National Institute for Health and Clinical Excellence

BORDERLINE PERSONALITY DISORDER
Guideline Consultation Comments Table
9 June – 4 August 2008

No	Type	Stakeholder	NO	Doc	Section	Page	Comments	Developer's Response
7	SH	Arts Psychotherapies Services	1	Full	5.12 General and specific. User surveys. Support for research Non published journals. Peer reviewed journals Inscape No research	research indicated 5.14.2 & 5.14.2.1 4 of 39 & 29 0f 39 etc 122 5.2.13 etc 188 clinical summary	Limited Research? Support Research for the Arts Therapies/Psychotherapies in the Guidelines. Please refer to submission of all art therapy/psychotherapy evidence by Richard Whitaker BAAT lead for NICE. The guidelines observe the limited research on the treatment of the person with this diagnosis. Page 4 of 39 & page 29 of 39 for example. RCTs and surveys are based on very small samples and this is acknowledged by the guidelines. We also see the inclusion of unpublished papers (Andrea, page 133) as evidence supporting inclusion in these guidelines. (I am presuming all journals included in the guidelines are peer reviewed?) I am concerned at the exclusion of the main journal for Art Therapy/Psychotherapy, Inscape now called The International Journal of Art Therapy, which is peer reviewed with articles cited for those with this diagnosis. (Franks, M. and Whitaker, R. (2007) The image, mentalisation and group art psychotherapy. International Journal of Art Therapy 12:1, pp. 3-16. Greenwood 2000 in Inscape, 5 (2) 53-61, Captivity and Terror in the Therapeutic Relationship. As the guidelines acknowledge there are very small samples size for most of that included and on this basis arts therapies/psychotherapies journal articles should be included. There is reference to this client group in (Gilroy 2006, Art Therapy: Research & Evidence Based Practice; Page 135-138, Sage) and McNeilly, in The Changing Shape of Art Therapy (ed, Gilroy & McNeilly 2000) discusses group analytic art psychotherapy with this patient group.	Thank you for your comment. The International Journal of Art Therapy was not fully covered by our searches (there is some patchy coverage in AMED which is one of the databases we routinely use). As a result of your comment, we have searched the table of contents of this journal by hand. We found no reports of primary research data – i.e., outcomes in people with borderline personality disorder. We are limited to 5 research recommendations per guideline which the GDG prioritised based on an expert consensus view of which piece of research, if completed and published before the guideline is due to be updated (usually in 4 years time), would be most likely to improve the guideline. Since there is no evidence for the effectiveness of arts therapies we feel the existing clinical summary is appropriate.

					Clinical Summary : negative affect		Given the regard (page 188) for the arts psychotherapies/therapies I would propose that NICE support research for the arts psychotherapies/therapies as it has for DBT/MBT. It is difficult to understand given it is acknowledged there is little evidence for all the approaches, why such as DBT/MBT have been singled out for such support, but the arts psychotherapies excluded. As Whitaker states in communication to me; 'In the need for research into treatments for BPD there is a distinct belief in the benefits of maintaining a coherent treatment model / conceptual framework combined with an attachment focus with treatments which are relatively long in duration, which no doubt explains the rise of both DBT and MBT as complex interventions. What is not clear is: why is there a distinction between these two preferred treatments and that of psychosocial treatments? (the number of RCT's in one or two modalities should not dictate the treatment available to a hugely disadvantaged patient group) given that the common features of effective treatments for BPD are shared between those listed as psychosocial and DBT/MBT? Research needs to be conducted as to the non-specific aspects of any treatments offered within either of these modalities'. (Richard Whitaker,2008) Haigh (2002) survey of 14 people is rightly and helpfully included in these guidelines. However on such a small sample it would seem appropriate for the guidelines to propose widening the user survey net across the range of services including the arts therapies/psychotherapies to discover what people have found helpful. (BAAT Survey 2007-8): http://www.baat.org/art_therapy.html. Accessed 8th July, 2008. Clinical Summary. I propose it is said that although no quantative research currently available this should not be taken to indicate that arts psychotherapies are not helpful and for this reason research should be supported. Based on the very small evidence base for the other entries I suggest it is not helpful to single out the arts therapies/psychotherapies as having nothing to recommend them in a lone paragraph under the heading 'Clinical Summary', (page 188), as it can be read as a negative statement. This	

							statement may be taken to imply that there is no need to consider the inclusion of any arts therapies/psychotherapies in treatment programmes for this patient group. It might be indicated to survey for example consultant psychiatrist/psychotherapists who I am certain will propose that on many occasions the arts therapies/psychotherapies have been the treatment of choice with good outcome.	
8	SH	Arts Psychotherapies Services	1	Full	5.12 From above Research	from above	Continued from above; As Whitaker also communicated to me; 'In regard TC's and day hospital (including TC) programs we would recommend the need for research into the specificity of the various interventions. A study by Karterud and Pederson (Karterud, Pederson, 2004) of the various therapeutic components of a short term day hospital treatment for personality disorder, found that the art group therapy was rated highest by all patient categories, i.e. personality disorders, mood disorders and anxiety disorders. They also found that the more severely disturbed patients "seemed to favour the pretend mode" of the art group therapy. Significantly, borrowing from the work of Bateman and Fonagy, they propose that the art group therapy "appears to be a safe method of exploring the mind in the presence of mentalising self objects". (Karterud, Pederson, 2004) They assert that their results should be considered when designing treatment programs for Personality Disorders. Johns and Karterud (Johns, Karterud, 2004) writing about guidelines for the Art Group Therapy reported in the above piece of research state that the most "successful day treatment programs being reported contain one mode or another of expressive group therapies", including the work of Bateman and Fonagy on the effectiveness of partial hospitalisation. Of note the model proposed by Johns and Karterud reflects aspects of group analytical practice and Kohut's self-psychology, and similar to the work of Bateman and Fonagy encourages a very structured and delineated treatment approach. "To this extent the therapy creates transitional objects and the therapists have to work at developing a transitional space within the group in which the created objects can be used to facilitate expression whilst maintaining stability of the self" (Bateman & Fonagy 2004). Whilst the theory of transitional objects is extremely	Thank you for your comment. Although arts therapies are popular with some patients, there is insufficient evidence on which to base a recommendation for the NHS.

							credible and much has to be said in how it may be present in both DBT, MBT and other therapies more research is required as to its specific agency in any clinical change' (Richard Whitaker 2008) Karterud S, Pederson G, (2004). 'Short term day hospital treatment for personality disorders: Benefits of the therapeutic components' Therapeutic Communities' Vol. 25, No. 1 pp 43-54. Bateman A, Fonagy P, (2004). Psychotherapy for Borderline Personality Disorder- mentalization based treatment. Oxford University Press. Johns S, Karterud S, (2004). 'Guidelines for Art Group Therapy as part of a day treatment for patients with personality disorders' Group Analysis. Vol. 37 No. 3. pp 419-430.	
9	SH	Arts Psychotherapies Services	1	Full	5.12 From above Research	from above	The Benchley Unit a TC for those with severe personality disorder, Maidstone, Kent undertook a survey (yet unpublished) in 2006/7 which mirrored the findings above. Of those patients, surveyed by a psychologist, on all the groups they participated in including verbal psychotherapy & community groups, art psychotherapy was deemed the most helpful. (Caroline Burgess, Art Psychotherapist at this Unit can be approached for further information). Bhurruth, M, Group Analysis, vol 37, no 3, 2006 supported Johns & Karterud & Tanna, N in 2004, vol 37, no 3, Group Analysis asked for support for further research, to prove it was a core treatment modality. Further research is indicated and we hope will be supported within these guidelines. An example of Art Psychotherapy/Therapy research is The MATISSE project funded by the Health Technology Assessment Unit and with matched funding from four NHS trusts in the UK which could be replicated for this patient group. The principal investigators, who are Drs Mike Crawford (Imperial), Helen Killaspy (UCL) and Professor Diane Waller OBE, (Goldsmiths, London University), could advise. Already this RCT has led to a number of	Thank you. Although evidence may be emerging that arts therapies may help people with borderline personality disorder, this is not of sufficiently high quality to form the basis of a recommendation for the NHS at the current time.

							parallel qualitative research projects being set up, which demonstrates how important we, as arts psychotherapists/therapists and fellow health professionals, see the need to build on the profession's existing evidence base. We, as many psychotherapists, arts therapists/psychotherapists, AHPs etc, are very concerned that qualitative data case studies, patient's views and so on are taken into account in drawing together any evidence. Our practice based evidence is instrumental in how Art Psychotherapy is practised across client populations within the NHS. The arts therapies/psychotherapies professions would welcome a positive statement to be included within the guidelines; that there is various qualitative evidence showing art psychotherapy to have good effect. However there is the requirement for substantial funding support in order to undertake quantitative research, e.g. RCTs. With a multi site RCT costing upwards of one million pounds, research funding is very scarce. This is no fault of NICE as it is made very clear that NICE is issuing 'guidelines'. However, unfortunately we are already experiencing post cuts and little, if any, development of new posts within the NHS and this may be due, in part, to the interpretation of NICE guidelines that because there is little quantitative evidence cited in your guidelines, suggesting there is no evidence base, for the arts psychotherapies/therapies, then no funding should be provided. Advances have been made in the past ten years in providing treatment for BPD and given the potential cost savings; it would be a great pity to limit treatment options. Ten years ago there was little evidence and the evidence remains rather thin as you acknowledge. Treatment advances come with innovation and it is important this potential is recognised. As small professions we do not have the infrastructure nor the funding source of the large professions. Even so increasingly we have research posts & doctoral research. The Art Therapy Practice Research Network (ATPRN) is a thriving and proactive forum supported by Dr Chris Evans, Professor in Psychotherapy research at Nottingham University and Consultant Psychotherapist at Rampton.	

							I suggest it would be helpful to take a more even approach to research inclusion and including the art therapies/psychotherapies within the research section within the guidelines can only be, in the long term, for the good of the patient with borderline personality disorder. We are very concerned that a wide range of research is supported by NICE within these guidelines including the arts therapies/psychotherapies. And due to NICE support, that crucially, a long established therapy for those with personality disorder is able to continue within the NHS on the solid ground of a quantative evidence base which would support the large amount of qualitative evidence which we know is out there.	
10	SH	Arts Psychotherapies Services	2	Full	8.5.11.2 5.13.1.1 Training Supervision	1.3.1 1.3.4.2 1.3.5.4. page 15, 1.3.1..1.3.4 Page 107, 4.6.2. Page 12 of 39 1.1.4 109 onwards in full version	Training-Supervision. 1 I propose there needs to be much more emphasis on staff training and supervision. (e.g. 1.3.5.4). 2 It is my long term experience working with people as Charge Nurse, Art Psychotherapist & Psychoanalytic Psychotherapist within various NHS settings with people with this diagnosis that risk levels can raise when staff are closing down from the impact of powerful projective experiences and the patient in turn feels uncontained. The person with this personality disorder disrupts professionals thinking & in addition their distress and pain is powerfully felt by the therapist and professionals and why the person with this diagnosis is often quickly rejected or discharged. Unconscious retaliation by professionals can without sufficient supervision, quickly occur, so enacting previous rejections and retaliations from the patients early life. Close dynamic supervision is a must. Trained psychotherapists (arts and verbal) with extensive experience of offering therapy to this patient group should be advised to be used for this supervision work. It is my experience that managers and professionals do not appreciate or know the depth of (dynamic) supervision required. For many professions it is not a regular in-depth experience as it is with the psychotherapists (and I include the arts psychotherapies). To increase the emphasis on training of the staff including working alongside 'user' groups in the delivery of training. This is priority from my experience at The Henderson, within outpatients and	Thank you for comment. We have included recommendations about training and support see 1.3.1.1, 1.3.4.4, 1.3.5.2 and 1.5.1.1 [draft NICE guideline numbering] which we consider cover your concerns. As a result of this and other comments we have also made a new recommendation about training and supervision in section 1.1 of the NICE guideline. We do not have sufficient evidence at the present time to support more detailed recommendations.

							working with such as' The Sun Project' SWLSTG MH Trust, a project run by ex users with this diagnosis. In-house trainings should have priority.	
11	SH	Arts Psychotherapies Services	3	Full	5.12 General and specific Art Psychotherapy as the therapy of choice. A formal psychological therapy.	Page 36 in NICE for example	A Formal Psychological Therapy. I am as colleagues the sole therapist for those with Borderline PD within outpatients having been referred these patients by the CMHTs. Clearly there is evidence that what we offer has value and we have patient feedback outcomes which are positive. Borderline patients within my service are assessed for analytic art psychotherapy or individual art psychotherapy. In addition we offer within outpatients a 'median' group approach which is a group where dialogue is possible, but not a necessity, and with the usual (but crucial) boundaries of time, setting, entry and exit. Often people with this diagnosis begin in this setting progressing over time to a more analytic approach. Noting as above that many we see have few words progressing to verbal expression much later. (See New Ways of Working- Art Psychotherapy, Sutton, Art Psychotherapy Service, SWLSTG MH Trust. (AHP/DH, 2008) There seems to be the assumption the arts psychotherapies are 'just' an adjunct to other treatments. It is a key component of therapeutic communities with positive feedback. Noting in comment No 1 above on The Benchley, Maidstone, Kent which is an award winning day service. In addition The Henderson Hospital art psychotherapists have written widely about the value of art psychotherapy. (Cole 1975, Mahony 1992, in Art Therapy a Handbook, (ed, Waller & Gilroy 1992). Unpublished papers include, Caroline Burgess, Art Psychotherapist The Benchley, Maidstone, Kent (Windsor TC conference 2006), 'Thinking Outside the Picture in a Severe Personality Disorder Unit' which showed the importance of image making in the context of art psychotherapy for those with severe personality disorder and for whom many other approaches had failed. This paper was co-authored with Sheila Butler, Clinical Research & Audit Co-ordinator for Kent and Medway NHS Trust's Psychological Services who demonstrated the complexity of the	Thank you for your comment. In light of this and other comments we have restructured the chapter.

							patient's pathology and how the image enabled expression & progress previously not thought possible. Assessment. Except in most TC programmes; within in, day and out settings patients are assessed for the appropriateness of this particular psychological therapy and group or individual arts psychotherapies determined or an alternative psychological therapy advised. Arts Psychotherapy/Therapy comes within the Parry, et al, definition of a 'formal' psychological therapy and the guidelines need to state this.	
12	SH	Arts Psychotherapies Services	4	Full NICE	8.5.14.1 The range of psychological interventions specified	e.g. page 18 of 39	The Range of Psychological Interventions includes the arts psychotherapies/therapies. I would like the range of psychological interventions specified (page 18 of 39 for example) and that this would include the arts psychotherapies. This would quickly inform the service managers what is required. As we see increasingly PD services being developed within outpatient & day settings then this quick point of reference is very important. It is also important for all professionals, commissioners and patients to know what they can expect and what should be provided.	Thank you. There is insufficient evidence to give the specific advice you suggest. This may be available when the guideline is reviewed. The chapter on psychological therapies has been restructured so that the section on arts therapies is not in the 'other therapies' section.
13	SH	Arts Psychotherapies Services	5	Full	General Acknowledgements; Jane Dudley	Page 8	Acknowledgement. Please amend to Jane Dudley: Consultant Art Psychotherapist & Psychoanalytic Psychotherapist, SWLSTG MH Trust & The British Association of Art Therapy. Consultant should be added.	Thank you. We have added your affiliation with SWLSTG MH NHS Trust and the BAAT. However we do not include the role held at the affiliations for special advisors.
14	SH	Arts Psychotherapies Services	6	Full	2.5.3	Page 29	Include Art Therapists/Psychotherapists as a professional grouping. Arts Therapists/Arts Psychotherapists should be added as a professional group in the third paragraph.....'Interventions are offered in a variety of ways..... '(And this may include art, music, dance movement or drama therapy/psychotherapy.) Similarly to be added 'within psychology, psychotherapy & arts psychotherapies departments... '	Thank you. Arts therapies are the subject of a separate section. This section is concerned with psychological therapies such as CBT, DBT etc.
15	SH	Arts Psychother	7	Full	General	Page 30, 32,33, 175	Creative Arts Therapies is not HPC recognised.	Thank you. We have amended the text.

