted, there need to be a metric that can be measured against. Therefore, we have retained reference to 'longer than 60 days' as an indicator of people who may meet the criteria for more complex needs. This is not meant to be an eligibility criteria for access to rehabilitation services.
Gloucestershire Health and Care NHS Foundation Trust	Question			Q1 Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. The biggest area of impact on practice by the NICE guidelines will be where NHS Trusts currently have no rehabilitation inpatient facilities or community rehabilitation team, with this then necessitating a full review of what the needs of the local population are in this regard and the resources which are going to be required in order to deliver on providing these services. Such a review would need to be undertaken by these NHS Trusts working closely with commissioners.	Thank you for your comment. We agree that a review of the needs of the local population will be required to determine what services are needed and have recommended this should happen. We have also recommended that commissioners should work together with health services, local authorities, housing providers and other partners to do this.
Gloucestershire Health and Care NHS Foundation Trust	Question			Q2 Would implementation of any of the draft recommendations have significant cost implications? This would be dependent to some extent on what rehabilitation services were already available locally and what plans there might be for any development of such services over time.	Thank you for your comment and providing this feedback. Your comments will be considered by NICE where relevant support activity is being planned.

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Gloucestershire Health and Care NHS Foundation Trust	Question			Q3 What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) Some of the challenges would be overcome by the provision of a whole system approach which delivered a range of rehabilitation services as close to home as practically possible for the individual patient and which also facilitated a defined pathway between the inpatient and community aspects of such a service, as the patient moved forward in their recovery over time.	Thank you for your comment and providing this feedback. Your comments will be considered by NICE where relevant support activity is being planned.
Leeds and York Partnership Foundation NHS Trust	Guideline	011	002	Access to healthcare, participation and understanding are consequent on communication skills. SLTs are experts in advising on accessible methods of communication using a range of media (eg auditory and visual). Care teams need insight into the person's level of communication skills to promote active role in recovery rather than passive. SLTs assess level of communication strengths and needs and offer individual or group approaches to promote communication and wider social skills (see also sections 1.5.9; 1.6.1; 1.7.5; 1.7.6; 1.7.7; 1.8.6; 1.8.9; 1.9.7; 1.10.9;)	Thank you for your comment. Speech and Language Therapists have been added to the list of specialties that the MDT should have access to. Assessment of communication needs has been added to the comprehensive biopsychosocial needs assessment (recommendation 1.7.2). Identification of any needs as a result of the assessment will enable them to be included in formulation and care planning.
Leeds and York Partnership Foundation NHS Trust	Guideline	011	003	MDT should include wider mention of SLT as a role embedded into the team to allow support, training and advice on communication across all aspects of recovery (also 1.5.8; 1.6.2; 1.6.4; 1.6.17; 1.8.4; 1.9.5)	Thank you for your comment. Speech and Language Therapists have been added to the list of specialties that the MDT should have access to.

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Leeds and York Partnership Foundation NHS Trust	Guideline	016	017	Staff competencies, SLTs offer training and support for staff and caregivers to enhance service users participation in recovery. Staff should have at least a basic training on induction around accessible language and communication strengths and needs (1.6.10; 1.9.7;)	Thank you for your comment. Assessment of communication needs has been added to the comprehensive biopsychosocial needs assessment (recommendation 1.7.2) and difficulties with swallowing have been added to the initial physical health check (recommendation 1.7.3). This should enable any needs to be identified and input sought from Speech and Language Therapists (who have been added to the list of specialties that the MDT should have access to). We have highlighted the higher prevalence of speech, language and communication difficulties in people with complex psychosis, which may contribute to complexity in rehabilitation (recommendation 1.7.5). We therefore do not think specialist training in communication and dysphagia awareness is necessary for all staff. We have also added that the recommendations on communication needs from the NICE guideline on people's experience in adult social care services should be followed and that communication needs as set out in the NHS Accessible Information Standard should be met.
Leeds and York Partnership Foundation NHS Trust	Guideline	018	003	SLT assessment of communication and swallowing: screening for difficulties on admission and then also review after 6 months (also 1.7.3;) . Also detailed reporting of any incidents associated with these difficulties to build history and inform care and risk mitigation *(Guthrie, S., Lecko, C. and Roddam, H., 2015. Care staff perceptions of choking incidents: What details are reported?. Journal of applied research in intellectual disabilities, 28(2), pp.121-132.; also ref above Walsh et al 2007)*	Thank you for your comment. Speech and Language Therapists have been added to the list of specialties that the MDT should have access to. Assessment of communication needs has been added to the comprehensive biopsychosocial needs assessment (recommendation 1.7.2) and difficulties with swallowing have been added to the initial physical health check (recommendation 1.7.3). Those with issues identified from the assessment would need to be referred to Speech and Language Therapists for specialist advice and treatment.

					Guthrie 2014 was not included as evidence because it looked at learning disabilities and all types of mental health disorder and was not limited to complex psychosis or related conditions. Walsh 2007 focused on rates of speech and language impairment in acute psychiatric units. This was not included as evidence because it was not a population based study and not limited to complex psychosis or related conditions.
Leeds and York Partnership Foundation NHS Trust	Guideline	018	004 - onwards	In terms of assessment, it mentions mental health broadly, but does not specify assessment of a persons relationship with their experiences of psychosis which is key to understanding and then formulating and helping the person develop new relationships with their experiences to help them both understand and cope. e.g relationship with voices, and coping strategies. This can be done through interviews like the Maastrict, or through questionnaires of which there are many. I believe this would benefit from further specification as currently the guidance is quite medical in its language.	Thank you for your comment. The guideline recommends a comprehensive biopsychosocial needs assessment (recommendation 1.7.1). Recommendation 1.7.2 clarifies that a psychological and psychosocial history (including relationships, life history, experiences of abuse and trauma, coping strategies, strengths, resiliency, and previous psychological, psychosocial interventions) should be included in this. We have not appraised the evidence for different tools to use in the assessment and so are not able to make recommendations to use Maastrict or questionnaires.
Leeds and York Partnership Foundation NHS Trust	Guideline	022	016	There is a lack of reference to any understanding of the psychological factors that are in play that are affecting ability to engage in daily activities – leisure activities etc. This doesn't take into consideration that if we are not psychologically informed then we fail to see that it may be psychological factors that prevent someone to be able to use the bus, budget, walk or cook for themselves, as well as the medical and social reasons. For example, we have someone who it is likely finding it difficult to walk due to psychological reasons. Also when we use interventions that are only social and vocational then we have found that the recovery is limited or the intervention doesn't work –	Thank you for your comment. We have amended recommendation 1.7.1 to clarify that this relates to a comprehensive biopsychosocial needs assessment, the results of which will be used in formulation and development of a care plan

				this can result in service users and team feeling stuck, fed up and frustrated which affects dynamics between service and service user. Some recognition needed in consultation that integrated bio, psycho, social model required and considered so can psychologically look at barriers to recovery which may help service users not being labelled as treatment resistant with high levels of medication that further adversely affects their brains and functioning or being referred to nursing/long stay supported homes at relatively young ages.	
Leeds and York Partnership Foundation NHS Trust	Guideline	026	003	Dysphagia may be associated with or influenced by medication: review should include evaluation of swallowing and any history of choking incidents, encouraging the person to self report and share decision making around mealtimes. If any concerns then referral for advice to SLT (also section 1.10) Annual health check should include this aspect – dysphagia and choking are prevalent in this population *(ref Walsh et al 2007, Guthrie et al 2017, Bazemore et al 1991,) also ref Cicala, G., Barbieri, M.A., Spina, E. and de Leon, J., 2019. A comprehensive review of swallowing difficulties and dysphagia associated with antipsychotics in adults. Expert review of clinical pharmacology, 12(3), pp.219-234; Kulkarni, D.P., Kamath, V.D. and Stewart, J.T., 2017. Swallowing disorders in schizophrenia. Dysphagia, 32(4), pp.467-471.*	Thank you for your comment. Assessment of difficulties with swallowing have been added to the initial physical health check (recommendation 1.7.3). Kulkarni 2017 and Cicala 2019 were not included as evidence in the guideline because their focus was the association of swallowing disorders with antipsychotics and schizophrenia and the evidence in this area was not appraised. Walsh 2007 focused on rates of speech and language impairment in acute psychiatric units. This was not included as evidence because it was not a population based study and not limited to complex psychosis or related conditions.
Leeds and York Partnership Foundation NHS Trust	Guideline	031	018	Monitoring for dysphagia and heightened risk of choking should be regularly repeated with staff training for all in mdt to increase awareness of this co-morbidity. The service user should be included in this using appropriate accessible information encouraging participation in reporting early signs of difficulty in swallowing (eg using resources such as ‘‘Me at Mealtimes’’ http://www.bild.org.uk/resources/easy-read-	Thank you for your comment. Difficulties with swallowing have been added to the initial physical health check (recommendation 1.7.3). This should enable any needs to be identified and input sought from Speech and Language Therapists (who have been added to the list of specialties that the MDT should have access to). We therefore do not think specialist training in monitoring for dysphagia awareness is necessary for all staff.

				information/health-easy-read-links/meatmealtimes/ Reporting incidents of suspected near miss choking should have sufficient detail to inform risk mitigation (Guthrie & Stansfield 2017; Guthrie et al 2015) also sections 1.7.1; 1.7.3; 1.7.4; 1.10.5. Detailed history of individual presentation during a choking incident is essential to inform risk mitigation and staff monitoring for early signs of difficulty and deterioration.	Guthrie 2014 & 2015 were not included because the evidence about swallowing and risk of choking was not appraised for the guideline. Additionally these studies looked at learning disabilities and all types of mental health disorder and were not limited to complex psychosis or related conditions.
Leeds and York Partnership Foundation NHS Trust	Guideline	General	General	Throughout the document there should be mention of the need and benefits of Specialist Speech and Language therapist (SLT) input promoting access to shared decision making, understanding recovery pathways, and participation in daily living, therapies, and relationships with caregivers, staff and specialists. Communication skills of patients and staff/carer insight into communication difficulties experienced by this population are key to recovery and inclusion. The prevalence of speech, language and communication difficulties is evidenced *(Walsh, I., Regan, J., Sowman, R., Parsons, B. and McKay, A.P., 2007. A needs analysis for the provision of a speech and language therapy service to adults with mental health disorders. Irish journal of psychological medicine, 24(3), pp.89-93.; Kramer, S., Bryan, K. and Frith, C.D., 2001. Mental illness and communication. International journal of language & communication disorders, 36(S1), pp.132-137.).*	Thank you for your comment. Speech and Language Therapists have been added to the list of specialties that the MDT should have access to. Assessment of communication needs has been added to the comprehensive biopsychosocial needs assessment (recommendation 1.7.2). Identification of any needs as a result of the assessment will enable them to be included in formulation and care planning. We have highlighted the higher prevalence of speech, language and communication difficulties in people with complex psychosis, which may contribute to complexity in rehabilitation (recommendation 1.7.5). We have also added that the recommendations on communication needs from the NICE guideline on people's experience in adult social care services should be followed and that communication needs as set out in the NHS Accessible Information Standard should be met. Walsh 2007 focused on rates of speech and language impairment in acute psychiatric units. This was not included as evidence because it was not a population based study and not limited to complex psychosis or related conditions.

					Kramer 2001 was not included as evidence in questions relating to communication needs because it is a qualitative study of two people with schizophrenia.

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Leeds and York Partnership Foundation NHS Trust	Guideline	General	General	It was surprising that a trauma informed approach linking life experiences to psychosis in this context, and the impact this has on the development of ADL's wasn't considered. The bio-psycho-social approach is crucial. The systemic understanding and delivery of care underpinned by a bio-psycho-social formulation and team based rehabilitation is key, so I would weight this more. Currently the way it is written in terms of psychological intervention is quite technical – although it acknowledges the importance of formulation. In our experience we find that barriers to recovery for going to shops, living independent lives is not just a matter of providing targeted occupational therapy or physical health, or dietitian that works but having a holistic approach that understands why someone doesn't eat a balanced diet and what is the best way of getting them to gym etc. e.g. Could be due to trauma responses that are completely ignored in the consultation document despite the growing strong research. Given the number of service users on our books that had a trauma history and the likelihood with continued stepped model for secondary services – the level of trauma in rehab will continue to rise and we can't omit this from these documents. This would parallel what can often happen in society - minimising or ignoring the impact of abuse. When societal institutions of power, ignore trauma then it is another way of positioning survivors of abuse in the victim role by silencing them and the experiences they have had. Can't do these separately with the complex presentations we see. There would be a lot of our service users that would not fit into this narrow definition of rehab needs. Need a culture that is psychologically informed and understands the trauma that people have experienced and acknowledges and validates that this may led to their current vulnerabilities. Voice dialogue was not mentioned	Thank you for your comment. We have amended recommendation 1.7.1 to clarify that this relates to a comprehensive biopsychosocial needs assessment, the results of which will be used in formulation and development of a care plan. Assessment of psychological and psychosocial history including traumatic experiences is included in recommendation 1.7.2 which specifies what this needs assessment should cover. We have added trauma informed care to the examples of psychological informed approaches that staff may need to be trained in (recommendation 1.9.8). Open dialogue is one approach to engage all those involved in enabling recovery to communicate constructively. However, this intervention is at an early stage in terms of the evidence base for its effectiveness and so it was not identified as a priority at scoping. As such we are not able to make any recommendations about it or make recommendations for additional research in this area. We will pass your comment to the NICE Surveillance team which monitors guidelines to ensure they are up to date as this study may be relevant to include in future updates of the guideline. The guideline has used commonly understood language to make it clear who the guideline is relevant for. The recommendations emphasise the importance of a multidisciplinary approach, undertaking a comprehensive biopsychosocial needs assessment to inform formulation and care planning and the need for a recovery orientated approach to rehabilitation. The first recommendation in the guideline clarifies that the focus of the guideline is on those people with treatment resistant symptoms and functional impairments that affect their activities of daily living and

				(Corstens and Longden). In terms of the recommendations for family work and research I thought it would be helpful to cite the work of Jakko Seikula is the lead for the Finnish research in open dialogue, especially given that there is a randomised control trial that is ongoing in the UK for open dialogue approach in early intervention. I wondered whether this was an area where more research might be helpful within Rehab context. Generally the language is still medical and psychiatric “treatment resistant” positive/negative symptoms. This doesn’t take into account how rehab services have moved on from medical approach to one that is recovery focussed, experts by experience, collaborative and shared decision making and so is out of step with NHS guidance and good practice. It isn’t holistic in its understanding of how service users come to need rehab services in the first place – makes too simplistic the very complex stories our service users have and the variety of paths that have brought them to services and a difficulty in engaging in daily functioning in the community. There is also no definition of complex – there could be a few levels of complexity that is being referred to in an unitary way.	social participation. The 'terms used in this guideline' section includes a definition for how the guideline uses them term 'complex psychosis'

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NHS England/ NHS Improvement	Guideline	010	001	Consider stressing importance of GP communication. CLOZAPINE is high risk and not prescribed by GP but must be flagged up on GP system. (DS)	Thank you for your comment. We have added informing GPs to the recommendation.
NHS England/ NHS Improvement	Guideline	011	013	The section details access to members of the multidisciplinary team and details access to a number of professions including dietitians and podiatrists. Individuals with complex psychosis and severe mental health conditions may require intervention from a range of professionals including speech and language therapists, Prosthetists and orthotists and the art psychotherapies. We would suggest reference to the MDT having access to a range of professionals including those specifically listed. (SC)	Thank you for your comment. We have changed recommendation 1.5.1 to clarify that inpatient and community rehabilitation services should be staffed by multidisciplinary teams comprising a range of professionals with skills and competence in mental health rehabilitation.
NHS England/ NHS Improvement	Guideline	019	003	Aspects of initial/annual health checks are outside of standard GP care. Currently often covered by SMI LCS or equivalent. (DS)	Thank you for your comment. The initial physical health check performed as part of the comprehensive needs assessment would be undertaken by rehabilitation services. The list of tests included in the annual physical health check may be undertaken by GPs. Whilst these tests may not all be currently included in standard GP care, the committee agreed that they align with the NHS long term plan for mental health care.
NHS England/ NHS Improvement	Guideline	024	016	Robust/prompt communication between MH/Rehab/GP teams essential as most prescribing decisions will not be taken by GP although prescribing responsibility (including specific monitoring) will usually sit with the GP	Thank you for your comment. Section 1.10 makes recommendations on physical healthcare, including responsibilities for healthcare providers and co-ordinating physical healthcare. We have also added a cross reference to the NICE guidance on medicines optimisation which makes recommendations on medicines-related communication systems when patients move from one care setting to another.

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NHS England/ NHS Improvement	Guideline	026	004	If pharmacological treatment is outside of marketing authorisation, this should be documented in correspondence if GP is asked to prescribe (DS)	Thank you for your comment. We have added informing the GP to the recommendation.
NHS England/ NHS Improvement	Guideline	028	006	In the absence of CVS symptoms, independent risk factors or QT issues, annual (screening) ECGs are likely to be of limited value and do have work load implications (DS)	Thank you for your comment. Antipsychotic medicines can cause cardiac abnormalities, for example lengthened QT interval on electrocardiography. Although the NICE guidelines on psychosis and schizophrenia in adults and bipolar disorder recommend ECGs only when starting antipsychotic medicines, the committee recommended considering annual ECGs (and more frequently for people with complex antipsychotic regimens or doses above BNF levels). They agreed this consideration was warranted for this population, many of whom have been on medicines long term, or combinations of medicines that may alter cardiac rhythm, or both. There was also evidence that this population have a higher prevalence of cardiovascular disease and members of the committee had specific experience of unexpected cardiac complications identified with ECGs in this group of people. It is already common practice to perform ECGs if exceeding BNF limits for antipsychotics.
NHS England/NHS Improvement	Guideline	004 and 005		Principles – Does the need for rehabilitation need to be linked to accommodation type. If people are content and at best level of functioning for their lifestyle with low healthcare maintenance needs why would they be under the care of a specialist team at all.	Thank you for your comment. Recommendation 1.1.1 is particularly focussed on those people who are likely not to have been offered a rehabilitation service as indicated by the groups in the bullet points. However, we have made amendments to make clear that a rehabilitation service should be offered to a wider group of people than just those in inpatient rehabilitation.

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NHS England/NHS Improvement	Guideline	025		This may be due to lack of RCT evidence but the psychological therapies section lacks mention of team formulation or the benefits for service users, and how psychological theory can underpin rehabilitation approach to relationships, engagement, building trust, doing no harm. Given the high prevalence of trauma experiences for this service user group, the impact of their trauma feels further neglected within these guidelines and the focus of interventions is on symptom management rather than meaning or acceptance, and on conforming to societal norms	Thank you for your comment. We have added to recommendation 1.7.7 that this is a team formulation so it would involve the expertise of the whole team including the psychologist. Trauma is included in the comprehensive biopsychosocial needs assessment (recommendation 1.7.2). Identification of any needs as a result of this assessment will enable them to be included in formulation and care planning. We have added trauma informed care to the examples of psychological informed approaches that staff may need to be trained in (recommendation 1.9.8).
NHS England/NHS Improvement	Guideline	026		There is guidance about prescribing a drug that isn't indicated for that purpose. Is this usual for NICE guidance?	Thank you for your comment. There are several circumstances where NICE guidance does make recommendations for off license use of drugs. In this case it is common clinical practice in the UK to use the drug in this indication. This has been stated in the relevant recommendation.
NHS England/NHS Improvement	Guideline	039		The research recommendations only focus on inpatient wards rather than community provision where the majority of people will have their care provided over their lifetime and where there is significant investment and transformation in line with the Long Term PlanThe research recommendation on inpatient care by the independent sector is only one part of care provided by non-NHS sectors. Should we also investigate the impact and outcomes of care provided by third sector, voluntary and community organisations providing care in the community?	Thank you for your comment. Only 2 of the research recommendations are specific to inpatient rehabilitation, the others are all relevant across the whole pathway (including those services provided by the voluntary sector).

