National Institute for Health and Clinical Excellence

Bipolar disorder (update)
Scope Consultation Table
16 May – 14 June 2012

No	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
1	British Association for Behavioural and Cognitive Psychotherapy (BABCP)	1	General	We appreciate this opportunity to give feedback on the scope document and hope that these comments will be useful. I have listed specific comments in relation to each point. In addition the following points should be highlighted -The needs of carers has not been adequately addressed. Further discussion is needed around the needs of carers and interventions that can specifically address these AND the role that carers can play in improving outcome for service users (eg. supporting recognition of early warning sites etc) and interventions which can involve them appropriately to maximise this impact. -There is no mention of interventions to train staff to improve knowledge, understanding and strategies for people with bipolar. -More detail generally on specific psychosocial interventions is needed to distinguish specific interventions with an evidence base, from those without - A life span perspective would be helpful to highlight the evidence for early intervention in bipolar – and progressing through to bipolar in older adults to help clinicians identify the best interventions depending on age and stage of illness -the importance of physical health monitoring to reduce LT health risks and reduced life expectancy and potential benefits of interventions to reduce diabetes in very overweight patients	Thank you for your comments. The input of carers on service user's experience of care will be considered during the development of the guideline, but specific carer interventions will not be reviewed. However, carer outcomes are listed in section 4.4. Specific details of training are a matter for local implementation, and outside the scope of this guideline. We hope that this guideline will improve the knowledge, understanding and strategies for the management of bipolar disorder for clinicians and service users. The focus of this guideline, and all NICE guidelines, is precisely to identify and recommend those interventions that have an evidence base.

					This guideline will be looking at the evidence for the treatment of bipolar in children, young people, adults and older adults and how different treatments may be needed for different age groups, as listed in section 4.3.1 j). We agree this was an oversight to omit monitoring of physical health and have added it to 4.3.1k).
2	British Psychological Society	1	General	The BPS has concerns that the proposed revisions to the 'C05, Bipolar Disorder Not Elsewhere Classified' category within DSM-V will significantly expand the number of individuals likely to receive this diagnosis, but that the evidence-base to date derives from narrower definitions of bipolar disorder.	Thank you for your comment. We agree this is an important issue, however we are unable to comment on a document that is not yet published. We will however clarify the relationship between the guideline and the revised DSM/ICD criteria in the introduction to the guideline.
3	NHS Direct	1	General	NHSD welcome the update and have no comments on the scope.	Thank you.
4	Royal College of Nursing	1	General	The Royal College of Nursing welcomes proposals to update this guideline. It is timely. The draft scope seems comprehensive	Thank you for your comments.
5	Royal College of Paediatrics and Child Health	1	General	The main issue is appropriate representation of patients/ users and carers. There are usually two users and one carer on a Guideline Development Group. As the guideline includes children and young people at least one user under 18 years and one parent carer (ideally under 16 years) should be included on the GDG.	Thank you for your comments. We will try to ensure there is a representative spread of experience across the whole GDG.
6	Royal College of Psychiatrists	1	General	On **behalf of the faculty of the Psychiatry of Intellectual Disability**, our comments are as follows: The scope of the guideline does not refer specifically to people with intellectual disabilities as one of the groups that may merit additional mention in the guideline.	Thank you for your comments, NICE have been commissioned to develop a guideline looking specifically at learning disabilities and mental health and therefore these issues

				I would like to bring to the attention of the guideline development/update group the “equity lens” that purports to balance any health inequalities arising as an inadvertent outcome of the clinical practice guidelines for disadvantaged population groups. The original guideline referred to people with intellectual disabilities as being at high risk of the disorder but we believe that the scope of the update should also mention this group before any changes are made to safeguard against omission. here is concern as to whether the evidence for BAD in this people with intellectual disabilities can be readily identified if it is not the main focus of the group and there are no experts in the speciality included in its discussion. **Ref: Mizen et al (2012). Implementation Science, 7:42**	will be covered in that guideline.
7	Association For Rational Emotive Behaviour Therapy	1	Section 1. Guideline title	11. Section 1. Guideline title: should the document address ‘bipolar disorder**s**’ and not ‘bipolar disorder’ in title and subsequent header/footers etc. It could be poor practice if clinicians started talking about bipolar disorder in general as there are different ones and distinctions of these kinds are crucial for accurate diagnoses. (Although we appreciate in the stakeholders covering letter bipolar disorders are mentioned but looking at the 2006 original guideline the booklet titled the booklet: bipolar disorder.)	Thank you for the comment. Bipolar disorder is a generic description of the condition and was the term used in the guideline that was originally published in 2006 and is now being revised. The guideline will be consider evidence for all types of bipolar disorder (as much of the research has done) and separately when data are available in bipolar 1 disorder, bipolar 2 disorder and rapid cycling in different age groups.
8	British Association for Psychopharmacology	1		**Need to appraise evidence on depot antipsychotics in bipolar maintenance**	Thank you for your comments, the evidence of antipsychotics will be reviewed.
9	British Association for Psychopharmacology	2		The critical question is whether or not the guideline should be reviewed. This seems clearly necessary given the vast amount of data identified that was not included in the 2006 guideline. We list this in detail below. Our overall conclusion is that there is real clinical equipoise around the use of a number of treatments, especially in the	Thank you for your comments, we will be updating the guideline.

				management of bipolar depression. We therefore strongly support a review.	
10	British Association for Psychopharmacology	3		There is variation in the practice that was recommended in the current guideline. Bipolar depression is main area for this – increased use of quetiapine as first-line and less use of antidepressants as data now confirms a suspicion that they don't work so well in bipolar depression.	Thank you for your comments, the evidence base for the use of pharmacological interventions will be reviewed in the guideline.
11	British Association for Psychopharmacology	4		There are new national policies or priorities that impact on the current guideline.	Thank you for your comments, the GDG will keep national policies in mind when drafting the guideline However they will not be specifically referenced in the recommendations as these should be based on data for the efficacy of interventions, not national policy.
12	British Association for Psychopharmacology	5		National/significant audits of practice/implementation have been reported since the publication of the current guideline	Thank you for your comments, the GDG will keep national policies in mind when drafting the guideline However they will not be specifically referenced in the recommendations as these should be based on data for the efficacy of interventions, not national policy.
13	British Association for Psychopharmacology	6		New evidence suggests that practice as recommended in the guideline may not be best practice. EG. new evidence for demonstrating clinical utility of assessments and clinical effectiveness, new studies demonstrating better value for money (i.e. cost-effectiveness studies) for the recommended interventions (see below), recent price fluctuations in resources/treatments for the recommended interventions: Lamotrigine came off patent and reduced from around £50 a pack to £5. Olanzapine will come off patent later this year (September 2011) Quetiapine plain will come off patent next year (March 2012)	Thank you for your comments, the guideline will review all recent and relevant evidence when making recommendations for the treatment of bipolar disorder.

				Risperidone came off patent in 2007 and significantly dropped in price Seroquel XL as being licensed for bipolar conditions rather than Seroquel plain	
14	British Association for Psychopharmacology	7		Relevant ongoing research :	Thank you.
15	British Association for Psychopharmacology	8		A new review of the evidence or an economic evaluation is likely to reduce existing uncertainties in areas of bipolar depression.	Thank you for your comments, the guideline will review all recent and relevant evidence when making recommendations for the treatment of bipolar disorder.
16	British Association for Psychopharmacology	9		There are current inequalities in access to services or service provision that are not addressed in the current guideline	Thank you for your comment, the inequalities of access for this group are very similar to those in people with schizophrenia and a comprehensive piece of work was carried out in the NICE Schizophrenia guideline. This guideline will look at instruments to improve recognition of bipolar.
17	British Association for Psychopharmacology	10		This seems clearly necessary given the vast amount of data identified that was not included in the 2006 guideline. There is real clinical equipoise around the use of a number of treatments, especially in the management of bipolar depression.	Thank you for your comments.
18	British Association for Psychopharmacology	11		Quetiapine (Seroquel) XL preparation	Thank you for your comments, the guideline will review all recent and relevant evidence when making recommendations for the treatment of bipolar disorder.
19	British Association for Psychopharmacology	12		Lamotrigine is now licensed for relapse prevention in bipolar depression (about a year ago, not many people know that) NPSA alert on lithium monitoring	Thank you for your comments, the guideline will review all recent and relevant evidence when making recommendations for the treatment of bipolar disorder.