		apies Services			Specific and throughout Creative Therapies is a term not recognised,	etc	The term 'creative arts therapies are not a recognised term and should not be used in any part of the documents (HPC regulation). To say art therapy or creative arts therapies is incorrect... final paragraph page 30 and page 32/33 etc 175 Only the description arts therapies/psychotherapies are recognised and should be used and for further clarification this could include one of more specialisms under this umbrella, i.e. art, music, dance movement or drama.	
16	SH	Arts Psychotherapies Services	8	Full	5 2.5.5 + other occurrences General Arts Psychotherapies are a psychological intervention.	Throughout Including 109 onwards in full version 11/14 of 39	Arts Therapies/Psychotherapies is 'not other'. At all stages in both documents the arts therapies/psychotherapies should be within any discussion on the psychological/talking therapies. It is 'not other'. It is one of the psychological & talking therapies and should not be excluded from this grouping. They are HPC regulated psychodynamic professions. By excluding the arts therapies/psychotherapies from under the psychological treatments/therapies umbrella and not making it explicit that the arts therapies/psychotherapies are one recommended approach within the range of approaches recommend by these guidelines, could mean the arts therapies/psychotherapies may not be considered as indicated by managers within services for this patient group. This would be a serious loss of treatment opportunity for those with a borderline personality disorder, including those with a learning disability & young people for example (p11 of 39 & 14 of 39)	Thank you – the sections on arts therapies have been moved in the relevant chapters.
17	SH	Arts Psychotherapies Services	9	Full	General & Specific Assumption of verbal expressio	Page 13, 22 etc, in short. Various in long version; Page 14, 1.2.11 etc	Assumption of verbal expression having priority. Some do not have this luxury of expression. E.g. Some younger people There is an assumption throughout the guidelines that words and verbal expression has priority and all can use this avenue of expression. (E.g. page 22 of 39). Many cannot and as a result we see extreme acting out behaviours. It is my experience working with people with this diagnosis over many years within outpatients,	Thank you. Arts therapies have been discussed in the full guideline. It is NICE rubric to include up to 5 research recommendations per guideline, which the GDG prioritised based on an expert consensus view of which piece of research, if completed and published before the guideline is

					n. Toward diagnosis. Younger people. Research support.		day services and at the Henderson Hospital that many do not have words and another way needs to be found for communication. Thus the arts therapies/psychotherapies can be the treatment of choice. Further research is indicated to confirm my view. Colleagues & I can provide many clinical examples. Many young people I see in my practice are not diagnosed and through assessment and subsequent therapy a diagnosis can be agreed with the Consultant Psychiatrist as Borderline PD. Examples can be provided. With reference to page 14 of NICE and thinking about younger people; we see many 17 upwards who are unable to use words and art psychotherapy has contained and enabled exploratory and transference work through weekly individual therapy. Words have gradually been found and acting out behaviours lessened. Research is needed on this area.	due to be updated (usually in 4 years time), would be most likely to improve the guideline.
18	SH	Arts Psychotherapies Services	10	Full	5.12 Incorrect Art Therapy/ Psychotherapy definition used. Separate definitions for each arts therapy/psychotherapy required Incorrect definition and explanati	33 of NICE & 187 of long version etc	Incorrect information and Definition on the Arts Therapies/Psychotherapies. Page 33, This definition is incorrect, rather dated and not one that should be used and not one proposed by me as expert practitioner. I ask that the following be included; 'Arts therapies are the creative use of the artistic media as vehicles for non-verbal and/or symbolic communication, within a holding environment, encouraged by a well-defined client-therapist relationship, in order to achieve personal and/or social therapeutic goals appropriate for the individual.' Karkou and Sanderson (2006) Arts Therapies: A Research Based Map of the Field, Elsevier, p 46. And I ask that separate definitions put in for each arts therapy/psychotherapy. As my letter stated to Rachel Rachel Burbeck Systematic Reviewer, National Collaborating Centre for Mental Health .....2007. 'There should be reference to each different arts therapies and for 'art' psychotherapy..There are important differences and they are not interchangeable.....' For further definition on art therapy/psychotherapy & also outlined	Thank you. We have amended the section on arts therapies in light of this and other comments. This has included re-organising the chapter so that the section on arts therapies is separated from 'other therapies' and removing the term 'creative therapies'.

					on of the arts therapies /psychoth erapies.		to Rachel Burbeck Art Therapy is a form of psychotherapy that uses art media as its primary mode of communication...The overall aim of its practitioners is to enable a client to effect change and growth on a personal level through the use of art materials in a safe and facilitating environment. The relationship between the therapist and the client is of central importance, but art therapy differs from other psychological therapies in that it is a three way process between the client, the therapist and the image or artefact. Thus it offers the opportunity for expression and communication and can be particularly helpful to people who find it hard to express their thoughts and feelings verbally. BAAT (2004) What is art therapy? Online: http://www.baat.org/art_therapy.html. Accessed 8th July, 2008.	
19	SH	Arts Psychother apies Services	11	Full	General The older person	Page 36	Late Diagnosis-The Older Person I suggest reference to late diagnosis particularly for the 'older person'. It is increasingly my experience in clinical practice that the person who has not had a diagnosis or is diagnosed with such as depression; is after review and contact through treatment from the psychotherapies (including art) diagnosed as Borderline PD. This area may be proposed for research or perhaps research is already taking place?	The guideline is intended to apply to adults of all ages and therefore specific mention of older adults has not been made. All services for people with borderline personality disorder whether general or specific should include people from any age group, and not descriminate on the basis of age.
20	SH	Arts Psychother apies Services	12	Full	5.2.3 Small evidence base for all interventi ons.	5.2.3 111, 110, 109, 5.2	Arts Therapies/Psychotherapies can be included as an analytic and/or psychodynamic psychotherapy. Given the very small evidence base for DBT, CAT, MBT, SFT etc and the many parallels that can be drawn between analytic psychotherapies and the arts psychotherapies, all should be listed within the section individual psychological therapies and that this includes the arts psychotherapies/therapies. Psychoanalytic therapies should include within this section art psychotherapy as transference based arts psychotherapy, page 109, 5.2.	The section on arts therapies has now been integrated into the chapter on Psychological treatments.
21	SH	Arts	13	Full	5.12	187	Not Just Non Verbal.	Thank you for your comment. We

		Psychotherapies Services			Non Verbal & Verbal		The arts therapies/psychotherapies do not necessarily focus on the 'non verbal'. As all psychotherapies, arts therapies/psychotherapies work within and with boundaries; boundary challenges for example. That the arts therapies/psychotherapies encourage or are in some way intrinsically linked to evoking or containing strong emotions is rather a myth. Strong emotions are not necessarily encouraged or advised within the arts therapies/psychotherapies. As with any psychotherapy one works with dynamic process, projections, transferences, defences and so on. Payne's definition is rather dated in this regard. The image is an added dimension within the triangular relationship. The image is considered by the art psychotherapist in its broadest context; the therapist, the space, the patient/s, unconscious enactment and so on. See above and comment 4 & 10 for further explanation and definition.	have amended the sentence to say 'use non-verbal…' rather than 'focus on non-verbal…'.
22	SH	Arts Psychotherapies Services	14	Full	2.5.5 Specific and general The heading Art & Creative Therapies is incorrect. Therapy times Dated literature	33 of 476	Art & Creative Therapies Schools is Incorrect- Dated Reference. Incorrect Information. In part the Meares and Hobson reference although rather dated is helpful in thinking about different levels of intervention however suggest without further explanation may b e misleading when 'plunging interpretations' are referred to. This observation can be applied to any psychological intervention and so should not be applied just to the arts therapies/psychotherapies. 'That traditionally art therapy is thought of as working with primitive emotional material': can be misleading and is not necessarily the case as with any psychotherapy. The image is an added dimension to/within the psychotherapeutic relationship with the potential through the image to express that which is too difficult or not possible to express verbally. There is much more up to date literature; Gilroy A, Art Therapy, Research and Evidence Based Practice, Sage 2006 & 'Karkou and Sanderson (2006) Arts Therapies: A Research Based Map of the	Thank you. The correct date for Waller/ Gilroy book has been added. The book by Gilroy (2006) has been referenced. This section on arts therapies has been amended in light of this and other comments. The section in the chapter on psychosocial and psychological therapies has also been amended.

					Group Size Length of Therapy.		Field, Elsevier. I am not aware of the major schools art and creative therapies. And if there is a creative therapies school of which I am unaware it should not be used in the same context as the arts therapies/psychotherapies. I find the whole section on the creative arts therapies confusing and that it seems to exclude the other arts therapies/psychotherapies in favour of art. Please use the definition/s in comment no 10. Karkou and Sanderson and also in comment 10 the BAAT definition for specifically art therapy/psychotherapy. The other arts therapies bodies should be asked to provide their own definitions for each of the arts therapies/psychotherapies and I have asked they do so. The length of therapy and the numbers within groups is not necessarily correct for all the arts therapies/psychotherapies. Group size varies from the usual 6-9 within analytic groups to above this number within median groups; see comment no 4. Individual therapy is usually fifty minutes. Groups 1.5 to 2 hours. Perhaps the actual time and numbers does not have to be included, but rather say group size and length of therapy will vary according to need. However boundaries of time and space are viewed as with all psychodynamic psychotherapies an intrinsic part of 'our' approach and for example important to adhere to in order for the person to feel contained and/or as a point of exploration; i.e. boundary challenges.	
23	SH	Arts Psychotherapies Services	15	Full	2.5.5 General and specific. Descriptive terms to be used throughout.	Throughout.	The description arts therapies/psychotherapies. The description arts psychotherapies/therapies should be used throughout both versions as per HPC regulation guidance. As this covers the whole range of specialisms and approaches which come under the umbrella of the arts therapies/psychotherapies. On no occasion should the description 'creative therapies' be used as it is not a recognised term by the Health Professions Council 'HPC'.	Thank you. We have amended the term and improved the sections on arts therapies in the introduction and in the chapter on psychosocial/psychological therapies in the full guideline.

					HPC		At the beginning of each guideline it should be outlined that art, music, dance movement and drama may be included under this umbrella. Please also note they are HPC registered professions.	
24	SH	Arts Psychotherapies Services	16	Full	GDG	End of Doc	Development Groups-Exclusion of Professions. I remain concerned at the absence of arts psychotherapists on the development group. I suggest on all NICE mental health panels there should be a representative from each profession. As it is the panels can seem in favour of psychiatry and psychology. (Good to see Anna Maratos on the Schizophrenia review panel this time around though). Although I do not doubt that the panels take into account all specialism's it is never easy to speak in depth for 'the other'. This speaking in depth is very important when there 'seems to be' little evidence available. I have twenty plus years of working with this patient group and in the face of lack of research, then voices such as mine and a wider range of users voices could have been better used to inform these guidelines. Arts Psychotherapists/Therapists particularly art psychotherapists are one of the most established specialism's with this patient group. For example for over thirty years at the Henderson Hospital and for twenty years in the provision of assessment, group and individual art psychotherapy within outpatient services at Sutton Hospital under SWLSTG MH Trust. Art Therapists/Psychotherapists work across all the settings and at different stages of the person's treatment; acute admission, day services, residential services and outpatients. Although positive to have been the Art Psychotherapy/Therapy advisor it would have been better to be able to proactive rather than reactive after the event. I would have liked for example to have seen the draft of the guidelines prior to going out for stakeholder consultation. As far as I recall was only consulted once.	Thank you for your comments. The constitution of the GDG is determined by the collaborating centre (NCCMH) and the GDG chair following wide consultation. Those selected (now through advertisements) must be able to provide expertise sufficient to cover the scope. The professional of individuals is not of primary importance; rather, their skills and expertise are the basis on which we make our selections. We do in addition ask people to act as special advisors where we need special advice on circumscribed areas of practice or interventions. Thank you for acting as a special advisor. It is not our usual practice to release copies of the guideline for advice pre consultation, except in special circumstances.

25	SH	Arts Psychotherapies Services	17	Full	8.5.11.2 5.13.1.1 General and specific Teams. Staff changes. Joint & Collaborative Working	1.3.1 1.3.4.2 1.3.5.4. page 15, 1.3.1..1.3.4 Page 107, 4.6.2. Page 12 of 39 1.1.4 109 onwards in full version	Collaborative Working-Supervision-Team Cohesion. 1 I propose there is more emphasis on joint & collaborative working. For example within the community setting the psychotherapist/art psychotherapist working alongside the CPN and with the patient is common practice within my service. (109 onwards) 2 In addition as we move increasingly to outpatient work for this patient group, it would be helpful to emphasise more strongly the desirability of combination of group and individual approaches and this can include (and indeed often does in my experience) the arts psychotherapies, individual and group. (109 onwards) 3 E.g. page 12 of 39, 1.1.4; I would like it proposed much more strongly that teams are aware of the impact of team changes, the impact of high staff turnover and such as psychiatrist & CPN changes. People with this diagnosis need steadiness, consistency and for people to get to know them. This consistency is good for the patient, the staff members and the team as a whole. It is my experience that professionals can under estimate or are unaware of the impact of such changes and risk increases at these times. I can provide clinical examples.	Thank you for your comments which we have numbered to aid response. 1 It not appropriate for NICE guidelines to specify particular professionals' roles. This is a matter for local implementation. 2 There is no specific evidence for this and therefore we were not able to make such a specific recommendation. 3 We agree that services need to provide a balance of challenge and stability fostering automony and providing support. The GDG think they have the balance right.
26	SH	Arts Psychotherapies Services	18	Full	General Specific Group and Individual therapy is available. Collaborative working	188 8 of the NICE 11 of the NICE	Arts Therapies/Psychotherapies-Assessment, Groups and Individual Therapy Also see comment No 4. I am unsure on what evidence that it is stated on page 188 that group therapy is more commonly provided? This may be so, however I suggest research is indicated to ascertain this is the case and further to draw out the fact that increasingly in my clinical experience that many are assessed as suitable for individual transference based art psychotherapy. The lack of opportunity of a range of arts therapies/psychotherapies interventions is often due to insufficient staffing provision of arts therapists/psychotherapists. They are often very part time and in some Trusts there are no arts therapists/psychotherapists at all.	Thank you for your comments. The statement is intended to reflect common practice rather than what is suitable for service users. We have restructured the psychological treatments chapter so that arts therapies are not in the section on other therapies.

					Psychological treatments. Learning Disabilities		In my service we are still fortunate to have a fair staffing ratio. We work closely with the Consultant Psychotherapists/Psychiatrists and will often decide that individual art psychotherapy is more appropriate for the person with this diagnosis than verbal analytic psychotherapy due for example to the complexity and high level of disturbance of the transference enactment. The image within the therapy can act as a point of expression, mediation, transference focus and subsequently exploration. This opportunity lessens the intensity of the enactment which cannot be worked with within one to one psychoanalytic psychotherapy. As we see the decline of residential options such as the Henderson Hospital and therapeutic community day hospitals then increasingly we see those within outpatients who require individual art psychotherapy and within the context of collaborative working. Many are not ready for group analytic art psychotherapy or group analytic psychotherapy. Trained as a Group Analytic Psychotherapist, Psychoanalytic Psychotherapist and Art Psychotherapist I am aware of the importance of not putting those with this diagnosis within a group until they are ready to work in this way. Assessment. The arts therapies/psychotherapists contribute to the assessment and/or carry out assessment towards diagnosis of this patient group; particularly indicated when the verbal approaches cannot be used, for example when the person is within acute admission facilities. Arts Psychotherapies/Therapies are formal psychological therapies.	
27	SH	Association for Cognitive Analytic (ACAT) Therapy, The	1	Full	General		ACAT welcomes the draft guidance and thanks the GDG for its hard work and expertise.	Thank you.