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NHS England/NHS Improvement	Guideline	004		"Treatment-resistance symptoms" is a very medical focused term. The reasons why some people continue to experience 'complex psychosis or related severe mental health conditions' is complicated and they are unique to the individual. Locating the 'problem' in the individual, is stigmatising.	Thank you for your comment. It was not our intention to locate the problem in the individual. We have double checked the language used complies with NICE style by referring to treatment resistant symptoms rather than the person being treatment resistant. The phrase 'people who have treatment-resistant symptoms and functional impairments that affect their activities of daily living and social participation' has been used to clarify which people should be offered a rehabilitation service. We believe that these are the terms that are commonly used and widely understood.
NHS England/NHS Improvement	Guideline	005		There is no mention of people having their own accommodation with their own tenancy.	Thank you for your comment. That would be encompassed within floating outreach.
NHS England/NHS Improvement	Guideline	006, 011	010 – 013, 001	Lines 1.3.4 and 1.5While supportive of joint commissioning arrangements and ability to better commission specialist services line 1.5 provides an unclear definition of "out of area" which will not support effective commissioning. Has this definition been agreed or is it evidence based. Out of area will mean very different things to different localities and geographies.	Thank you for your comment. The definition was agreed by the committee. We have amended the definition of out of area to make it clearer.

NHS England/NHS Improvement	Guideline	General	General	There is a significant lack of RCT evidence for many of the recommendations included in this draft guidelines. NICE needs to carefully consider recommending services and advising commissioners what to put in place without stronger RCT evidence and health economic data. Many of the recommendations are based on expert advice rather than RCT or health economic data.	Thank you for your comment. Whilst it would be ideal to have RCT evidence to support the recommendations in the guideline this was not available for many of the questions. Therefore, the committee have had to make the best use of the evidence that was available. It is rare to have strong evidence when looking at service delivery questions. The guideline aims to promote effective rehabilitation as soon as need is identified across all settings providing services for people with complex psychosis. The committee acknowledged the evidence that was reviewed that identified how people with complex psychosis will have often been unwell over an extended period and would usually have had multiple readmissions to hospital prior to accessing rehabilitation services. It was noted that many NHS mental health trusts have reduced the number of inpatient rehabilitation units. As a result, the committee were of the view that this reduction has driven the increase in the number of placements in the independent sector, outside the person's local area. This creates social dislocation from family and friends and the local community resources required for successful discharge, leading to unnecessarily long admissions which undermine the person's rehabilitation. A costing analysis was developed for this guideline, comparing the costs between a hypothetical reduction in out-of-area placements with the current rate of out-of-area placements. The model also integrates the impact on downstream costs along the rehabilitation pathway based on discharge rates to supported housing. The results suggested that a reduction in out-of-area placements, and higher rate of referral to more independent living would be cost saving.

					The committee were also in agreement that reducing out-out-area placements would improve clinical outcomes for people with complex psychosis as well as their quality of life. might not be as large as implied by this analysis, as the independent sector may be able to make appropriate adjustments to be more geared towards providing a rehabilitation service in accordance with NHS wards. Whilst the economic analysis implies an overall large cost saving, there may be a high resource impact for Local Authorities as the people are discharged at a faster rate to supported accommodation. Whilst the components of funding vary between individuals, Local Authorities commission the provision of community accommodation for people who have been originally detained under Section 3 of the Mental Health Act 1983 (as amended). To some degree, this resource impact may be offset by faster transitions between different levels of supported accommodation such as a reduction in residential care, and an increase in more independent modes of living such as supported housing and floating support. Nevertheless, the overall health benefits of people spending more time in contact with community based services, and less in inpatient facilities would override any additional resource impact.
NHS England/NHS Improvement	Guideline	General	General	In parts the guideline moves away from what evidence supports in terms of treatment and sets out a policy stance for rehabilitation services and service configuration.	Thank you for your comment. It was not the intention of the committee to take a policy stance on rehabilitation services and service configuration. The purpose of the guideline was to examine what an ideal service configuration would look like based on the best available evidence. We have

					amended the recommendations in section 1.3 to be clearer about how this might be done.
NHS England/NHS Improvement	Guideline	General	General	In terms of implementation of any of the draft recommendations having significant cost implications - Current service configuration in many areas does not align to the to the draft guidance. Development and building of local inpatient and high dependency units will have very high capital costs. Establishment of new specialist community rehab teams for only people with psychosis will be expensive and have high staffing needs. Implementation of these guidelines as they stand now would be prohibitively expensive for local commissioners.	Thank you for your comment. CCGs currently invest over £500m/year in inpatient mental health rehabilitation services, with the majority of this spent on out of area placements. Health economic modelling conducted by this guideline, showed that the provision of local rehabilitation was less costly than out of area placements. The guideline therefore recommends investment in local mental health rehabilitation services, which is also in line with CQC recommendations and the NHS Mental Health Implementation Plan 2019/20 – 2023/24, to improve clinical outcomes and reduce the costs of care through reducing lengths of stay in inpatient rehabilitation services. The committee recognise that new inpatient and high dependency units could have a high initial capital cost but in the longer term this largely amounts to a substitution of capital costs incurred out of area to those incurred more locally. Nevertheless, the committee also recognised that it would not be practical for every local area to have inpatient facilities and the recommendations about service configuration were amended so as to frame them in the context of a local rehabilitation pathway needs assessment being the basis for determining the exact service requirements, including whether local inpatient facilities are required, for the local population. The rationale and impact section has been amended to make it clearer that decisions about service configuration should be made in the context of this local rehabilitation pathway needs assessment.

					Community rehabilitation teams are already in place in around half the NHS mental health Trusts in England. The committee are aware that many have been developed without increased staffing costs, but through reconfiguring existing community staff. We have amended our recommendations on rehabilitation in the community to make it clearer what their role is. Based on feedback from stakeholders, we have amended the recommendations to make it clearer that: • each locality should have a defined rehabilitation pathway, which is part of the comprehensive local mental healthcare system • this pathway should have access to a range of service components in different settings, to provide the appropriate rehabilitative treatment and support that people need to facilitate their recovery and allow them to progress from high support settings to more independent settings • a local needs assessment will need to be conducted to determine which service components are required for the local population as this is likely to vary from one area to another. • The rehabilitation services need to be provided as locally as possible but that some service components can be shared across areas The committee thought it likely that different levels of support would be needed to enable people's full recovery, wherever they are living in both community and inpatient settings but that the results of the needs assessment will

					determine exactly which services are needed and where for the local population.

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NHS England/NHS Improvement	Guideline	General	General	There is lack of focus on person centred care, trauma informed care and a strengths-based approach with some of the language and principles dated, with the focus being on the configuration of services rather than what a person will receive.	Thank you for your comment. All the recommendations in the guideline have been developed with a focus on service users, including those recommendations on service delivery. The views of the service user members of the committee were integral to developing the recommendations. The guideline states that the overarching principles of rehabilitation (recommendation 1.2.1) are that rehabilitation services should provide a recovery orientated approach that ensures individualised, person-centred care through collaborative working and shared decision making. There are further recommendations about how to achieve this from section 1.6 onwards. A strengths based approach with personal goal setting is emphasised and we have added trauma informed care to the examples of psychological informed approaches that staff may need to be trained in (recommendation 1.9.8).

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NHS England/NHS Improvement	Guideline	General	General	By specifying what services should be commissioned, how they should operate and naming them it removes focus on what a person should be able to access, regardless of where the team sits or what it is called.	Thank you for your comment. We have reflected on feedback and amended the recommendations to make them more broadly about the services people should have access to rather than being prescriptive about specific service components.
NHS England/NHS Improvement	Guideline	General	General	There is significant difference in what constitutes 'rehabilitation services' in the wider health system, with many current rehabilitation services delivering care to people with a wide range of diagnosis. Is this guideline just related to people with complex psychosis rather than rehabilitation services more generally and what is currently being delivered in practice? Should the guidance be renamed as just care for people with complex psychosis if that is what its focused on?As it is unlikely that another guideline on rehabilitation services for other diagnosis will be developed in the short term, there is possibility that people with those other diagnosis may not receive as good care. If this document is just focussing on those with psychosis, it should at least acknowledge the benefit of rehabilitation for other cohorts of people, or better still talk about individual people with individual needs rather than focussing on diagnosis at all.It's clear from the draft guidance that a multidisciplinary whole system approach is needed, with greater integrated, personalised and biopsychosocial care for people requiring rehabilitation. So focusing on rehabilitation of only psychosis in absence of other of other types of diagnoses that are complex, long term and co-existing with other needs there is a significant risk that this guideline will mean people with those other diagnosis may not receive as good care.	Thank you for your comment. This guideline is about rehabilitation for people with complex psychosis, as indicated in the title. We have inserted a revised definition in the guideline to clarify who the guideline covers. The type of rehabilitation services required by people with other diagnoses is entirely different to that required by people with complex psychosis and other severe mental health disorders and it would therefore not be possible to combine these populations into a single guideline. We have made changes at the start of the guideline to be clear that senior rehabilitation practitioners can also provide advice to services outside the rehabilitation pathway on appropriate treatment and support, including specialist placements and tailored support packages, for people with other primary mental health diagnoses or neurodevelopmental conditions.

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NHS England/NHS Improvement	Guideline	General	General	The draft guidelines uses slightly patronising language that we wouldn't use for any other group for example – "For people who would like to work towards mainstream employment" rather than saying that "People who want paid employment should be offerered…". Other parts of the guideline say there is a recognition that people may not achieve a previous level of functioning, which may be true for some, but some people reach far greater functioning than they have previously. It fails to acknowledge the circumstances of a person's life prior to the onset of illness which is highly likely to be related to the onset – and therefore this feels like a negative and simplistic view of 'level of functioning'. Yes some people need to stay in supported accommodation long term. And many don't, and where the support has been properly provided and resourced, live in their own properties managing tenancies.	Thank you for your comment. We have reviewed the language throughout the guideline with the service user members of the committee to ensure it is not patronising. As the evidence identified that employment is not a recovery goal for everyone the committee felt it was important that the wording of the recommendation reflected the need to ensure that individuals are supported to have choice about this. We agree that recovery is an aspirational goal for service users which is why the guideline recommends that rehabilitation has a recovery orientated approach. However, as the evidence identified that only a small percentage of people with complex psychosis achieve fully independent living over five years; the committee felt it was important to emphasise the need for longer term service planning for those requiring ongoing support. We have also amended the recommendations on rehabilitation in the community to provide more detail about the role of the community mental health rehabilitation team in facilitating this support.

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NHS England/NHS Improvement	Guideline	General	General	This may be due to lack of RCT evidence but there is little focus on the benefit of having third sector, housing and peer support embedded in the rehabilitation pathway and wider system.	Thank you for your comment. The third/voluntary sector and housing services are included as part of the whole system required to deliver rehabilitation services (see recommendations 1.3.4 and 1.3.5). Support workers are already included in the MDT (recommendation 1.5.1) which would include peer support workers. We also recommend peer support for structured group activities to improve interpersonal skills (recommendation 1.8.4) and in programmes to engage people in community activities (recommendation 1.8.7). As documented in the rationale and impact section, although peer-support interventions were widely valued by the committee, there was no directly relevant research to guide the development of peer support for community activities in complex psychosis and rehabilitation services. They therefore recommended further research to determine how peer-support interventions can be used most effectively to support people with complex psychosis using rehabilitation services.

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NHS England/NHS Improvement	Guideline	General	General	Under physical health care – there is recommendation that GP be responsible for physical health. This is very unlikely to happen in practice and may involve repeating of many checks and interventions. If a person is still on clozapine in the community would that not be under care of clozapine clinic or the community rehab team?	Thank you for your comment. In line with the recommendations in the NICE guideline on psychosis and schizophrenia in adults, people's physical health care should, ideally be primarily the responsibility of their GP when they are living in the community. The physical health section includes recommendations to ensure that people are able to access routine physical health monitoring and treatment in line with people who do not have mental health problems (i.e. parity of esteem), but with the recognition that some people may have difficulties doing so. The guideline also includes recommendations (1.10.4 and 1.10.5) to ensure close liaison between primary care and mental health services to provide continuity of care across settings and avoid duplication of effort. Recommendation 1.3.18 specifies that there should be an agreed protocol with the community mental health service, to start or re-start clozapine in the community. This protocol would include informing the GP. People who are prescribed clozapine would be receiving monitoring of their clozapine through the clozapine clinic and are likely to be under a community mental health team or community rehabilitation team. This is separate to their general physical health needs.
Northamptonshire Healthcare NHS Foundation Trust.	Evidence review A	General	General	NHFT have an established Community Rehabilitation Team (CRT) that work not only with people with complex psychosis, but people with a primary diagnosis of emotionally Unstable Personality Disorder (EUPD) Would NICE advocate the pathway/team be dedicated to psychosis only and that the pathway for PD be different?	Thank you for your comment. We have made clear in the guideline that in the group of people with complex psychosis, mental health comorbidities are common and their presence does not exclude rehabilitation.

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Northamptonshire Healthcare NHS Foundation Trust.	Evidence review A	General	General	NHFT has an established process and team approach to a joint funding model. The CCG commission a dedicated team to address placement and funding and review processes and alongside this we have a Community Rehabilitation team and would be happy to submit/share our experience to the NICE shared learning data base.	Thank you for your comment. We will pass this information to our local practice collection team.
Northamptonshire Healthcare NHS Foundation Trust.	Evidence review E	General	General	NHFT have one inpatient rehabilitation ward for males, all other inpatient rehabilitation/high dependency rehabilitation is funded via private providers.	Thank you for your comment and for providing this information.
Northamptonshire Healthcare NHS Foundation Trust.	Evidence review H	021	005	NHFT do not initiate or titrate clozapine in the community, all service users are admitted to our inpatient services. The CRT does not operate outside of the core 9-5 Mon-Fri hours.	Thank you for your comment and providing this information.
Papyrus	Guideline	General	General	Thank you for your email, I am aware that the deadline has now passed but I did pass this on to Senior Management. As our work focuses specifically on suicide prevention and we aren't specialists in rehabilitation in adults with complex psychosis, we aren't able to comment on this guideline, though we do appreciate you inviting us to offer our input. We would love to be kept informed of future consultations that you think we may be able to contribute to.	Thank you for your comment.
Pennine Care NHS Foundation Trust	Guideline	General	General	We think the guidance is very positive, clear and comprehensive. It is recovery focused and clearly articulates the need to work with an individual holistically.It recognises all the professionals who can support the individual with their recovery journey as well as their own	Thank you for your comment and support of the recommendations in this guideline.

				involvement and how important this is. It also clearly outlines responsibilities regarding physical health and the need to meet both mental and physical health needs.	
Royal College of Nursing	General	General	General	The Royal College of Nursing (RCN) welcomes the opportunity to comment on the NICE draft guidelines – Rehabilitation in adults with complex psychosis and related severe mental health condition. The RCN invited members who care for people with this illness to review the document on their behalf. The comments below reflect the views of our reviewer.	Thank you for your comments. We have responded to your feedback below.
Royal College of Nursing	Guideline	025	011 - 028	The draft guidelines are comprehensive and read well. We look forward to the publication of the final guidance and it being implemented.	Thank you for your comment and your support of our recommendations.
Royal College of Nursing	Guideline	General	General	In terms of content, given its comprehensiveness, it is not clear why Family Intervention (FI) is not emphasised, in equal footing as Cognitive Behavioural Therapy (CBT) (Recommendations 1.9.5 to 1.9.7). FI is mentioned but maybe more or less as a presentation issue which can easily be missed.	Thank you for your comment. The guideline included a review question which aimed to identify what principles should guide adjustments to standard treatments in the management of underlying psychosis in people using rehabilitation services. This question investigated the effectiveness of interventions for treatment of refractory psychosis resistant to standard treatment and looked at modifications of CBT and family interventions. No evidence about modifications to family interventions, that met the inclusion criteria of the protocol, was identified. Therefore, the committee did not make any recommendations about modifications to this intervention. Continuing to offer Family Intervention (in line with the NICE guideline on psychosis and schizophrenia in adults) is already included in recommendation 1.9.6.
Royal College of Nursing	Guideline	Question	Question	Question 1: Which areas will have the biggest impact on practice and be challenging to implement? The biggest challenge would be ensuring that multi-disciplinary working	Thank you for your comment and your support of the recommendations.

				across health, social and third-sector organisations are all working in sync. Nonetheless, it is always a crucial factor to ensure the provision of seamless care. It is pleasing to see the guideline emphasising on this and the key personnel involved.	
Royal College of Nursing	Question			Question 3: 3. What would help users overcome any challenges?Service users and their families/carers, health care professionals should be made fully aware of this guideline and be supported to seek the recommended treatment and care.	Thank you for your comment. We will endeavour to ensure that all interested parties are made aware of the guideline when it is published so that service users are supported to seek the recommended treatment and care.
Royal College of Occupational Therapists	Guideline	004 - 005	015 – 016	The core philosophy of occupational therapy is individualised, person-centred, collaborative working with an individual relating to their occupational needs incorporating shared-decision making.	Thank you for your comment and providing this information about the core philosophy of occupational therapy.
Royal College of Occupational Therapists	Guideline	010	001 - 003	It is often problematic for people who need clozapine in the community to be able to access appropriate advice and support. It is very positive that the guidance recommends that the lead commissioner agrees a local protocol.	Thank you for your comment and for your support of our recommendation.
Royal College of Occupational Therapists	Guideline	011	009	Occupational therapists are a vital profession to be included in the multidisciplinary teams as rehabilitation is a core part of the profession, and they are best placed to do this.	Thank you for your comment. Occupational therapists are already listed as part of the MDT.
Royal College of Occupational Therapists	Guideline	011	019 - 020	The provision of smaller accommodation facilities can promote self-management, autonomy and social integration for people living there.	Thank you for your comment and for your support of our recommendation.
Royal College of Occupational Therapists	Guideline	012	002 - 004	In-patient rehabilitation units operating with an expected maximum length of stay can reduce institutionalisation, however, the needs of each individual must be at the centre of any decision regarding length of stay. Occupational therapists play a vital role in assessing a	Thank you for your comment. Investigating which roles would be most effective at delivering the recommendations made in the guideline was not identified as a priority at scoping. As such we are not able recommend any specific role types.

				person's current occupational needs, co-operatively identify rehabilitation goals, and help a person to prepare for the next stage of their recovery when planning discharge from the in-patient unit.	
Royal College of Occupational Therapists	Guideline	012	018 - 021	It is very positive that the guidance recommends a shared team caseload approach, in order for people's care to be discussed at regular team meetings to pool and agree ideas about care and treatment.	Thank you for your comment and for your support of our recommendation.
Royal College of Occupational Therapists	Guideline	012	023 - 028	The assessment of a person's capacity with regard to moving to supported accommodation must be done at the earliest opportunity.	Thank you for your comment and for your support of our recommendation.
Royal College of Occupational Therapists	Guideline	013	004 - 005	The importance of occupational therapists being a core part of rehabilitation for people in supported accommodation is reflected in the guidance where it states that people should have support with activities of daily living while encouraging independence and participation in society. This is a core intervention of occupational therapists.	Thank you for your comment and for your support of our recommendation.
Royal College of Occupational Therapists	Guideline	013	010 - 011	Occupational therapists are skilled in assessing the person, their occupations (activities) and their environment. It is extremely important that the guidance recommends that people have a safe space that they can personalise and view as their own.	Thank you for your comment and for your support of our recommendation.
Royal College of Occupational Therapists	Guideline	013	017 - 018	The guidance highlights the importance of people being placed in accommodation locally and limit the use of out-of-area placements.	Thank you for your comment.