20	British Association for Psychopharmacology	13		POMH-UK on use of lithium, showed monitoring was very poor	Thank you for your comments, the guideline will review all recent and relevant evidence when making recommendations for the treatment of bipolar disorder.
21	British Association for Psychopharmacology	14		SEQUEL trial, Oxford, quetiapine +/- Lamotrigine +/- folic acid	Thank you for your comments, the guideline will review all recent and relevant evidence when making recommendations for the treatment of bipolar disorder.
22	British Association for Psychopharmacology	15		**Recent publications on bipolar (since 2006)** **Maintenance therapy** **Aripiprazole** Aripiprazole is now licensed for prevention of recurrence of manic episodes in bipolar I, in people who have responded acutely. The maintenance dose is the same as the acute dose. In supporting studies, 15–30mg/d was superior to placebo for reducing relapse in bipolar mania in those responding over 6/52 (n=161, RCT, d/b, p/c, 6/12, Keck *et al*, *J Clin Psychiatry* 2006;67:626–37; two-year extension, n=161, RCT, d/b, p/c, two years, Keck *et al, Am J Psychiatry* 2007;164:1480–91). **Olanzapine** Olanzapine is indicated for the prevention of recurrence in patients with bipolar disorder whose manic episode has responded to olanzapine, where maintenance olanzapine reduces relapse to subsequent mood disorder compared to placebo, although people with an index depressive episode in the open phase were excluded (n=361, RCT, p/c, 48/52, Tohen *et al*, *Am J Psychiatry* 2006;163:247–56; MS; comment by Citrome, *EBMH* 2006;9:73). Two systematic reviews from Cipriani have summarised the data. One concludes that olanzapine helps prevent manic episodes, but only in people who have responded in an acute or mixed episode and have not	Thank you for these references, they will be reviewed to see if they fit our inclusion criteria, along with all other identified new research.

				responded to lithium or valproate (s=5, RCT, Cipriani *et al, J Psychopharmacol* 2010;[in press]). Cochrane concludes that although the data is limited, olanzapine may prevent relapses in people responding during an index manic or mixed episode and who have previously not responded to lithium or valproate, although the evidence is stronger for lithium as a first-line maintenance treatment of bipolar disorder (s=5, n=1165, Cipriani *et al, Cochrane Database Syst Rev* 2009; 1:CD004367). A meta-analysis of studies has concluded that although there is evidence to support olanzapine being more effective than in placebo in preventing relapse of mania in people who have responded to it in the acute phase, there was **no** difference between olanzapine (alone, or with lithium or valproate) and placebo (alone, or with lithium or valproate) in preventing relapse to any other mood episode (s=5, RCT, n=1165, Cipriani *et al, J Psychopharmacol* 2010;**24**:1729-38). So extrapolation of license as meaning it's a mood stabiliser is wrong. **Lithium + antipsychotics** In patients stabilised on quetiapine and lithium, continued treatment reduced the risk of relapse (20% vs 52%) compared to placebo (n=1953, open, <36/52; then n=628, RCT, d/b, p/c, <104/52, Suppes *et al, Am J Psychiatry* 2009;166:476–88; see also RCT, d/b, p/c, <2 years, Vieta *et al, J Affect Disord* 2008;109:251–63). **Lithium + oxcarbazepine** Oxcarbazepine appeared more effective and better tolerated than carbamazepine as add-on to lithium for residual bipolar I and II symptoms (n= 52[c=52], RCT, d/b, 8/52, Juruena *et al, Prog Neuropsychopharmacol Biol Psychiatry* 2009;33:94–9). **Valproate + antipsychotics** Many combinations are used, although there is little data to show a proven efficacy. In patients stabilised on quetiapine and valproate, continued treatment reduced the risk of relapse (20% vs 52%) compared to placebo (n=1953, open, <36/52; then n=628, RCT, d/b,	

				p/c, <104/52, Suppes *et al, Am J Psychiatry* 2009;166:476–88; see also RCT, d/b, p/c, <2 years, Vieta *et al, J Affect Disord* 2008;109:251–63). **Lithium and lamotrigine is better for BP than lithium monotherapy** Addition of paroxetine helps but not in people who have not responded to lithium and Lamotrigine (n=124, RCT, d/b, p/c, 16/52, van der Loos et al, Acta Psychiatr Scand 2010;122:246-54). **Antidepressants** A meta-analysis has shown that long-term adjunctive antidepressants are not superior to mood-stabilisers alone, and with an unfavourable risk:benefit for antidepressants as long-term therapy in bipolar (s=7, n=350, Ghaemi *et al, Acta Psychiatr Scand* 2008;118:347–56). Valproate + lithium The BALANCE study has shown lithium, and valproate plus lithium, to be superior to valproate alone for relapse prevention (n=330, RCT, open, ≤2yrs, Geddes *et al, Lancet* 2010;**375**:385-95). **MANIA AND HYPOMANIA** Systematic reviews have shown combining a second generation antipsychotic with a mood stabiliser (MS) is significantly more effective than a MS alone in acute mania (s=24, n=6187, Scherk *et al, Arch Gen Psychiatry* 2007;64:442–55; comment by Perlis, EBMH 2007;10:111; s=8, n=1124, RCT, Smith *et al, Acta Psychiatr Scand* 2007;115:12–20). **Aripiprazole** Aripiprazole is at least as effective as haloperidol in acute mania, maintained for 12 weeks, with haloperidol having more side-effects	

				(n=485, RCT, d/b, p/c, 12/52, Young *et al, Br J Psychiatry* 2009;194:40–8; n=272, RCT, d/b, p/c, 3/52, Sachs *et al, J Psychopharmacol* 2006;20:536–46). **Asenapine (may be licensed 2011)** In manic or mixed episodes, asenapine (mean 18.2mg/d) was rapidly effective, well tolerated and as effective as olanzapine (n=488, RCT, d/b, p/c, 3/52, McIntyre *et al, Bipolar Disord* 2009;11:673–86). **Lithium + allopurinol** Allopurinol 600mg/d was significantly superior to placebo as an adjunct to lithium in mania and may provide an alternative to antipsychotics (n=120, RCT, d/b, p/c, 4/52, Machado-Vieira *et al, J Clin Psychiatry* 2008;69:1237–45). **Olanzapine + carbamazepine** Olanzapine plus carbamazepine had no advantage (and had more side-effects) compared to carbamazepine alone in mania, (n=118, RCT, d/b, p/c, 6+20/52, Tohen *et al, Br J Psychiatry* 2008;192:135–43; MS). **Valproate + folic acid** Folic acid added to valproate was superior to placebo as an adjuvant in acute mania, an astonishing finding (n=88, RCT, d/b, p/c, 3/52, Behzadi *et al, Acta Psychiatr Scand* 2009; 120:441–5). **Tamoxifen** Tamoxifen (a protein kinase C inhibitor) has, at last, an RCT confirming that it has significant antimanic activity and is remarkably well tolerated (n=66[c=50], RCT, d/b, p/c, 3/52, Yildiz *et al, Arch Gen Psychiatry* 2007;64:255–63). Tamoxifen 20–140mg/d was also significantly superior (63% response) to placebo (13% response) in bipolar mania, as early as day 5 (n=16, d/b, p/c, 3/52, Zarate *et al, Bipolar Disorders* 2007;9:561–70).	