28	SH	Association for Cognitive Analytic (ACAT) Therapy, The	2	Full	5.14.2.1 (4.3)	190 31	The A in ACAT stands for Analytic not Analytical – the therapy is thus Cognitive Analytic Therapy (CAT). This appears wrongly in both the full and guideline drafts.	Thank you. We have amended this.
29	SH	Association for Cognitive Analytic (ACAT) Therapy, The	3	Full	General		ACAT warmly welcomes the promotion of thoughtful, compassionate, boundaried and collaborative styles of working with this client group, that are recommended throughout the guidance.	Thank you.
30	SH	Association for Cognitive Analytic (ACAT) Therapy, The	4	Full	General		ACAT is one of the largest training organisations within UKCP and has developed trainings in 4 other countries. Over the last 25 years ACAT has developed an integrated model of psychotherapy that emphasises a relational understanding of personality disorder. It has been widely applied as an individual psychotherapy format but has also developed as a group psychotherapy in several sites, and a tool for systemic consultation. Personality disorder services using the CAT model as the 'base platform' (EG: In Sheffield and Somerset) are able to be reflect and support generic mental health professionals in working positively with all clients with BPD. In this sense, CAT is being widely applied as an inclusive complex intervention using a consultation and supervision framework tied in with widespread availability of 2 year Practitioner level trainings. (REF: Ian B Kerr (1999) 'Cognitive Analytic Therapy for Borderline Personality Disorder in the Context of a Community Mental Health Team: Individual and Organisational Psychodynamic Implications', British Journal of Psychotherapy 15(4) pp 425-438.)	Thank you for your comment. We cannot make a recommendation for CAT since there are very few data supporting its efficacy. However, we have amended the recommendation about psychological therapies at 1.5.4.3 [draft NICE guideline numbering] in light of various comments from stakeholders.
31	SH	Association for Cognitive Analytic (ACAT) Therapy,	5	Full	General		DIVERSITY ACAT supports diversity and creativity in psychological therapies for people with BPD. Different clients suit different approaches and the maintenance of choice and diversity is an important principle in the future development of effective treatments. Premature	Thank you. This is a good point. We believe our recommendations reflect the current evidence base which is relatively narrow at the present time.

		The					narrowing of the field could close down a currently flourishing area of mental health development and reduce choice and access to effective treatments in the future. It would seem more important to share good practice and integrate proven technique and theory at this stage then for the NHS to head towards a monotherapy culture.	
32	SH	Association for Cognitive Analytic (ACAT) Therapy, The	6	Full	5 General		QUALITY ACAT supports the need for high levels of training and supervision for professionals working with this complex client group. It is cautious about the widespread rolling out of simplified therapy models based on complex interventions extracted from intensive RCTs conducted in centres of excellence. It is not proven that the efficacy of these trials can be replicated in ordinary clinical settings in a diluted form and delivered by generic mental health staff with limited training.	Thank you for your comment. The guideline does not suggest simplified therapy models. Rather it recognises that there is a paucity of evidence of the effectiveness of psychological treatments in people with borderline personality disorder. It recommends that therapy is delivered within an explicity coordinated framework, with an integrated theoretical base and provided within structured care and includes therapist supervision. See the modified recommendation 1.3.5.4 [draft guideline numbering]. As a result of this and other comments we have made a new recommendation about training and supervision in section 1.1 of the NICE guideline.
33	SH	Association for Cognitive Analytic (ACAT) Therapy, The	7	Full	5 General		OVER-RELIANCE ON RCT EVIDENCE With the evidence base for the efficacy and cost effectiveness of psychological therapies for BPD at such an early stage, and with serious concerns about the diagnostic criteria and outcome measures available, it may be unhelpful to pay such little attention to the non-RCT and qualitative literature concerning treatment using a diverse range of therapies, many of which are likely to involve valuable and efficacious contributions to the field. It is far from accepted internationally that RCTs are indeed the 'gold standard' for trials of relational interventions such as psychotherapy and the UK seems to have veered to one end of the	Thank you for your comment. Concerns over diagnosistic criteria and outcome measures do not mean that RCTs are still not the best available research design for assessing the efficacy and effectiveness of treatments. This is recommended in the NICE handbook for developers (see http://www.nice.org.uk/media/052/6A/GuidelinesManual2008Consultation.pdf). The GDG recognised that

							spectrum on this. There is a danger that it might seem to be more valuable to leap straight to an RCT than to develop a tried and tested model of therapy with a system for training, measurement of adherence, accreditation and supervision before putting the intervention to the scrutiny of an RCT. Conducting RCTs in this field is an expensive and complex challenge and beyond the resources of the vast majority of therapy organisations. Lack of RCTs is not necessarily evidence of lack of efficacy. Future research may be best directed at elucidating the efficacious factors common to a range of approaches and not aim to prematurely narrow the field down to a head to head between the two named complex interventions (DBT and MBT). There is the compounding effect of prematurely narrowing the field in that the approaches with the early RCT data are likely to be the only ones to attract future funding. Intensive single case study methodology is a promising approach that ACAT is using in a current multicentre trial. (Kennett S., Bennett D and Ryle A. in progress). (References re: Methodology: 1. Hilliard, Russell B. (1993) Single-case methodology in psychotherapy process and outcome research. Journal of Consulting and Clinical Psychology. Vol 61(3) 373-380).2. Kellett S (2005) The treatment of Dissociative Identity Disorder with Cognitive Analytic Therapy: Experimental Evidence of sudden gains. Journal of Trauma and Dissociation. 6(3)55-81.)	the development of psychological therapies for people with borderline personality disorder is at a relatively early stage compared with that in other mental health disorders. However, this does not mean that we should lower our standards when making recommendations. We agree that lack of evidence does not mean therapies are not efficacious, but that does not mean we should make recommendations. Only DBT, which has a relatively large evidence base, is specifically mentioned by name in a recommendation. We have carefully reworded the recommendtion in 1.3.5.4 [draft guideline numbering]. We appreciate the issue of stifling development in the field.
34	SH	Association for Cognitive Analytic (ACAT) Therapy, The	8	Full	5.14.3.1 (4.1)	29	OUTCOME MEASURES ACAT welcomes the caution around reliance on current diagnostic criteria and outcome measures for BPD. In addition to consensus around measures there is an urgent need for more research into developing measures that have greater validity, stability and correlation with health economic analysis. The most important issue around outcome measures is the growing awareness from both psychotherapeutic and bio-behavioural literature that emotional reactivity in people with BPD shows little stability over time and relates closely to current environmental factors and, that a paradoxical factor emerges in that under higher levels of stress	Thank you. These are good points, but we feel they represent too much detail for the research recommendation.

							there is a tendency to dissociation which causes a decrease in reactivity and self-report of emotional arousal. (REF: A recent review is Rosental, M.,Z. et al. (2008) Borderline personality disorder and emotional responding : A review of the literature, Clinical Psychology Review, 28; 75-91.) This finding has major implications for the validity of self-report measures in RCTs and the heavy reliance on the analysis of these trials in these guidelines. Before the baby is thrown away with the bathwater of qualitative studies there must be a much stronger consensus that outcomes measures actually measure qualities related to well being that are stable over time.	
35	SH	Association for Cognitive Analytic (ACAT) Therapy, The	9	Full	5.14.1.1 and 5.14.2.1 (4.2.and 4.3)	30-31	OUT-PATIENT INTERVENTIONS ACAT is grateful for CAT's inclusion in the out-patient intervention recommendation for further research and hopes to be able to demonstrate greater efficacy and cost-effectiveness to NICE, based on the results of additional RCTs (another of which is completed) and other outcome studies, in time for the next revision. More traditional OP individual and group interventions are likely to be highly cost-effective in comparison with complex interventions, especially when combined with high quality community care informed by the development of personality disorder teams and networks, as is happening in many trusts. Travel costs in allowing clients to access complex interventions in rural Trusts should be considered.There is no evidence that branded 'complex interventions' are better than the joined up approaches already established in the NHS.	Thank you. It is NICE rubric to include up to 5 recommendations per guideline to increase the probability of research funding being available and, therefore, the GDG prioritised carefully based on which research, if completed and published before the guideline is updated, would be most likely to improve the guideline. We found that treatments given within a structured framework (initially termed 'complex' in the draft guideline) showed more consistent effects on symptoms than 'traditional' interventions. See chapter 5 in the full guideline.
36	SH	Association for Cognitive Analytic (ACAT) Therapy, The	10	Full	5.13.1.1 (1.3.5.4)	19	MULTIPLE MODALITIES AND COMPLEX INTERVENTIONS The following recommendation is confusing, very concerning and requires further clarification: When a decision has been made to offer psychological treatment to a person with borderline personality disorder, healthcare professionals should offer one that provides therapy in at least two modalities (for example, individual or group), has a well-structured programme and a coherent theory of practice. Therapist supervision should be included within the framework of the service.	Thank you for your comment. This recommendation has been amended in light of your and other stakeholders' comments.

				Full	5.8 (lines 21-25)	173	It is confused also in the full guidance: … if a psychological therapy is being considered, it should be delivered in the formats which the evidence suggests they are effective. That is, it should provide therapy it at least 2 modalities, be well structured and have a coherent theoretical basis. In addition, therapists should be provided with adequate supervision. By no means all clients can tolerate group work and need a period of relationship-building in an individual therapy relationship as their first intervention. Conversely, some clients prefer initial work in a group and move on to individual work. Others take a period of irregular contact and persistent attempts at engagement to gather enough trust to embark on therapy. This recommendation does not offer guidance for this group (the majority) who are 'non-complaint' with a complex intervention (and are excluded from the trials on which this guidance is based). This is unrealistic and gives undue weight to the named complex interventions; as if it is proven that they can be replicated in real clinical settings and applied universally across the diverse group of clients with BPD. The recommendation contradicts the elements of consideration of client choice and individual difference in 1.3.5.2. It is unclear if clients should be offered more that one modality at the same time or a choice of modalities. 'At least two' implies multiple other modalities. What are these? The word 'modality' is often used to describe a therapy model rather than the format of delivery, so this term is confusing. ACAT would suggest that therapists should be properly trained and supervised, not just supervised. Taken literally, this recommendation could be used by Trusts, keen to make cost savings, to restrict treatment options to a very limited number of therapies and exclude more traditional out-patient individual and group therapies. ACAT feels this to be completely unjustified and that the wording of this recommendation, if this is indeed the intention, is not in keeping with the balance and objectivity of the rest of the guidance. ACAT strongly urges the	

							GDG to re-consider this recommendation to suggest that a combination of individual and group approaches, at the same time, may help some clients and should be available alongside other joined up approaches.	
37	SH	Association for Cognitive Analytic (ACAT) Therapy, The	11	Full	5.13.1.2 and 5.14.1.1 (4.2 and 1.3.5.5)	30 19	DIALECTICAL BEHAVIOUR THERAPY (DBT) ACAT welcomes the inclusion of support for the use of DBT with some women for whom repeated self-harm is a key issue, as this is supported by the evidence base. ACAT is cautious, however, about the generalizability of the trial data to real clinical settings; particularly the fact the clients with BPD are expected to 'comply' with a highly boundaried programme or are excluded at the referral stage or during treatment. This severely limits the application of this model to real life clinical settings, and can be experienced as rejecting and punitive by clients. The recommendation for a trial of DBT vs MBT against high quality community care is well worded and raises the points that need addressing. The difficulty of such a trial is that many clients that would be able to receive high quality community care would not be suitable for DBT (and to a lesser extent MBT) making meaningful comparison difficult. There is the danger of a circular argument in the DBT model of treatment in that suitability criteria select for those clients who are most motivated to seek help to change. Further pilot work needs to show that the DBT approach can be more widely applied with difficult to engage clients before 4.2 is meaningful clinically.	Thank you. This is a good point and is the reason why the previous recommendation does not mention specific therapies. However, the GDG considered there was sufficient evidence to support the more specific recommendation about DBT in women.
38	SH	Association for Cognitive Analytic (ACAT) Therapy,	12	Full	5.14.1.1 (4.2)	30	MENTALIZATION-BASED THERAPY (MBT) ACAT welcomes the relational understandings of MBT, and feels that this is an important step forward in the application of psychoanalytic concepts to the broader NHS.	Thank you for your comment. Because of the relatively early developmental stage of reseach in this area the guideline does not recommend MBT per se. Rather it recommends therapy delivered

		The					However, ACAT has questions around the generalizability of the trial of partial-hospitalization (Bateman and Fonagy, 1999 and subsequent), and its relation to what is being rolled out nationally as Mentalization-based therapy (MBT). The partial hospitalization format described is in fact a complex and intensive mix of established psychotherapy modalities, namely individual and group analytic psychotherapy and psychodrama, delivered in a partial hospitalization setting with elements of a therapeutic community model and including regular psychiatric and medication review. This eclectic mix of talking and more expressive therapies with joined up psychiatric care is quite widespread in personality disorder day programmes across the country. It has excellent face validity and ACAT welcomes this carefully conducted trial that shows that such a complex programme can cause lasting benefit. If it did not show benefit over TAU then we should all be dismayed. However, it is unclear how the trial interventions relate to the model of MBT as now being rolled out, and which could be seem to have been applied post-hoc to what is a highly intensive and eclectic framework of approaches in an established centre of excellence. How will adherence to MBT as extrapolated from the partial hospitalization trial be measured formally (there is only informal adherence in the trail) ? ACAT would suggest that there needs to be further piloting and development of the MBT approach in terms of the model, accreditation of training for practitioners and supervisors and adherence tools, to substantiate that it is deliverable by a range of generic mental health professional without a base psychotherapy platform to draw on.	within an explicit theoretical base shared by both the treatment team and service user which includes structured care in accordance with this guideline, plus therapist supervision included within the framework of the service (see amended recommendation 1.3.5.4 draft NICE guideline numbering). The research recommendation is intended to establish the efficacy of treatments which there was evidence of effectiveness against the same standardised control.
39	SH	Association for Cognitive Analytic (ACAT) Therapy,	13	Full	General	1	OMISSION OF OLDER PEOPLE: There is no analysis of issues related to BPD as it manifests in older people despite the considerable literature that is overlooked. The presentation of BPD has been shown to be altered in later life with less overt self-harm and more somatization and dissociative	Thank you. The guideline applies to adults of all ages and the GDG did not think it necessary to identify specific recommendations for older people.

		The					presentations, which has important implications for identification, diagnosis and treatment. (Refs: 1. Abrams R C, Horowitz S V (1999) Personality disorders after age 50: A meta-analytic review of the literature. In: Rosowsky E and Zweig R A (Eds.) Personality disorders in older adults: Emerging issues in diagnosis and treatment. Lawrence Erlbaum Associates Publishers, Mahwah, NJ, US., 2. Hepple, J., (2004) Borderline traits and dissociated states in later life. In Hepple, J. and Sutton, L., (Eds.). Cognitive Analytic Therapy and later life. A new perspective on old age. Hove & New York. Brünner-Routledge.) There is evidence to suggest that dramatic cluster traits are actually more prevalent in older people compared with middle aged people. It is well established that the ageist configuration of services severely limits access to psychological therapies by older people and ACAT would suggest that the omission of the literature around BPD in later life is likely to perpetuate this problem. This issue was raised at the scoping stage but unfortunately the scope was not extended to explicitly include older people. It is not too late to introduce this section in the way that those with learning disabilities, BME and younger people have been explicitly included.	
40	SH	Association for Cognitive Analytic (ACAT) Therapy, The	14	Full	5.4		CHANEN (UNPUB) TRIAL ACAT is grateful for the inclusion, by the GDG, of unpublished data from the Chanen trail in the full guidance. Dr Chanen is clear that this is not a trial of CAT vs TAU but CAT vs a manualised 'good clinical care'. He is responding to you directly over this but ACAT would like to reinforce this point which would increase the quality of evidence for CAT in this RCT.	Thank you – we have corrected this.
815	SH	Association for Family Therapy and Systemic Practice	1	Full	General		We are pleased to comment on the draft guideline because the multidisciplinary membership of the Association for Family Therapy and Systemic Practice includes not only UKCP registered Family and Systemic Psychotherapists, but also staff with different levels of training who work in different settings.	Thank you.