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Royal College of Occupational Therapists	Guideline	013	028 - 031	The specification of timings for placement reviews is crucial to ensure that a person's accommodation still meets their needs.	Thank you for your comment and for your support of our recommendation.
Royal College of Occupational Therapists	Guideline	014	015 - 025	Occupational therapists are vital members of multidisciplinary teams who enable recovery-orientated rehabilitation services. The guidance mentions 'meaningful occupation' of which only occupational therapists are skilled to assess and provide interventions focusing on occupational-centred/enabling approaches.	Thank you for your comment. Occupational therapists are already listed as part of the MDT.
Royal College of Occupational Therapists	Guideline	015	001 - 002	Occupational therapists are skilled at assisting people to gain skills in managing both personal and domestic activities of daily living, and are the only profession trained to do this focusing on a person's occupational needs.	Thank you for your comment. Occupational therapists are already listed as part of the MDT.
Royal College of Occupational Therapists	Guideline	016	004 - 016	It is highly important and very positive that the guidance identifies that rehabilitation staff must be non-judgemental, have collaborative relationships with people who use services, and acknowledge and manage any feelings of pessimism about people's recovery. Support for staff, including supervision, reflective practice, peer support groups and training is vital.	Thank you for your comment and your support of our recommendations.
Royal College of Occupational Therapists	Guideline	016	017 - 018	Occupational therapists are trained and skilled in delivering structured group activities and promoting daily living skills.	Thank you for your comment. Occupational therapists are already listed as part of the MDT.
Royal College of Occupational Therapists	Guideline	017	019 - 023	Occupational therapists assist people with all of the areas mentioned in the guidance including travel training, engagement in social and recreational activities, employment and education.	Thank you for your comment. Occupational therapists are already listed as part of the MDT.

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Royal College of Occupational Therapists	Guideline	018	004 - 030	It is important that people have a comprehensive needs assessment within 4 weeks of entering a rehabilitation service. This would include an assessment of the person's occupations (activities) including their daily living skills.	Thank you for your comment and your support of our recommendations.
Royal College of Occupational Therapists	Guideline	021	010 - 023	It is commendable that the guidance states that rehabilitation services should develop a culture that promotes activities to improve daily living skills as highly as other interventions (for example, medicines). This promotes the importance of occupational therapy assessments and interventions.	Thank you for your comment and your support of our recommendations.
Royal College of Occupational Therapists	Guideline	022	017 - 028	The importance of engagement in meaningful occupations is highlighted in this section which is a core skill of occupational therapists.	Thank you for your comment and your support of our recommendations.
Royal College of Occupational Therapists	Guideline	023	001 - 016	Occupational therapists play a vital role in enabling people to engage in education, volunteering and employment as appropriate.	Thank you for your comment. Occupational therapists are already listed as part of the MDT.
Royal College of Occupational Therapists	Guideline	028	023 - 028	Occupational therapists can play a key role in helping people to manage their own medicines.	Thank you for your comment. Occupational therapists are already listed as part of the MDT.
Royal College of Occupational Therapists	Guideline	004	004 - 007	It is extremely important for people with severe mental health conditions to be offered rehabilitation as soon as possible after functional impairments have been identified which affect their activities of daily living and social participation. Occupational therapists are the only health and social care professionals trained to do these assessments and interventions and have the relevant skills and experience required.	Thank you for your comment. We have amended recommendation 1.1.1 to clarify that a rehabilitation service should be offered as soon as treatment resistance and functional impairment are identified. Investigating which roles would be most effective at delivering the recommendations made in the guideline was not identified as a priority at scoping. As such we are not able recommend any specific role types.

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Royal College of Occupational Therapists	Guideline	006	026 - 029	It is vital that the lead commissioner has an in-depth knowledge and experience of commissioning services for people with psychosis and other severe mental health conditions.	Thank you for your comment and for your support of our recommendation.
Royal College of Occupational Therapists	Guideline	007	021 - 023	People must experience smooth transitions between different services in the integrated pathway and with other parts of the mental health system and health/social care service.	Thank you for your comment and for your support of our recommendation.
Royal College of Occupational Therapists	Guideline	007	024 - 027	It is important that people be enabled to join and leave the rehabilitation pathway at different points, and move between parts of the pathway that provide higher or lower levels of support according to their changing needs.	Thank you for your comment and for your support of our recommendation.
Royal College of Occupational Therapists	Guideline	008	003 - 014	The transitions requirements/expectations are helpful as they will assist everyone involved during the transition (with the person using services at the centre of every decision). The proposed local rehabilitation panel would be very important as professionals can discuss cases and receive advice.	Thank you for your comment and for your support of our recommendation.
Royal College of Occupational Therapists	Guideline	008	015 - 017	It is extremely important for people to be able to visit potential supported accommodation before moving in to help them make an informed choice about the service. Occupational therapists are often involved in the assessment of the suitability of accommodation for an individual which meets their needs and offers the opportunity for rehabilitation.	Thank you for your comment and for your support of our recommendation.
Royal College of Occupational Therapists	Guideline	009	005 - 007	People with severe mental health problems need to have improved access to physical health screening programmes, health promotion, monitoring and interventions.	Thank you for your comment and for your support of our recommendation.

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Royal College of Psychiatrists	Guideline	026	003	Recommendation 1.9.8 For people with complex psychosis and related severe mental health conditions whose symptoms have not responded adequately to clozapine alone, consider options such as augmenting clozapine with: an antipsychotic, for example aripiprazole and/ora mood stabiliser and/oran antidepressant Comment: The evidence base supporting pharmacological clozapine-augmentation strategies is inconsistent and weak. There is no mention that the choice of type of medication used to augment clozapine treatment will rather depend on the clinical indication (i.e. target symptoms and/or behaviour). Further, there is no justification provided for selecting aripiprazole as an example of an antipsychotic medication to be used to augment clozapine treatment.This recommendation further notes that the clinician should, 'Seek specialist advice if needed, for example from a specialist mental health pharmacist.' Comment: Psychiatrists who provide care for patients with complex psychosis should have the necessary expertise to provide that care, a core element of which is prescribing practice. That said, there is a key role to be played by a specialist mental health pharmacist as a member of a mental health team.	Thank you for your comment. We have amended recommendation 1.9.9 to clarify that what is used to augment clozapine treatment depends on the clinical indication. As documented in the rationale and impact section, the committee specifically mentioned aripiprazole as an example while recommending augmentation with antipsychotics. This was because amisulpride is more commonly prescribed than aripiprazole, but the evidence did not show a change in psychosis symptoms following amisulpride, while there was some evidence regarding the effectiveness of aripiprazole in reducing total psychosis symptoms. Specialist mental health pharmacists have now been included in the MDT.
Royal College of Psychiatrists	Guideline	026	012	Recommendation 1.9.9 If combination treatment is used, consider 2 antipsychotics with different receptor-binding profiles.Comment: There is no evidence that any particular combination of antipsychotic medications is superior to monotherapy. For example, amisulpride and olanzapine or aripiprazole and risperidone have very different receptor binding profiles, but there is no evidence to support superior efficacy with such combinations. This recommendation is more relevant to the augmentation of clozapine with a second antipsychotic but even then, the	Thank you for your comment. We have deleted the recommendation about antipsychotic polypharmacy.

				evidence for even a modest benefit is limited. Further, with combined antipsychotic medications there is the risk of, often inadvertent, high-dose prescribing, which has a greater side-effect burden and warrants additional physical health monitoring.	
Royal College of Psychiatrists	Guideline	026	014	Recommendation 1.9.10 Optimise the dosage (as tolerated) of medicines used in the management of complex psychosis (see recommendations 1.9.1 and 1.9.8) according to the BNF and therapeutic plasma levels in the first instance.Comment: Checking plasma clozapine levels is a reasonable approach if the illness has shown insufficient response, as there is an identified plasma clozapine level required to ensure an adequate trial. But otherwise, the value of plasma level information for other antipsychotic medications to inform clinical management is questionable.	Thank you for your comment. We have made a change to justify monitoring for other drugs as well as clozapine.
Royal College of Psychiatrists	Guideline	027	001	Recommendation 1.9.11 Only use multiple medicines, or doses above BNF or summary of product characteristics limits, to treat complex psychosis: • if this is agreed and documented at a meeting with a multidisciplinary team and the person (and their family, carer or advocate, as appropriate) • as a limited therapeutic trial, returning to conventional dosages or monotherapy after 3 months, unless the clinical benefits of higher doses or combined therapy clearly outweigh the risks • if the medicines are being used to treat specific symptoms (for example, positive and negative symptoms) Comment: With regard to the last bullet point, it could be argued that for a treatment-refractory, complex psychotic illness, the 'specific symptoms' that might warrant a trial of 'multiple medicines' or high dosage would need to be clear and persistent target symptoms that have been identified as disabling, intolerable or distressing. To refer to positive or negative	Thank you for your comment. We have changed the 3rd bullet point to clarify that you should only consider multiple medicines if the medicines are being used to treat specific symptoms that are disabling/distressing.

				symptoms seems rather too vague. In those patients with complex and/or treatment refractory psychosis, symptom remission is often an unrealistic goal; the treatment target may be, for example, improvement that allows engagement with psychological interventions and/or a rehabilitation programme.	
Royal College of Psychiatrists	Guideline	027	025	Recommendation 1.9.14 Monitor drug levels to check adherence and guide dosing: • at least annually and as needed for clozapine and mood stabilising anti-epileptic medicinesComment: There is very little evidence for benefit with mood stabilisers such as valproate in 'complex psychosis and related severe mental health conditions' and little value in conducting routine plasma levels as there do not seem to be any clinically useful dose-response or dose-toxicity relationships for valproate, at least in patients with epilepsy (Scottish Intercollegiate Guidelines Network. Diagnosis and management of epilepsy in adults. Edinburgh: SIGN; 2013).	Thank you for your comment. We have amended the recommendation to clarify that augmentation with a mood stabiliser would be for psychosis with significant affective symptoms. We have made a change to justify monitoring for other drugs as well as clozapine.
Royal College of Psychiatrists	Guideline	028	001	Recommendation 1.9.15 Consider monitoring prolactin levels annually if the person is taking a medicine that raises prolactin, and more regularly if they have symptoms.Comment: Elevation of plasma prolactin is a known effect of many antipsychotic medications, so the value of routine monitoring is uncertain, certainly in males. If a woman with a complex psychosis is planning a pregnancy, and taking an antipsychotic medication with the potential to elevate plasma prolactin, then the serum prolactin level should be checked, 'More regular monitoring' is recommended for patients 'if they have symptoms', but if this refers to signs and symptoms of	Thank you for your comment. People with complex psychosis do not always report side effects. For example men with high prolactin levels may be experiencing side effects (e.g. lactation) and not report it. Therefore the committee recommended monitoring of prolactin levels should be considered.

				hyperprolactinaemia, it would be helpful to be more specific about their nature	
Royal College of Psychiatrists	Guideline	General	General	We are concerned that the specific needs and vulnerabilities of young adults and those who have just turned 18 have not been addressed at all. In clinical practice there are young adults or 18 year olds with complex psychosis who will benefit from rehab but might need a provision, which is developmentally sensitive and young person friendly. What was the reason the committee decided not to discuss this group?	Thank you for your comment. The guideline scope included adults aged 18 and over. Therefore, the guideline is not able to make recommendations for individuals who are younger than 18. However we agree that those who have just turned 18 should be included in the local rehabilitation pathway needs assessment to ensure that all those likely to benefit from mental health rehabilitation services are included in service planning and have added this to recommendation 1.3.3. There is also existing NICE guidance on Transition between inpatient mental health settings and community or care home settings (NG53).
Royal College of Psychiatrists	Guideline	General	General	Proposed Research Recommendation: Are young adults with complex psychosis a distinct group with specific needs? What is the effectiveness and cost-effectiveness of a bespoke developmentally sensitive rehabilitation program for this group?	Thank you for your comment. The guideline did not investigate a question on the specific needs of young adults. Therefore the evidence in this area has not been appraised and we are not able to make recommendations on this issue.
Royal College of Speech and Language Therapists	Equality Impact Assessment			In the Equality Impact Assessment the RCSLT were very surprised that communication difficulties were not considered as a matter of priority. There is growing evidence that there is a clear link between communication needs and mental health: Many adults with mental health needs have unidentified speech, language and communication difficulties(Walsh, I., Regan, J., Sowman, R., Parsons, B. and McKay, A.P., 2007).Specific mental health problems have communication and eating, drinking and swallowing difficulties commonly associated with them, for example, schizophrenia, psychosis, dementia and depression (Bryan K. Psychiatric disorders and	Thank you for your comment. We have added communication difficulties to the Equality impact assessment. Walsh 2007 focused on rates of speech and language impairment in acute psychiatric units. This was not included as evidence because it was not a population based study and not limited to complex psychosis or related conditions.

				Communication. 2014. Louise Cummings (ed) Handbook of Communication Disorders. (pp. 300-318) Cambridge: Cambridge University Press)Language and communication breakdown is central to mental illness, both in terms of diagnosis and pathology(Walsh I. Language and Communication in Schizophrenia. 2004. Jenny France (ed) Communication and Mental Illness. (pp 351-pp 400) Jessica Kingsley Publishers). Communication difficulties can compound an individual's negative experience of mental illness and reduce benefit from treatment programmes(France, J. Disorders of communication and mental illness. In: France J, Kramer S (eds). Communication and mental illness. London: Jessica Kingsley, 2001: 15-25). Based on this evidence the RCSLT recommends that communication difficulties are added to the Equality Impact Assessment.	Bryan 2014, France 2001 and Walsh 2004 were not included as evidence because they are book chapters rather than a primary research studies.
Royal College of Speech and Language Therapists	Guideline	014 – 015	018 – 025 001 - 019	Recommendation 1.6.2 to 1.6.4.There needs to be further alignment between this guideline on "Rehabilitation for adults with complex psychosis and related severe mental health conditions" and the Guideline on "People's experience in adult social care services". The latter is clear that speech and communication needs must be accommodated, whilst this guideline fails to recognise the presence of such vulnerability or need. Failure to identify such needs has significant patient risks and wider service ramifications.We recommend that this omission is re-evaluated.	Thank you for your comment. We have added that the recommendations on communication needs from the NICE guideline on people's experience in adult social care services should be followed and that communication needs as set out in the NHS Accessible Information Standard should be met.

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Royal College of Speech and Language Therapists	Guideline	010	004 - onwards	Section 1.4Further guidance needs to be provided to support access to rehabilitation. This guidance should include information on how communication needs are supported to enable access to services and the reasonable adjustments that they may be required. Many rehabilitation and therapies make substantial language and communication demands. These interventions need to be adapted to individual needs. Access to interventions would be poor if communication needs were unrecognised and unsupported.The Mental Health Act 1983 states that information is provided in an accessible format and in a format and or language that the individual can understand. The Mental Health Act Code of Practice is also clear that people with communication difficulties need to be identified to enable the needs of each person to be supported in the most appropriate way. Based on this legislation and guidance we recommend that further information is added to the Guideline to support people with communication difficulties.	Thank you for your comment. Assessment of communication needs has been added to the comprehensive biopsychosocial needs assessment (recommendation 1.7.2). Identification of any needs as a result of the assessment will enable them to be included in formulation and care planning. We have highlighted the higher prevalence of speech, language and communication difficulties in people with complex psychosis, which may contribute to complexity in rehabilitation (recommendation 1.7.5). We have also added that the recommendations on communication needs from the NICE guideline on people's experience in adult social care services should be followed and that communication needs as set out in the NHS Accessible Information Standard should be met.

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Royal College of Speech and Language Therapists	Guideline	011	003 - onwards	Recommendation 1.5.1There is no mention of speech and language therapists. Speech and language therapists are core members of the MDT and delivery integrated rehabilitation for the benefit of people with mental health needs.Without speech and language therapy input, those with communication needs will find it extremely difficult to be involved in co-production, to explain their needs or have their needs met. People with communication needs or eating, drinking and swallowing difficulties need access to speech and language therapy: Dysphagia is “a common and significant cause of morbidity and mortality in adults with mental illness” (Aldridge, K. J. & Taylor, N. F. (2012). Dysphagia is a Common and Serious Problem for Adults with Mental Illness: A Systematic Review. Dysphagia, 27, 124-137. 80% of people with mental health problems have impairment in language.Walsh I, Regan J, Sowman R, Parsons B, McKay AP (2007) A needs analysis for the provision of a speech and language therapy service to adults with mental health disorders. Ir J Psyche Med. 2007 Sep;24(3):89-93.30% of people with mental health problems have swallowing difficultiesWalsh I, Regan J, Sowman R, Parsons B, McKay AP (2007) A needs analysis for the provision of a speech and language therapy service to adults with mental health disorders. Ir J Psychol Med. 2007 Sep;24(3):89-93.The risk of choking is 30 time more likely if you have schizophrenia (D. RUSCHENA, P. E. MULLEN, S. PALMER, P. BURGESS, S. M. CORDNER, O. H. DRUMMER, C.WALLACE and J. BARRY-WALSH (2003) Choking deaths: the role of antipsychotic Medication, BRITISH JOURNAL OF P SYCHIATRY (2003). An individual’s communicative competence is a key element in the assessment of mental health status and in determining their response to treatment interventions (Walsh I. Language and	Thank you for your comment. Speech and Language Therapists have been added to the list of specialties that the MDT should have access to. Assessment of communication needs has been added to the comprehensive biopsychosocial needs assessment (recommendation 1.7.2) and difficulties with swallowing have been added to the initial physical health check (recommendation 1.7.3). Identification of any needs as a result of the assessment will enable them to be included in formulation and care planning. We have highlighted the higher prevalence of speech, language and communication difficulties in people with complex psychosis, which may contribute to complexity in rehabilitation (recommendation 1.7.5). We have also added that the recommendations on communication needs from the NICE guideline on people's experience in adult social care services should be followed and that communication needs as set out in the NHS Accessible Information Standard should be met. Walsh 2007 focused on rates of speech and language impairment in acute psychiatric units. This was not included as evidence because it was not a population based study and not limited to complex psychosis or related conditions. Kramer 2001 was not included as evidence in questions relating to communication needs because it is a qualitative study of two people with schizophrenia. Bryan 2014 was not included because it is a book chapter rather than a primary research study.

				communication in schizophrenia: a communication processing model. In: France J, Kramer S, Communication and mental illness. London: Jessica Kingsley, 2001: 351-70.) This suggests a key role for speech and language therapy. People with speech, language and communication difficulties and mental health problems are unable to engage in rehabilitation and psychological programmes, which are delivered verbally and reliant on people's language skills. (Bryan K. Psychiatric disorders and Communication. 2014. Louise Cummings (ed) Handbook of Communication Disorders. (pp. 300-318) Cambridge: Cambridge University Press). However speech and language therapists can adapt these verbally mediated programmes, such as using a lower level of language, to make them accessible. This supports people to engage in verbally mediated interventions, such as talking therapies, and support engagement and better recovery (RCSLT Factsheet on Mental health https://www.rcslt.org/policy/uk-wide/fact-sheets-on-speech-and-language-therapy)	Aldridge 2012 was not included as it looked at all types of mental health disorder and was not limited to complex psychosis or related conditions. Ruschena 2003 was not included as evidence in the guideline because it looked at the association between death from choking and antipsychotic medication and the evidence in this area was not appraised.
Royal College of Speech and Language Therapists	Guideline	011	013	Recommendation 1.5.2The MDT should have access to speech and language therapy. There should be clear referral routes so all people with speech, language and communication needs or swallowing difficulties can have these needs met in a timely fashion. Failure to meet these needs results in: Eating, drinking and swallowing difficulties have potentially life-threatening consequences. They can result in choking, pneumonia, chest infections, dehydration, malnutrition and weight loss. They can also make taking medication more difficult. Swallowing difficulties can result in avoidable hospital admission and in some cases death.(RCSLT Factsheet on Dysphagia	Thank you for your comment. Speech and Language Therapists have been added to the list of specialties that the MDT should have access to. Assessment of communication needs has been added to the comprehensive biopsychosocial needs assessment (recommendation 1.7.2) and difficulties with swallowing have been added to the initial physical health check (recommendation 1.7.3). Identification of any needs as a result of the assessment will enable them to be included in formulation and care planning.