				Bipolar depression **Quetiapine** Quetiapine is now licensed for treatment of severe depressive episodes in bipolar disorder, but not for prevention of recurrence. A slower dose increase is recommended: (night-time, day 1 50mg; day 2 100mg; day 3 200mg; day 4 300mg). Monotherapy efficacy has been shown in two robust RCTs (BOLDER 1 and 2). BOLDER 1 showed response rates in bipolar 1 depression of 58.2% (600mg/d) and 57.6% (300mg/d), compared with 36% for placebo (remission was 52.9% vs 28.4%). Treatment for emergent mania was 3–4% for both groups (n=542, RCT, d/b, p/c, 8/52, Calabrese *et al, Am J Psychiatry* 2005;162:1351–60). A secondary analysis showed an anxiolytic effect in bipolar I depression (n=542, RCT, 8/52, p/c, Hirschfeld *et al, J Clin Psychiatry* 2006;67:355–62) and a post-hoc analysis showed an NNT=5 for response and remission of bipolar depression (Cookson *et al, Int Clin Psychopharmacol* 2007;22:93–100).BOLDER 2 showed quetiapine 300mg and 600mg/d monotherapy were equally effective in bipolar I and II depression, with less switching than placebo and the effect visible from week 1 (n=509[c=300], RCT, 8/52, d/b, p/c, Thase *et al, J Clin Psychopharmacol* 2006;26:600–9; s=2, n=694, RCT, d/b, p/c, 8/52, Weisler *et al, J Clin Psychiatry* 2008;69:769–82), replicated by the EMBOLDEN trials (e.g. n=270, RCT, d/b, p/c, 8/52, Suppes *et al, J Affect Disord* 2010;12:106-15). Comparison of quetiapine vs. lithium in acute bipolar depression - Quetiapine 300 and 600mg/d were superior to placebo, whereas lithium wasn't (n=802, RCT, d/b, p/c, 8/52, Young et al, J Clin Psychiatry 2010;71:150-62). **Valproate** Systematic review and meta-analysis Preliminary evidence for some efficacy 24% response on placebo 41% on valproate **So NNT= 5.9**	

				(s=4, n=142, RCT, d/b, p/c, Smith et al, J Affect Disord 2010;122:1-9; bizarrely the same s=4, n=142, RCT, d/b, p/c, Bond et al, in the same J Affect Disord 2010;124:228-34). **Lithium + lamotrigine** In the only augmentation study, significantly more people responded to lamotrigine augmentation of lithium than placebo in acute bipolar depression (n=124, RCT, d/b, p/c, 8/52, van der Loos *et al, J Clin Psychiatry* 2009;70:223–31). **Olanzapine + fluoxetine (OFC)** The olanzapine-fluoxetine combination (OFC) is licensed for bipolar depression in the US as 'Symbyax' (6/25, 6/50, or 12/50mg/day. OFC was more effective than lamotrigine 200mg/d for bipolar I depression but with more side-effects, although relapses were equivalent (n=410, RCT, d/b, 25/52, Brown *et al, Int J Neuropsychopharmacol* 2009;12:773–82, MS; see also n=410, RCT, d/b, 7/52, Brown *et al*, *J Clin Psychiatry* 2006;67:1025–33: MS; comment by Nirenberg, *EBMH* 2007;10:12, noting that the 5/52 titration period with lamotrigine would have left only 2/52 at full dose so it is surprising it did so well). **Antipsychotics (other)** There is some preliminary data on the use of aripiprazole, e.g. mean 15mg/d was effective and reasonably well tolerated as add-on in resistant bipolar depression (n=30[c=16], open, Ketter *et al, Ann Clin Psychiatry* 2006;18:169–72) and aripiprazole as adjunctive (54%) or monotherapy (46%) was associated with some improvements (n=85[c=80], open, 16/52, Mazza *et al, Expert Opin Pharmacother* 2008;9:3145–9), supported by a chart review (n=12, 8/52, Kemp *et al, Prog Neuropsychopharmacol Biol Psychiatry* 2007;31:574–7). **Lamotrigine** A robust and independent meta-analysis of the 5 studies (3 unpublished) showed a consistently beneficial effect in bipolar	

				depression, greater in more severe depression (s=5, n=1072, RCT, d/b, p/c, Geddes *et al, Br J Psychiatry* 2009;194:4–9). In patients with bipolar depression unresponsive to a mood stabiliser and at least one antidepressant, response to lamotrigine was 24% (cf. inositol 17% and risperidone 5%; n=66, RCT, 16/52, open, Nierenberg *et al*, *Am J Psychiatry* 2006;163:210–6). **Omega-3 fatty acids** Ethyl-EPA (ethyl-eicopentaenoic acid) was effective in bipolar depression, with 1–2g/d superior to placebo (n=75, RCT, d/b, p/c, 12/52, Frangou *et al, Br J Psychiatry* 2006;188:46–50), but in another study EPA 6g/d had no overall efficacy on any marker in bipolar depression (RCT, p/c, 4/12, Keck *et al, Biol Psychiatry* 2006;60:1020–3). Antidepressants: In patients who got better with antidepressants and an MS after bipolar depression: In those that carried on with antidepressants: No statistical benefit of antidepressants, no symptomatic benefit, no enhanced remission, no relapse prevention, although mild positive effects seen, rapid-cycling was worse though (n=70, 3yrs, Ghaemi *et al, J Clin Psychiatry* 2010;**71**:372-80).	
23	British Association for Psychopharmacology	16		Lithium monitoring – huge variation, NPSA have data, lots of reported incident in some areas of the UK	Thank you for your comments, the guideline will review all recent and relevant evidence when making recommendations for the treatment of bipolar disorder.
24	College of Occupational Therapists	1		The College of Occupational Therapists welcomes the draft scope on Bipolar Disorder, and has no additional comments to make at this time.	Thank you.
25	Department of Health	1		Thank you for the opportunity to comment on the draft scope for the above clinical guideline.	Thank you.

				I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.	
26	Lancashire Care NHS Foundation Trust	1	3.1 a	I am pleased to see the use of the phrase “potentially lifelong condition” as previous guidance (and many other publications) fail to acknowledge the potential for recovery and the lack of longitudinal evidence around the long term prognosis for people with this diagnosis.	Thank you.
27	Lancashire Care NHS Foundation Trust	2	3.1 b	We queried the adult and young person’s UK prevalence figures, could these be double checked please?	Thank you for your comment, we have double checked and slightly amended these figures.
28	Lancashire Care NHS Foundation Trust	3	3.1 d	Given the disparity between biomedical and psychosocial research funding in this area, it may be fairer to assume that the jury is still out on questions about the relative roles of biological and environmental influences on aetiology. Perhaps a truly balanced approach to the current state of evidence might state that “it is thought that biological, psychological, social and environmental factors may contribute to the development and maintenance of bipolar disorder, (but further research is required in this area).	Thank you for your comments. We have stated that the aetiology is unknown but that genetic and biological factors are important given that there is compelling evidence that genetics and pregnancy are implicated in the onset of at least some cases of bipolar disorder, but that so far no other aetiological factors have been clearly established. We have amended the text to implicate psychological factors (such as high expressed emotion, attributions and self-esteem) as playing a role in the course of the condition from observational, experimental and intervention studies, along with lifestyle e.g. social rhythm and environmental e.g. temperature or seasonal factors.
29	British Psychological	2	3.1. d)	We believe it would be appropriate to note that psychological factors have a role in bipolar disorder.	Thank you for your comments. We have amended the text to implicate

	Society				psychological factors (such as high expressed emotion, attributions and self-esteem) as playing a role in the course of the condition from observational, experimental and intervention studies, along with lifestyle e.g. social rhythm and environmental e.g. temperature or seasonal factors.
30	British Association for Behavioural and Cognitive Psychotherapy (BABCP)	2	3.1.b	**"The lifetime prevalence of bipolar I disorder (depression and mania) is estimated at 0.8% of the adult population, with a range between 0.4% and 1.6%."** This is probably an underestimate – note Merikangas et al's (2012) recent epidemiological study shows a lifetime rate of 2.4% in adolescents; 1.7% for the lifetime occurrence of a syndromal manic episode.	Thank you for your comment, we have double checked and slightly amended these figures.
31	British Association for Behavioural and Cognitive Psychotherapy (BABCP)	3	3.1.b	**"The median age of onset is 21 years for both men and women."**Similarly, the median age at onset of 21 is on the high side. See Merikangas et al (2009) – mean age of 18.	Thank you for your comment. In view of the work of Merikangas and others, we have amended our estimate of the median age of onset to 19 years.
32	British Association for Behavioural and Cognitive Psychotherapy (BABCP)	4	3.1.d	**"The aetiology of the disorder is uncertain but genetic and biological factors are important. The impact of environmental factors is also uncertain but there is growing evidence that environmental and lifestyle features can have an impact on severity and course of illness."**It is stated that genetic and biological factors are important, and environmental and lifestyle features are mentioned, but I think it might be good to emphasize psychological factors as well and to make sure that the term "environmental" includes stress and daily hassles. Especially given the recent review about attitudes towards mental health problems in Acta Psychiatrica Scandinavica (Schomerus et al., 2012) showing that adopting a medical model of mental health issues is not necessarily related to a decrease in negative attitudes, I think we need to watch carefully not to overemphasize biology and	Thank you for your comments. We have amended the text to implicate psychological factors (such as high expressed emotion, attributions and self-esteem) as playing a role in the course of the condition from observational, experimental and intervention studies, along with lifestyle e.g. social rhythm and environmental e.g. temperature or seasonal factors.