							Most UKCP registered Family and Systemic Psychotherapists are employed within CAMHS services, but others work in the NHS: adult mental health, Early Intervention with Psychoses, with the elderly, learning difficulties or physical ill health; or with the families of children in Local Authority Care, and other vulnerable families involved with local authorities and voluntary agencies. Some posts have been set up to reflect the importance of working across different agencies because of the number of professionals involved with people with complex relational problems, with members of a family or social network. Staff with different levels of training in Family and Systemic Psychotherapy use their approach and skills within their other roles, which is particularly important when working with those who are vulnerable to develop borderline personality disorder, such as young people in local authority care, or who struggle with looking after their children because of past emotional and psychological difficulties.	
816	SH	Association for Family Therapy and Systemic Practice	2	Full	General		Many of the 'multiple and complex problems' covered in 'Think Families' (2008) will be found in the social networks of someone with a diagnosis of borderline personality disorder – substance misuse, domestic violence, and other factors associated with instabilities and difficulties in engaging with services.	Thank you.
817	SH	Association for Family Therapy and Systemic Practice	3	Full	General		The Full document covers many factors in family relationships and trauma associated with borderline personality disorder, as well as considering the impact of its symptoms on those living with or caring about someone with borderline personality disorder. The implications are that several interventions addressing relational problems should be accessible to people with borderline personality disorder, since problems present in a complex ways, have different influences on relationships or may be reactions to stresses within relationships. This acknowledgement of the importance of interpersonal and family relationships is lost in the Guidelines – which seem to take a position of only offering a service to individuals who	Thank you. The guideline includes recommendations about including families and carers depending on the service user's wishes. The issue of children of BPD parents is outside the scope of the guideline. The topic has been reviewed by SCIE http://www.scie.org.uk/publications/briefings/files/briefing24.pdf). We would suggest that it may make a suitable topic for suggestion to the NICE topic selection panel.

							have lost all meaningful or supportive relationships by the time that they are eligible for treatment, as happens sometimes for someone with complex needs and a diagnosis of borderline personality disorder. A volatile, unstable, impulsive relationship may lead to separation from a partner, whilst parents may become more tense and emotional or more distant. But the greatest risks of the individual focus will be for parents with borderline personality disorder and their families; since if the guidelines do not include relationships with children, the risks are that the parent with borderline personality disorder becomes excluded from the care of the child.	
818	SH	Association for Family Therapy and Systemic Practice	4	Full	General parenting	3	Since there are more women than men with the diagnosis, it would be helpful to have data on the proportion of mothers (and fathers) and how many sustain parenting responsibilities.	Thank you. The issue of parenting is outside the scope of the guideline. The topic has been reviewed by SCIE http://www.scie.org.uk/publications/briefings/files/briefing24.pdf).
819	SH	Association for Family Therapy and Systemic Practice	5	Full	General Full / 1.1.5	/ 12	The shift from identifying different family members in the Full version to the use of the generic term 'carer' in the Guidelines disguises the significance of individual relationships, and the dynamics around attachment (2.4.5), and the effectiveness of psychotherapy in improving attachment problems. The relationships between a mother and infant, between partners, or between a child and his/her parent(s) will all have different meanings and dynamics to those involved, and can all be addressed within a family approach. Could 'mothering' inspire motivation to recover for someone with borderline personality disorder as has been shown for other disorders? (Brown & Kandirikirira, 2007)	Thank you. We have amended the term carer to families/carer in the NICE guideline to take into account various comments from stakeholders. The specific issues addressed during therapy are a matter for the therapist. There was no specific evidence for family therapy for people with BPD.
820	SH	Association for Family Therapy and	6	Full	9.10.1 (1.1.1.2 1.1.5.2)	10 12	Taking a 'whole family approach' will help to reduce the risks of young people falling through the net when they fail to meet the eligibility criteria of services prior to the diagnosis of borderline personality disorder, particularly when different	Thank you. This issue is outside the scope of the guideline.

		Systemic Practice					services become involved. See AFT's response to The CAMHS Review for comments on the gaps in services for young people with complex needs (looked after children, domestic violence, parental mental health), as well as the evidence that supports whole family approaches with mainstream adult mental health services, and children with disabilities, parent-infant relationships, multifamily work with anorexia nervosa and education, and supporting parents. (Parker, 2008)	
821	SH	Association for Family Therapy and Systemic Practice	7	NICE	1.1.5	12	The comments under the section 'Involving carers' for adult services and CAMHS do not convey the many complex issues raised in the Full Guidelines, either around the nature of the problems in these relationships, their complexity, co-morbidity, or the risks associated with only providing education about borderline personality disorder, eg Hoffman and colleagues (2003) study provides a cautionary note about information. Their findings suggested that more information alone could be associated with more distress. (Full guidelines. 4.4.3 p 103) Whilst the statement 'ensure that the involvement of carers does not lead to withdrawal of, or lack of access to, services' will be applicable in some situations, there is nothing else that acknowledges the value of keeping the family in mind, so that the needs of an individual and close relatives can be addressed, and therapy offered, whether the 'carer' is a parent, partner or child.	Thank you. The evidence does not support more specific recommendations.
822	SH	Association for Family Therapy and Systemic Practice	8	Full	8.5 (1.3.3)	16	The risk assessment offers opportunities to consider the impact of experiences such as a child witnessing domestic violence, difficulties bonding with an infant, or a child being assaulted or abused by someone else within the network. This does require that CAMHS and adult mental health staff have training opportunities to consider both the range of risks to assess, as well as the interventions locally available, since few of these exist within adult services. For domestic violence, families may be supported in the	Thank you. We have amended 1.3.2.2 to include an assessment of the needs of and risks to dependent children. 1.3.1.1 recommends that staff have relevant training. [Paragraph numbers are those in the draft NICE guideline].

							recovery from the aftermath, possibly in collaboration with child protection, providing opportunities, when children feel safe, for them to talk to parent(s) about their distress about the violence that they have witnessed (Cooper and Vetere, 2005). When couples choose to stay together, the safety of the children is particularly important. Other risks, such as a child's disclosure of abuse by a close relative, may trigger a crisis for a parent who was also abused in childhood, although reports do not identify borderline personality disorder (eg Webster, Hatfield & Mohamad, 1999). Parents with low level mental health problems may still have difficulties that impact on their children's emotional health and development.	
823	SH	Association for Family Therapy and Systemic Practice	9	Full	8.5.12 (1.3.7)	20	The Report on the evidence base of Systemic Family Therapy gives an overview of studies that are relevant when considering co morbidity, and NICE guidelines for problems such as depression, bi-polar, eating disorders and learning difficulties. www.aft.org.uk/docs/Reportontheevidencebaseofsystemicfamilytherapy2005.doc.	Thank you. The separate management of comorbid disorders is outside the scope.
824	SH	Association for Family Therapy and Systemic Practice	10	Full	General		Although there is little specific evidence on systemic family therapy and borderline personality disorder, apart from those covered in the Full version, couple therapy has been found to be effective in reducing depression, increasing relationship satisfaction and in emotional deregulation. (Kirby & Baucom 2007).	Thank you. The guideline is based on the best-available evidence. There is insufficient evidence for a recommendation to the NHS for couple therapy at the present time.
825	SH	Association for Family Therapy and Systemic Practice	11	Full	2.5.5. Other therapies	33	The following gives a more accurate description of 'Systemic therapy' than is given in the Full document (which does not fit with either the description or way family and systemic therapy is practised). Family and Systemic Psychotherapy is for individuals and support networks, regardless of who the index patient is. It aims to maximise family strengths and resilience to help people overcome problems experienced by individual family	Thank you for your comments. This description has been amended to include elements of this material.

							members or the family as a whole. It helps family members to understand how they function as a family and to develop more helpful ways of interaction and supporting each other. Fully trained Family & Systemic Psychotherapists often work in multidisciplinary teams. The individual and family or support network will have access to the ideas and hypotheses discussed in the team, so that different experiences and points of view can be heard and acknowledged. Family & Systemic Psychotherapy always takes account of the impact of inequalities arising from gender, race, ability, sexual orientation, ethnicity, religion, age and socio-economic status on relationships, communication, behaviour and choices, while helping the family / support network to bring about the changes that they have identified as therapeutic goals. There are a number of models of systemic theory and interventions, such as Milan, social constructionist, narrative, solution focused, structural and strategic. A common technique employed is circular questioning, for example, "What do you think your brother would think about your mother's answer to that questions?" which enables family members to discover and acknowledge differences in opinion and beliefs, and to track links between beliefs and behaviour. Other techniques, such as reframing, offer opportunities to explore these in empathic and non-judgemental ways. A genogram (pictorial representation of family relationships) can help to identify the strengths as well as the problems in relationships across the generations. Whether or not the details of any past trauma is explored with the family together, the impact will be held in mind while exploring ways to live with the consequences. The dynamics within the whole family may be important in maintaining or exacerbating the presenting problems and borderline personality disorder, and if the family are willing to participate, Family & Systemic Psychotherapy can be effective in developing new ways of communicating within a	

							family that may be self-sustaining. Because of the flexibility of Family & Systemic Psychotherapy, it may be used with a young adult, the parents and siblings; with a partner; or with a mother and her children (and partner or parents). Over the course of treatment, therapy can be offered individually and with members of the social network, or a combination of these (Lord, 2007). This fits some of the predicaments associated with borderline personality disorder, such enabling a young woman to talk to her mother about the impact of sexual abuse in childhood. Involving partner, parents and children can be crucial for strengthening attachments for a family who wants to stay together, such as when a mother, who has depression and borderline personality disorder, finds it difficult to look after an infant. For those who have separated from a troubled relationship, involving a new partner can facilitate recovery.	
826	SH	Association for Family Therapy and Systemic Practice	12	Full	5.14.2.1 (4.3)	31	Research recommendations: There is an important place for further research on Family & Systemic Psychotherapy for people with borderline personality disorder. Exploratory randomised controlled trials of outpatient psychosocial interventions (such as schema-focused therapy, cognitive analytical therapy, (insert: systemic family interventions), and modified therapeutic community approaches) should be conducted. Such studies should examine medium-term outcomes (for example, quality of life, psychosocial functioning, employment outcomes, and borderline personality disorder symptomatology) over a period of at least 18 months and pay particular attention to training and supervision of those delivering interventions. See Full Guideline 4.4.6 (p104): There is an absence of research into whether family interventions alter the social outcome and welfare of a person with borderline personality disorder. Research on Family and Systemic psychotherapy with	Thank you – we have amended the recommendation.

							individuals could show the importance of techniques such as circular questioning and ways of stimulating curiosity about possibilities for change, opening up choices; working with the past, present and future in finding alternative solutions. Some of these concepts and techniques are used in other individual approaches. Given the likely involvement of close relatives and support networks with people with learning difficulties, could Family and Systemic Psychotherapy provide and effective intervention?	
827	SH	Association for Family Therapy and Systemic Practice	13	Full	2.1	16	Family and Systemic Psychotherapy has a potentially significant preventative role as well as a treatment for the impact of borderline personality disorder, because of the flexibility in working with families and support networks across the life span, and because it is often combined with other appropriate treatments for people with complex needs.	Thank you. This section is intended to 'set the scene' rather than specify therapies or review evidence.
828	SH	Association for Family Therapy and Systemic Practice	14	Full	8.6.1.1 (4.5)	105	Early intervention was considered crucial in preventing a major deterioration in the disorder, and having the option to self-refer would help prevent further unhelpful and negative experiences. Early interventions following sexual or physical abuse, domestic violence and parental mental health or instability, could enhance attachments, lead to improved communication and relationships, whether the index patient is a partner, parent or child. Such interventions need to be developed collaboratively with other services within frameworks of 'Every Child Matters', services for Young Carers, child protection, adoption and fostering and services which work with domestic violence in adults or parents with mental health problems. Delaying treatment options until the diagnosis of borderline personality disorder is made, whether in CAMHS or adult mental health services, increases the possibilities of seclusion and getting out of control, and the pressures on the support systems. Early interventions are particularly important for developing attachments for mothers (and fathers) and	Thank you for your comment which makes a good point. However, this was outside the scope of the guideline.

							infants.	
829	SH	Association for Family Therapy and Systemic Practice	15	Full	9.8.2	331	Given that most young people with borderline personality disorder live with their families, with foster parents, or in social services residential placements, involving carers in treatment may be helpful, although no studies evaluating such treatment appear to have been undertaken. Where available, Family and Systemic Psychotherapy provides supervision for staff, consultations to other agencies as well as working therapeutically directly with support networks, although this will be described as something like 'working with Looked After Children' rather than focusing on the diagnosis.	Thank you. The scope of the guideline limited our evidence to that undertaken in those with a diagnosis of borderline personality disorder.
830	SH	Association for Family Therapy and Systemic Practice	16	Full	8.5.10 (1.3.3)	16	Managing someone in crisis with borderline personality disorder eg when there are several presentations to services each week over a period of time, is a challenge for services as well as for support networks. Crises involve numerous different professionals repeatedly undertaking risk assessments. The experience of seeing many different staff can exacerbate the feelings of rejection and abandonment and repeatedly remind the person of previous traumas, which increase risk taking, without making a difference to problems of engagement. A Systemic consultation, bringing together the different agencies and teams that are involved, allows space to reflect on the issues that the person in crisis is struggling with, as well as developing more collaborative ways of working together and relating to the person in crisis. By offering space to reflect on the patterns of relationships with staff and with members of the family and social network, staff can consider when to provide containment by 'being there', and think about the timing of appropriate and available interventions and psychological treatments. The consultation will include thinking about the family and social network. These are particularly helpful when there are disagreements about management or the risks.	Thank you for your comments. We believe we have covered the points you make in the existing recommendations (for example, considering the needs of dependent children and recommendations about care planning). There is no specific evidence on the value of a systemtic approach versus other approaches.

							Consultations also provide opportunities for staff in the adult services to address any difficulties around considering the needs of the children or young people involved, and how these may be addressed. This is particularly important when the culture of adult services is unfamiliar with the expectations of all professionals outlined in Every Child Matters, Think Family, and in child protection procedures.	
831	SH	Association for Family Therapy and Systemic Practice	17	Full	8.5.10.3 (1.3.3.3)		Family and Systemic Supervision offers a useful framework for the relationships involved – between the person with borderline personality disorder and the staff, between staff in different teams, as well as the meaningful relationships within the social network. The influence of past trauma or abusive relationships is borne in mind, whilst considering whether these need to be explored in depth, or whether a narrative or solution focused approach might help the person to be more in charge of the way that they live with the problems. Supervision aims to increase the staff's sense of confidence about their own practice, as well as expanding their knowledge and skills in managing the problems and relationships.	Thank you. We have no specific evidence for particular models of managing relationships in the way you suggest. This recommendation is about risk assessment rather than considering therapeutic approaches, which is the topic of other recommendations, for example, in section 1.3.5 [draft NICE guideline numbering]. We have added a new recommendation about supervision at the end of the section on general principles.
832	SH	Association for Family Therapy and Systemic Practice	18	Full	General		There is a great shortage of Family and Systemic Psychotherapists in adult mental health, but they do work with people with borderline personality disorder. In one psychological therapy service, which offered the choice of a family approach to those who were referred, women asked to be seen with new partners, as well as young adults wanting to be seen with their parents. Systemic psychotherapy with individuals can address relationship problems between a parent and child, whilst also working with thoughts, beliefs, sense of self and relationships, past and present trauma, and exploring possible choices for change – and being proactive.	Thank you. The guideline is based on the best-available evidence. There is insufficient evidence for a recommendation to the NHS for couple therapy at the present time.
833	SH	Association for Family Therapy and Systemic Practice	19	Full	General	9	Training staff to work with volatile relationships would be helpful, and would need to be linked to ongoing supervision.	Thank you for your comment. As a result of this and other comments we have made a new recommendation about training and supervision in section 1.1 of the NICE guideline.