				https://www.rcslt.org/-/media/Project/RCSLT/rcslt-dysphagia-factsheet.pdf?la=en&hash=18AEDA640CDABD6D2CAB1A9293E8F44ED4E9572A)Communication is vital to life. Such difficulties results in incorrect assumptions of capacity, people being deprived of their liberty and decisions being made for them (RCSLT Factsheet on Living with aphasia https://www.rcslt.org/policy/uk-wide/fact-sheets-on-speech-and-language-therapy)(RCSLT Factsheet on Capacity https://www.rcslt.org/-/media/Project/RCSLT/mental-capacity.pdf?la=en&hash=137EF9EA60588EADA79D37D6FF1A0ABC5648CD5D)	
Royal College of Speech and Language Therapists	Guideline	014	014 - onwards	Section 1.6It is essential that access to speech and language therapy is highlighted in supporting people's recovery and rehabilitation. Identifying and supporting speech, language and communication needs is essential to enabling active participation in rehabilitation services. Research has found that many adults with mental health needs have speech, language and communication needs (Walsh I, et al, Bryan K, et al). Our members tell us that services without speech and language therapy are rarely adapted for people with communication needs and that people are expected to "fit" into services that are not designed for them in mind.There must be an acknowledgement that people with severe mental health conditions are likely to experience difficulties with communicating effectively, expressing their ideas and thoughts, being able to reflect on and discuss aspects of their behaviour and presentation as well as the skills to establish and maintain relationships. Speech and language therapists can help support individuals in these areas. Speech and language therapists assist people to	Thank you for your comment. Speech and Language Therapists have been added to the list of specialties that the MDT should have access to. Assessment of communication needs has been added to the comprehensive biopsychosocial needs assessment (recommendation 1.7.2). Identification of any needs as a result of the assessment will enable them to be included in formulation and care planning. We have highlighted the higher prevalence of speech, language and communication difficulties in people with complex psychosis, which may contribute to complexity in rehabilitation (recommendation 1.7.5). We have also added that the recommendations on communication needs from the NICE guideline on people's experience in adult social care services should be followed and that communication needs as set out in the NHS Accessible Information Standard should be met.

				make informed decisions when balancing the risks and benefits of treatment options. Speech and language therapists ensure that all interventions are tailored to the specific communication needs of the individual person and guide others on how best to communicate with the individual, including understanding any reasonable adjustments that may be required. This ensures that the person can contribute to treatment decisions.	Walsh 2007 focused on rates of speech and language impairment in acute psychiatric units. This was not included as evidence because it was not a population based study and not limited to complex psychosis or related conditions.
Royal College of Speech and Language Therapists	Guideline	014	014 - onwards	Section 1.6It cannot be assumed that staff working in rehabilitation services are able to support and maintain appropriate and effective communication. Failure to appropriately support communication means: People are at risk of being unable to communicate and converse People are not involved in care planning and decision making. Assumptions are made around capacity and consent We recommend that support speech and language therapy is critical to drive forward good quality rehabilitation.	Thank you for your comment. We have highlighted the higher prevalence of speech, language and communication difficulties in people with complex psychosis, which may contribute to complexity in rehabilitation (recommendation 1.7.5). We have added that the recommendations on communication needs from the NICE guideline on people's experience in adult social care services should be followed and that communication needs as set out in the NHS Accessible Information Standard should be met.
Royal College of Speech and Language Therapists	Guideline	014	014 - onwards	Section 1.6Evidence suggests that recovery requires social inclusion and social inclusion helps to promote recovery. This is a key component of psychiatric practice. Mental health services should promote social inclusion and be delivered jointly by health and social care services. (Evidence from the Royal College of Psychiatrists).However people with speech, language and communication needs may face barriers to social inclusion which could affect their recovery. We recommend that consideration and support of communication needs is considered as part of rehabilitation and longer term support.	Thank you for your comment. We have highlighted the higher prevalence of speech, language and communication difficulties in people with complex psychosis, which may contribute to complexity in rehabilitation (recommendation 1.7.5). We have added that the recommendations on communication needs from the NICE guideline on people's experience in adult social care services should be followed and that communication needs as set out in the NHS Accessible Information Standard should be met.

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Royal College of Speech and Language Therapists	Guideline	015	009 - 012	Recommendation 1.6.2Supporting understanding and communication is central to sections of this guideline including section 1.6.2 line 9-12 which discusses improves people's understanding of their experience. However, no accommodations to spoken communication have been taken into account. The evidence shows that people with communication difficulties struggle to access group interactions, especially as this places demands on spoken language ((Bryan K. Psychiatric disorders and Communication. 2014. Louise Cummings (ed) Handbook of Communication Disorders. (pp. 300-318) Cambridge: Cambridge University Press). Support must be offered to allow all people to fully take part. We recommend that involvement from speech and language therapy will be essential to ensure that people truly understand their experience and have the opportunity to express their thoughts and wishes.	Thank you for your comment. Speech and Language Therapists have been added to the list of specialties that the MDT should have access to. Assessment of communication needs has been added to the comprehensive biopsychosocial needs assessment (recommendation 1.7.2). Identification of any needs as a result of the assessment will enable them to be included in formulation and care planning. We have highlighted the higher prevalence of speech, language and communication difficulties in people with complex psychosis, which may contribute to complexity in rehabilitation (recommendation 1.7.5). We have also added that the recommendations on communication needs from the NICE guideline on people's experience in adult social care services should be followed and that communication needs as set out in the NHS Accessible Information Standard should be met. Bryan 2014 was not included as evidence because it is a book chapter rather than a primary research study.
Royal College of Speech and Language Therapists	Guideline	015	014 - 028	Recommendation 1.6.3 to 1.6.5Speech and language therapy is central to high quality and accurate decision making. The evidence shows:Where speech and language therapists support capacity assessments, more people demonstrate the capacity to make decisions for themselves (Marler H, and Palmer H, "All practicable steps"? Exploring the need for communication support during Mental Capacity Assessment", 2019)We recommend that support from speech and language therapy is central to all decisions of mental capacity and this suggests a key role within mental health teams for SLTs to drive this work forward.	Thank you for your comment. Speech and Language Therapists have been added to the list of specialties that the MDT should have access to. Assessment of communication needs has been added to the comprehensive biopsychosocial needs assessment (recommendation 1.7.2). Identification of any needs as a result of the assessment will enable them to be included in formulation and care planning. Marler 2019 was not included as evidence because it is a poster presentation and not focused on complex psychosis or rehabilitation.

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Royal College of Speech and Language Therapists	Guideline	016	001 - 025	Recommendations 1.6.6 to 1.6.12The RCSLT recommend that universal staff competencies must include training, support and workforce development in :Communication training to support communication skills and communication strengths Accessible language Reasonable adjustments Dysphagia awareness training - so staff can recognise signs and symptoms of dysphagia and now how to and where to refer on	Thank you for your comment. Assessment of communication needs has been added to the comprehensive biopsychosocial needs assessment (recommendation 1.7.2) and difficulties with swallowing have been added to the initial physical health check (recommendation 1.7.3). This should enable any needs to be identified and input sought from Speech and Language Therapists (who have been added to the list of specialties that the MDT should have access to). We have highlighted the higher prevalence of speech, language and communication difficulties in people with complex psychosis, which may contribute to complexity in rehabilitation (recommendation 1.7.5). We therefore do not think specialist training in communication and dysphagia awareness is necessary for all staff. We have also added that the recommendations on communication needs from the NICE guideline on people's experience in adult social care services should be followed and that communication needs as set out in the NHS Accessible Information Standard should be met.
Royal College of Speech and Language Therapists	Guideline	018	001	Section 1.7True person centred care planning is reliant on the full participation of the individual. This process would be flawed if the person had unidentified and unmet communication needs. We recommend that all mental health teams have access to speech and language therapists to identify and support people's needs, so everyone is able to express their wishes and views and participate in person centred care planning.	Thank you for your comment. Speech and Language Therapists have been added to the list of specialties that the MDT should have access to. Assessment of communication needs has been added to the comprehensive biopsychosocial needs assessment (recommendation 1.7.2). We have highlighted the higher prevalence of speech, language and communication difficulties in people with complex psychosis, which may contribute to complexity in rehabilitation (recommendation 1.7.5). We have also added that the recommendations on communication needs

					from the NICE guideline on people's experience in adult social care services should be followed and that communication needs as set out in the NHS Accessible Information Standard should be met.
Royal College of Speech and Language Therapists	Guideline	018	006	Recommendation 1.7.2.The comprehensive needs assessment must include speech, language and communication needs. This is based on the evidence of the high levels of unmet speech, language and communication needs experienced by people with mental health needsEvidence (Bryan K. Psychiatric disorders and Communication. 2014. Louise Cummings (ed) Handbook of Communication Disorders. (pp. 300-318) Cambridge: Cambridge University Press). (Walsh I. Language and communication in schizophrenia: a communication processing model. In: France J, Kramer S, Communication and mental illness. London: Jessica Kingsley, 2001: 351-70.)Furthermore, research has suggested a link between medication and an effect on speech (Sinha, P., Vandana, V. P., Vincent Lewis, N., Jayaram, M. & Enderby, P. (2015). Evaluating the effect of risperidone on speech: A cross-sectional study. Asian Journal of Psychiatry, 15, 51-55.)Identifying communication needs will allow reasonable adjustments to be put in place to enable better access to services and support people's recovery.	Thank you for your comment. Assessment of communication needs has been added to the comprehensive biopsychosocial needs assessment (recommendation 1.7.2), which would encompass speech and language. Identification of any needs as a result of the assessment will enable them to be included in formulation and care planning. We have highlighted the higher prevalence of speech, language and communication difficulties in people with complex psychosis, which may contribute to complexity in rehabilitation (recommendation 1.7.5). We have also added that the recommendations on communication needs from the NICE guideline on people's experience in adult social care services should be followed and that communication needs as set out in the NHS Accessible Information Standard should be met. Bryan 2014 and Walsh 2001 were not included as evidence because they are book chapters rather than research studies.

					Sinha 2015 was not included as it as a non-randomised study evaluating side effects of risperidone and the evidence for this area was not appraised.
Royal College of Speech and Language Therapists	Guideline	019	003	Recommendation 1.7.3.The initial physical health check should include eating, drinking and swallowing difficulties. This is based on the evidence of the high levels of eating, drinking and swallowing needs experienced by people with mental health needs. There is a high prevalence of swallowing problems with people taking anti-psychotic medicationPeople in mental health settings are at risk of choking due to unidentified swallowing needs, so there is a real patient risk to identify these difficulties as early as possible. Evidence: (Miarons Font, M. & Rofes Salsench, L. (2017). Antipsychotic medication and oropharyngeal dysphagia: systematic review. European Journal of Gastroenterology & Hepatology, 29 (12), 1332-1339.) (Guthrie, S., Lecko, C. and Roddam, H., 2015. Care staff perceptions of choking incidents: What details are reported?. Journal of applied research in intellectual disabilities, 28(2), pp.121-132.; (Walsh et al 2007)(Cicala, G., Barbieri, M.A., Spina, E. and de Leon, J., 2019: A comprehensive review of swallowing difficulties and dysphagia associated with antipsychotics in adults. Expert review of clinical pharmacology, 12(3), pp.219-234)(Kulkarni, D.P., Kamath, V.D. and Stewart, J.T., 2017.	Thank you for your comment. Assessment of difficulties with swallowing have been added to the initial physical health check (recommendation 1.7.3). Identification of any needs as a result of the assessment will enable them to be included in formulation and care planning. Mairons 2017, Kulkarni 2017 and Cicala 2019 were not included as evidence in the guideline because their focus was the association of swallowing disorders with antipsychotics and schizophrenia and the evidence in this area was not appraised. Guthrie 2014 was not included as evidence because it looked at learning disabilities and all types of mental health disorder and was not limited to complex psychosis or related conditions. Walsh 2007 focused on rates of speech and language impairment in acute psychiatric units. This was not included as evidence because it was not a population based study and not limited to complex psychosis or related conditions.

				Swallowing disorders in schizophrenia. Dysphagia, 32(4), pp.467-471)(Walsh, I., Regan, J., Sowman, R., Parsons, B. and McKay, A.P., 2007. A needs analysis for the provision of a speech and language therapy service to adults with mental health disorders. Irish journal of psychological medicine, 24(3), pp.89-93)	
Royal College of Speech and Language Therapists	Guideline	022	002	Recommendation 1.8.4.We would expect to see a stronger link with supporting understanding and communication running through the section on “Social skills”. Good communication skills are required to maintain and develop social networks, and these would be impaired with enduring mental health presentation.Furthermore, there is an emphasis on group activities, which the evidence shows are difficult for people with communication problems to access due to the language demands.	Thank you for your comment. The evidence showed that group activities were most likely to assist this patient group in improving interpersonal and social skills. We are aware that this group of people may have communication problems, which is why we have recommended that all staff are trained and skilled in supporting structured group activities and promoting daily living skills (see recommendation 1.6.12). We have also added that the recommendations on communication needs from the NICE guideline on people's experience in adult social care services should be followed and that communication needs as set out in the NHS Accessible Information Standard should be met.
Royal College of Speech and Language Therapists	Guideline	024	013	Section 1.9The evidence shows clear links between swallowing problems in mental health populations. It is essential that staff know how to recognise signs and symptoms of dysphagia and where to refer people onto receive speech and language therapy. Antipsychotic medications can be associated with swallowing difficultiesChoking is very prevalent in this population (Walsh, I., Regan, J., Sowman, R., Parsons, B. and McKay, A.P., 2007. A needs analysis for the provision of a	Thank you for your comment. Assessment of difficulties with swallowing have been added to the initial physical health check (recommendation 1.7.3). Identification of any needs as a result of the assessment will enable them to be included in formulation and care planning. Kulkarni 2017 and Cicala 2019 were not included as evidence in the guideline because their focus was the association of swallowing disorders with antipsychotics and

				speech and language therapy service to adults with mental health disorders. Irish journal of psychological medicine, 24(3), pp.89-93)(Guthrie, S., Lecko, C. and Roddam, H., 2015. Care staff perceptions of choking incidents: What details are reported?. Journal of applied research in intellectual disabilities, 28(2), pp.121-132.; also ref above Walsh et al 2007) (Cicala, G., Barbieri, M.A., Spina, E. and de Leon, J., 2019: A comprehensive review of swallowing difficulties and dysphagia associated with antipsychotics in adults. Expert review of clinical pharmacology, 12(3), pp.219-234)(Kulkarni, D.P., Kamath, V.D. and Stewart, J.T., 2017. Swallowing disorders in schizophrenia. Dysphagia, 32(4), pp.467-471)	schizophrenia and the evidence in this area was not appraised. Guthrie 2014 was not included as evidence because it looked at learning disabilities and all types of mental health disorder and was not limited to complex psychosis or related conditions. Walsh 2007 focused on rates of speech and language impairment in acute psychiatric units. This was not included as evidence because it was not a population based study and not limited to complex psychosis or related conditions.
Royal College of Speech and Language Therapists	Guideline	030	028	Recommendation 1.10.9We recommend that this guideline cross references to the NHSE Accessible Information Standard. The guideline mentions providing clear and accessible information and this standard highlights the expectations in relation to being 'clear and accessible'.	Thank you for your comment. We have added a cross reference to the standard in recommendation 1.6.4.
Royal College of Speech and Language Therapists	Guideline	031	019	Recommendation 1.10.13We recommend that the physical health check should include monitoring for swallowing problems. Monitoring for dysphagia and heightened risk of choking should be regularly repeated with staff training for all in the MDT to increase awareness of this co-morbidity. Reporting incidents of suspected near miss choking should have sufficient detail to inform risk mitigation:(Guthrie, S., Lecko, C. and Roddam, H., 2015. Care staff perceptions of choking incidents: What details are reported?. Journal of applied research in intellectual disabilities, 28(2), pp.121-132)(Guthrie & Stansfield 2017)Detailed history of individual presentation during a choking incident is essential to inform risk mitigation and staff monitoring for early signs of difficulty and deterioration. The person should be included in this using appropriate accessible	Thank you for your comment. Difficulties with swallowing have been added to the initial physical health check (recommendation 1.7.3). This should enable any needs to be identified and input sought from Speech and Language Therapists (who have been added to the list of specialties that the MDT should have access to). We therefore do not think specialist training in monitoring for dysphagia awareness is necessary for all staff. Reporting incidents is a general issue which would apply to all mental health services and is not specific to rehabilitation for complex psychosis, so we have not made a recommendation in this area.

				information encouraging participation in reporting early signs of difficulty in swallowing.	Guthrie 2015 and Guthrie & Stansfield 2017 were not included as evidence because they looked at learning disabilities and all types of mental health disorder and were not limited to complex psychosis or related conditions.
Royal College of Speech and Language Therapists	Guideline	General	General	It is disappointing that, although many vulnerabilities are listed, there is absolutely no mention of speech, language and communication needs or eating, drinking and swallowing needs (dysphagia). The evidence is clear that vulnerabilities for communication need within this population are high along with the associated impact of having communication problems:Many adults with mental health needs have unidentified speech, language and communication difficulties (Walsh, I., Regan, J., Sowman, R., Parsons, B. and McKay, A.P., 2007).80% of people with mental health problems had impairment in language in a study.Walsh I, Regan J, Sowman R, Parsons B, McKay AP (2007) A needs analysis for the provision of a speech and language therapy service to adults with mental health disorders. Ir J Psyche Med. 2007 Sep;24(3):89-93.Specific mental health problems have communication and eating, drinking and swallowing difficulties commonly associated with them, for example, schizophrenia, psychosis, dementia and depression (Bryan K. Psychiatric disorders and Communication. 2014. Louise Cummings (ed) Handbook of Communication Disorders. (pp. 300-318) Cambridge: Cambridge University Press)Some mental health medication has been found to effect speech (Sinha, P., Vandana, V. P., Vincent Lewis, N., Jayaram, M. & Enderby, P. (2015). Evaluating the effect of risperidone on speech: A cross-sectional study. Asian Journal of Psychiatry, 15, 51-55. 30% of people with mental health	Thank you for your comment. Speech and Language Therapists have been added to the list of specialties that the MDT should have access to. Assessment of communication needs has been added to the comprehensive biopsychosocial needs assessment (recommendation 1.7.2) and difficulties with swallowing have been added to the initial physical health check (recommendation 1.7.3). Identification of any needs as a result of the assessment will enable them to be included in formulation and care planning. We have highlighted the higher prevalence of speech, language and communication difficulties in people with complex psychosis, which may contribute to complexity in rehabilitation (recommendation 1.7.5). We have also added that the recommendations on communication needs from the NICE guideline on people's experience in adult social care services should be followed and that communication needs as set out in the NHS Accessible Information Standard should be met. Walsh 2007 focused on rates of speech and language impairment in acute psychiatric units. This was not included as evidence because it was not a population based study and not limited to complex psychosis or related conditions.

				problems have swallowing difficultiesWalsh I, Regan J, Sowman R, Parsons B, McKay AP (2007) A needs analysis for the provision of a speech and language therapy service to adults with mental health disorders. Ir J Psychol Med. 2007 Sep;24(3):89-93.Dysphagia is “a common and significant cause of morbidity and mortality in adults with mental illness”(Aldridge, K. J. & Taylor, N. F. (2012). Dysphagia is a Common and Serious Problem for Adults with Mental Illness: A Systematic Review. Dysphagia, 27, 124-137)	ryan 2014 was not included because it is a book chapter rather than a primary research study. Sinha 2015 was not included as it is a non-randomised study evaluating side effects of risperidone and the evidence for this area was not appraised. Aldridge 2012 was not included as it looked at all types of mental health disorder and was not limited to complex psychosis or related conditions.
Royal College of Speech and Language Therapists	Guideline	General	General	NICE recognises that understanding and good decision making is dependent on communication skills. This is a key component of the work of the Shared Decision Making Collaborative. Therefore we were disappointed that this supporting decision making as part of a person centred service wasn’t given a sharper focus within this guideline.	Thank you for your comment. Assessment of communication needs has been added to the comprehensive biopsychosocial needs assessment. Identification of any communication needs as a result of this will enable them to be included in formulation and care planning and should ensure that shared decision making is possible. In addition, NICE is developing a guideline on shared decision making.