				genetics.	
33	Lancashire Care NHS Foundation Trust	5	3.2 b	Whilst it is true that more people are under the care of community services rather than inpatient services, Is there data to support the statement that "most people with bipolar disorder are … supported by community mental health teams"? Does this refer to bipolar 1 or all subtypes? What proportion of people who meet criteria for a bipolar diagnosis are not in contact with any mental health services? Also, it is worth acknowledging the range of community based specialist mental health services (e.g. Crisis Resolution & Home Treatment Teams, Early Intervention (at least for people experiencing psychotic symptoms).	Thank you for this comment. Your point is well taken. We have examined some service use data from a number of studies performed in the United Kingdom that show people with bipolar 1 disorder are supported by a range of community services including community mental health teams. We have removed the reference to community mental health teams.
34	Association for Family Therapy and Systemic Practice (AFT)	3	3.2.a 5.3.1.	Suggest the value of family based treatments is included for people who have bipolar plus some other disorders, as there are recommendations for these treatments that will be relevant. The significance of family therapies is recognised as effective for young people with alcohol and drug problems, depression and to prevent Antisocial Personality Disorder as well as couple therapies for adults with alcohol problems, and common mental health disorders. The relevance of family interventions for psychoses is also recognised. CG115 Alcohol Dependence and Harmful Alcohol Use CG77 Antisocial Personality Disorder	Thank you for your comments, it is not the purpose of the scope to make recommendations for treatment of bipolar but rather to set out the areas in which the GDG will look for evidence when drafting the guideline.
35	British Association for Behavioural and Cognitive Psychotherapy (BABCP)	5	3.2.b	**"...While most people with bipolar disorder are treated or maintained in the community, supported by community mental health teams, during severe depressive and hypomanic/manic episodes hospital admission is sometimes required -** I think that we should make sure that the term "hypomania" is deleted here since a hospitalization would indicate mania or this would open the doors to lower the threshold for hospitalization.	Thank you for your comment, this has been amended.
36	British Association for Behavioural and	6	3.2.c	There have been recent proposals to extend the diagnostic group of bipolar disorder – I think it needs to be highlighted that there are	Thank you for your comment. We acknowledge that both DSM-V and

	Cognitive Psychotherapy (BABCP)			potentially both benefits and costs of doing this – and that more research is needed to understand that likely balance of these for individuals	ICD-11 are currently considering criteria for the bipolar spectrum but these are not finalised. This group of patients are outside the scope of the current guideline, which will be confined to bipolar 1 and bipolar 2 disorder including rapid cycling and mixed affective episodes..
37	British Association for Behavioural and Cognitive Psychotherapy (BABCP)	7	3.2.f	This outlines the devastating effects of bipolar disorder which is crucial. However, the guideline needs to also acknowledge the possible benefits that some people experience in relation to bipolar and the need to understand these as well in order to fully engage people in treatment eg Lobban et al 2012 – Journal of Affective Disorders	Thank you for your comment which we will bear in mind during guideline development when we consider service user and carer experience. Service users and carers will be represented on the Guideline Development Group and their experiences form an important part of the guideline.
38	Lancashire Care NHS Foundation Trust	4	3.2a	Typographical error in examples of comorbid conditions “substance drug misuse”. Also, anxiety disorders & PTSD should be included here.	Thank you for your comment, the typo has been amended. This list is purely illustrative and not exhaustive.
39	Lancashire Care NHS Foundation Trust	6	3.2c	Will the updated guidance include consideration of the bipolar spectrum concept within its’ scope? **There was considerable support for this from the stakeholder scoping workshop.**	Thank you for your comment. We agree this is an important issue, however we are unable to comment on a document that is not yet published. We will however clarify the relationship between the guideline and the revised DSM/ICD criteria in the introduction to the guideline.
40	Lancashire Care NHS Foundation Trust	7	3.2f	As physical health can be a major issue for this population, it may be helpful to address physical health screening in the guidance.	Thank you for your suggestion, on reflection we agree this was an oversight and have added the monitoring of physical health to 4.3.1k).

41	Lancashire Care NHS Foundation Trust	8	4.1	As stated previously, there was **strong support** from stakeholders at the scoping workshop for the inclusion of the broader bipolar spectrum concept in addition to the more narrowly defined DSM/ICD categories listed here. The exclusion criteria seem reasonable and pragmatic.	Thank you for your comment. We agree this is an important issue, however we are unable to comment on a document that is not yet published. We will however clarify the relationship between the guideline and the revised DSM/ICD criteria in the introduction to the guideline.
42	British Association for Behavioural and Cognitive Psychotherapy (BABCP)	8	4.1.1	Although there is not much evidence out there yet, it might be useful to include “cyclothymic disorder” in the groups that will be covered to increase awareness (see page 3, point 4.1.1). I am not sure and have not checked but I assume that the NICE guidelines for depression will have included “dysthymia”; therefore it would only be logical to at least cover cyclothymic disorder as well	Thank you for your comment, it has been agreed that cyclothymic disorder will not be included in this scope as it is not included in the diagnosis of bipolar disorder, and was not covered in the original bipolar NICE guideline.
43	Lundbeck	1	4.1.1	Lundbeck recommend that NICE consider elderly patients as a specific sub-group. While the treatment strategies for geriatric bipolar disorder patients are similar to those for younger patients, it is clear that special consideration must be given to the elderly patient. This is particularly relevant with regard to pharmacologic interventions because of the pharmacokinetic differences in drug metabolism in older individuals. In addition, elderly patients may have greater difficulty with issues such as transportation and accessibility and may have complicated financial situations that present further challenges to treatment.(Kyomen HH ,The impact of elderly patients with bipolar disorder on the health care system. Presented at the American Psychiatric Association 159th Annual Meeting; May 20-25, 2006;Toronto, Ontario, Canada)	Thank you for your comments. This guideline will be looking at the evidence for the treatment of bipolar in children, young people, adults and older adults and how different treatments may be needed for different age groups, as listed in section 4.3.1 j).
44	Lundbeck	2	4.1.1	Lundbeck additionally recommend that NICE look specifically at the issue of long-term patient safety when choosing antipsychotic treatments. Specifically, Lundbeck recommend NICE consider the treatment-associated risks of increased weight gain to patients with metabolic syndrome or at risk of developing metabolic syndrome. Lifestyle, illness and treatment factors in people with bipolar disorder	Thank you for your comments, this guideline will be looking at side effects of medication (see section 4.3.1 k) and specifically interventions for weight gain (see section 4.3.2 b).