41	SH	Association for Psychoanalytic Psychotherapy in the NHS (APP) – Referee 1	1	Full	General	All	APP welcomes this much-needed guidance to enable patients with BPD to gain access to effective psychological therapies through the NHS. As the NICE guideline will be read more widely, the more 'Generalist and / or stylistic' comments below will mostly follow this version. A few 'Specific and / or technical' comments on evidence are related to the Full version. A few comments on both guidelines overall are made at the start. Section numbers will be stated in column 3. Page numbers will be stated in column 4. Whilst the GDG are clear that the RCT evidence base is limited, there is a larger evidence base, as yet untapped, from collection of routine outcomes for this patient population. Use of this kind of evidence, however, would require a more sophisticated methodology of analysis and synthesis. Our comments below cannot provide that, and are qualified by virtue of reflecting the perspective of one part of the professional community, psychoanalytic practitioners, albeit in consultation with a range of mental health organisations through the New Savoy Partnership. Nor are our comments intended to imply depreciation of the potential benefit of this guideline.	Thank you
42	SH	Association for Psychoanalytic Psychotherapy in the NHS (APP) – Referee 2	1	Full	General		This is a reasonable document as far as it goes but it is difficult to understand why there is no mention of personality disorder in older people. It is widely, naively and erroneously believed that personality disorder "burns out" and does not manifest in later life. This is not the case although it's presentation changes. There is much information in the literature and I hope you will consult this before producing the final guideline. Thank you for taking note of this point.	Thank you. The guideline is intended to apply to adults of all ages and therefore specific mention of older adults has not been made. All services for people with borderline personality disorder whether general or specific should include people from any age group, and not descriminate on the basis of age.
43	SH	Association for Psychoanalytic Psychotherapy in the NHS (APP) – Referee 1	2	Full	General	All	To assist consultation, as well as dissemination, it would be helpful if the NICE guideline (which will be most commonly read) were cross-referenced with the Full guideline (ie: page, Section, para number). It is generally accepted scientific practice also to reference evidence statements and (argument-based) claims, ie: where a specific RCT, for example, is being relied upon for a specific recommendation (or a series of RCTs) this/these should be listed; where some statistical analysis has been performed by the NICE GDG, which is what the recommendation relies upon, this should be listed; where the guidance or consensus of the GDG (or any wider consultation) has been relied upon, this should be	Thank you for your suggestions. The full guideline contains all the scientific and clinical evidence considered in the production of this guideline along with the statistical tests and inferences performed/used. It also contains a summary of the evidence for each intervention linking the evidence to the recommendations which follow. All the recommendations in the full

							specified. Without these references it is difficult to follow how or why the GDG have arrived at their recommendations. The process of comment, review, and validation would be facilitated if NICE clinical guidelines adopted accepted scientific practice in this.	guideline are extracted and constitute the NICE guideline in its entirety. Whilst it would be possible to establish electronic links between recommendations in the NICE guideline and the evidence underpinning the recommendations in the full guideline, this is not possible at present. We recommend that you read the full and NICE guidelines in parallel as this will satisfy your requirements. It should be noted that the NICE guideline is primarily intended to advise on practice rather than to discuss evidence.
44	SH	Association for Psychoanalytic Psychotherapy in the NHS (APP) – Referee 1	3	Full	General	All	The Department of Health lead official, and the SHA leads for each SHA, who are responsible for ensuring this guideline is implemented, should be named. The Care Quality Commission official, who is responsible for inspecting how well / badly the NHS is implementing this guideline, should also be named. The relevant official within NIHR who is responsible for ensuring the research recommendations are implemented should be named. A named implementation lead from NICE should be specified to coordinate the above implementation process and respond to requests for help. Without any clarification of who is accountable – which should also be specified locally – this clinical guideline will be ignored or inadequately implemented.	Thank you. Your suggestions are not appropriate within the guideline documents. The NICE implementation team are posted on the NICE website.
45	SH	Association for Psychoanalytic Psychotherapy in the NHS (APP) – Referee 1	4	Full NICE	4.6.1.1 9.10.1.1 (1.1.1 & 1.1.2)	10 & 11	We agree entirely that all patients across the age range are entitled to help and, where they wish, to access psychological treatment for personality problems on the spectrum of BPD disorder. The known barriers to access should be specified (eg. young people, esp. young BME men with BPD) will not generally refer themselves to primary care NHS settings – they are more likely to be identified (if training in screening were given) eg. by counsellors working in school settings? Access goals or standards should be specified and pro-active efforts made at local level to identify patients and offer treatment early. Given evidence of prevalence of self-harm behaviours in adolescence the guideline should delineate a	Thank you for your comment which covers some important issues. However, these are outside the guideline. We have included a recommendation for clinicians working in primary care to help identify people with borderline personality disorder and to take appropriate action (1.2.1.1 in the NICE guideline, draft guideline numbering). We also make

							stepped care pathway for this group.	recommendations in the self-harm guideline for the best way to manage younger people who present following self-harm.
46	SH	Association for Psychoanalytic Psychotherapy in the NHS (APP) – Referee 1	5	Full NICE	4.6.2.1 (1.1.4)	12	Most of the treatment evidence shows high discontinuation rates for this group, emphasising that sustaining an optimistic and trusting relationship is of equal importance to developing and engaging trust. Elsewhere, the guideline makes important recommendations about training (1.3.1.1) the care system (1.3.3.4), the need for clinical supervision (1.3.5.4). Here, the guideline should also refer to these essential support structures needed for staff.	Thank you. As as a result of this and other comments, we have added a separate recommendation about support at the end of the general principles.
47	SH	Association for Psychoanalytic Psychotherapy in the NHS (APP) – Referee 1	6	Full NICE	4.6.4.1 (1.1.6)	13	The guideline should describe what an assessment actually entails here – what should it typically consist of; what are the competencies required to undertake it? (Some of this is detailed lower down 1.3.2.2 – this could be cross-referenced here ie: see point 1.3.2.2).	Thank you for your comment. We have changed the subheading to make it clear that this recommendation is concerned with the approach to assessment, wherever assessment takes place. 1.3.2.2 spells out the content of assessment in so far as this specifically applies to people with BPD. In addition, NICE rubric prohibits cross-referencing between recommendations.
48	SH	Association for Psychoanalytic Psychotherapy in the NHS (APP) – Referee 1	7	Full NICE	4.6.5.1 (1.1.7)	13	The guideline should differentiate here between planned endings – ie: which follow the original care plan – and unplanned endings, and particularly unplanned endings precipitated by services (either because the team or the individual professional is moving on / being restructured etc). In each case, the patient should have an entitlement to request a review of their Care Plan (as well as an explanation if they have been let down). How will the quality of endings (and outcomes) be audited? Are routine follow up procedures recommended? There should be guidance on both these points.	Thank you. We think the recommendation deals adequately with endings, although we recognise that endings that are unplanned can't be dealt with by prior planning. Although the guideline gives best practice recommendations as to how services can minimise harm, it is not the role of the guideline to give guidance on how to correct bad practice.
49	SH	Association for Psychoanal	8	Full NIC	8.5.11.2 (1.3.4.2)	18	Everyone would agree with the recommendation that "All Healthcare professionals … should ensure that treatment and service delivery are well integrated". Yet experience of working with	Thank you for your comment. We have amended the recommendation to take into

		ytic Psychotherapy in the NHS (APP) – Referee 1		E			patients with BPD confirms consistently "this is a custom more honoured in the breach than the observance" (to quote ? an early BPD sufferer? Hamlet). In the full guideline, examples from service users underline this point that breakdown of communication amongst the various health professionals occurs invariably in the care – or absence of care – for this patient group. Here, what is important to stress is that an enhanced CPA should contain provision for review of when communication difficulties between service users and professionals, and between different professionals in different parts of the care system, are occurring. It is also important to stipulate that when things have not been "well integrated", there should be an emphasis on learning from this experience – both an explanation provided for the patient, and an attempt to understand how this came about, in a review of the care plan.	account your concerns.
50	SH	Association for Psychoanalytic Psychotherapy in the NHS (APP) – Referee 1	9	NICE	1.2 through to 1.5	14 to 27	There are many useful recommendations here but there are several unanswered questions and some inconsistencies – so these general comments apply across all these Sections. A. There is evidence to show considerable overlap in the patient populations with BPD currently treated and managed in primary care settings, community settings, outpatient psychotherapy settings, and specialist settings. There is insufficient evidence from routine practice-based studies to determine which settings are better for which patients. The guidance veers between wanting to acknowledge this, but wanting also to offer some proscriptive recommendations – for example, that assessment and management routinely be done by CMHT and CAMHS teams. There are significant access barriers to these teams, unacceptably long waiting times for assessment, lack of trained staff to undertake assessment and treatment, and many other inefficiencies in care pathways created by their entry criteria – the guideline makes an important research recommendation in acknowledgement of this (4.5). B. There is good evidence to support the effectiveness of experienced clinicians, including with this patient population, as the major variable in outcomes, rather than the choice of treatment modality or specific setting.	Thank you for your comments. A there is considerable variation in provision of services and referral pathways for people with BPD; this is why it has been important to describe a care pathway within this guideline which focuses predominantly on the delivery of care by general community services. B This is a mis-reading of the evidence regarding effectiveness and therapist characteristics, especially in the context of BPD. It is very important that we identify the treatments most likely to be effective, and in time, to get a better understanding of therapist factors and patient factors relevant to the psychological treatment of people with BPD. C We found no evidence for brief dynamic interventions despite

							C. Given that diagnosis and aetiology of this condition is not well defined, and appears to be heterogeneous, it would be more useful to identify a stepped care or collaborative care approach for the majority of patients who will not need complex interventions. There is some evidence to support brief dynamic interventions, for example, which could be applied in primary care settings under suitable supervision (which the GDG did not look at). D. There is an emphasis on the CPA approach whilst at the same time an admission that RCT studies have not established what are the useful common outcomes for treatments to aim for realistically - again, this is addressed as an important research recommendation (4.1). E. There is a very welcome stipulation that drug treatments are not effective for BPD, alongside an equally unwelcome recommendation that when they are considered there should be an "opportunity for [the patient] to discuss this"?? Either the GDG recommends drug treatments are not used for BPD – and shows how to put in place audit mechanisms to monitor where they are still being used ineffectively – or doesn't. Section 1.3.6.1 needs deleting. 1.3.6.3 should refer to 1.3.7 and 1.3.8 (where medication use is for co-morbid symptoms, or use with crises).	systematic searches. D We do emphasise the importance of having well structured co-ordinated and planned care which balances support with individual responsibility carefully. The CPA approach is amenable to these principles for the delivery of care for people with BPD. E Section 1.3.6 describes how drugs should be used when they are prescribed. The guideline recognises that drugs can be prescribed for comorbid conditions and in crises.
51	SH	Association for Psychoanalytic Psychotherapy in the NHS (APP) – Referee 1	10	Full NICE	8.5.10.1 NICE 1.3.3	16	In addition to the very helpful recommendations here it would be useful to elaborate on risk assessment as an immediate issue from risk assessment as part of treatment planning, which is clearly ongoing. This process is sometimes complicated by the nature of trying to establish a coherent narrative both of the patient's personal history and their history of contact with services – therapeutic considerations should be paramount during the process of risk assessment as previous traumas can be reignited unwittingly by inexperienced or unsupervised clinicians – in other words, part of risk management should be attending to the stress imposed on patients by the demands (and the limitations) of the service itself.	Thank you. The GDG believe that this has been adequately addressed throughout the guideline, which places a significant emphasis on reducing the harm that services can often do to patients with this diagnosis.
52	SH	Association for Psychoanalytic	11	NICE	1.3.5	18 - 20	This Section should state clearly that all patients with BPD are entitled to be offered a choice of psychological treatments and that psychological treatment will normally be the treatment of choice. The range of treatments, which are safe and have shown limited	Thank you. There is no evidence for the effectiveness of most of these therapies and therefore we cannot recommend them. There

		Psychotherapy in the NHS (APP) – Referee 1					but promising effectiveness should be listed here: they include mentalisation based therapy, DBT, transference-focussed psychoanalytic psychotherapy, brief dynamic therapy, schema focussed CBT, cognitive analytic therapy, arts therapies, group therapies and therapeutic communities. Inadequate investment in R&D by the NHS to further demonstrate the efficacy of these treatments to date should not be a justification for withholding them or restricting patient choice. Failure to specify the 'menu' of options, which local services should ensure is available will result in no treatment being made available. This would be unacceptable.	are a number of studies which were not yet close enough to publication to be included in the guideline which may help to establish effectiveness in the future. These will be considered when the guideline is updated.
53	SH	Association for Psychoanalytic Psychotherapy in the NHS (APP) – Referee 1	12	Full NICE	8.5.12.1 NICE 1.3.7 & 1.3.8	20 - 24	It would be useful to elaborate here on referral protocols with IAPT and other services, and that these should be provided to the patient as part of planning and agreeing the CPA, as well as specifying which professional needs to be responsible for co-ordinating the patient's journey between different services, and what the case management / supervision / funding arrangements are / will be – with the aim of ensuring continuity of care for the patient. Given that "crises" are a regular feature of the treatment process with some patients with BPD, some discussion of this eventuality should take place during initial engagement. (See also 15, below).	Thank you. It would be premature to elaborate on referral protocols with IAPT, services which have not yet begun on a national basis and are specifically focused on common mental disorders, not pesonality disorder. With regard to your suggestions about care planning and CPA we feel these are adequately dealt with in 1.3.2 (Care Planning), and in other parts of the guideline. Crisis is dealt with in a number of places throughout the guideline, in care planning (1.3.2), in risk assessment (1.3.3) and in the management of crises (1.3.7).
54	SH	Association for Psychoanalytic Psychotherapy in the NHS (APP) – Referee 1	13	Full NICE	7.7.1.1 & 7.7.3.1 (1.3.9)	24	The impact of insomnia on the course of illness and the patient's functioning should be included in the assessment process – where this symptom features prominently as part of the syndrome consideration should be given to treatment of a minimum of once-weekly frequency of individual psychotherapy. Effective management of this symptom, and others, is generally possible within a contained treatment of this kind, delivered by an experienced clinician, without recourse to medication because attention can be paid to the emotional and psychological determinants.	Thank you for your comment. Insomnia itself requires specific consideration which is the purpose of this brief section.
55	SH	Association for Psychoanal	14	Full NIC	8.5.13.1 (1.3.10)	24-25	Prior to discharge a review of the outcome of treatment, measured against pre-treatment goals, as defined by both patient and clinician, should be undertaken. This outcome should be written up	Thank you. This is what is suggested in this recommendation.

		ytic Psychother apy in the NHS (APP) – Referee 1		E			and included with any ongoing care plan sent to the primary care clinician.	
56	SH	Association for Psychoanal ytic Psychother apy in the NHS (APP) – Referee 1	15	NIC E	1.4	25-26	Given the expense to the NHS and 'cost' to patients of repeated acute admissions or crises leading to a compulsory detainment, consideration should be given to brief, respite referral to a therapeutic community setting, as an option available to crisis resolution teams. All patients, including young people, who have been given a diagnosis of BPD, should have an entitlement to choose this form of treatment if they prefer it, and if the complexity of their case warrants it (Haigh, 2002).	Thank you for your comment. We could not make a specific recommendation about therapeutic communities because there is no high quality evidence of their effectiveness or for their cost-effectiveness (an important consideration given the likely high cost of residential TCs) (see chapter 5 of the full guideline).
57	SH	Association for Psychoanal ytic Psychother apy in the NHS (APP) – Referee 1	16	NIC E	1.5	26-27	This Section should be entitled Organisation, Planning and Commissioning of Services. It should specify what the cost of the Specialist teams should be (in the range of – depending on population size, deprivation etc.) and what the cost impact of implementing the guideline in full will be. It should specify whom in the PCT / SHA should be responsible for a Commissioning strategy for service expansion to implement the guideline in full within its anticipated lifetime (4-5 years), prior to review.	Thank you for your comment. The cost of implementing the guideline is calculated by NICE and will be available as a set of costing tools published with the guideline and downloadable from the NICE website.
58	SH	Association for Psychoanal ytic Psychother apy in the NHS (APP) – Referee 1	17	NIC E	3 (impleme ntation section)	28-29	This is the most important Section of the entire guideline. There is nothing in it.	Thank you. This section does not contain recommendations. Audit criteria are prepared from the key recommendations for implementation by NICE. NICE also prepare implementation tools which are available on their website after guideline publication.
59	SH	Association for Psychoanal ytic Psychother apy in the NHS (APP) – Referee 1	18	NIC E	4 Research recs	29-32	4.1 This is a very welcome recommendation with only one caveat. We do not yet have a patient-centred instrument for measuring outcomes, and given the degree of co-morbidity across mental health disorders it does not make sense to use only disorder specific instruments – it is unlikely that a consensus would be reached on which of the existing instruments should be used, but more likely that consensus could be reached on which domains were important to measure (eg. quality of life, functioning etc). This	4.1 Thank you. This is a good point and we have amended the recommendation. 4.2 Thank you. These are good points but we prefer to keep the recommendation as it is to avoid making it over-complicated.