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Royal College of Speech and Language Therapists	Guideline	General	General	It is also disappointing that speech and language therapy is not mentioned in the guideline. Speech and language therapists should be embedded into the mental health team to support, train and advice on communication across all aspects of recovery. Speech and language therapists also assess levels of communication strength and offer supportive approaches to promote communication and wider social skills. There are many opportunities where speech and language therapy presence would aid quality of care to this population.Many mental health teams have embedded speech and language therapists, offering vital support with communication and swallowing. Failure to provide such support can result in: People being unable to engage in rehabilitation and psychological programmes, which are often delivered verbally and reliant on people's language skills, which impacts on length of stay in mental health settings (Bryan K. Psychiatric disorders and Communication. 2014. Louise Cummings (ed) Handbook of Communication Disorders. (pp. 300-318) Cambridge: Cambridge University Press).Being able to communicate is essential in explaining concerns around mental health and explaining and getting your wider health and mental health needs met. People with communication problems and mental health needs often have poor health literacy, and less understanding of, and insight into, managing and maintaining their own mental health, resulting in barriers to rehabilitation and recovery.(Rees H, Forrest C, Rees G (2018) Assessing and managing communication needs in people with serious mental illness. Nursing Standard. doi: 10.7748/ ns.2018.e11104)Difficulties with swallowing can lead to unsafe eating and drinking. In turn this puts people at risk of malnutrition, dehydration, chest infections, and choking.There is a greater prevalence of dysphagia in acute and community mental health settings compared to	Thank you for your comment. Speech and Language Therapists have been added to the list of specialties that the MDT should have access to. Assessment of communication needs has been added to the comprehensive biopsychosocial needs assessment (recommendation 1.7.2) and difficulties with swallowing have been added to the initial physical health check (recommendation 1.7.3). Identification of any needs as a result of the assessment will enable them to be included in formulation and care planning. We have highlighted the higher prevalence of speech, language and communication difficulties in people with complex psychosis, which may contribute to complexity in rehabilitation (recommendation 1.7.5). We have also added that the recommendations on communication needs from the NICE guideline on people's experience in adult social care services should be followed and that communication needs as set out in the NHS Accessible Information Standard should be met. Bryan 2014 was not included because it is a book chapter rather than a primary research study. Rees 2018 was not included because it is an expert review rather than a primary research study. Groher 1986, Corcoran 2003 and Bazemore 1991 were not included because they were not limited to complex psychosis or related conditions.

				the general population(Groher, M.E. and Bukatman, R. 1986. 'Prevalence of swallowing disorders in two hospitals', Dysphagia 1:1, 3-6)There is evidence for an elevated rate of death due to asphyxia in acute mental health settings due to the effects of medication and the neurological condition(Corcoran, E. and Walsh, D. 2003. 'Obstructive asphyxia: a cause of excess mortality in psychiatric patients', Irish Journal of Psychological Medicine 20:3, 88-90)(Bazemore, P.H., Tonkonogy, J. and Ananth, R. 1991. 'Dysphagia in psychiatric patients: clinical and videofluoroscopic study', Dysphagia 6:1, 2-5)	
Second Step - Bristol Community Rehabilitation Service	Guideline	010	001	Where current policy / protocol is to restart clozapine in inpatient settings, additional resources would be required to enable restarting clozapine in the community.	Thank you for your comment. We acknowledge that additional resources would be required to enable restarting clozapine in the community. However this would still require less resources than having an inpatient admission to achieve the same action.
Second Step - Bristol Community Rehabilitation Service	Guideline	011	002	From our experience the make-up of the Multi-disciplinary team should include paid Peer Workers as a core part of the team to improve the skills set of the team and to offer a different type of intervention.	Thank you for your comment. Support workers are already included in the MDT which would include peer support workers.
Second Step - Bristol Community Rehabilitation Service	Guideline	011	022	In addition to QuIRC, this section could reference AIMS standards for inpatient and community rehabilitation	Thank you for your comment. Evidence about AIMS standards was not identified by our review and therefore we are not able to make any recommendations about them.

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Second Step - Bristol Community Rehabilitation Service	Guideline	012	011	Line 2 references a maximum length of stay for inpatient rehabilitation. In our experience this should be added to line 8 Community Rehabilitation as services we believe benefit from having a targeted length of stay (again used as a guide rather than an absolute).	Thank you for your comment. Whilst we had evidence showing inpatient rehabilitation units with an expected maximum length of stay were associated with better quality care, we did not find equivalent evidence for supported accommodation. Therefore we are not able to make the change you suggest.
Second Step - Bristol Community Rehabilitation Service	Guideline	012	018	From our experience in a community rehabilitation service we have named designated care co-coordinators responsible for overseeing and delivering a service users care rather than a shared caseload. We do agree with the second part of this line about the importance of discussing care at team meetings. This would benefit from being clarified.	Thank you for your comment. We have added to the recommendation that a designated care co-ordinator should be provided for each client. However the committee considered that they would still need to operate with a shared caseload approach.
Second Step - Bristol Community Rehabilitation Service	Guideline	019	003	In our experience of delivering a community mental health service responsibility for completing physical health checks should be part of a local agreement. This will be shared with the GP and other community health providers (e.g. dentist). For people who are reluctant to engage with health services, this may be part of the intervention as opposed to the assessment. The care-co-ordinator has a role in overseeing the wider physical health and access to health services for checks.	Thank you for your comment. Section 1.10 makes recommendations on physical healthcare, including responsibilities for healthcare providers.
Second Step - Bristol Community Rehabilitation Service	Guideline	019	003	We use a physical health screening and intervention tool – Lester and we would recommend that this is considered for use by rehabilitation services.	Thank you for your comment. We did not look at the evidence on screening tools and so are not able to make any recommendations in this area.
Second Step - Bristol Community Rehabilitation Service	Guideline	022	022	This line refers to peer support. In our experience Peers can be volunteers, paid staff or peer support between patients / clients. It would be beneficial to clarify this line of guidance. We use paid peer staff and peer mentor volunteers.	Thank you for your comment. We did not find any evidence about whether peer support should be paid or not and so are not able to make any recommendations on this issue.

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Second Step - Bristol Community Rehabilitation Service	Guideline	004	002	Section 1.1In our experience this is a narrow definition of the service user group. We work with a more diverse / broad range of diagnosis including personality disorder and trauma. The wording of the guidelines seems to limit this much more to complex diagnosis and would exclude much of our client group. Also within that definition there is no reference of readiness to change. In our experience it is helpful to undertake a motivational assessment to establish their readiness to change and the likelihood that they would benefit from a rehabilitation service.	Thank you for your comment. As specified in the scope, this guideline focusses on people with complex psychosis. Many will have comorbidities which may include complex trauma/personality disorder. However, those who have experienced trauma or who have personality disorder as a primary diagnosis are outside the scope of this guideline. The guideline has not examined the evidence base for these conditions as there is existing NICE guidance for the specialist care required for antisocial personality disorder, borderline personality disorder and post-traumatic stress disorder. To address the issues raised by stakeholders we have made the following amendments to the guideline: • included an introductory statement to clarify which group this guideline covers • made changes at the start of the guideline to be clear that senior rehabilitation practitioners can also provide advice to services outside the rehabilitation pathway on appropriate treatment and support, including specialist placements and tailored support packages, for people with other primary mental health diagnoses or neurodevelopmental conditions. • emphasised the mental health comorbidities that may make rehabilitation more complex, including linking to relevant existing NICE guidelines (such as those on personality disorder). • added trauma informed care to the examples of psychological informed approaches that staff may need to be trained in (recommendation 1.9.8).

					added trauma informed care to the examples of psychological informed approaches that staff may need to be trained in (recommendation 1.9.8). In addition, experience of trauma and systematic assessment for comorbidities is included in the initial assessment (recommendation 1.7.2). The aim of the recommendations is to be as inclusive as possible for people with complex psychosis; readiness to change can be an excluding concept and therefore has not been mentioned. Recommendation 1.1.1 is particularly focussed on those people who may have been excluded from rehabilitation services. However, we have made amendments to make clear that a rehabilitation service should be offered to a wider group of people than just those in inpatient rehabilitation.
Second Step - Bristol Community Rehabilitation Service	Guideline	004	002	Section 1.1 In our experience it can be beneficial to use electronic patient information to identify people who would benefit from the community rehabilitation service. We have developed a case finding tool to support this.	Thank you for your comment. The focus of the question that was investigated was who should be offered a rehabilitation service, not the method for doing so. As such we have not looked at the evidence in this area and are unable to make recommendations on case finding tools. We emphasise a local rehabilitation pathway needs assessment as key to local population identification.
Second Step - Bristol Community Rehabilitation Service	Guideline	005	017	We see this as a very positive recommendation.	Thank you for your comment and support of our recommendation.

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Second Step - Bristol Community Rehabilitation Service	Guideline	006	009	The term frail on this line is ambiguous. This would benefit from being clarified or removed.	Thank you for your comment. We have clarified in the guideline that this means 'physically frail'.
South London & Maudsley NHS Foundation Trust, National Psychosis Service	Guideline	013	020	Section 1.5.11 We suggest altering the first bullet point to read “people who need treatment in a highly specialist or tertiary unit, including people with psychosis and brain injury, or psychosis and autism spectrum disorder,	Thank you for your comment. We have not adopted your suggested wording as the committee agreed that citing the population first was clearer.
South London & Maudsley NHS Foundation Trust, National Psychosis Service	Guideline	013	023	Section 1.5.11 We suggest altering the last line to read “people who have a clear clinical or legal requirement to receive treatment outside their home area”	Thank you for your comment. We have made your suggested change.
South London & Maudsley NHS Foundation Trust, National Psychosis Service	Guideline	015	012	Section 1.6.2 – We suggest adding reference to optimising medication and moving towards medication self-management as part of this section	Thank you for your comment. We have added moving towards self management of medication to the bullet points.

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South London & Maudsley NHS Foundation Trust, National Psychosis Service	Guideline	019	020, 011	1.7.3 Physical Health - We would suggest renal function tests for all on initial health checks as many may have been prescribed nephrotoxic medication in the past. This should also include electrolytes, given the possibility of hyponatraemia related to antipsychotics and its potential contribution to QTc prolongation and arrhythmias. So we suggest adding urea and electrolytes (including creatinine or estimated GFR). Likewise, a low threshold for considering tests such as vitamin B12 and folate levels and following local guidance on blood borne virus testing and syphilis screening would be useful. Additionally, it would be important to give specific mention to constipation monitoring/advice for people taking clozapine (Shirazi et al, 2016).“renal and calcium levels”, should read “renal function tests and calcium levels”.	Thank you for your comment. We have added renal function tests and monitoring for constipation in those taking clozapine to the tests included in the initial physical health check. As renal function tests would include urea and electrolytes, we have not specified these in the recommendation. We have not added vitamin B12, folate, blood borne virus testing and syphilis screening to the list as these would only be appropriate for people with a particular history, whereas this recommendation is for all people entering a rehabilitation service. Obviously this would not prevent these tests being done if it were clinically indicated. We have made the suggested amendment to 'renal function tests and calcium levels'. Shirazi 2016 was not included in the guideline as evidence because the evidence in the area of clozapine induced constipation was not appraised.
South London & Maudsley NHS Foundation Trust, National Psychosis Service	Guideline	024	018	1.9.1 Re the webpage given for the NICE guideline on psychosis and schizophrenia in adults , this page has been moved	Thank you for your comment. We have corrected the hyperlinks so that they go directly to the sections referenced in the recommendation.

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South London & Maudsley NHS Foundation Trust, National Psychosis Service	Guideline	024	025	1.9.1 Regarding the recommendations for those with bipolar disorder, it is not clear why one would be preferentially directed to the anti-psychotic section of the NICE bipolar Guidelines– people with complex bipolar disorder should, if feasible, have appropriate access to effective mood stabilisation. 1.9.3 It was good to see the recommendation to look out for and treat mental health co-morbidities	Thank you for your comment. We have amended the cross reference so it specifies the title of section 1.10 in the Bipolar disorder guideline (how to use medication).
South London & Maudsley NHS Foundation Trust, National Psychosis Service	Guideline	026	006	Section 1.9.8 It would be important to mention here that clozapine should be optimised before adding an augmentation agent.	Thank you for your comment. We have made this change.
South London & Maudsley NHS Foundation Trust, National Psychosis Service	Guideline	026	007	Section 1.9.8 Aripiprazole may be a reasonable clozapine augmentation agent to mention because of its potential to improve tolerance. However, high quality evidence of its superiority in psychotic symptom reduction is limited. In the Siskind 2018 review and meta-analysis the favourable results for aripiprazole augmentation were “tempered by the poor quality of the majority of studies”. When those poor-quality studies were excluded, the results were non-significant. Further, in the one study reporting clozapine levels, they were higher in the aripiprazole group.	Thank you for your comment. As documented in the rationale and impact section, the committee specifically mentioned aripiprazole as an example while recommending augmentation with antipsychotics. This was because amisulpride is more commonly prescribed than aripiprazole, but the evidence did not show a change in psychosis symptoms following amisulpride, while there was some evidence regarding the effectiveness of aripiprazole in reducing total psychosis symptoms.

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South London & Maudsley NHS Foundation Trust, National Psychosis Service	Guideline	026	008	Section 1.9.8 The addition of a mood stabiliser or anti-depressant does not have high-quality evidence of effectiveness in the management of treatment resistant schizophrenia, though is often useful in treating the relevant affective dimensions of psychosis. As giving an anti-depressant to someone with a current manic dimension to their psychosis may make matters worse, we suggest adding a qualifier here such as; consideration of an anti-depressant or mood stabiliser in the context of the predominant affective dimension.It may also be worth noting that while the Zheng W et al 2016 meta-analysis observed an effect for topiramate augmentation, in the Zheng W et al 2017 meta-analysis the conclusion was that "Topiramate augmentation had a too-high discontinuation rate." Topiramate can have a deleterious effect on cognitive function.	Thank you for your comment. We have amended the recommendation to clarify the context in which augmentation with a mood stabiliser or an antidepressant would be appropriate. Topiramate has not been specifically recommended and it would not be the first "go-to" mood stabiliser. Zeng 2016 was not included as evidence because it focused on ECT augmentation of clozapine and this was not relevant to our review protocol. Zeng 2017 was not included because there were more up to date systematic reviews (Bartoli 2019, Polese 2019 and Siskind 2018) of these interventions.
South London & Maudsley NHS Foundation Trust, National Psychosis Service	Guideline	026	010	Section 1.9.8 We would suggest changing: "Seek specialist advice if needed, for example from a specialist mental health pharmacist" to "A psychiatrist specialising in treatment resistance and/or a specialist MH pharmacist.	Thank you for your comment. We have made this change.
South London & Maudsley NHS Foundation Trust, National Psychosis Service	Guideline	026	012	Section 1.9.9 There is a recommendation that if combination anti-psychotic treatment is used, prescribers should consider 2 antipsychotics with different receptor-binding profiles. There is no comparative evidence that this approach is superior to others and this could be interpreted as a recommendation to prescribe antipsychotic polypharmacy. With the exception of clozapine augmentation, the evidence base does not support	Thank you for your comment. We have deleted the recommendation about antipsychotic polypharmacy.

				antipsychotic polypharmacy. We recommend instead that antipsychotic polypharmacy to achieve remission is specifically recommended against.	
South London & Maudsley NHS Foundation Trust, National Psychosis Service	Guideline	026	016	Section 1.9.10 The routine use of therapeutic plasma levels in non-clozapine anti-psychotics is not evidence-based, (although in specific circumstances it may be useful, for example an absence of medication in the blood may indicate non-adherence; or to confirm toxicity/pharmacokinetic drug interactions). It may be helpful to specify clozapine levels here.	Thank you for your comment. We have made a change to justify monitoring for other drugs as well as clozapine.
South London & Maudsley NHS Foundation Trust, National Psychosis Service	Guideline	027	001	Section 1.9.11 "Only use multiple medicines, or doses above BNF or summary of product characteristics limits, to treat complex psychosis". We suggest this should be modified to read "multiple medicines in the same class"	Thank you for your comment. We have not made this change as the committee are keen to encourage minimal numbers of medications from all classes.

South London & Maudsley NHS Foundation Trust, National Psychosis Service	Guideline	027	017	Section 1.19.12 “If pharmacological treatment is not successful, consider stopping the medicine but be cautious when reducing doses, because people with complex psychosis and related severe mental health conditions may have been on medicines for many years.”The decision to discontinue antipsychotic medication is highly complex and requires a very thorough review of treatment, history and careful planning. There is a lack of evidence to guide this practice and more recent syntheses of evidence show that reducing anti-psychotic dosage beyond a certain point increases the risk of relapse: One meta-analysis found that maintenance treatment with moderately low doses (50%-100% of World Health Organization- defined standard doses) was comparable in preventing relapse to standard doses, whereas very low doses (less than 50% of standard doses) increased the risk of relapse (Uchida H, Suzuki T, Takeuchi H, et al: Low dose vs standard dose of antipsychotics for relapse prevention in schizophrenia: meta- analysis. Schizophr Bull 2011; 37:788–799). A subgroup analysis in a 2019 meta-analysis indicated that only a post-reduction CPZ dose of ≤ 200 mg/day was associated with an increased risk of relapse (RR = 2.79; 95% CI, 1.29-6.03).(https://www.nature.com/articles/s41386-019-0573-7). Relapse post discontinuation of antipsychotics may lead to failure of placement and other short- and long-term negative consequences for the patient and their carers, so should not be undertaken lightly. We suggest adding “If pharmacological treatment is not successful, consider referring for a second opinion from a specialist service for treatment resistant psychosis”. Given the current balance of risks, where evidence of potential harms from discontinuation appears to exceed clear evidence of benefit, it is not clear why NICE would specifically	Thank you for your comment. We agree that the decision to discontinue antipsychotic medication is complex and requires careful planning. We have now recommended a thorough review of treatment before considering stopping a medicine. It is within the competence of a mental health rehabilitation service to carry out a full medication review to inform reduction or stopping of medicine. Recommendation 1.9.19 has been amended to include consideration of a referral to a specialist service for a second opinion. Uchida 2019 was not included as evidence in this guideline because evidence about maintenance treatment for schizophrenia was not appraised in this guideline.

				recommend that clinicians discontinue medications rather than review treatment strategies. However clinicians often need to respond to such requests from their patients, and in such situations, we suggest initially jointly seeking a second opinion, if possible from a service specialising in the person's condition, to determine whether alternative treatment approaches would suit the patient better, and if medicine discontinuation is to go ahead, it should be in the context of a carefully and expertly formulated care and risk/benefit plan that is fully informed by the patient and key stakeholders (i.e informal carers). The recommendation: "be cautious when reducing doses, because people with complex psychosis and related severe mental health conditions may have been on medicines for many years" is not sufficiently clear.	
South London & Maudsley NHS Foundation Trust, National Psychosis Service	Guideline	028	014	Section 1.9.19: We suggest adding: "if symptoms persist despite following the NICE guideline on medicine optimisation, consider referring for a second opinion from a specialist service for treatment resistant psychosis".	Thank you for your comment. Recommendation 1.9.19 has been amended to include consideration of a referral to a specialist service for a second opinion.