				(BD) may confer additional risk of morbidity and mortality due to the increasing rates of obesity, metabolic syndrome, diabetes mellitus and cardiovascular mortality in the general population. (Richard Morris J Psychopharmacol November 2005 vol. 19 no. 6 suppl 94-101). Because some of the currently used antipsychotics increase the risk of developing metabolic syndrome, Lundbeck recommend that NICE pay particular attention to those patients who are at a higher risk of developing metabolic syndrome (For example patients with BMI>25) or those who have already a metabolic syndrome. A poor metabolic profile is associated with an increased risk of diabetes, coronary heart disease and other metabolic complications. (Wilson PWF et al. Circulation. 1998: 97:1837-1847)	
45	Mind	1	4.1.1 and 3.2 (c) and (d)	Is cyclothymia excluded from the scope? My understanding was that it is part of the bipolar spectrum and the diagnostic distinction between bipolar II and cyclothymia is in any case very narrow (I have received both diagnoses from separate consultants on the basis of the same history). I would suggest including it as a) many people with cyclothymia are subsequently diagnosed with bipolar I or II and b) treatment regimes are very similar and c) given the note in 3.2 (d) on the under-recognition of hypomania any guidance on the recognition and management of hypomania should reference its manifestation both in bipolar II and cyclothymia.	Thank you for your comment, it has been agreed that cyclothymic disorder will not be included in this scope as it is not included in the diagnosis of bipolar disorder, and was not covered in the original bipolar NICE guideline.
46	British Association for Behavioural and Cognitive Psychotherapy (BABCP)	9	4.1.2 a)+b)	Clear links need to be made to guidelines for common co-morbid disorders if they are not to be covered in this guideline	Thank you for your comments, other relevant guidelines will be clearly cross referenced.
47	British Psychological Society	3	4.1.2. a)	If this guideline will not make recommendations about coexisting conditions, we believe that links to other guidelines should be made extremely clear so that clinicians and patients can find such guidance easily. This is particularly the case for problems such as substance misuse and anxiety, for which there are increasing arguments for integrating	Thank you for your comments, other relevant guidelines will be clearly cross referenced.

				service delivery with that for bipolar disorder itself.	
48	South West Yorkshire Partnership NHS Foundation trust	1	4.2	Will there be clarification of the responsibilities of primary care and secondary care practitioners in the physical monitoring of this patient group as there are clear differences in opinion in different Trusts, as well as fundamental differences in the parameters listed for QOF points in primary care and for example the Maudsley Guidelines which are used in secondary care?	Thank you for your comment, this level of detail is a matter for local implementation, we have however added the monitoring of physical health to 4.3.1k).
49	Lancashire Care NHS Foundation Trust	11	4.2.3a	See comments for 4.3.1 d. Also, the psychosis/schizophrenia guidance is for adults, and will not cover service level interventions for children and young people (perhaps with the exception of people who meet EIP criteria).	Thank you for your comments, it was an omission to not include reference to the *Psychosis and Schizophrenia in Children and Young People* in which service level interventions for children and young people will be explored. This has been added to this section.
50	Lancashire Care NHS Foundation Trust	12	4.2.3b	there is a recent review in the literature regarding the pharmacological management of weight gain, so this should be included in the scope, so clinicians can be provided with a view regarding the relative risks and benefits of this approach	Thank you for your comments, this guideline will be looking at side effects of medication (see section 4.3.1 k) and specifically interventions for weight gain (see section 4.3.2 b).
51	London Respiratory Team	1	4.3.1	It would be fantastic to specifically mention physical health issues in the final guidance - as stated in sections 3.2 (f) and 4.4 (c) of the scope - such as: • Referral to stop smoking services when appropriate • Specific consideration of other physical health problems (COPD, TB) which may be more prevalent in this group especially if smoking cannabis or other drugs • Communication with GP or other healthcare professionals regarding assessment and management Note: NICE Guidance 38 notes recording “smoking status” and monitoring but not offering stop smoking support and treatment We are also keen to promote that interventions should take place in an environment free from secondary smoke from other clients, carers or healthcare professionals	Thank you for your comment, we have added the monitoring of physical health to 4.3.1k).

52 a	Lundbeck	3	4.3.1	Pharmacological interventions for the treatment of mania and hypomania will be updated. The International Classification of Diseases (ICD) 11th Revision is due by 2015. The World Health Organization are currently collaborating with APA to harmonize the update of the ICD with the ongoing update of the DSM IV to become DSMV in May 2013, Lundbeck recommend that NICE align with the ongoing discussion regarding the definition of bipolar disorder and especially the replacement of "mixed episodes" by "Mixed Features Specifier" for manic and depressive episodes (see http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=483). In addition, clinical management of anxiety, sleep and cognitive disturbances should be considered in this section 4.3.1	Thank you for your comment. We agree this is an important issue, however we are unable to comment on a document that is not yet published. We will however clarify the relationship between the guideline and the revised DSM/ICD criteria in the introduction to the guideline.
52 b	Rethink	3	4.3.1	**Carer involvement** We welcome recognition of carer outcomes. However, we argue that information sharing with, and involvement of, carers plays an important role in the clinical management of bipolar disorder. The benefits of education for families/carers are also documented, however this is likely only to be facilitated by health services which promote good practice in family/carer involvement, as demonstrated by studies such as: Sarah Peters, Eleanor Pontin, Fiona Lobban and Richard Morriss (2011) Involving relatives in relapse prevention for bipolar disorder: a multi-perspective qualitative study of value and barriers BMC Psychiatry 2011, 11:172 Sharing information with carers and appropriate involvement requires a competence of staff to understand the potential sensitivities and negotiate the right level of consent from the person with the diagnosis of bipolar disorder. However, information shared by carers seeking support should also be received and acted upon appropriately,	The input of carers on service user's experience of care will be considered during the development of the guideline, but specific carer interventions will not be reviewed. However, carer outcomes are listed in section 4.4.

				including maintaining confidentiality for the carer. Good practice in information sharing with carers is set out in a briefing produced by Rethink Mental Illness and the Department of Health: SDO (2006). Sharing mental health information with carers: pointers to good practice for service providers.	
53	Royal College of Nursing	2	4.3.1	Since the guideline's initial development there are a number of antipsychotic drugs licensed for the treatment of bipolar disorder which need to be fitted into the treatment algorithms. The Spectrum Centre in Lancashire are running multi centre RCTs for multiple psychological treatments in Bipolar Disorder. It would be worth reviewing the evidence earlier for this review.	Thank you for your comments, the guideline will review all recent and relevant evidence when making recommendations for the treatment of bipolar disorder.
54	Mind	2	4.3.1 (a)	There have been important recent developments in the field of neuro imaging and the establishment of biomarkers for bipolar disorder that help, for example, distinguish bipolar from unipolar depression (MDD). Are these in scope?	Thank you for your comment. Biomarkers are not in the scope of the guideline and are still very much in an early stage of research.
55	Royal College of Nursing	3	4.3.1 a)	Will this include the Mental Health Clustering Tool?	Thank you for your comment, all tools with evidence available will be reviewed.
56	British Association for Behavioural and Cognitive Psychotherapy (BABCP)	12	4.3.1 b)	Psychological interventions should explicitly mention interventions to support families and other people supporting the person with bipolar. This should focus on both relatives outcome per se, and then impact that supporting the relative can have on service user outcomes	Thank you for your comment, any data identified regarding family interventions will be reviewed.
57 a	Royal College of Nursing	4	4.3.1 b)	The evidence for group psycho-education is twenty-one sessions NOT sixteen (Colom and Vieta 2006, *Pscho-education manual for bipolar disorder*). Can this section be updated so it is evidence based?	Thank you for your comments, the evidence base for all psychosocial interventions will be reviewed and recommendations will be made based on the evidence.
57 b	Rethink	1	4.3.1 b)	**Early intervention & psychoeducation** Rethink Mental Illness is currently conducting a research project on	Thank you for your comments. We will of course review any relevant literature that fits our inclusion

				effective support from the perspective of people with a diagnosis of bipolar disorder. This will be published later in 2012, but initial findings emphasize the importance of responding to early warning signs, part of which requires education for the person with the diagnosis and also for carers. Most people report that they have early warning signs that they are going up or down and that awareness of these can be helpful in self-management and improving outcomes. Detection of early warning signs allows for action to be taken, such as employing coping strategies; if this action is taken quickly enough it may avoid or minimize the effects of extreme mood states and crisis situations. Each person will have a unique mix of early warning signs and therefore require a unique set of coping strategies to help prevent extreme moods. Awareness by a mental health professional of a particular person's early warning signs may allow them to take action such as pointing these out to the person so that coping strategies (e.g. changing their environment, medication, or social stimulation) can be employed. Whilst psychological and psychosocial interventions are cited for inclusion, we also ask that psycho-education methods are also considered. Suggested action points for considering within the scope of the NICE guidelines for bipolar disorder include: • Talk to clients and those who provide support about early warning signs of going up or down, and agree on action in response. • Look out for early warning signs and alert the client. Follow through any agreed steps to avert a crisis. That people can access mental health services when they need them. • That people using mental health services who may be at risk of crisis are offered a crisis plan.	criteria. The list in section 4.3.1b) is purely illustrative, however we have added 'early warning signs' for clarity.