							would form the basis for developing and validating a suitable free-to-use instrument for the NHS. 4.2 An additional arm, using a patient-preference design, could be added to compare against treatment in a residential setting. The age range for these trials should include younger people. 4.3 Consideration of setting as a factor – to include treatment delivered in primary care and educational settings – should be designed into these trials, as well as different length of treatment for different severity of disorder. TFP should be tested in UK settings. 4.4 A combination arm of this trial should be added as a comparator, again using a patient preference design (ie: medication + psychological therapy; placebo + psychological therapy; medication alone; placebo alone; psychological therapy alone). 4.5 This is clearly the most important recommendation and should be carried out across multiple sites, with substantial input from a diverse cross-section of service users and carers in the design and implementation of the research, and a collaborative team of academics and clinicians representing a wide range of expertise.	4.3 Again, the GDG felt this would make the recommendation too complex and therefore less likely to attract funding. 4.4 The GDG felt this would make the recommendation too complicated. 4.5 Thank you.
60	SH	Association for Psychoanalytic Psychotherapy in the NHS (APP) – Referee 1	19	Full	Appendix 6	360-361	APP made comments on the draft scope, and we are pleased to see these reflected in several clinical questions on the patient experience being central to care; preventive strategies and treatments, aimed at younger people; a wide range of service settings, and a flexible model of delivery of care; and a patient's family and social and cultural context. Rather than provide a detailed critique of the Full guideline, which is beyond our expertise, the 'Specific or technical' comments below will focus on the areas we highlighted in our comments on the scope – and the extent to which the GDG was able to address these. There is one overall methodological criticism, however. In reviewing the evidence for services, the guideline states: "the most appropriate research design to answer this question is the randomised controlled trial" [effectiveness of service and role of specialist service] 8.2 p. 269. We would qualify this. It is inconsistent with the Research Recommendation 4.5 where a mixed methods design is preferred, and unclear how this builds on evaluations led by Dr. Mike Crawford – these were not pilot RCTs. The two central questions – which psychological therapy is most effective? Are	Thank you for your comments. We do not agree. The available evidence for therapies for BPD is currently relatively weak and the guideline recommendations reflect this. Considering a'more sophisticated' range of evidence in the way you suggest would lead to lower standards of evidence appraisal not higher.

							particular therapies suited for particular service settings? – are not answered here. This is not because there are no RCTs, nor because there aren't enough RCTs, but because psychological therapies are delivered within complex systems of care. Until a more balanced range of evidence is considered, and a more sophisticated way of synthesising a range of qualitative as well as quantitative evidence can be developed as part of NICE's methodology, including but not privileging statistical analyses of several RCTs to compare and determine clinically significant effects of different interventions, the utility of NICE clinical guidelines for enabling sustainable improvement of NHS psychological therapy services will be limited. The guideline preface (Uses and limitation of clinical guidelines p.10-11) makes several similar qualifications to those above – these tend to get 'lost in translation'. Hence, the very valuable accounts of service users and the review of the qualitative literature of patient experience, from which useful clinical practice recommendations are drawn (4.6) is nevertheless not accorded status in evaluation of effective treatments.	
61	SH	Association for Psychoanalytic Psychotherapy in the NHS (APP) – Referee 1	20	Full	8.5 & 9.5	282-302 & 322-323	We agree that assessment tools at present are not much use for this patient group, are not patient-centred (2.2; 9.5) and are not a substitute for proper clinical assessment. It is probably not safe to assume, however, that "those working in primary care are far more likely to see people who have already received this diagnosis following contact with mental health services" (8.5.3). Experienced clinicians in primary care may well be managing and treating a fairly similar cohort to those referred to more specialist services. Most of these patients will not have had a formal diagnosis, and this may not be of benefit to these patients, or lead to any better care. More developed systems of supervision and training would enhance care provided at this level.	Thank you. We agree and have removed the sentence.
62	SH	Association for Psychoanalytic Psychotherapy in the NHS (APP) – Referee 1	21	Full	9.6 9.7, 9.8, 9.9 & 9.10	323-336	The guideline makes very useful recommendations for different CAMHS Tiers, and these could be developed into a stepped care model. The one proviso would be that new, more flexible ways of working means staff with competence to engage and treat these patients may well be working across all Tiers, and that new configurations of services may well be less stratified. This should be encouraged. What is also under-emphasised here, perhaps, is the value of treatment models with a developmental theoretical	Thank you. There was little evidence specifically in young people. The treatment models to which you refer are discussed elsewhere in the guideline.

							basis (eg. mentalisation, transference-focused), and therapies with a family component (conjoint child psychotherapy and family work), which enable interpersonal and intra-psychic issues to be more fully addressed.	
63	SH	Association for Psychoanalytic Psychotherapy in the NHS (APP) – Referee 1	22	Full	5 & 8	109-191 & 267-307	The guideline is exemplary in its attention to support, training and supervision infrastructures needed to ensure services can sustain effective work. There is clear acknowledgement that these services are in a developmental phase. It would be more useful to encourage a greater degree of diversity, and a more balanced range of provision across different settings – in some places the guideline supports this, but there is little mention of transference-focused psychoanalytic psychotherapy, for example, despite this treatment having demonstrated its efficacy. Understanding of relationship dynamics and competence in working with transference would seem to be a core skill for this patient group, but this is not stated. Also, although the work of Abbass is included (an RCT for brief dynamic treatment) this was excluded from analysis – results for BPD patients were not reported separately. These results are readily obtainable directly from the author – and the GDG wrote to several other authors for these. This omission risks denying patients the choice of a brief dynamic intervention which has been shown to be effective for this patient group in a good quality RCT.	Thank you for our comment. We were not able to establish the efficacy of TFP because there is only one trial from which we were unable to extract data in a usable format. We contacted the study authors for data in an extractable format, but because of the statistical methods used, the data supplied are still problematic and the authors did not wish us to calculate betwee-group effect sizes as we do with othr studies. It should be noted that we base our conclusions about studies on calculating effect sizes from data given in the papers rather than on the statistical analyses undertaken by study authors (usually with conclusions based on statistical significance rather than the clinical significance of the effect size). It rare that a strong recommendation specifying a particular therapy would be made from a single RCT), particularly one with relatively few participants. The best that can be said of the existing data for many psychological treatments in BPD is that they are still at an experimental stage. We have received data from Abbass relating to the BPD group.

								However, there were only 6 participants in each arm, which is too few. The total N in the study was 27 which is also very low.
64	SH	Association for Psychoanalytic Psychotherapy in the NHS (APP) – Referee 1	23	Full	2.4 4, 5, 8.7 & 8.8, 9	22-25, 62-108, 109-191, 304-307, 308-336	The guideline is also to be commended for its attention to patients in the context of their family, carer, and social and cultural backgrounds. There are clear statements of these interlinked factors, which need to be taken into account when planning and implementing care. Again, it would have been useful if the guideline went on to describe treatment models based on working directly with these factors, specifically, psychoanalytic therapies and those targeting the prevention of inter-generational transmission of psychopathology, eg. interventions based on psychoanalytic research and work with parents who suffer from BPD (eg. Hobson et al 2005).	Thank you for comment. The issue of prevention is outside the scope of the guideline.
65	SH	Association of Adult Psychotherapists	1	Full	4.6.2	107	The section on developing an optimistic and trusting relationship with people with BPD does not sufficiently take into account the impact of the individuals shifting states. It implies the professional is working with a constant and collaborative partner and this is not always the case.	Thank you. We disagree. Of course people with BPD do characteristically have shifting self states and it will at times be challenging for healthcare professionals to maintain an optimistic approach or, indeed, a consistent and trusting relationship with the service user. This is quite a strong theme throughout the guideline – to try to make sure that the patient's problems do not put off course a proper professional dependable relationship between healthcare professionals and service users.
66	SH	Association of Adult Psychotherapists	2	Full	4.6.3	108	The 'families' and 'careers' need to be identified by the service user who may choose someone outside of the family to support them.	Thank you. We believe this is clear from the use of 'carer' which is well understood within mental health care. As a result of other comments we have amended the term used in the recommendations to 'families/carers' and we hope this answers your point as well.

67	SH	Association of Adult Psychotherapists	3	Full	4.6.5.1	108	Should the care plan read 'the patient be aware of resources available to them at times of crisis?'	Thank you. We prefer the existing wording which is more specific.
68	SH	Association of Adult Psychotherapists	4	Full	5.14 Psych research recs	189	No psychodynamic research is included. The Newcastle research is relevant and the reference is: - Cookson, A., Espie, J., Yates, Y. (2001) The Edinburgh Project: A pilot study for the treatment of Borderline and other Severe Personality Disorders. British Journal of Psychotherapy 18 (1)	Thank you for your comment. It is NICE rubric to include up to 5 recommendations per guideline to increase the probability of research funding being available and, therefore, the GDG prioritised carefully.
69	SH	Association of Adult Psychotherapists	5	Full	5.2.8	116	The report refers to the Multiwave study but not the overall results. It does not mention that it was a 'three armed study.'	The Clarkin (2004) study (we refer to studies based on the first paper to be published) is marked as a 3-arm trial in table 7. There are no extractable data in the published papers, so, and the authors were then asked to provide data in a usable format. However, the resulting data were still problematic because of the statistical methods used by the authors, who also did not wish us to use the data to calculate between-group effect sizes as we do with other studies. We have made this clear in the chapter.
70	SH	Association of Adult Psychotherapists	6	Full	5.2.9 Table 7	118	The table does not mention the Multiwave study published in 2007.	The study to which you refer is referenced as Clarkin (2004) and is included. We refer to studies from which more than 1 paper has been published by the date of the earliest paper. This avoids double-counting. All the publications relevant to a study are listed in the references section in appendix 16 (draft appendix numbering) (study characteristics).
71	SH	Association	7	Full	5.14		Glen Gabbard wrote in his editorial in the June 2007 American	Thank you. The interpretations of

		of Adult Psychother apists			General		Journal of Psychiatry: "In a recently published report on a different dimension of these findings [those reported by Clarkin et al], Levy et al. [JCCP 2006; 74:1027-1074] demonstrated that transference-focused psychotherapy produced additional improvements that were not found with either dialectical behavioural therapy or supportive psychotherapy. Participants who received transference-focused psychotherapy were more likely to move from an insecure attachment classification to a secure one. Moreover, they showed significantly greater changes in mentalizing capacity (measured by reflective functioning) and in narrative coherence compared with those in other groups." (AJP, 164:6, 854).	this study's findings are based on pre-post changes within each therapy group. For the guideline we base our conclusions about studies by calculating between-group effect sizes from data given in the papers. We do not use conclusions drawn by study authors based on statistical analyses (usually based on statistical significance rather than the clinical significance of the effect size). Also the outcomes mentioned in the editorial you quote, although important, are process outcomes relevant to therapies in development, rather than outcomes relevant to the guideline. TFP may show promise in helping people with BPD but there is as yet insufficient evidnece on which to base a specific recommendation.
72	SH	Association of Adult Psychother apists	8	Full	5.8	173	Line 27 says there is no clinical evidence that individual psychodynamic psychotherapy is efficacious which is patently inaccurate (See above - point 7).	Thank you. There are no extractable data in the relevant published papers, but we have contacted the authors for data in a usable format. However, there were few extractable data from these papers, and the authors were then asked to provide data in a usable format. However, the resulting data were still problematic because of the statistical methods used by the authors, who also did not wish us to calculate between-group effect sizes from their data as we do for other studies. We could not therefore draw any conclusions about the effectiveness of

								psychodynamic-focused therapy.
73	SH	Association of Adult Psychotherapists	9	Full	General		1 NICE's wish to have everything manualised and standardised is inappropriate when working with people with BPD. 2 People can see the value of developing reflective skills in the workforce but understanding the dynamic process can be just as helpful. 3 Adult psychotherapists aren't specifically mentioned as a profession when many are working in PD services - psychiatrists, psychologists and nurses are specifically referred to. 4 The chapter on service users' accounts were very helpful.	Thank you for your comments which we have numbered to aid response. 1 The guideline recommends best practice based on the current evidence base. It is not intended as a treatment manual. 2 Recommending specific ways of understanding BPD is outside the scope. 3 The various lists of professions are intended as examples. 4 Thank you.
74	SH	Association of Adult Psychotherapists	10	Full NICE	4.6.1.1 (1.1.1.1.)	6	Evidence would indicate that BPD patients respond better to managed/planned treatment within the context of a reliable attachment to a mental health professional rather than crisis interventions, which increase the intensity of contact. The viability of crisis intervention needs to be assessed within the context of a previously agreed management plan. Increased crisis intervention might sometimes be contra-indicated.	Thank you. The management of crisis is dealt with in 1.3.7 [NICE guideline], which specifically includes reference to the need to ensure short-term approaches to the crisis fit with the long-term management plan. The reference to crisis interevention is simply as an alternative to be considered when the only other approach available is an inpatient admission. The consistency of care that you highlight is very much a central feature of the guideline.
75	SH	Association of Adult Psychotherapists	11	Full NICE	5.13.1.1 (1.3.5.4)	8	At the end of treatment, structures should be in place to support the patient and re-establish their ongoing development of life. This seems to have huge implications for resources, service delivery models and training, which aren't addressed. The modalities specified in the full version are individual and group and the term might generally be thought of as including other ways of delivering therapy as well. Ideally therapist supervision should be multi-modal of the whole team by an external supervisor able to take an objective position	Thank you. This recommendation has been amended in light of this and other stakeholders' comments and reference to modality has been removed. There is no specific evidence on how supervision should be provided although we have included a new recommendation about supervision

							and have enough seniority and expertise to manage splitting and conflict in the therapist team. For a number of patients, skills based training to help reduce self-harm behaviours (such as Stop & Think groups) may be useful preparation before undertaking in depth psychotherapy.	and support at the end of the section on general principles. We found no evidence of the value of skills-based training before psychotherapy.
834	SH	Association of Professional Music Therapists	1	Full	2.5.5	33	Suggest deleting the section entitled 'Art and Creative Therapies' and incorporate the arts therapies under psychological therapy (2.5.3) treatments as below.	Thank you – as a result of your and other comments the chapter has been restructured.
835	SH	Association of Professional Music Therapists	2	Full	2.5.3	28	Line 20 – suggest adding arts therapies	Thank you. We have restructured this chapter slightly to reflect the restructuring in chapter 5. This is to take into account various comments about arts therapies.
836	SH	Association of Professional Music Therapists	3	Full	2.5.3	29	End of line 9 – suggest adding 'Arts Therapies treatments (see chapter 5 below) have developed coherent psychotherapeutic theoretical frameworks for this client group and where available are accessed by people with personality disorder. The active creative component within a psychologically safe therapeutic relationship seems to enable people with a high level of disturbance to engage and sustain involvement in these therapies.	Thank you. Modifications to the draft document have been made in the light of these comments.
837	SH	Association of Professional Music Therapists	4	Full	2.5.3	29	Line 29 – suggest adding arts therapists	Thank you. This section is about psychological therapies such as CBT. The section on arts therapies has been moved to its own separate section.
838	SH	Association of Professional Music Therapists	5	Full	2.5.4	30	Line 42 – 'Art Therapy, Creative Arts Therapies' should be replaced by 'Arts Therapies' (which is the official registered title)	Thank you – we have amended the text.
839	SH	Association of Professional Music Therapists	6	Full	2.5.5	33	Line 4 - Art and Creative Therapies - Suggest deleting this entire paragraph if incorporated into earlier section. If not, suggest change to: Arts Therapies	The term art and creative therapies has been replaced by the term 'arts therapies' throughout.