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South London & Maudsley NHS Foundation Trust, National Psychosis Service	Guideline	030	022	Section 1.10.7 We suggest adding mention of the effect of changes in smoking habits on clozapine concentrations in the blood	Thank you for your comment. We have added an extra recommendation to be aware of the potential significant impact of reducing cigarette smoking on the metabolism of other drugs, particularly clozapine.
South London & Maudsley NHS Foundation Trust, National Psychosis Service	Guideline	031	019	Section 1.10.13 We suggest there would be a case to be made for doing annual FBC & U&Es alongside LFTs	Thank you for your comment. Full blood count and renal function tests have been added to the annual physical health check.
South London & Maudsley NHS Foundation Trust, National Psychosis Service	Guideline	032	010	Section 1.10.16 We suggest that it may be worth considering blood borne viruses more broadly to include HIV	Thank you for your comment. We have made this change.

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South London & Maudsley NHS Foundation Trust, National Psychosis Service	Guideline	004	005	Section 1.1 It would be useful to include a definition of what is meant by treatment-resistant symptoms, and to include a requirement that a review has taken place ensuring that the appropriate evidence-based treatment strategies have indeed been offered and that the person in question meets the definition.	Thank you for your comment. We have included a definition of treatment resistant symptoms. We think the concept of following the recommendations in the NICE guideline for the person's condition but that the person still has not recovered is adequately conveyed by using the phrase 'have treatment resistant symptoms'. Including this as one of the eligibility criteria for accessing rehabilitation could have the undesired effect of people not being offered rehabilitation soon enough.

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South London & Maudsley NHS Foundation Trust, National Psychosis Service	Guideline	General	General	Dear NICE Rehabilitation Guidelines Committee, Thank you for this hugely important document. It will greatly enhance access to good quality rehabilitation for people with complex psychosis and related severe mental health conditions. We wished to submit some comments from the National Psychosis Service (NPS). The NPS is not a rehabilitation service - rather it is a clinical-academic NHS Tertiary service providing innovative individualised evidence-based multi-disciplinary treatments for those people with complex psychosis where standard treatment guidelines have proven ineffective or have not been tolerated. The NPS provides second opinions to colleagues across the country, often from rehabilitation services. The service advises on the management of people who have a relatively unique clinical picture which cannot be readily managed in secondary care. Themes include complex co-morbid physical health conditions which directly affect psychiatric treatment options; clozapine re-challenge after a significant adverse reaction; clozapine non-response (ultra-treatment resistance). The NPS has led the way in introducing novel pharmacotherapeutic approaches into practice in a safe manner. Without access to this service, these patients risk spending extensive periods in restrictive hospital settings. Most NPS patients are seen in our outpatient/ outreach service, with a minority requiring admission to the National Psychosis Unit, based in the Bethlem Royal Hospital, South London and Maudsley NHS Foundation Trust. As the NPS is a single central service run by clinicians with links to a specialist university (the Institute of Psychiatry, Psychology and Neuroscience) many of our inpatients will inevitably be some distance from home. The average length of stay is 9-12 months with admissions kept as short as possible, the focus being on getting the person to the	Thank you for your comments and your support of the guideline. Thank you for providing this information about the NPS. The committee recognise the work of the NPS as an NHS tertiary service. The recommendations in the guideline are not intended to undermine this valuable work. They consider that the NPS would sit within the definition of a highly specialist rehabilitation unit, albeit operating at a broader than regional level, rather than an out of area placement. As such we would not anticipate that the recommendations would be misinterpreted as precluding admission to the National Psychosis service. We have amended recommendation 1.9.19 to include considering getting a second opinion from a relevant specialist service for those people with treatment resistant complex psychosis. Malik 2017, Whiskey et al, 2019, Lally 2019 and Shirazi 2017 were not included as evidence because they focus on the side effects of clozapine and the evidence in this area was not appraised for this guideline. Krivoy et al, 2019 and Sarkar 2014 were not included because they are before and after studies of tertiary care for treatment-refractory psychosis. When we examined the evidence for adjustments to standard treatments in the treatment-refractory population we only included randomised trials of specific interventions.

				point where their care can continue in their local area, rather than aiming for elimination of symptoms.At present in the draft Guidelines there is no reference to seeking a second opinion when someone has treatment resistant highly complex psychosis, or to tertiary inpatient care for this group if needed. The only options mentioned for further support are highly specialist rehabilitation units with very long expected lengths of stay of over 3 years. The guidance to commissioners suggesting that an out-of-area placement may be possible where there "is a clear clinical or legal requirement to remain outside their home area" should allow a referral to NPS, but equally risks being misinterpreted by commissioners as a NICE recommendation not to refer out of area. Admissions to the National Psychosis Service have been demonstrated to result in significant falls in symptoms and costs with accommodation costs in this severely ill population dropping by £21,000 pa on average; those who came from highest intensity settings, saved an average of £41,358 per person per year (Sarkar et al, 2014). Mental Health bed usage drops from medians of 326 to 69 days when the 2 years prior are compared to 2 years post admission) (submitted). The university base of the NPS service allows it to capitalize on its synergies with other national specialist services such as CAMHS (we do joint assessments of adolescents), Specialist CBT for psychosis (PICUP), Affective disorders, Autism.One role of the NPS is to safely introduce innovative treatment strategies into practice and disseminate evidence on their use. We share emerging evidence and monitor outcomes to advise on safe, effective care, , e.g., the medical challenges of clozapine use, incl. neutropaenia on valproate co-prescription (Malik et al, 2017), haematological monitoring (Whiskey et al, 2019); re-challenge post neuroleptic malignant syndrome	Onwumere 2015 was not included as evidence because it covers the impact of early psychosis on carers and the evidence in this area was not appraised for this guideline. Please see NICE guideline NG150 for relevant guidance in this area.

				(Lally et al, 2019); constipation on clozapine (Shirazi et al, 2017); hepatitis and interstitial nephritis on clozapine (Lally et al, 2019); the use of IM clozapine (submitted). We routinely disseminate our findings to colleagues face to face or through peer reviewed publications and publish treatment strategies most linked to symptom reduction (Krivoy et al, 2019).We have a strong educational and training presence. We provide training programmes in the management of resistant psychosis, including a Massive Open Online Course for Carers (https://www.futurelearn.com/courses/caring-psychosis-schizophrenia)(Onwumere, 2015), training workshops, clinical discussions and contribution to books, including the Maudsley Guidelines. Our sessions at the annual International Congress of the RCPsych are the joint most highly attended. We would suggest that the NPS provides an important service not just to the patients who directly receive care from us, but also to the patients and families who work with colleagues who liaise with us through clinical consultation, training or our publications. We ask the Guidelines to be edited slightly so that those reading them cannot misinterpret them as precluding admission to the National Psychosis service. We have listed some specific suggestions below which we hope are helpful.	

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Southern Health NHS Foundation Trust	Evidence review N	General	General	The evidence review about interventions to engage in healthy living has missed a substantial literature on weight management as illustrated in the previous point.	Thank you for your comment. We excluded some trials of physical fitness and weight management interventions in people with mental illness because our review protocol specified that trials had to be in people with complex psychosis who were currently receiving rehabilitation in an inpatient rehabilitation unit or while living in supported accommodation in the community. Weight management outside this specific rehabilitation population is covered by existing NICE guidelines for schizophrenia (CG178), bipolar disorder (CG185) and obesity (CG189).
Southern Health NHS Foundation Trust	Guideline	030	025	1.10.8 While supporting the general concept that it is important to support a healthy lifestyle, the latest evidence casts doubt on the effectiveness on the currently available programmes. The STEPWISE trial (Holt et al Br J Psychiatry. 2019 Feb;214(2):63-73), which was undertaken to help mental health providers commission appropriate lifestyle programmes to address obesity, did not lead to significant weight loss in people with schizophrenia. This is not an isolated as reported in a systematic review by Speyer et al (Psychother Psychosom. 2019;88(6):350-362). The previous NICE guidance that mental health providers should offer a combined lifestyle programme is based on its 2014 review of 24 studies. Although the review concluded that lifestyle interventions could lead to a mean weight reduction, the evidence is limited by the short duration of follow-up and small numbers in the studies. The review also commented on the high risk of bias and substantial heterogeneity of effect size between studies. In a later meta-analysis by Naslund et al (Gen Hosp Psychiatry. 2017 Jul;47:83–102), only 2 of the 6 studies lasting longer than a year achieved a statistically significant	Thank you for your comment. The committee were aware of the results from the STEPWISE trial, which have as yet failed to identify effective lifestyle programmes for people with schizophrenia. However they though it was important to continue to offer people and encourage their engagement with healthy eating and physical activity in line with general advice for the entire population, particularly given the specific physical health co-morbidities for this group. Holt 2019, Speyer 2019 and Naslund 2017 were not included as evidence in the guideline because our evidence review was concerned with engagement with healthy living interventions specifically in the rehabilitation population with complex psychosis and related conditions. We did not appraise evidence for the effectiveness of healthy living interventions in people with schizophrenia in general as this is covered by other NICE guidance.

				weight loss.It appears that the recommendation in this guidance has been brought forward from the previous NICE guidance on psychosis and schizophrenia in adults without taking account of the latest evidence about the effectiveness of these programme	
Sussex Partnership NHS Foundation Trust	Guideline	026 (& 068)	007	I am surprised by the evidence for aripiprazole is this because it is a newer drug than amisulpride therefore more company led trials? 1.9.10 should come before 1.9.8 adherence and plasma levels should be done before augmentation1.9.9 - If a combination is used this may make it above HDAT and appropriate monitor should occur.	Thank you for your comment. As documented in the rationale and impact section, the committee specifically mentioned aripiprazole as an example while recommending augmentation with antipsychotics. This was because amisulpride is more commonly prescribed than aripiprazole, but the evidence did not show a change in psychosis symptoms following amisulpride, while there was some evidence regarding the effectiveness of aripiprazole in reducing total psychosis symptoms. The ordering of the recommendations matches those in the NICE guideline on psychosis and schizophrenia in adults and relates to monitoring of the augmented treatments. As such we do not think it should be changed as you suggest.
Sussex Partnership NHS Foundation Trust	Guideline	011	007	Use of the title 'Psychologist' is problematic as its not a protected title and causes misunderstanding. Please can you use a protected title such as Clinical psychologist or Practioner Psychologist	Thank you for your comment. We have changed the text to practitioner psychologist as suggested.
Sussex Partnership NHS Foundation Trust	Guideline	011	012	It would be good to include Housing Support Staff as essential part of the workforce.	Thank you for your comment. We have amended recommendation 1.5.1 to clarify that the multidisciplinary teams should comprise a range of professionals including the roles specified in the bulleted list. This list is not meant to be exhaustive.

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Sussex Partnership NHS Foundation Trust	Guideline	011	012	It would be good to include Peer Recovery workers	Thank you for your comment. We have amended recommendation 1.5.1 to clarify that the multidisciplinary teams should comprise a range of professionals including the roles specified in the bulleted list. This list is not meant to be exhaustive.
Sussex Partnership NHS Foundation Trust	Guideline	011	012	1.5.1 -specialist pharmacists should be part of the MDT team (as many complex medications are prescribed - clozapine, HDAT, lithium, long acting injections or valproate) also as NMP or ACPs	Thank you for your comment. Specialist mental health pharmacists have now been included in the MDT.
Sussex Partnership NHS Foundation Trust	Guideline	025	012	Can you include 'Continue to offer Family Intervention' as recommended by NICE Schizophrenia. The evidence for Family Interventions is very strong. It seems odd to have a fair bit written about CBT, but very little on Family Intervention, other than as an additive to CBT. It would be good to stress the different needs of families at this point in their relatives recovery, may be more emphasis on 'negative symptoms' and importance of addressing possible grief or loss for relatives as their hoped for future is significantly altered. In addition Family Intervention may involve working with people who now have family of their own, possibly with couples where both have severe and complex MH difficulties, and may involve parenting work if they have children of their own. There are some significant differences in Family Intervention in Rehab as opposed to crisis settings, or in EIS.	Thank you for your comment. We have amended recommendation 1.9.6 so that it gives more emphasis to Family Intervention.
Sussex Partnership NHS Foundation Trust	Guideline	025	019	Can you change 'not able to engage' to 'not ready to engage' as it suggests this may change. People aren't permanently unable to make use of psychological work. The key issue is 'can they identify a goal'	Thank you for your comment. We have made this change.

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Sussex Partnership NHS Foundation Trust	Guideline	025	025	Important to also include 'and the person's goals'	Thank you for your comment. Recommendation 1.9.7 is about different types of psychological intervention that could be used. The importance of including the person's recovery goals in care planning is included in recommendation 1.7.5.
Sussex Partnership NHS Foundation Trust	Guideline	025	028	Can you use the term 'psychologically informed' interventions rather than 'low intensity' which is no longer used within IAPT services as it suggests something 'lesser'. The psychologically informed work can actually be very intensive, so low intensity is misleading.	Thank you for your comment. We have changed the text to 'psychologically informed approaches'.
Sussex Partnership NHS Foundation Trust	Guideline	026	002	Please add Psychological Formulation with the Multi Disciplinary Team to inform the care or treatment offered.	Thank you for your comment. Psychological formulation would happen before treatment was offered and therefore it is not appropriate to included it in a recommendation about psychological treatments.
Sussex Partnership NHS Foundation Trust	Guideline	026	004	This section just discusses clozapine I am aware earlier that NICE guidance should be followed but then it goes straight into augmentation?	Thank you for your comment. We have amended recommendation 1.9.9 to clarify that augmentation is for those whose symptoms have not responded adequately to clozapine alone at an optimised dose.
Sussex Partnership NHS Foundation Trust	Guideline	028	014	1.9.18 - need to include NPS (New or Novel Psychoactive substances)	Thank you for your comment. We have removed the word "illegal" from this recommendation so it now covers non-prescription drugs whether legal or illegal.
Sussex Partnership NHS Foundation Trust	Guideline	031	030	1.10.13 - need to include monitor for constipation with clozapine	Thank you for your comment. This has been added to recommendation 1.9.12.

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Sussex Partnership NHS Foundation Trust	Guideline	050	012	Should not be just input from specialist pharmacists but part of the team. Also involved with medication optimisation, adherence to medication, side effect monitoring, sourcing and storage of the medication, ensure medication is legally prescribed and also legal in terms of the MHA.	Thank you for your comment. Specialist mental health pharmacists have now been included in the MDT.
Sussex Partnership NHS Foundation Trust	Guideline	064	007	Psychological Therapies only refers to CBt, please can you include Family Intervention for Psychosis in this section too.	Thank you for your comment. This text describes the evidence that was identified in this area. It is not a recommendation for practice. As such it would not be appropriate to make the change you have suggested as no evidence was found on family intervention for the population covered by this guideline**.** However Family intervention has been recommended in 1.9.6.
Turning Point	Guideline	029	020	Coordinated Physical Health Care In Community Mental Health Independent Hospitals, that offer packages of Rehabilitation, treatment and care, Service Users are registered with a GP for all of their physical health problems. Appointments are made often by Service Users and are treated in line with GDPR and patient confidentially. GP's can/have prescribed medication for Service Users. This information is not always, or routinely shared with the treating RC or members of the MDT in the Hospital the Service User is a patient in. This can pose a risk to the Service User's health and well being, as many of these Service Users are taking Clozapine or other antipsychotics, sometimes high dose anti psychotics.	Thank you for your comment. We agree, which is why the guideline has recommended nominating a trained healthcare professional to ensure continuity of care across different settings.
University of Glasgow/NHS Greater Glasgow & Clyde	Guideline	016	001	While we agree that staff should be trained in using a recovery-oriented approach but in our experience training does not always result in implementation. We suggest that the standard should include a statement that there should be some mechanism for evidencing that implementation of a recovery approach is occurring.	Thank you for your comment. Recommendation 1.5.4 covers tools that can be used to support quality improvement in services.

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University of Glasgow/NHS Greater Glasgow & Clyde	Guideline	016	027	As noted in Comment 3 above, we suggest that the expected standard for provision of substance misuse treatment should be stronger.	Thank you for your comment. Recommendation 1.6.14 focusses on training for staff in rehabilitation services. The guideline makes further recommendations on substance misuse in Section 1.8 (recommendations 1.8.15 - 1.8.19) which cover the issues you raise here.
University of Glasgow/NHS Greater Glasgow & Clyde	Guideline	018	012	A feature of the standard overall is the limited coverage of suicide as a clinical need. There is only brief mention of the need to address risk of harm to self or others under 1.7.2.	Thank you for your comment. Risk of suicide is an issue that applies across all mental health services and is not specific to rehabilitation for people with complex psychoses. Consequently it was not an issue that was prioritised for investigation by the guideline and no recommendations have been made. However, we have added suicide risk to the initial assessment.
University of Glasgow/NHS Greater Glasgow & Clyde	Guideline	020	003	In our view, the list of comorbidities relevant to people with complex psychosis should include cognitive-neuropsychological problems. Problems with executive functioning can be a significant impediment to successful community placement and independent functioning and seem worthy of explicit attention as a co-morbidity (given that they are not part of relevant core diagnostic criteria).	Thank you for your comment. We have added a new recommendation which makes people aware of the high prevalence of cognitive impairments, including executive dysfunction, in those with complex psychosis.
University of Glasgow/NHS Greater Glasgow & Clyde	Guideline	020	005	The dilation of treatment and admission timelines can be a substantial source of despondency and pessimism for patients, their families, and staff. We ask that the committee consider setting a standard for informing patients of the timelines for their rehabilitation programme.	Thank you for your comment. It is very difficult to recommend precise timelines as these vary for different individuals. Recommendation 1.7.9 recommends regular reviews of progress to ensure that there is active rehabilitation taking place.
University of Glasgow/NHS Greater Glasgow & Clyde	Guideline	004	004	It is good that the guideline starts with a clear but not overly prescriptive discussion of the characteristics of intended recipients of rehabilitation for complex psychosis. In particular, not setting a specific duration of acute hospital stay reflects the reality that “extended stays” occur for a multitude of reasons. With this in mind, it would seem more consistent to remove the reference to “longer than 60	Thank you for your comment. For a local rehabilitation service needs assessment to be conducted, there needs to be a metric that can be measured against. Therefore, we have retained reference to ‘longer than 60 days’ as an indicator of people who may meet the criteria for more complex needs. This is not meant to be an eligibility criteria for access to rehabilitation services.

				days" later on when recurrent or extended stays are discussed further (page 6, line 2)	
University of Glasgow/NHS Greater Glasgow & Clyde	Guideline	043	010	The guidance on local organisation of rehab pathways is understandable and welcome but we propose that there is also a need to be clear about the ratio of services to population needs (e.g. number and type of units relative the epidemiological evidence about rates of incomplete recovery from complex psychosis).	Thank you for your comment. Different areas will require different ratios and so this cannot be specified in a recommendation. The local rehabilitation service needs assessment (recommendation 1.3.3) should provide this information.
University of Glasgow/NHS Greater Glasgow & Clyde	Guideline	043	026	The different mental health legislation in devolved nations has different implications for statutory rights to after care. For instance, there is no such safeguard for people detained under the Scottish mental health legislation.	Thank you for your comment. NICE guidance applies in England. As such the recommendations only need to be consistent with the mental health legislation for England.
University of Glasgow/NHS Greater Glasgow & Clyde	Guideline	047	005	We agree that there is clinical wisdom in the statement that front-end investment in improving rehabilitation should produce future cost savings. However, given the state of the evidence to support this claim we wondered if this should be flagged as a key area for future research (e.g. health economic analysis of the benefits of more integrated rehabilitation for complex psychosis).	Thank you for your comment. In order for there to be further health economic analysis of the benefits of more integrated rehabilitation for complex psychosis, more clinical data would be needed as this is what drives economic analysis. The committee have already made a research recommendation to determine if an integrated care system is effective at promoting successful progress for people with complex psychosis to a more independent setting
University of Glasgow/NHS Greater Glasgow & Clyde	Guideline	009	021	We propose that the guideline's approach to meeting treatment needs linked to addiction is a threat to appropriately coordinated care. At present, Specialist Substance Misuse services are treated in a similar way to a physical medical speciality (e.g. cardiology) and it is assumed that patients should be referred out to such services to get their needs met. Our experience is that substance use and addiction problems are part of the core treatment needs seen in psychosis rehabilitation services and so it should be expected that rehabilitation staff are	Thank you for your comment. Recommendation 1.3.17 is for the Lead Commissioner to agree local protocols with specialist substance misuse services so that people in inpatient or community rehabilitation with substance misuse problems can receive the treatment that they need. The guideline makes further recommendations on substance misuse in Section 1.8 (recommendations 1.8.15 - 1.8.19) which cover the issues you raise here.

				trained to provide effective care of people with psychosis marked by substance misuse problems. Later sections of the guideline clearly envisage that the rehabilitation workforce should be skilled in the detection and psychological treatment of substance misuse problems and so we encourage the committee to fully incorporate this into the expected standard of care.	
University of Glasgow/NHS Greater Glasgow & Clyde	Guideline	General	General	We congratulate the Guideline developers for producing such a comprehensive and clinically relevant document. Our specific comments and suggestions do not dilute our over-arching view that this is an important step in improving the standards of care for people with complex psychosis.	Thank you for your comment and support of the guideline recommendations. We have responded to your specific comments below.
University of Glasgow/NHS Greater Glasgow & Clyde	Guideline	General	General	Our observation is that the extensive physical health co-morbidities in people with complex psychosis can often result in needs relevant to end of life and palliative care when there is the development of life-limiting and terminal conditions. There seems to be considerable variation in practice arounds this (e.g. variable access to hospice care) and so we propose that this is an area where more research is needed.	Thank you for your comment. We agree that the physical health co-morbidities in people with complex psychosis can result in needs relevant to end of life and palliative care. However this issue was not identified as a priority at scoping, so the evidence base in this area has not been appraised and we are unable to make any recommendations, including research recommendations.