				• Find out who the client's carer or supporting person is • Take notice of and take seriously a client's or their supporters communication of early warning signs and take quick action to avert a crisis • Facilitate quick access to mental health services such as access to prescriber to change medication There is also RCT research evidence which supports an education approach for bipolar to increase length of time between manic episodes, and for better employment outcomes, such as: Perry, A., Tarrier, N., Morriss, R., et al (1999) Randomised controlled trial of efficacy of teaching patients with bipolar disorder to identify early symptoms of relapse and obtain treatment. BMJ, 318, 149–153. And demonstrating the efficacy of lifestyle advice and teaching coping mechanisms to prevent onset of depressive relapse, such as: Colom F, Vieta E, Reinares M, Martínez-Arán A, Torrent C, Goikolea JM, Gastó C. (Sep 2003) Psychoeducation efficacy in bipolar disorders: beyond compliance enhancement. J Clin Psychiatry.;64(9):1101-5.	
58	Lancashire Care NHS Foundation Trust	10	4.3.1 d	The recognition that the psychosis and schizophrenia guideline will not necessarily cover service level interventions that are applicable to the bipolar population is a positive step from the original proposal (which did not acknowledge that, whilst there is a partial overlap between bipolar disorder and psychosis, at least 50% of people with bipolar disorder do not experience psychotic episodes, particularly in children. This issue is particularly salient regarding access to Early Intervention for Psychosis services in England, where the service is generally only offered to people who have experienced a psychotic episode (or are assessed as at ultra high risk of experiencing psychosis). Whilst there may be a strong case for expanding the remit of EIP services to include all people with first onset of bipolar symptoms, this is not currently common practice.	Thank you for your comment.

59	British Psychological Society	4	4.3.1 general	The BPS recommends that consideration is given to including family approaches within this section and, in particular, approaches designed to support carers.	Thank you for your comment, any data identified regarding family interventions will be reviewed. The input of carers on service user's experience of care will be considered during the development of the guideline, but specific carer interventions will not be reviewed. However, carer outcomes are listed in section 4.4.
60 a	British Psychological Society	6	4.3.1 k)	The BPS believes that it would be helpful to explore the side effect issue in relation to psychological as well as pharmacological and physical interventions. In particular, the risks associated with psychological care delivered by inadequately trained or supervised staff are important.	Thank you for your comments, any data found on the side effects of psychological interventions will be reviewed – 4.3.1k) specifically does not limit this to pharmacological side effects for this reason. We have also added 'non-pharmacological interventions' to 4.3.1l).
60 b	Rethink	2	4.3.1 k)	**Physical health monitoring** The outcomes section of this scope cites physical health which we hope will link to this section on the monitoring of side effects. We would welcome the inclusion of any screening, checking and recording activity within primary care and secondary mental health care which has been shown to lead to better outcomes for people with this and other diagnoses. This may involve the use of tools such as the Physical Health Check tool from Rethink Mental Illness, which can be used by support workers and care coordinators in a range of services. (www.rethink.org/phc). This should also include advice and support to engage with healthy lifestyles and activities, not only pharmacological interventions for weight gain, as supported by studies such as:	Thank you for your suggestion, on reflection we agree this was an oversight and have added the monitoring of physical health to 4.3.1k).

				Sylvia LG, Nierenberg AA, Stange JP, Peckham AD, Deckersbach T. (2011 May) Development of an integrated psychosocial treatment to address the medical burden associated with bipolar disorder. J Psychiatr Pract.;17(3):224-32. We welcomed the inclusion of recommendations for GP annual physical health checks within the guidelines for schizophrenia, and hope to see similar recommendations for bipolar disorder.	
61	Association for Family Therapy and Systemic Practice (AFT)	2	4.3.1. (j)	Suggest including support for parents who have a bipolar disorder, such as through couple and family therapy.	Thank you for your comment, any data identified regarding family interventions will be reviewed and it has been added to 4.3.1b).
62	British Psychological Society	5	4.3.1. d)	The BPS welcomes this section, as the fluctuating nature of bipolar disorder means that for many people, the service models developed for more 'consistent' disorders, such as schizophrenia and psychosis, do not serve them well (Highet *et al.*, 2007; Merikangas *et al.,* 2007). References: Highet, N.J., McNair, B.G., Thompson, M., Davenport, T.A. & Hickie, I.B. (2007). *Experience with Treatment Services for People with Bipolar Disorder.* https://www.mja.com.au/journal/2004/181/7/experience-treatment-services-people-bipolar-disorder. Accessed June 2012 Merikangas, K.R., Akiskal, H.S., Angst, J., Greenberg, P.E., Hirschfeld, R.M.A., Petukhova, M. & Kessler, R.C. (2007). *Lifetime and 12-Month Prevalence of Bipolar Spectrum Disorder in the National Comorbidity Survey Replication.* http://archpsyc.jamanetwork.com/article.aspx?doi=10.1001/archpsyc.64.5.543 Accessed June 2012.	Thank you for your comments.
63	Association for	1	4.3.1.(b	Systemic couple and family therapy is effective as an early	Thank you for your comment, any

	Family Therapy and Systemic Practice (AFT)		)	intervention as well as for long term bipolar, and the evidence for Focused Family Therapy indicates its value.	data identified regarding family interventions will be reviewed and it has been added to 4.3.1b).
64	Lancashire Care NHS Foundation Trust	9	4.3.1.b	It would be helpful to use more specific language to describe psychological interventions than used in the previous (2006) guidance – "structured psychological interventions" is a fairly generic description, and even more specific terms such as bipolar-focused Cognitive-Behavioural Therapy could still cover a range of different approaches from pragmatic enhanced relapse prevention + psychoeducation to a cohesive theory driven approach such as the TEAMS model (declaration of interest – I've been involved with developing the TEAMS model). Of course it would also be helpful to include consideration of evidence for a broad range of psychological interventions, including CBT, CAT, IPSRT, MBCT, ACT and (at least brief coverage of the less empirically-based therapies such as humanistic, systemic and psychodynamic approaches – this may assist commissioners and trusts in designing services and workforce planning). With regards to the provision of psychological and psychosocial interventions, it would be helpful to include advice on appropriate levels of training, supervision, core competencies etc as quality assurance indicators in order to enable providers to deliver interventions that maintain the effectiveness and safety of those identified in the literature. Family focused psychological interventions (including multi-family and brief psychoeducational interventions as well as more formal therapies) should be included here. The term "acute and long-term management" could be replaced with either "acute and long term treatment" as the word "management" may imply that recovery is not possible (such an assertion would require solid evidence and may also have an adverse impact on service users', families' and staff attitudes that could create a self-fulfilling prophecy). The inclusion of a wide range of "low intensity" interventions such as psychoeducation, exercise, facilitated self-help, support groups etc is a positive development and fits well with stepped	Thank you for your comments, the guideline will review all recent and relevant evidence when making recommendations for the treatment of bipolar disorder – any intervention with high quality evidence efficacy data would be included in our guideline. However, we have added family therapy to section 4.3.1b) for clarity. Specific details of training are a matter for local implementation, and outside the scope of this guideline. We prefer the term 'management' to 'treatment' as it is felt to be more inclusive and involving of service users as they are able to jointly manage any condition, rather than be 'treated' by clinicians.