							Arts Therapies treatments (see chapter 5 below) have developed coherent psychotherapeutic theoretical frameworks for this client group and where available are accessed by people with personality disorder. The active creative component within a psychologically safe therapeutic relationship seems to enable people with a high level of disturbance to engage and sustain involvement in these therapies. Aims are around affect regulation, interpersonal relating, enhancing a self-reflective capacity and enabling a person to work through past traumas if appropriate. The creative medium in the arts therapies allows the therapist to work at different levels according to the level of disturbance in the client and particularly offers unique opportunities for working non-verbally when this is therapeutically necessary.	
840	SH	Association of Professional Music Therapists	7	Full	5	109	Regarding the overall positioning of the arts therapies in this chapter. Arts therapies are more sensibly grouped with other psychological therapies as opposed to with complementary therapies (see HPC regulation guidance on competencies for registered arts therapists). The following paragraph (lines 27 - 33 on page 109 under Psychological Therapies) applies to the arts therapies: 'Despite these differences, psychological therapies for borderline personality disorder have many factors in common, possibly even more than psychological treatments for other conditions, through adaptation to the needs of this population. These include a high level of structure, consistency, theoretical coherence, taking account of relationship problems (including the difficulty in engaging positively with the therapist), and adopting a flexible and individualised approach to care.' Complementary therapies are very different, with different aims and really should not fall alongside the arts therapies in this chapter.	Thank you for your comment. As a result of your and other comments we have restructured the chapter.
841	SH	Association of Professional Music	8	Full	5.9	175	Line 15 - 'art therapy, creative arts therapies' should be 'arts therapies'	Thank you. We have amended the text.

		Therapists						
842	SH	Association of Professional Music Therapists	9	Full	5.12	188	Line 4 - Typo: 'co-creating' should probably be 'co-create'	Thank you, the text has been amended.
843	SH	Association of Professional Music Therapists	10	Full	5.13.1.1	189	Recommendations - If Arts Therapies are not grouped under psychological interventions above, then recommendation 5.13.1.1 will not be understood as applicable to the arts therapies as well as the purely verbal psychological therapies. Arts therapies fit these criteria and are frequently offered in conjunction with other verbal treatments. There have a coherent theory of practice, high frequency of clinical supervision and a well-structured intervention. They are commonly used in clinical practice alongside other interventions and they are not brief therapies. There is no less evidence base for these than for other psychological therapies coming under this definition (e.g. IPT), therefore they should be included.	Thank you. This recommendation has been amended. However, there is no specific evidence for the effectiveness of arts therapies and so they are not specifically mentioned.
844	SH	Association of Professional Music Therapists	11	Full	Appendix 6	360	As above, the arts therapies are structured psychological therapies and despite the lack of RCTs or other evidence, are practised widely throughout the UK with this client group. It is misleading to place them under a separate heading and it is especially misleading to place them next to Complementary Therapies which do not rely on the same psychological boundaries or extensive training. We realise that it is too late to restructure the clinical questions but would like to make the point anyway so that it can be taken into account for the main results section if possible. If this is not possible, could the Arts Therapies, which are a regulated, coherent group of professions, please come above and not next to Complementary Therapies which are not regulated and practised in a more ad hoc way with this client group. We realise this may seem petty but it is often a struggle to get ourselves recognised as coherent clinically sound interventions, in particular when the assumption by the lay person is often that we are a complementary therapy- e.g use music for relaxation etc.	Thank you. We have restructured Ch5 in the full guideline to take your point into account.
80	SH	Association	1	Full	1.1.1.1		It is not clear from this document whether the failure to mention	Thank you for your comment. The

		of Psychoanalytic Psychotherapy in the NHS			General		older people specifically was because it is assumed that they would conform to the diagnostic categories and respond to treatment strategies offered to younger patients. Unfortunately it does not read like this, and appears not to have older patients in mind at all. This is particularly important as people with learning disability are specifically mentioned.	guideline is intended to apply to adults of all ages and therefore specific mention of older adults has not been made. All of the recommendations are relevant to the care of older adults.
81	SH	Association of Psychoanalytic Psychotherapy in the NHS	2	NICE Access to services	1.1.1.1 NICE 1.1	6, 10	And AGE. Given that non-discriminatory access is mentioned specifically for groups such as young people, people from BME groups and those speaking languages other than English, it might be reasonable to consider the needs of the older person with borderline personality disorder. In addition to there being access for older people, BPD services need to be “accessible”	Thank you for your comment. The guideline is intended to apply to adults of all ages and therefore specific mention of older adults has not been made. All of the recommendations are relevant to the care of older adults.
82	SH	Association of Psychoanalytic Psychotherapy in the NHS	3	NICE	Introduction	3	There is still debate about the differing presentation of BPD, even more so in the aging individual. What is agreed among clinicians and researchers is that it does exist in old age, probably in similar numbers to younger people and is highly relevant in terms of potential for suicide, treatment resistance, and increased use of resources. There is very clear literature on BPD in older adults which is over ten years old (Ames & Molinar 1994, Mezzich et al 1987, and Molinari and Marmion 1993). This has been described clinically by Hepple (Book author Psychological Treatment for older people) and others. The main issues are that older patients who might have fulfilled DSM criteria for BPD in younger life, may have found sufficient “mature” containing aspects of environment by the time they reached their middle years, that would reduce the incidence of problematic and self harming behaviours (Tyrer 1980; vaillant & Perry 1990). This suggests that BPD also has a psycho-social paradigm. In old age, physical illness and losses both stress the individual, and may remove the external factors that were acting as containers for the fears associated with BPD. Thus old age “unmasks” previously contained “immature” PD and causes an increase in apparent late onset BPD(Reich 1999; Stone 1993) McGlashen 1986,and Paris et al 1987 have suggested in long term	Thank you for your comments. The guideline is intended to apply to adults of all ages and therefore specific mention of older adults has not been made.

							follow-up studies that the impulsive and explosive aspects of BPD improve with age. This may make the individual less overtly disruptive in public, but may have severe effects of depression and anxiety to the patient with an increase in DSH (Dennis et al 2005). Other carers such as families or GPs may become more involved What is disappointing is that while old age practitioners know the pd literature in general, the converse is not the case and practitioners seem unaware of the pd literature (such that exists) in old age.	
83	SH	Association of Psychoanalytic Psychotherapy in the NHS	4	Full NICE Psychological treatment	5.13.1.1 (1.3.5.4)	8	The main treatment strategy for BPD is psychological. Services for older adults are notoriously poorly resourced with psychological therapies input. There is a case to be made for the stepped care model being transferable to old age psychiatry secondary services (after primary care management in step 1 and 2), with reference to complex cases with axis II diagnosis, and treatment resistant affective disorder, particularly when BPD is part of the picture. Access to PD services should be available to those cases whose singular complexity demands a more specialist service. For psychological expertise in older people's CMHT's there exists a manpower (human resource gap at present).	Thank you for your comment. The guideline applies to adults of all ages and the GDG did not consider it necessary to make additional recommendations for older adults. Applying the guideline to older adults is therfore a matter for local implementation. It may be that the issue you face is age discrimination, which is clearly outside the scope of the guideline.
84	SH	Association of Psychoanalytic Psychotherapy in the NHS	5	Full NICE Managing DSH behaviour and suicide risk	8.3.10.1 (1.1.8)	14	Older people are at greater risk of completed suicide than are younger adults. There is some evidence to suggest that those with PD are at greater risk (Lebret 2006)	Thank you. The GDG did not consider that the care of older people should differ from that of other adults.
85	SH	Association of Psychoanal	6	Full NIC	5.14.3.1 (4.1)	29	Older people's services and user groups should also be represented.	Thank you for your comment. The GDG did not feel it necessary to highlight services for older people

		ytic Psychotherapy in the NHS		E Determining a set of agreed outcomes on the treatment of BPD				as the guideline applies equally to adults of all ages.
86	SH	Association of Therapeutic Communities	1	Full	4 General		Given the limited evidence for "therapeutic communities to support the positive statements made in the personal accounts" (4.3.1) the guidelines should make an explicit recommendation for further qualitative research.	Thank you. This is a good point, however, the GDG consider that such a recommendation took priority over other research recommendations made. It is NICE rubric to include up to 5 recommendations per guideline to increase the probability of research funding being available.
87	SH	Association of Therapeutic Communities	2	Full	4.5 and 4.6		Despite Therapeutic Communities being identified as "life changing" for four out of the five personal accounts and the Clinical Practice Guidelines being dominated by an approach to BPD already in place in both residential and day TC settings, there is no mention of TCs specifically in these sections. At the very least the guidelines should acknowledge that TCs already use these guidelines/principles and have a robust accreditation and quality improvement system in place which reflects this. Whilst standards and participation in self- and peer-review and accreditation is not accepted as evidence for the guidelines - they have to acknowledge the extent to which TCs already demonstrate a sophisticated approach to BPD and are therefore further ahead than other services in this regard. People with BPD would be best served by enabling those approaches which are already	Thank you for your comment. Whilst we acknowledge that the service users who provided testimonies for this chapter were helped by TCs, when we reviewed the evidence for them (see chapter 5 of the full guideline) we did not find high quality evidence for their effectiveness, and so were unable to make a specific recommendation.

							acknowledged as useful and "effective" to train other services which are less "emotionally intelligent" and to further develop the evidence base. Therefore mentioning them specifically in the guidelines and recommending research would acknowledge the service users preference, support existing good practice and enable other services to identify where they may gain the help and support necessary to implement the clinical practice guidelines.	
88	SH	Association of Therapeutic Communities	3	Full	5.1		Why are TCs not categorised or included as a "complex intervention" and yet their lack of "high quality evidence for their efficacy" is stated in the conclusion of this section. TCs provide an environment within which everything is therapy and specific therapeutic interventions named in this guideline e.g. DBT can also be provided within a secure framework of trusting relationships	Thank you. The term 'complex therapy' has been replaced because of the confusion caused. The GDG considered therapeutic communities warranted a separate section since they provide a very different environment compared with that offered in studies of what were initially termed complex therapies.
89	SH	Association of Therapeutic Communities	4	Full	5.9		The guideline cites TC research studies but not others - why not? E.g. e.g. Dolan (1996/7), the systemic review of Lees et al (1999) and reports e.g. Reed (1994). They point to the limited evidence and recommend research for modified TCs - they need to recommend further research for TCs.	The evidence base for the guideline comprises primary research studies (i.e., studies with outcomes from relevant patient populations) from which the GDG draw their own conclusions rather than relying on existing reviews.
90	SH	Association of Therapeutic Communities	5	Full	5.12.4		The guidelines points out that art therapies have little or no evidence but receive a qualifying statement i.e. "Although they are potentially valuable interventions" – perhaps other interventions including TCs should also receive equal encouragement and support.	Thank you. We have amended the sentence to reflect the fact that we have not been able to assess the effectiveness of these interventions because of the lack of high quality evidence.
91	SH	Association of Therapeutic Communities	6	Full	8 General		There needs to be specific mention of those service users who require more intensive treatment outside mainstream provision. It is clear that there is a need for specialist tier 4 services (NIMHE and NSCG) and clearly identified care pathways – or stepped care. Brown (2004) acknowledged the strength of residential TCs in managing risk. HMP TCs are testament the relational containment for SPD.	Thank you for your comment. This was outside the scope of the guideline. We recognise the importance of this topic, which has been the subject of a great deal of policy from the DOH and departments dealing with prisons. We are not aware of a great deal of empirical evidence for interventions

								for such complex problems in people with very severe PDs. There is a case to be made for a guideline on this topic alone ('Guideline for the management of people with complex and severe personality disorders in mental health and forensic settings').
92	SH	Association of Therapeutic Communities	7	Full	General		Overall there is a need for: 1 A recommendation for further qualitative research into TCs 2 A recommendation for TCs to do further "gold standard research" i.e. RCTs or equivalent (?) • TCs to be named in clinical practice guidelines at the very least (until the publication of acceptable research) as providing an environment conducive to the treatment of BPD	Thank you for your suggestions. It is NICE rubric to include up to 5 research recommendations per guideline which the GDG prioritised based on an expert consensus view of which piece of research, if completed and published before the guideline is due to be updated (usually in 4 years time), would be most likely to improve the guideline.
96	SH	Barnsley PCT	1	Full	5		Re: The omission from the NICE Borderline Personality Disorder (BPD) draft guidance of the following empirical papers: Clarkin, Levy, Lenzenweger, Kernberg (2007). Evaluating three treatments for Borderline Personality Disorder: A Multiwave Study. American Journal of Psychiatry. 164:6, 922-8. Levy, Meehan, Kelly, Reynoso, Weber, Clarkin, Kernberg (2006). Change in Attachment Patterns and Reflective Function in a Randomized Control Trial of Transference-Focused Psychotherapy for Borderline Personality Disorder. Journal of Consulting and Clinical Psychology. 74:6, 1027-40 I am writing to strongly request the inclusion in the NICE BPD guidance of the above cited studies (i.e. Clarkin et al., 2007; Levy et al., 2006) which reported findings from a randomised controlled trial (RCT) comparing Transference-Focused Psychotherapy (TFP), Dialectical Behaviour Therapy (DBT), and Supportive	Thank you. Clarkin et al 2007 and Levy et al 2006 are publications of additional data from the Clarkin et al 2004 study. We generate a study-id based on the first author and publication year for each study, with follow-up data or data published in subsequent papers being added to the original study to avoid double-counting. The references of all publications relating to a trial can be seen in the reference section of the study characteristics tables (appendix 16 (draft appendix numbering) in the draft guideline). Therefore, the data from Clarkin et al 2007 was considered. However, there were few extractable data

							Psychodynamic Therapy (SPT) over the duration of one year with a sample of ninety patients. The results indicated patients treated with TFP demonstrated significant improvements in 10 of the 12 experimental outcome variables; these were suicidality, anger, facets of impulsivity, anxiety, depression, social adjustment, global functioning, irritability, verbal, and direct assault. DBT was associated with significant improvements in only five outcome variables: suicidality, depression, anxiety, global functioning, and social adjustment. And SPT with significant improvements in six of the variables (depression, anxiety, global functioning, social adjustment, anger, and facets of impulsivity) (Clarkin et al., 2007). Moreover, patients who were treated with TFP showed a significant increase in the number classified as securely attached on the Adult Attachment Interview (AAI) which was not demonstrated in the DBT or SPT groups (Levy et al., 2006). TFP patients also showed significant improvements in narrative coherence and Reflective Function (RF) (Levy et al., 2006). The aforementioned RCT (Clarkin et al, 2007; Levy et al., 2006) is exceptional in that it is the first to compare three comprehensively described manualised psychotherapies for BPD, one of which is DBT that is considered a standard in the field. Furthermore, the RCT's experimental design combines the most salient features of efficacy and effectiveness research rendering the results particularly meaningful with regard to extrapolation to clinical practice. As the above cited articles (i.e. Clarkin et al, 2007; Levy et al., 2006) fulfil the NICE guidance development group's database search criteria for study inclusion into the Borderline Personality Disorder guidance (cf. Draft Full Guidance p45 lines 14-21; p117, Table 6) it is appropriate they be included in the guidance. In light of the positive and robust findings regarding the efficacy of TFP, the articles' inclusion would necessarily result in the amendment of the NICE BPD guidance to include and name TFP	from these papers, and the authors were then asked to provide data in a usable format. However, the authors did not wish us to use the data to publish between-group effect sizes calculated using the new data. No conclusions can be drawn about this study. It should be noted that we base our conclusions about studies on calculating effect sizes from data given in the papers rather than on the statistical analyses undertaken by study authors (usually with conclusions based on statistical significance rather than the clinical significance of the effect size). It rare that a strong recommendation specifying a particular therapy would be made from a single RCT), particularly one with relatively few participants. The best that can be said of the existing data for many psychological treatments in BPD is that they are still at an experimental stage.