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University of Southampton	Guideline	General	General	Having worked for 8 years as a Consultant Occupational Therapist across four different mental health rehabilitation units and having recently completed my PhD entitled 'Mental Health Rehabilitation; what benefit is it to the individual, their quality of life and functional performance' I am delighted to be reading these draft guidelines. I have four overall comments a) While this document is about changing the provision of rehabilitation service to be more recovery focused I feel one of the biggest challenges will be the ongoing desire of services torebrand themselves as recovery services without investing in more fundamental changes to ensure staff are truly and genuinely working in a client centered and recovery oriented way. Therefore I feel the most challenging thing to implement is a true shift in the way staff work and interact with service users (this links to point b) below). Unless services are given a 'must do' directive I do not believe things will change until the skill mix of professional groups is changed. b) The sound sense of strength based goal setting, meaningful occupations and activities of daily living running throughout the guidelines is to be applauded – however to make this rhetoric reality, rehabilitation services require a higher presence of occupational therapists (OT's) to deliver on this. OT is a profession whose primary focus is based around goal setting, meaningful occupation and activities of daily living and using occupation based interventions to challenge occupational injustices, resulting from long term mental illness. I would therefore urge the authors to increase the pressure on the commissions to address the nursing /	Thank you for your comment. A) NICE guidelines are not able to make 'must do' recommendations unless they relate to legal requirements so we are not able to make this change. However a key theme running through the guideline is a focus on delivering a recovery-orientated service and specific recommendations have been made detailing how this should be done, including about staff skill mix and competencies. This should help to ensure a shift happens in the way staff work and interact with service users. B) Thank you for your support for the recommendations. Investigating which roles would be most effective at delivering the recommendations made in the guideline was not identified as a priority at scoping. As such we are not able recommend additional Occupational Therapists. However, Occupational Therapists are specified as members of the MDT. C) We agree and this is why have recommended the implementation of specialist community mental health rehabilitation teams, as distinct from CMHTs. These are defined in the 'terms used in the guideline' section. D) We agree and this forms part of the comprehensive biopsychosocial needs assessment that is recommended to inform formulation and care planning.

				therapy skill mix and increase the presence of occupational therapists in rehabilitation units - to the highly radical point of being the most present professional in recovery oriented rehabilitation environments (inpatient units and community teams) This would bring the social, occupational and environmental aspects of rehabilitation to the forefront of care to give people a more holistic rehabilitation experience. c) The third most challenging aspects I feel is the support from a community mental health rehabilitation team – unless this team is a different and distinguishable team from the general CMHT in terms of funding allocation and management – rehabilitation service needs will always come second. d) One a slightly different note - One theme that emerged from my own doctoral research was the range and depth of losses people had experienced before admission to the rehabilitation unit – rehabilitation was viewed as a 'fresh start' and within that 'rebuilding a life of meaning' was a strong theme. Therefore, as per my own recommendations, I urge the authors to consider how people can be supported to practically and psychologically come to terms with such losses and to start to regain a valued sense of self again. Such re-establishment depends not only on addressing symptoms and medication, but also incorporating meaningful roles and positive habits and routines. Again I feel this could be addressed by a more balance skill mix of professionals where there is a greater presence of staff who focus on these aspects of rehabilitation	

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Vocational Rehabilitation Association	Evidence review D	006	014	We suggest there needs to be greater focus of early detection services in order to make accurate assessments and referrals AND instil hope and trust and to facilitate further treatment by forming early therapeutic alliancesSee: Jansen, J.E., Pedersen, M.B., Hastrup, L.H., Haahr, U.H. and Simonsen, E., 2018. Important first encounter: Service user experience of pathways to care and early detection in first-episode psychosis. Early intervention in psychiatry, 12(2), pp.169-176.	Thank you for your comment. Early detection of first episode psychosis and related health conditions was not in the remit of the guideline. This is why Jansen 2018 was not included as evidence. Evidence about identifying service users with complex psychosis for referral to rehabilitation services was appraised for the guideline – see evidence report A.
Vocational Rehabilitation Association	Evidence review D	006	014	We believe the exploration of vocational and education aspirations or history is warranted at the earliest stage and considered in any recovery plan. Work, Recovery and Inclusion (Perkins et al, 2009) report highlights that “work is good for mental health and is central to recovery for people with mental health conditions”. Indeed, a central theme of a number of mental health reviews (Perkins et al, 2009; Government HMs, 2009) is that we need to be doing more to help people with severe mental illness gain and maintain employment.See: Repper, J. and Perkins, R., 2009. Recovery and social inclusion. Mental health nursing skills, pp.85-95.	Thank you for your comment. The committee recommended that a comprehensive biopsychosocial needs assessment should be carried out within 4 weeks of entering the rehabilitation service (see recommendations 1.7.1 and 1.7.2).They recommended that this assessment should include occupational and educational history, including educational attainment and reason for leaving any employment. Perkins 2009 was not included as evidence because it is not a research study. Repper 2009 was not included as evidence because it is a book chapter and not a research study. HM Government (2009) New Horizons: A shared vision for mental health was not included as evidence because it is a policy document rather than a primary research study.

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Vocational Rehabilitation Association	Evidence review D	007	021	We believe EMPLOYMENT and study must be explored in assessments and care plans, given work or study is good for mental health and central to recovery for people with a mental health condition. A recovery based approach positively promotes health and wellbeing and life chances and includes early and positive conversations about work, control of care and self care etc.Suggest studies on importance of work and health that promote recovery such as:Killackey, E., Allott, K., Jackson, H.J., Scutella, R., Tseng, Y.P., Borland, J., Proffitt, T.M., Hunt, S., Kay-Lambkin, F., Chinnery, G. and Baksheev, G., 2019. Individual placement and support for vocational recovery in first-episode psychosis: randomised controlled trial. The British Journal of Psychiatry, 214(2), pp.76-82.Maraj, A., Mustafa, S., Joober, R., Malla, A., Shah, J.L. and Iyer, S.N., 2019. Caught in the "NEET Trap": The Intersection Between Vocational Inactivity and Disengagement From an Early Intervention Service for Psychosis. Psychiatric Services, 70(4), pp.302-308.	Thank you for your comment. The committee recommended that a comprehensive biopsychosocial needs assessment should be carried out within 4 weeks of entering the rehabilitation service (see recommendations 1.7.1 and 1.7.2). They recommended that this assessment should include occupational and educational history, including educational attainment and reason for leaving any employment. Kilackey 2019 and Maraj 2019 were not included as evidence because their participants were early in their first episode of psychosis.
Vocational Rehabilitation Association	Evidence review F	013	016	Return to employment or study needs to be considered in the recovery pathway and clinical staff have positive conversations about these goals and have resources to support the person with a recovery plan that considers these goals. Clinical staff need training on myth busting and impact that work and study can have on a person's recovery	Thank you for your comment. The committee recommended a comprehensive initial assessment to inform treatment care and planning (recommendation 1.7.2) This assessment includes occupational and educational history. Personal recovery goals should also inform the care plan (recommendation 1.7.7),
Vocational Rehabilitation Association	Evidence review F	006	016	Expand on social functioning as a goal to include community activities and explicitly talk about work~ highlight varies RCTs on IPS supporting people with early psychosisSee: Rinaldi, M., Miller, L. and Perkins, R., 2010. Implementing the individual placement and support (IPS) approach for people with mental health conditions in England. International Review of Psychiatry, 22(2), pp.163-	Thank you for your comment. This area of text summarises the review protocol. The impact of IPS on social functioning is covered in evidence review M rather than this evidence review. Rinaldi 2010 was not included as evidence because it is an expert review.

				172.See: Heffernan, J. and Pilkington, P., 2011. Supported employment for persons with mental illness: systematic review of the effectiveness of individual placement and support in the UK. Journal of Mental Health, 20(4), pp.368-380.See: Modini, M., Tan, L., Brinchmann, B., Wang, M.J., Killackey, E., Glozier, N., Mykletun, A. and Harvey, S.B., 2016. Supported employment for people with severe mental illness: systematic review and meta-analysis of the international evidence. The British Journal of Psychiatry, 209(1), pp.14-22.	Heffenan 2011 and Modini 2016 were systematic reviews and were not included themselves but were checked for relevant references
Vocational Rehabilitation Association	Evidence review G	047	004	Under shared vision must include coproduction and peer support.Under service landscape must include welfare, housing AND EMPLOYMENT/RETUNR TO STUDY SUPPORT	Thank you for your comment. Shared vision and service landscape were themes identified from the qualitative evidence review and the statements listed here were taken directly from the evidence as examples of these themes.
Vocational Rehabilitation Association	Evidence review G	006	015	We believe its critical to integrate peer support workers into clinical teams and pathways. Peer support workers can Support outreach/engagement and bridge building, enhance relationship building, assist with co-creating support and wellness tools and help positively influence the clinical team culture around what's possible for patients around their recovery including future return to work and study.See: Leggatt, M. and Woodhead, G., 2016. Family peer support work in an early intervention youth mental health service. Early intervention in psychiatry, 10(5), pp.446-451.See: Gumley, A., Bradstreet, S., Ainsworth, J., Allan, S., Alvarez-Jimenez, M., Beattie, L., Bell, I., Birchwood, M., Briggs, A., Bucci, S. and Castagnini, E., 2020. Early Signs Monitoring to Prevent Relapse in Psychosis and Promote Well-Being, Engagement, and Recovery: Protocol for a Feasibility Cluster Randomized Controlled Trial Harnessing Mobile Phone Technology Blended With Peer Support. JMIR Research Protocols, 9(1), p.e15058.	Thank you for your comment. The committee recommended the involvement of peer support in rehabilitation programs (see section 1.8). Although peer-support interventions are widely supported in the broader literature for people with mental illness, and were valued by the committee, there was no directly relevant research to guide the involvement of peer support in complex psychosis and rehabilitation services. The committee therefore made a research recommendation in this area. Leggatt 2016 was not included as evidence because it focused on first episode psychosis rather than complex psychosis and related conditions. We did not appraise evidence about digital ways for connection to this cohort. Gumley 2020 was not included as evidence in the guideline for this reason and also because it is a trial protocol.

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Vocational Rehabilitation Association	Evidence review M	014	019	It's harder to be cost-effective at Band 5 because the input costs (staffing) are more expensive. However, concerns that you they do not take into account that you might get different outcomes from a band 4 vs band 5 member of staff - this is an important gap in their analysisIn addition, the cost-effectiveness seems to be based purely on use of health services and quality of life improvements. This does take into account tax/benefit impact (perhaps given this is from NICE, but suggest a need to reference this wider benefit)	Thank you for your comment. It may well be the case that different outcomes are associated with different bands of staff delivering the intervention. The clinical data which informed this analysis was largely made up of studies from the US, where resource use involved in delivering IPS differs considerably from the UK context. We have already noted this as a limitation in the evidence report. NICE economic analysis are conducted from a general NHS perspective and do not incorporate budget impact. However, such budget impacts are taken into account in the NICE resource impact statement which is compiled separately to this analysis.
Vocational Rehabilitation Association	Evidence review M	014	031	NOTE: IPS RCT highlight that the model is reliable across countries See: Brinchmann, B., Widding-Havneraas, T., Modini, M., Rinaldi, M., Moe, C.F., McDaid, D., Park, A.L., Killackey, E., Harvey, S.B. and Mykletun, A., 2019. A meta-regression of the impact of policy on the efficacy of Individual Placement and Support. Acta Psychiatrica Scandinavica.	Thank you for your comment. The committee noted that similar effect sizes were seen in the European IPS studies compared to the US studies - which supports the idea that the IPS model is applicable to different countries. The Brinchmann 2019 study was not included in the evidence review because it was published online in December 2019 (in print in March 2020) during the guideline consultation. Had the Brinchmann 2019 study been included it would not have changed the recommendations: the committee agreed that IPS was effective but it may not be suitable for everyone. Some people may not be ready for mainstream employment and would benefit from alternatives to IPS such as transitional employment schemes.
Vocational Rehabilitation Association	Evidence review M	015	004	Need to capture qualify of life improvements from being in work	Thank you for your comment. The quality of life improvements from being in work, defined as 'employed' in this analysis have already been factored in to the economic model for this question, which was considered by the committee when agreeing recommendations.

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Vocational Rehabilitation Association	Evidence review M	019	021	Rather than recommending other employment schemes in addition to IPS, why not recommend that IPS services support people who don't find work to achieve other goals, e.g., using peer support workers to move off the IPS caseload. Also this area inaccurately suggest that most people are accompanied to IPS appointments by a support worker, which isn't real practice	Thank you for your comment. This recommendation was guided by the results of the guideline systematic review. Peer support interventions were identified in the protocol and discussed by the committee, though it was noted that there was no directly relevant research in rehabilitation services that met the inclusion criteria as outlined in the protocol. The committee therefore made a research recommendation in this area.
Vocational Rehabilitation Association	Evidence review M	006	017	Need to ensure work AND STUDY are clear focus and PART OF recovery plans given the age of the cohortSee: Bond, G.R., Drake, R.E. and Campbell, K., 2016. Effectiveness of individual placement and support supported employment for young adults. Early intervention in psychiatry, 10(4), pp.300-307.	Thank you for your comment. The committee agreed that people should be offered a range of educational and skill development opportunities – tailored to their level of ability and wellness (see recommendations 1.8.7 to 1.8.9). Bond 2016 was not included as evidence because it is a secondary analysis of trials already included in the evidence review.
Vocational Rehabilitation Association	Evidence review M	006	017	Recognise the importance of digital health and digital ways for connection for this cohortSee: Gumley, A., Bradstreet, S., Ainsworth, J., Allan, S., Alvarez-Jimenez, M., Beattie, L., Bell, I., Birchwood, M., Briggs, A., Bucci, S. and Castagnini, E., 2020. Early Signs Monitoring to Prevent Relapse in Psychosis and Promote Well-Being, Engagement, and Recovery: Protocol for a Feasibility Cluster Randomized Controlled Trial Harnessing Mobile Phone Technology Blended With Peer Support. JMIR Research Protocols, 9(1), p.e15058.	Thank you for your comment. We did not appraise evidence about digital ways for connection to this cohort, Gumley 2020 was not included as evidence in the guideline for this reason and also because it is a trial protocol.

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Vocational Rehabilitation Association	Evidence review O	007	014	Clear evidence that IPS can support people with substance misuse history. Consider VR integration into clinical pathwaysSee: Lones, C.E., Bond, G.R., McGovern, M.P., Carr, K., Leckron-Myers, T., Hartnett, T. and Becker, D.R., 2017. Individual placement and support (IPS) for methadone maintenance therapy patients: a pilot randomized controlled trial. Administration and Policy in Mental Health and Mental Health Services Research, 44(3), pp.359-364.See: Black, C.M., 2016. An Independent Review Into the Impact on Employment Outcomes of Drug Or Alcohol Addiction and Obesity. Department for Work and Pensions.	Thank you for your comment. We agree that employment or other occupation may have beneficial effects for those with substance misuse problems but the focus of this question was ways to help these service users engage with substance misuse interventions. Lones 2017 was not included in our evidence reviews because it does not focus on a complex psychosis population. Black 2016 was not included in our evidence reviews because it does not focus on people with both complex psychosis and substance misuse problems - but is concerned with substance misuse in general.
Vocational Rehabilitation Association	Evidence review Q	013	004	Need to also consider how real time access to employment support at time of admission could help reduce time and impact of the psychosis. IPS has been shown to be effective in helping young adults with severe mental illness to attain competitive employment. When young adults acquire competitive jobs and initiate a path towards normal adult roles, they may avoid the cycle of disability and psychiatric patient roles that are demeaning and demoralisingSee: Bond, G.R., Drake, R.E. and Campbell, K., 2016. Effectiveness of individual placement and support supported employment for young adults. Early intervention in psychiatry, 10(4), pp.300-307.	Thank you for your comment. This section of text summarises any evidence found in the evidence review. We looked for evidence of the availability of local components of the rehabilitation pathway (which could include employment support) on successful transition. While working skills and employment status were positively associated with successful discharge there was no evidence about the impact of employment support (although see evidence report M). Duration and severity of psychosis was not prioritised as an outcome for this question however recovery would be captured by the "successful transition from rehabilitation service to other parts of the mental health, social care or primary care systems" outcome. Bond 2016 was not included in the evidence review because it was a secondary analysis of 4 randomised trials already included.

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Vocational Rehabilitation Association	Evidence review Q	006	021	Employment and study must be explored in any holistic assessment and considered as a critical element for a clinician to explore as part of any recovery plan. Recovery is about growth versus a cure. Studies suggest young people do want help with return to study or work and the IPS approach, integrated effectively within early psychosis teams, doubles the rate of success.See: Rinaldi, M., Killackey, E., Smith, J., Shepherd, G., Singh, S.P. and Craig, T., 2010. First episode psychosis and employment: a review. International Review of Psychiatry, 22(2), pp.148-162.	Thank you for your comment. The committee agreed that occupational and educational history should form part of a comprehensive biopsychosocial needs assessment to inform the care plan (see recommendation 1.7.2). Rinaldi 2010 was not included as evidence because it focuses on first episode psychosis whereas our guideline's focus was complex psychosis.
Vocational Rehabilitation Association	Evidence review Q	006	021	A holistic assessment needs to determine support networks and the strength and coping of those networks. We suggest it is useful to understand the potential profound affect of Persons psychosis on carers, relatives and friends and engage with them and support them to support future recovery plan.	Thank you for your comment. The committee agreed that current social network, including any caring responsibilities should form part of a comprehensive biopsychosocial needs assessment to inform the care plan (see recommendation 1.7.2).
Vocational Rehabilitation Association	Evidence review R	010	006	Suggest importance of integrated Vocational rehabilitation services in secondary and community care to support recovery focused plans and transitions into other parts of the health system	Thank you for your comment. This section of text summarises any evidence found in the evidence review. For the housing stability outcome no evidence was found. The committee recommended care plans should be shared with everyone involved in the persons care at each transition point in the rehabilitation pathway (recommendation 1.7.12).
Vocational Rehabilitation Association	Evidence review R	006	015	Under outcomes articulate an aspiration of links with employment support or study or community activities	Thank you for your comment. The outcomes listed here were agreed by the committee before the evidence review was carried out and cannot be changed at this stage. Employment support and community activities were covered in evidence report M.