				or matched care models of service delivery that are becoming more common within NHS services. Specific coverage of group vs individual therapeutic interventions would be helpful. I would also be keen to see the inclusion of "therapeutic activities" as routinely delivered by Occupational Therapists in psychiatric inpatient units.	
65	British Association for Behavioural and Cognitive Psychotherapy (BABCP)	10	4.3.1a)	There is a drive for early identification, coming from public and professionals, and calls to increase the sensitivity of assessment in order to provide early diagnosis. Whilst this is important in ensuring people receive the correct support and treatment, clearly there needs to be equal attention paid to the specificity of assessment. There should perhaps be some attention on the potential risks of inappropriate diagnosis. There is an associated need to be mindful of the effect of assessment and diagnosis on the prevalence rates.	Thank you for your comment, instruments for the recognition of bipolar disorder will be covered by this guideline.
66	British Association for Behavioural and Cognitive Psychotherapy (BABCP)	11	4.3.1a)	In assessing bipolar there is often an assumption that the main focus should be on preventing relapse. There is a need for more focus on recovery focussed measures	Thank you for your comment, the GDG will prioritise outcomes when they meet.
67	British Association for Behavioural and Cognitive Psychotherapy (BABCP)	13	4.3.1c)	The pros and cons of monitoring mood should be considered as for some individuals monitoring may increase anxiety and have a negative impact on their outcome (no research data – but clinical experience)	Thank you for your comment, we will bear this in mind when developing the guideline, as outlined in 4.3.1c).
68	British Association for Behavioural and Cognitive Psychotherapy (BABCP)	14	4.3.1e)	How strong is the evidence base for these agents? I don't know of any studies that show that fish oil is a good monotheraphy for BD, although it may be a useful supplement to mood stabilizers or atypical. The evidence for these other agents is weak at best.	Thank you for your comments, the aim of the guideline is to review this evidence to identify any helpful treatments, and illuminate the use of unhelpful ones.
69	British Association for Behavioural and Cognitive Psychotherapy (BABCP)	15	4.3.2	Although there is clearly some overlap – there is a danger that services for people with bipolar disorder continue to be designed for people with schizophrenia and then just applied – as happened with community mental health teams. The fluctuating nature of the condition makes it very important that the system meets their needs – for example, complicated systems of referral and discharge that do not	Thank you for your comment. This guideline will review any evidence of service level interventions that apply particularly to a population of people with bipolar, but we will not be re-reviewing data that looks at a

				allow people to move flexibly in and out of services as they need them would be very problematic	population of people with mixed conditions that experience psychosis and these will have been looked at in the other guidelines. We have made this clearer in 4.3.2a).
70	Mind	3	4.3.2 (a)	As drafted this implies service level interventions for bipolar disorder in general and psychosis are excluded but I assume what is meant is interventions for psychosis occurring in the context of bipolar disorder? Removing the comma at the end of the first line would make this clear.	Thank you for your comment, this section has been redrafted for clarity.
71	South West Yorkshire Partnership NHS Foundation trust	2	4.31b	Will timeframes for the introduction of such interventions be included to ensure the speedy provision of such services and highlight health services where such interventions may exist but are difficult to access for the population in need of them.	Thank you for your comment, this would be a matter for local implementation and too detailed for a clinical guideline.
72	South West Yorkshire Partnership NHS Foundation trust	4	4.31d	Where there is diagnostic uncertainty, eg between Bipolar Affective Disorder and Emotionally Unstable Personality Disorder, and in the wake of a variety of transformations in Mental Health Services in different Trusts, should such patients be granted access to both groups' service level interventions, and which treating subspecialty would/should take the lead in their care to prevent such patients from being lost in the system/unable to access any of the services?	Thank you for your comments, this is more a matter for local implementation and too detailed for a clinical guideline.
73	British Association for Behavioural and Cognitive Psychotherapy (BABCP)	16	4.4	When talking about outcomes (see page 6, Point 4.4) psychosis is mentioned as an outcome in relation to mania. I would omit this special reference to "mania and psychosis" since psychotic mania is from my point of view 'just' a very severe form of mania an since depression can become psychotic as well but here "psychosis" is not specifically mentioned	Thank you for your comment, on reflection we agree with you and have deleted the reference to 'psychosis' here.
74	Lancashire Care NHS Foundation Trust	14	4.4	As discussed in the scoping workshop, I am pleased to note the inclusion outcomes related to the wider concepts of "recovery" and "wellbeing" (including social, educational and vocational outcomes), as well as more traditional measures such as symptoms and relapse rates.	Thank you for your comments.
75	Royal College of Nursing	5	4.4	There is no reference to Safeguarding or Vulnerability.	Thank you for your comments, this would not be an appropriate inclusion for the outcomes section.

76	British Association for Behavioural and Cognitive Psychotherapy (BABCP)	17	4.4 – a)	Symptoms, frequency and time to event for – what about “distressed caused by” – for example hypomania may be a valued experience for some people at some times	Thank you, we agree this is important and the GDG will identify the outcomes they think of primary and secondary importance when they meet - the current list is illustrative, not exhaustive.
77	British Psychological Society	7	4.4 a)	We recommend that duration and impact of relapses for each of the episode types are considered.	Thank you, this would be helpful but is rarely recorded as an outcome in trials and therefore we will not include in this list.
78	British Psychological Society	8	4.4 general	We recommend that consideration is given to how interventions contribute to personal recovery outcomes for people with bipolar disorder.	Thank you, we agree this is important and the GDG will identify the outcomes they think of primary and secondary importance when they meet - the current list is illustrative, not exhaustive.
79	Association For Rational Emotive Behaviour Therapy	4	4.4.	44. A section on differential diagnosis and its importance could be included.	Thank you for your comment, instruments for the recognition of bipolar disorder will be covered by this guideline (see 4.3.1 a).
80	Lancashire Care NHS Foundation Trust	13	4.4a	I would suggest separating mania and psychosis, as they are distinct if sometimes overlapping states (just as depression and psychosis can sometimes co-occur).	Thank you for your comment, psychosis has been deleted from this section.
81	South West Yorkshire Partnership NHS Foundation trust	3	4.4e	Will discussion of functional disability provide a clear outline of the different DVLA implications for medication changes, non-compliance, relapse in illness, and hospitalisation? Such implications will likely affect work, education, family and social domains.	Thank you, we agree this is important and the GDG will identify the outcomes they think of primary and secondary importance when they meet - the current list is illustrative, not exhaustive.
82	British Association for Behavioural and Cognitive Psychotherapy (BABCP)	18	4.4g) and h)	I wonder if it would be useful to include the concept of service engagement/attachment? Service use and drop-out concepts place the onus on the patient: here they are being used as a measure of how well the person is/how well managed the disorder is. Service engagement/attachment concepts also draw out relational factors, and explore the contribution of both the service and the individual	Thank you, we agree this is important and the GDG will identify the outcomes they think of primary and secondary importance when they meet - the current list is illustrative, not exhaustive.

83	British Association for Behavioural and Cognitive Psychotherapy (BABCP)	19	4.5	Costs will only include NHS and social services – what about productivity – is the biggest cost not loss of work and therefore should also be included?	The perspective of the analysis as stated in the scope (NHS and personal social services) is that recommended by NICE for the reference case (See "The Guidelines Manual" and the "Guide to the Methods for Technology Appraisal" available from the NICE website). NICE does recommend secondary sensitivity analyses that adopt a wider perspective, if costs to other government bodies are believed to be significant. The findings of such analyses should be presented alongside the reference case results. However, NICE clearly states that "productivity costs […] should not be included in any analyses". Productivity losses are not considered in NICE guidance as this might raise equity issues and would be discriminatory against certain sub-groups of the population with lower productivity potential (e.g. children, elderly, people with disabilities).
84	Association For Rational Emotive Behaviour Therapy	3	Section 3.	33. Perhaps a section preceding section 3 could be inserted with comments about the aetiology of bipolar disorders.	Thank you for your comment, section 3.1 d) touches on the aetiology of bipolar disorders but this a short summary and not does not aim to cover in detail the origins of bipolar. There will be further exploration of this in the full guideline.
85	Association For	2	Section	Section 3. Epidemiology: List could include Bipolar I, bipolar II,	Thank you for your comment, this is

	Rational Emotive Behaviour Therapy		3. Epidemiology	cyclothymia and bipolar NOS (DSM V), and describe each condition separately before covering the epidemiological data. It could also refer the reader to DSM for specifiers under each type.	only meant to be a very brief overview of the condition and your suggestions would be too detailed for this document – we will however cover the issues you have raised in the introduction to the full guideline.