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Vocational Rehabilitation Association	Question			Q1 - Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why.We think the biggest challenge will be changing clinical staff perceptions about what's possible for patients in terms of return to study or work or starting study or work as part of their recovery journey. Change is necessary to achieve a recovery vision where the individual drives their recovery plan with aspirational thinking promoted by clinical staff such that employment and study are expected goals in a person's life and co-production and peer workers are integrated into clinical pathways and practice.Recovery is an individual journey that occurs within a social and political context. The focus needs to move from treatment, care and containment to civil and human rights, promoting opportunity, choice and control.Recovery-focused mental health policy requires a shift from a primary focus on problem/symptom removal to helping people to live the lives they want to lead, do the things they want to do and participate as equal citizens. Therefore, it is necessary to consider not only ways of changing the person so they 'fit in' (by treating symptoms and remedying skills deficits), but changing the world so it can accommodate the person." Perkins 2012It will be critical to provide clinical staff with training on the link between work/study and health and recovery. Furthermore, consider how to provide practical resources to support them in assisting patients realise broader employment and study goals. This involves ensuring they have access to employment specialist/vocational rehabilitation workers to undertake job seeking and job retention work. Or support in planning for return to study.	Thank you for your comment. We agree and hope that the guideline supports this to happen. Perkins 2012 was not included as evidence in the guideline because it is an expert's view on UK mental health policy development rather than a primary research study in mental health rehabilitation.

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Vocational Rehabilitation Association	Question			Q2 - Would implementation of any of the draft recommendations have significant cost implications?Mental health services need to be stripped back to specialist assessment, treatment and therapy. These professional services need to be easily accessible when needed. A recovery focused ethos where choice and control can be facilitated via personal health budgets allowing anyone with a longer term condition to purchase the treatment and support they find helpful – either from NHS treatment and therapy services or elsewhere should we so desire. Services could include support to manage study or employment, return to study or employment or find study options or employment options. Access to Recovery Colleges.Recovery can, and does, occur without professional interventions! Peer workers and engaging others with lived experience can assist in a person's recovery. "A person's own resources and those available to him/her outside the mental health system are central to the process. There are many paths to recovery, including choosing not to be involved with the mental health system. Recovery is not a professional intervention, like medication or therapy, and mental health workers do not hold the key. Many people have described the enormous support they have received from others who have faced a similar challenge." Perkins and Repper 2003	Thank you for your comment. We hope that the focus on recovery principles is helpful to rehabilitation services. Perkins and Repper 2003 was not included as evidence in the guideline because it is a book about social inclusion and recovery rather than a primary research study in mental health rehabilitation.
Vocational Rehabilitation Association	Question			Q3 - What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.)IPSGROW – IPS mobilistaion support and support in the development of integrated clinical and employment teams NHS England and NHS Improvement – Adult Mental Health Team – policy and governance advice and guidanceCentre for Mental Health – training Vocational Rehabilitation	Thank you for your comment and for highlighting these initiatives. The websites listed were not included as evidence in the guideline as the evidence was limited to published research studies only. Policy papers were not included as evidence, however the committee agreed any that were prominent or commonly mentioned policy documents

				Association – standards, communities of practice and best practice guides for delivery of vocational rehabilitation to compliment clinical care see: https://vrassociationuk.comRecovery colleges at various Trusts and community organisations - https://www.theguardian.com/society/2019/may/14/mental-health-recovery-colleges	relevant to the current time and UK context should be highlighted in the discussion section of the evidence reports.
West London NHS Trust	Guideline		General	It would be helpful to include a section on the values-base expected in a rehabilitation service as these determine the way in which recovery ways of working are fostered. This is referenced to some degree later in section 1.6.7 but would benefit from being developed further. It may be helpful to suggest a model such as Positive Behaviour Support in providing a framework.	Thank you for your comment. The guideline has recommended a recovery-orientated approach which is referenced in recommendation 1.2.1 at the start of the guideline. Section 1.6 covers this in more detail including information about values so we think this is adequately covered as is. We did not find any evidence on the use of Positive Behaviour Support as a model to implement a rehabilitation service. Therefore we are not able to recommend this.
West London NHS Trust	Guideline	011	012	We wish to draw attention to the AIMS-rehab standard for the specific inclusion of peer support workers within rehabilitation services.	Thank you for your comment. Peer support workers have been added to the MDT.
West London NHS Trust	Guideline	012	002 and 005	We think it would be helpful to recommend inpatient units develop clear aims for treatment which broadly determine the purpose of the admission and the anticipated length of stay	Thank you for your comment. This issue is covered by the recommendations on care planning (1.7.7 - 1.7.11). The focus of recommendations 1.5.6 and 1.5.7 is in describing the service that needs to be commissioned.
West London NHS Trust	Guideline	013	001 & 012	This recommendation may be a challenging change in practice because many organisations providing supported accommodation offer a time-limited stay with the use of licences rather than tenancies. The recommendation to “give the person stability” may not be possible but may be better phrased as “promote stability”.In addition, we would suggest that accommodation should take into account a person’s cultural and social needs as well as their mental and physical health needs.	Thank you for your comment. We have made your suggested change about promoting stability. We have also amended the third bullet point of recommendation 1.5.10 to include cultural networks. We have also added a bullet to clarity that supported accommodation should provide support appropriate to the person’s mental and physical health needs.

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West London NHS Trust	Guideline	014	010	We think that an additional recommendation to include regular reviews of progress to define the steps to return to a placement in the local area would be helpful	Thank you for your comment. Recommendation 1.5.16 focusses on what information should be provided to the person in writing when an out of area placement is required. Reviewing progress and agreeing next steps are already covered in recommendation 1.5.15
West London NHS Trust	Guideline	014	014	We are concerned that this description of recovery-orientated rehabilitation does not include enabling	Thank you for your comment. The ethos of the recommendations on recovery-orientated rehabilitation is to facilitate enabling. We do not think this word needs to be specifically mentioned for this to happen.
West London NHS Trust	Guideline	014	021	Given the importance of engagement and use of the therapeutic relationship in rehabilitation, it would be helpful to frame this recommendation as “developing continuity of individual relationships” rather than maintaining	Thank you for your comment. We have amended the text to 'developing and maintaining continuity of individual relationships…'
West London NHS Trust	Guideline	015	009	We are concerned that this recommendation conflates the need to provide accessible information with the therapeutic goal of supporting service users to improve their understanding of their experiences. It may be helpful to frame these as two distinct recommendations	Thank you for your comment. We consider that the two concepts are linked as these are examples of ways in which to improve people's understanding. We have therefore not separated the recommendation as suggested.
West London NHS Trust	Guideline	015	General	We think it would be helpful to include “providing opportunities for skills development” and “self-management” in this section.	Thank you for your comment. Self management of medications has been added to recommendation 1.6.2. The concept of opportunities for skill development is already covered by the existing bullet points in recommendation 1.6.2.
West London NHS Trust	Guideline	015	General	We are concerned that there is no mention of trauma-informed care throughout the document and given the growing evidence base and emphasis in recent NHS guidance e.g., The Community Framework it would be helpful to develop this theme throughout the document.	Thank you for your comment. Trauma is included in the comprehensive biopsychosocial needs assessment (recommendation 1.7.2). Identification of any needs as a result of this assessment will enable them to be included in formulation and care planning. We have added trauma informed care to the examples of psychological informed approaches that staff may need to be trained in (recommendation 1.9.8).

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West London NHS Trust	Guideline	015	General	We are concerned that there is no mention of addressing negative symptoms throughout the document. It would be helpful to reference this in the context of using skills-work, strengths-based work, engagement and re-motivation as part of the MDT approach to treatment	Thank you for your comment. We think that there are multiple references to addressing functional impairments secondary to negative symptoms throughout the guideline (see section 1.6).
West London NHS Trust	Guideline	016	007	We think it would be helpful to recommend the use Reflective Practice and Forums for support e.g., complex case formulation not only as a means by which to acknowledge and manage expectations, but as a means by which to make sense of complex presentations and the challenging behaviours which are a central skill in working with this client group.	Thank you for your comment. Reflective practice is already in the recommendation. We did not find any evidence to support recommending forums.
West London NHS Trust	Guideline	016	012	We would support the widening of non-discriminatory practice to include responding to the specific needs of people with protected characteristics (including, for example, LGBT+)	Thank you for your comment. We have amended the recommendation to include everyone who may experience stigma resulting from their mental health condition as well as any minority status. Those from black, Asian and minority ethnic groups are cited as a specific example because evidence for these groups was identified.
West London NHS Trust	Guideline	016	019	We think it would be helpful to recommend that staff are able to formulate risk and develop risk management plans which seek to manage identified risks	Thank you for your comment. We have amended the recommendation to clarify that staff should be trained and skilled in risk assessment and management.
West London NHS Trust	Guideline	016	023	We think the guidance should go further in recommending that healthcare staff are competent in provide low intensity work which support those with co-existing substance misuse difficulties to access more specialist treatments	Thank you for your comment. These issues are covered in the recommendations on substance misuse in section 1.8 (see recommendations 1.8.15 - 1.8.19).
West London NHS Trust	Guideline	018	General	We think this section should include a prompt for seeking to define protective factors and a more strengths based approach to assessment and formulation	Thank you for your comment. Strengths are already included in recommendation 1.7.2 under taking a psychological and psychosocial history.
West London NHS Trust	Guideline	018	General	We think this section could usefully recommend the use of additional screening tools, especially those for Trauma	Thank you for your comment. Screening tools were not identified as a priority at scoping and so we are not able to make any recommendations in this area.

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West London NHS Trust	Guideline	0	General	We think this section could go further in being more explicit in recommending that the service user takes a central role in co-creating their care plan Good care plans describe the overall aims of the person's stay in rehabilitation as well as break down these goals into smaller, achievable goals.Care plans can also usefully describe the onward care pathway or "move on plans" which are agreed with the service user.	Thank you for your comment. We have amended the recommendation to make it explicit that the care plan should be developed collaboratively with the person.
West London NHS Trust	Guideline	024	003	Additional recommendations could usefully include the staff utilising their skills in using approaches such as motivational interviewing when supporting those with co-existing substance misuse	Thank you for your comment. Motivational interviewing is recommended in 1.8.16.
West London NHS Trust	Guideline	024	013	As in point 1 above it would be helpful to refer more specifically to "pharmacological treatments" rather than "treatment"	Thank you for your comment. This section covers both psychological and pharmacological treatments so we have not made your suggested change.
West London NHS Trust	Guideline	025	011	We think it would be helpful to include third wave CBT approaches which have an emerging evidence base such as Acceptance and Commitment Therapy (ACT) and Compassion Focused Therapy CFT.	Thank you for your comment. We have not appraised the evidence on ACT and CFT as they are emerging techniques and therefore are not able to make any recommendations in this area. We will pass your comment to the NICE Surveillance team which monitors guidelines to ensure they are up to date as evidence on these interventions may be relevant to include in future updates of the guideline.
West London NHS Trust	Guideline	025	011	We think it would be useful to acknowledge the importance of psychologically informed care in guiding the treatment and care planning in rehabilitation services	Thank you for your comment. We have recommended a comprehensive biopsychosocial needs assessment in recommendation 1.7.1, including a psychological and psychosocial history. Identification of any needs as a result of this assessment will enable them to be included in formulation and care planning.

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West London NHS Trust	Guideline	025	011	We think it would be useful to recommend the use of group work which is either supported by or informed by psychological principles of care e.g., recovery groups, interpersonal effectiveness, moving on groups, hearing voices groups, (this list is not exhaustive)	Thank you for your comment. The guideline included a review question which aimed to identify what principles should guide adjustments to standard treatments in the management of underlying psychosis in people using rehabilitation services. This question investigated the effectiveness of interventions for treatment of refractory psychosis resistant to standard treatment and looked at adaptions of psychological interventions, modifications of CBT and modifications of family interventions. We did not find any evidence to support recommending the interventions listed in your comment. However we have emphasised the importance of group work in recommendation 1.8.4.
West London NHS Trust	Guideline	025	011	Reflecting existing NICE guidance, we would welcome the inclusion of offering arts therapies to assist in promoting recovery, particularly in people with negative symptoms.	Thank you for your comment. The guideline included a review question which aimed to identify what principles should guide adjustments to standard treatments in the management of underlying psychosis in people using rehabilitation services. This question investigated the effectiveness of interventions for treatment of refractory psychosis resistant to standard treatment and looked at adaptions of psychological interventions, modifications of CBT and modifications of family interventions. We did not find any evidence to support recommending adjustments to standard art therapies for the population covered by this guideline. Psychological therapies were considered in evidence reports K, L and M. For example art therapy was considered in evidence report L.
West London NHS Trust	Guideline	029	020	We would support the specific inclusion of a recommendation to enable equitable access to primary and secondary healthcare services for physical health comorbidities in this group	Thank you for your comment. It is the aim of the recommendations in section 1.10 to ensure equitable access for those with complex psychosis and physical health comorbidities.

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West London NHS Trust	Guideline	004	005	We are concerned that using the term “treatment-resistant symptoms” to describe the point at which the client group will require rehabilitation services is too narrowly orientated towards pharmacological treatments. It has been suggested the term “incomplete recovery” (IR) is a preferred term which would be more consistent with the spirit of recovery emphasised in the guidelines.	Thank you for your comment. We have used the term 'treatment-resistant symptoms and impairments affecting their social and everyday functioning’ to describe who should be offered a rehabilitation service. As such we do not consider this to be focussed on pharmacological treatment and have not made your suggested change. Treatment resistant symptoms are defined in the ‘terms used in this guideline’ section.
West London NHS Trust	Guideline	005	004	We are concerned that use of the term illness to consider future expectations for progress would be better phrased as “onset of difficulties” so as to orientate the reader to a “wellness model” which is more appropriate when considering the needs of this client group.	Thank you for your comment. Illness is the terms that the service user members of the committee described so we have not made your suggested change.
West London NHS Trust	Guideline	006	001	We think that alongside defining the needs of this client group in the context of “recurrent admissions” or “extended stays” that it is helpful to consider the benefit of rehabilitation as “an intensive period of treatment required to support the service user to gain/re-gain their skills and where less intensive levels of care and/or containment would be insufficient”. We also think it is helpful to consider the need for some service users to be offered a phased approach to discharge to enable them to step-down to an appropriate level of support.	Thank you for your comment. This recommendation is about the data that should be collected in a local rehabilitation service needs assessment to ensure that all those likely to benefit from mental health rehabilitation services are included in service planning. As such it is not appropriate to make your suggested change. We have amended recommendation 1.2.1 to be more explicit that the aim of the rehabilitation service is to help people to progress from more intensively supported to more independent settings over time.

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West London NHS Trust	Guideline	009	024	We are concerned that this guideline does not go far enough in terms of recommending an integrated approach to those with co-existing substance misuse problems. It would be helpful to reference the 2016 NICE guidelines and the importance of partnership working	Thank you for your comment. Recommendation 1.3.17 is for the Lead Commissioner to agree local protocols with specialist substance misuse services so that people in inpatient or community rehabilitation with substance misuse problems can receive the treatment that they need. The guideline makes further recommendations on substance misuse in Section 1.8 (recommendations 1.8.15 - 1.8.19) which includes cross references to the relevant NICE guidance.
West London NHS Trust	Guideline	General	General	We are concerned that there is no mention of the importance reducing Restrictive Practice and the published Guidance by NICE which would be helpful to link and reference	Thank you for your comment. We believe that your comment relates to the use of restraints. This area was not identified as a priority at scoping and so we are not able to make any recommendations on this issue. The NICE guidance on violence and aggression (NG10) contains many recommendations about using restrictive interventions in inpatient psychiatric settings, and NICE expects staff to follow that guidance.
West London NHS Trust	Guideline	General	General	We think it would be helpful to be more explicit about working with challenging behaviours and the role of psychological formulation in understanding the function of behaviours e.g., as a communication	Thank you for your comment. Challenging behaviours were not identified as a priority at scoping and so are not able to make any recommendations on this issue. However, we have emphasised the importance of assessing communication and comorbid mental health conditions. There is existing NICE guidance on Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges (NG11) and Learning disabilities and behaviour that challenges: service design and delivery (NG93).

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West London NHS Trust	Guideline	General	General	We think it would be helpful to describe the work of a rehabilitation service not just in signposting but supporting service users to access community resources e.g., recovery colleges, hearing voices groups.We also think it would be helpful to acknowledge the importance of such groups in providing different ways in which a service user can make sense of their difficulties. Such groups also provide a key role in providing peer support	Thank you for your comment. The section on 'Engagement in community activities, including leisure, education and work' recognises the importance of community engagement, the voluntary sector and peer support for people with complex psychosis. It makes recommendations about supporting service users to engage and does not simply focus on signposting. Where evidence was identified to support naming specific interventions in the recommendations we have done so (for example recovery colleges).
West London NHS Trust	Guideline	General	General	We would suggest that some acknowledgment is given to the role that rehabilitation services can play within the wider community to address stigma to reduce secondary handicaps consequent to peoples' mental health difficulties	Thank you for your comment. We have added reducing stigma to recommendation 1.2.1, which describes the overarching principles of the guideline.
West London NHS Trust	Guideline	General	General	In addition to the specific feedback which focuses on including the perspectives of the MDT to provide a more holistic understanding of the needs of the service users, we are concerned that the current document does not sufficiently recommend the biopsychosocial model in understanding the needs of this client group. We would hope, therefore, that Rehabilitation guidelines are a real opportunity to consider the skills and competencies required when working with this client group. We believe the document is helpful in fully considering the importance of integrated approaches to commissioning and service provision but could go much further in describing the need for clinical teams to take an integrated and holistic approach to their work. Such work needs also to take place within a framework of high level competencies and values which underpin the successful delivery of biopsychosocial informed treatments for this group of highly complex individuals.	Thank you for your comment. We agree and have amended recommendation 1.7.1 to emphasise the biopsychosocial nature of the comprehensive needs assessment, the results of which are used in formulation and care planning. We recognise that a multidisciplinary approach is required and have recommended this in 1.5.1, including specifying some of the members of the MDT required in mental health rehabilitation services, all of whom have a role in developing the formulation and individualised care plans for each service user. We have also recommended in 1.5.2 those specialties which the MDT will need to have access to. In recommendations 1.6.8 – 1.6.14 we also cover the staff competencies required for all those working in rehabilitation services.

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West London NHS Trust	Guideline	General	General	We think it would be helpful to reference documents which have attempted to develop the understanding of Psychosis from biopsychosocial model. The BPS document Understanding Psychosis and Schizophrenia 2017 would be a helpful reference on this point.We also think citing broader programmes such as IMROC which aim to embed recovery ways of working across organisations would be helpful to reference.	Thank you for your comment. Unfortunately, we are not able to cross reference to non-NICE guidance in the recommendations. We have also not examined the evidence on programmes such as IMROC and so are not able to recommend them.