These organisations were approached but did not respond:

2gether NHS Foundation Trust
ABPI Pharmaceutical Serious Mental Illness Initiative
Action on Postpartum Psychosis
Adults Strategy and Commissioning Unit
Adverse Psychiatric Reactions Information Link
Afiya Trust
Africa Advocacy Foundation
Alder Hey Children's NHS Foundation Trust
All Wales Senior Nurses Advisory Group
Anglesey Local Health Board
Anxiety Alliance
Anxiety Care
Anxiety UK
Arts Psychotherapies Services
ASSIST Trauma Care
Association for Dance Movement Psychotherapy UK
Association for Psychoanalytic Psychotherapy in the NHS
Association of Anaesthetists of Great Britain and Ireland
Association of British Insurers

Association of Child Psychotherapists, The
Association of Dance Movement Therapy UK
Association of Directors of Adult Social Services
Association of Therapeutic Communities
Astrazeneca UK Ltd
Autism West Midlands
Avon and Wiltshire Mental Health Partnership NHS Trust
Barnet Primary Care Trust
Barnsley Primary Care Trust
Bengali Women's Group forum
Big White Wall
Bipolar UK
Black Health Agency
Black Mental Health UK
Black People's Mental Health Association
Borderline UK LTD
BPDWORLD
Bradford and Airedale Primary Care Trust
Bristol-Myers Squibb Pharmaceuticals Ltd
British Association for Counselling and Psychotherapy
British Association of Art Therapists
British Association of Psychodrama and Sociodrama
British Association of Social Workers
British Geriatrics Society
British Medical Association
British Medical Journal
British Muslim Forum

British National Formulary
C. R. Bard, Inc.
Calderdale and Huddersfield NHS Trust
Calderstones Partnerships NHS Foundation Trust
Cambridgeshire & Peterborough Mental Health Trust
Camden and Islington NHS Foundation Trust
Camden Carers Centre
Camden Link
Campaign Against Living Miserably - CALM
Capsulation PPS
Care Quality Commission (CQC)
Central & North West London NHS Foundation Trust
Central Lancashire Primary Care Trust
Centre for Mental Health
Centro de Terapia Familiar
Cheshire & Wirral Partnership NHS Trust
Chinese Mental Health Association
Chinese National Healthy Living Centre
Clifford Beers Foundation
College of Mental Health Pharmacists
College of Mental Health Pharmacy
Combat Stress
Commission for Social Care Inspection
Community Health Involvement & Empowerment Forum
Contact
Co-operative Pharmacy Association
Crisis

Critical Psychiatry Network
Cumberland Infirmary
Cyberonics
Cygnet Hospital Harrow
David Lewis Centre, The
Department of Health, Social Services and Public Safety - Northern Ireland
Depression Alliance
Depression UK
Devon Partnership NHS Trust
Doctors Support Network
Dorset Mental Health Forum
Drinksense
Eastbourne District General Hospital
Eli Lilly and Company
Equalities National Council
Faculty of Public Health
First Person Plural
First Signs
Five Boroughs Partnership NHS Trust
Forum for Advancement in Psychological Intervention
Fremantle Hospital
George Eliot Hospital NHS Trust
GlaxoSmithKline
Glencare
Gloucestershire LINk
Gorlin Syndrome Group
Great Western Hospitals NHS Foundation Trust

Greater Manchester West Mental Health NHS Foundation Trust
Hafal
Hafan Cymru
Hammersmith and Fulham Primary Care Trust
Hampshire Partnership NHS Trust
Handicapped Families Council
Health Quality Improvement Partnership
Healthcare Improvement Scotland
Healthcare Inspectorate Wales
Hearing Voices Network
Hertfordshire Partnership NHS Trust
Hindu Council UK
Human Givens Institute
Humber NHS Foundation Trust
Independent Healthcare Advisory Services
Integrity Care Services Ltd.
ISPS UK
Janssen
Kent and Medway NHS and Social Care Partnership Trust
Lancashire LINk
Leeds Teaching Hospitals NHS Trust and Leeds Radiology Academy
Lincolnshire Teaching Primary Care Trust
Making Space
Medicines and Healthcare products Regulatory Agency
Mellow Campaign
Mencap
Mental Health Act Commission

Mental Health Alliance
Mental Health Foundation
Mental Health Group- Nutrition & Dietetics
Mental Health Matters
Mental Health Nurses Association
Mental Health Providers Forum
Mersey Care NHS Trust
Mild Professional Home Ltd
Mind Wise New Vision
Mindfulness Centre of Excellence
Ministry of Defence
Muslim Council of Britain
Muslim Health Network
National Association for Gifted Children
National Association for People Abused in Childhood
National Black and Minority Ethnic Mental Health Network
National Clinical Guideline Centre
National Collaborating Centre for Cancer
National Collaborating Centre for Mental Health
National Collaborating Centre for Women's and Children's Health
National Institute for Health Research Health Technology Assessment Programme
National Institute for Health Research
National Institute for Mental Health in England
National Nurse Consultants in CAMHS forum
National Patient Safety Agency
National Perceptions Forum
National Public Health Service for Wales

National Self-Harm Network
National Treatment Agency for Substance Misuse
National Voices
Network of Sikh Organisations UK
Neurolink
NHS Connecting for Health
NHS Herefordshire
NHS Milton Keynes
NHS Newcastle
NHS Plus
NHS Trafford
Niger Delta University
No Panic
North Essex Mental Health Partnership Trust
North Staffordshire Combined Healthcare NHS Trust
North Yorkshire & York Primary Care Trust
Northumberland, Tyne & Wear NHS Trust
Nottinghamshire Acute Trust
Nottinghamshire Healthcare NHS Trust
OCD Action
OTUSKA PHARMACEUTICALS
Oxford Health NHS Foundation Trust
P.T.S.D.
PAPYRUS
Parkwood Healthcare
Patient Assembly
PERIGON Healthcare Ltd

Pfizer
Pharmametrics GmbH
Pilgrim Projects
POhWER
Pottergate Centre for Dissociation & Trauma
Powys Local Health Board
Public Health Wales NHS Trust
Relate
Rethink Mental Illness
Richmond Fellowship
Ridgeway Partnership
Roche Products
Rotherham Primary Care Trust
Royal Berkshire NHS Foundation Trust
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of General Practitioners in Wales
Royal College of Midwives
Royal College of Paediatrics and Child Health
Royal College of Paediatrics and Child Health , Gastroenetrology, Hepatology and Nutrition
Royal College of Pathologists
Royal College of Physicians
Royal College of Psychiatrists
Royal College of Psychiatrists in Scotland
Royal College of Psychiatrists in Wales
Royal College of Radiologists
Royal College of Speech & Language Therapists

Royal College of Surgeons of England
Royal Pharmaceutical Society
Royal Society of Medicine
Royal West Sussex NHS Trust
Rupanyup Hospital/Nursing Home
SANE
Sanofi
Scottish Intercollegiate Guidelines Network
SEE BETSI CADWALADR - North Wales NHS Trust
Sheffield Primary Care Trust
Shelter
Social Anxiety UK
Social Care Institute for Excellence
South Asian Health Foundation
South East Coast Ambulance Service
South Essex Partnership NHS Foundation Trust
South Essex Partnership University Foundation Trust
South Staffordshire and Shropshire Healthcare NHS Foundation Trust
Speaking Up
Spectrum Centre for Mental Health Research
St Andrews Healthcare
St Jude Medical UK Ltd.
St Mungo's
Step4Ward Adult Mental Health
Stockport Primary Care Trust
Suffolk Mental Health Partnership NHS Trust
Surrey and Border Partnership Trust

Survivors UK
Sussex Partnership NHS Foundation Trust
Sustain: the alliance for better food and farming
TACT
Tees, Esk and Wear Valleys NHS Trust
Teva UK
The Association for Clinical Biochemistry
The Association of the British Pharmaceutical Industry
The Food Commission
The For All Healthy Living Centre
The National Body of Black Prisoner Support Groups
The National LGB&T Partnership
The Princess Royal Trust for Carers
The Rotherham NHS Foundation Trust
The Samaritans
The Survivors Trust
Together
Triumph over Phobia
Turning Point
UK Specialised Services Public Health Network
Unite - the Union
United Kingdom Council for Psychotherapy
United Lincolnshire Hospitals NHS
United Response
University of Edinburgh
University of Oxford Department of Psychiatry
Victims and Survivors Trust

Welsh Government
Welsh Scientific Advisory Committee
West London Mental Health NHS Trust
Western Cheshire Primary Care Trust
Westminster Local Involvement Network
Whitstone Head Educational
WISH - A voice for women's mental health
Worcestershire Health and Care NHS Trust
YMCA
YMCA
York Hospitals NHS Foundation Trust
Young Muslims UK
Young People's Unit
YoungMinds