							in the main guidance as at least a "psychosocial intervention," and preferably a "complex intervention," as TFP can and has also been delivered in group format. Furthermore, the conclusion that "there is no convincing evidence that the individual psychological interventions are efficacious…" (Draft Full Guidance p173, lines 27-29) in the treatment BPD should be amended to reflect the findings of the research described herein (i.e. Clarkin et al, 2007; Levy et al., 2006). Importantly, Clarkin et al, (2007) and Levy's (et al., 2006) significant findings regarding TFP would also necessitate the revision of the conclusion that "health professionals should offer one [a psychotherapy] that provides therapy in at least two modalities (for example, individual or group)" (Draft Nice Guidance, p.8, para. 1), as this conclusion is not supported in view of the evidence presented here. Finally, the findings from the Transference-Focused Psychotherapy RCT would require the revision of the guidance's research recommendations for psychological interventions to include the call for further research into TFP.	
97	SH	Berkshire Healthcare NHS Trust	1	Full	General		Need provision of support groups for Carers, Relatives and Children of those with BPD diagnosis	Thank you. The guideline is for the NHS to cannot recommend support groups specifically.
98	SH	Berkshire Healthcare NHS Trust	2	Full	General		CMHTs need further training in assessing, diagnosing and managing BPD, especially in the management of those people who are deemed too risky for local PD services	Thank you. We have included 2 recommendations about training 1.3.1.1 and 1.5.1.1 (draft guideline numbering).
99	SH	Berkshire Healthcare NHS Trust	3	Full	8 General		What specialist provision is there going to be for those people with BPD who are deemed too unsafe for existing day therapeutic communities? There is an expectation that CMHTs will 'manage' these clients without the support and containment of specialist services. There needs to be nationally funded, 24 hour, specialist services for those with severe BPD (eg Henderson or Cassel models of treatment), to exist alongside other forms of TC, and psychological therapies, to offer choice to BPD clients. Collaboration between disciplines and agencies to allow a 'step	Thank you for your comment. The GDG took the view that the majority of treatments for people with BPD would take place within CMHTs backed up, where needed, by specialist PD services within each Trust. The GDG did not recommend the use of day therapeutic communities and there

							down' transition for those who need more input from 24 hour care, reducing gradually through the recovery programme	was no evidence to support the use of inpatient therapeutic communities. The GDG did recognise, and recommends, the need for CMHTs and other services providing care for people with BPD to be well structured and safe. This would be no less the case for people with more severe problems who are likely to be dealt with specialist services.
100	SH	Berkshire Healthcare NHS Trust	4	Full	5 General		The different disciplines and 'schools' need to work more collaboratively in assisting people with BPD to access suitable psychological therapy.	Thank you. We agree.
101	SH	Berkshire Healthcare NHS Trust	5	Full	5 General		Where a preferred therapy is not available, people with BPD should be offered the opportunity to 'cross local borders' to access this, where no similar, suitable therapy exists.	Thank you. This is a matter for local implementation and depends on funding arrangements between PCTs.
102	SH	Berkshire Healthcare NHS Trust	6	Full	5 General		Provision of more psycho-educational groups, and the development of peer support groups, needs to be encouraged by services, including groups that might run in the evening.	Thank you. There is no evidence for the effectiveness of psychoeducation or peer support. The question of what time of day any recommended groups are run is a matter for local implementation.
103	SH	Berkshire Healthcare NHS Trust	7	Full	5 General		Family therapy needs to be more widely available in Adult Mental Health Services. A diagnosis of BPD denotes problems in maintaining relationships. My practice experience and my qualitative research highlight the tensions and struggles that families often have to cope with over the course of many years when their relative is going through a series of crises.	Thank you. There was no evidence for the effectiveness of family therapy in people with borderline personality disorder. This does not mean that it is not effective but without high quality evidence we cannot recommend it.
104	SH	Berkshire Healthcare NHS Trust	8	Full	General		When a person with a diagnosis of BPD is a parent, Family Therapy should be accessible and /or collaborative working with CAMHS. Working with accountability and parental responsibility within a supportive and respectful framework can be a protective factor in perpetuating Trans -generational psychological problems and can be re-constructive of positive narratives about parenting for the individual with BPD.	Thank you. Although this is an important issue, it is outside the scope of the guideline. The topic has been reviewed by SCIE http://www.scie.org.uk/publications/briefings/files/briefing24.pdf). We would suggest that it may make a suitable topic for suggestion to the

								NICE topic selection panel.
105	SH	Berkshire Healthcare NHS Trust	9	Full	8 General		We need to increase flexibility in terms of service availability. By this I mean the planned services offering exploratory therapy and psycho-educational support. Out of hours crisis service is not sufficient and an inadequate response to the service needs.	Thank you. We believe we have indeed done this. There is now a relatively comprehensive care pathway, integrating the major treatments we have reviewed that have evidence for efficacy for people with borderline personality disorder. We did not review the issues around availability of out-of-hours crisis services. However, we have made recommendations in some detail about the management of crises, whenever they occur, by all mental health services.
106	SH	Berkshire Healthcare NHS Trust	10	Full	8 General		There needs to be suggestion of funding arrangements for providing: specialist teams, supervision, DBT etc. Where will this money come from?	Thank you. NICE issue a costing tool about 6 weeks after the publication of the guideline which is designed to help services cost and plan more effectively any new services. These tools should be used in conversations with PCTs. They can be downloaded from the NICE website www.nice.org.uk.
107	SH	Berkshire Healthcare NHS Trust	11	Full	8 General		There needs to be more information on the role of care co-ordinators, e.g. how long people would aim to care co-ordinate long-term CMHT clients for, whether there should be more than one care co-ordinator, when the person care co-ordinating should change within the team.	Thank you. This is too detailed for the guideline and is unlikely to be specific to BPD.
112	SH	Bright	1	Full	General		NICE Guidelines on the treatment and management of borderline personality disorder We appreciate the opportunity to respond to this important consultation, and the extensive information-gathering that is going into establishing the guidelines. Bright is a campaigning charity, running the Star Wards project which works collaboratively with mental health wards to improve inpatients' daily experiences and treatment outcomes. Inevitably, many of the patients our member wards support are those with BPD and our interest is furthered	Thank you for your comments. The guideline is intended to represent best practice based on the available evidence.

							because Bright's director, Marion Janner, has BPD. The draft guidelines are really excellent, and we enthusiastically support your recommendations. However, our usual optimism is stretched to a state of unprecedented scepticism when considering the vast gulf between existing 'mainstream' mental health services, let alone the standards of specialist services, and approaches you propose. We hope we're wrong. Because BPD is often so entrenched, complex, high risk and neighbourly with other psychiatric conditions, even the most specialised therapy for 40 or 50 minutes a week may be unable to make sufficient headway within a 'reasonable' timeframe. We feel the guidelines could be clearer or more emphatic about the benefits of concurrent treatments/services, such as a combination of individual, group, creative therapies, mental health education (the spookily named 'psychoeducation'), social skills' practice, crisis management skills and in particular the value of mutual support by people with BPD. It's hard to feel optimistic about the likelihood of implementation of your almost too excellent or ambitious recommendations for supporting people with BPD when most of these are so far from current service standards. It's heartening to imagine a time when crisis teams are trained and skilled in working with people with BPD. But many of us would happily settle for a team where staff still aren't too clear about the difference between BPD and Bipolar Disorder but where they: a. have a 24:7 service which doesn't include use of answerphones and where they ring back if they say they will b. staff aren't stupid c. staff aren't among the 10% of the adult population with the lowest levels of empathy, compassion and common sense. For example, whose d. response to a distraught person phoning them contains a caring acknowledgment of the person's state, ideally within the first minute but even by the end of the phone call.	

							The incredibly frustrating thing is that the Samaritans manage to recruit, train and retain a pool of 17,000 volunteers who provide a national service which: a. responds to almost all phone calls within 3 rings b. with someone who is gentle, empathetic, patient, highly skilled in inter-personal skills and has a sufficiently sound knowledge of mental health issues. And above all, is a great, non-judgmental, non-directive listener c. also enables people to contact them by email, text, letter or in person. (In tipi at music festivals.) Recommendation #1 In order for the more 'generic' mental health needs of people with BPD to start to be met by CRHTs, no member of a crisis team should be let loose on clients before they have acquired the necessary level of skills from training by the Samaritans. We're bemused by the apparently standard, officially acceptable level of contact that CRHTs have with someone in crisis – popping in once or twice a day. This can in no way be said to be an 'alternative to inpatient care', although it is a valuable adjunct to CMHTs. Recommendation #2 CRHTs should provide a genuinely intensive service, comparable to intensive services in social care – i.e. up to 24 hours a day support to the individual in their home and local community. The support encourages the client to get involved in activities which are socially and emotionally beneficial – eg creative arts. Similarly, while it would be amazing if inpatient staff were knowledgeable about BPD, how realistic, and how much of a priority is that when the ward Marion was on over Easter had 22 acutely ill patients (with acuity comparable to a PICU) and only 19 beds. 3 women slept on sofas in the small lounge each night. As a patient with BPD, Marion's priorities were: a. to have had a lock on her bedroom door (she realises she was relatively fortunate to have both a bed and a bedroom,	

							but the 24/7 noisy presence of other patients added mild homicidality to severe suicidality.) b. socially competent staff with the time and communication skills to cope with patients' emotional pain c. staff having a clear understanding of the reality (and counter-intuitiveness) of self-harming motivation and functions	
114	SH	British Association for Psychopharmacology	1	Full	General		We congratulate the Guideline Group on a comprehensive review of a very diverse range of clinical trials and observational studies.	Thank you.
115	SH	British Association for Psychopharmacology	2	Full	2.1 and general	various	We are glad to note that the Guideline recognises the frequent occurrence of co-morbid Axis 1 disorders with Borderline Personality Disorder. While the Guideline is focussed largely on aspects of the treatment BPD specifically, it does not seem to fully recognise the frequent demand to treat these co-morbid conditions pharmacologically nor the view of many physicians that this may often be appropriate. The sections on Pharmacological Treatments are appropriately focussed on symptoms arising as part of BPD. However, while it is difficult to disentangle, there does not seem to be much consideration of examining the effectiveness of treatments for these co-morbid conditions – which may respond differently in BPD.	Thank you for your comment. The separate treatment of comorbid conditions is outside the scope of the guideline. When searching for studies of treatments for people with borderline personality disorder, we did not find any studies which provided evidence specifically regarding the treatment or comorbidities in the context of BDP. We are also aware that in other guidelines devoted to the treatment of conditions commonly comorbid with BPD, there is also a paucity, if not a complete absence, of this type of evidence. As a result the guideline makes recommendations about the right services within which the treatment of comorbidites should take place, but we do not make specific recommendaitons about the treatments of those comorbidities nor about the extent to which other guideline recommendations could be modified in the presence of a

								borderline personality disorder. These issues are discussed in the full guideline.
116	SH	British Association for Psychopharmacology	3	Full	6.4.4	231	The reviewers report that there are only 3 adequate RCTs of antidepressants in BPD. Yet, though mood symptoms are often prominent, there is no proposal for further research into the effects of antidepressants.	Thank you for your comment. NICE rubric allows up to 5 research recommendation per guideline which the GDG prioritised based on an expert consensus view of which piece of research, if completed and published before the guideline is due to be updated (usually in 4 years time), would be most likely to improve the guideline. The GDG did not consider one about antidepressants to be a priority.
117	SH	British Association for Psychopharmacology	4	Full	6.10 6.11.1.2	256 258	There is recognition that there have been few adequate studies of antipsychotic drugs and that some have suggested modest effects. Yet a fairly clear edict against their use is delivered and there is no recommendation for further research on their effects. A major deficiency of most pharmacological trials in BPD is the short length of the trials (mostly a few weeks). It would seem appropriate to at least propose proper long-term trials of antipsychotics.	Thank you for your comment. Although there are some modest effects, the effect sizes are nevertheless small. Since the side effects of antipsychotics are clinically significant, the GDG did not consider that antipsychotics should be used in the absence of co-morbid psychotic illness. It is NICE rubric to include only 5 research recommendations which the GDG prioritised based on an expert consensus view of which piece of research, if completed and published before the guideline is due to be updated (usually in 4 years time), would be most likely to improve the guideline. A recommendation for a trial of antipsychotics was not considered a priority.
118	SH	British Association	5	Full	6.12.1.1	258	We strongly support the view that the effects of mood stabilisers should be examined further.	Thank you.

		for Psychopharmacology						
119	SH	British Association for Psychopharmacology	6	Full	7.5.1.4	264	It is suggested that the use of 'sedative medication' may be considered cautiously in situations of crisis. It is not clear what is meant by 'sedative medication'. Does this mean benzodiazepines, for which no specific evidence is available. Or does it mean certain antipsychotics, for which the view in Section 6 was rather negative? Given the potential problems associated with use of benzodiazepines in this population we feel this statement is a little vague in providing practitioners with some security against both unreasonable demands from sufferers and potential complaints of overuse.	Thank you. We agree that this recommendation was not sufficiently clear. We do not consider either benzodiazepines or antipsychotics to be appropriate and have given sedative antihistamines as an example.
120	SH	British Association of Art Therapists	0 1	Full Full	5 General 5.12.2 (Table 51)	P188	This response is submitted in conjunction with the issues raised in the stakeholder response by Jane Dudley, advisor to the GDG, rather than repeat the points raised, this stakeholder organisation fully endorses the concerns raised in her response. Following the submission of a letter by the Art Therapy advisor to the GDG, suggesting specific search terms that cover theory and practice of Art Psychotherapy, why where these terms not used? Why the search terms listed in the full guideline and not the ones submitted? To what extent did consultation to the professional bodies of Arts Therapies actually take place, given the omission of supplied information?   Acrobat Document Acrobat Document Additional literature, some of which is referred to in this document	Thank you for your comment. We checked that the terms suggested by Jan Dudley were covered by the 'exploded' indexing terms used by the electronic databases used in our searches. Therefore there was no need to search on the more specific terms suggested.
121	SH	British Association of Art Therapists	2	Full	5 General		Following from above point, Art Psychotherapy is a formal Psychological Therapy and should be listed as such?	Thank you. As a result of your and other comments we have restructured the chapter.
122	SH	British	3	Full	2.5.5		Why again when information was supplied via an appointed advisor	Thank you. The GDG used the

		Association of Art Therapists					to the GDG was not this information used for the definition of “Art Therapy”?	definition supplied by the special advisor to inform their work. We did not reproduce it verbatim, but we make all the same points (see chapter 5 [draft guideline numbering]).
123	SH	British Association of Art Therapists	4	Full	5.13.1.1 (1.3.5.4) NICE 1.3.5	18-19	The short guideline is non specific in its recommendations for psychological therapy, why is this? (That is apart from DBT) It adds a caveat that the therapy should have a coherent theory of practice? Might it be helpful to spell this out? I.e. Maintaining a coherent treatment model or conceptual framework around treatment allied to working with an attachment focus (core deficit) with treatments, which are relatively long in duration. A taxonomy of psychological therapies might prove helpful here and one that perhaps includes Art Psychotherapy? The full version provides an overview of psychological therapies might a summary be possible for the shortened version?	Thank you. The short guideline contains only recommendations for the NHS. The evidence is not strong enough to be more specific.
124	SH	British Association of Art Therapists	5	Full	5.14.2.1 (4.3)	30	In terms of the need for research into treatments for BPD there is a distinct belief in the benefits of maintaining a coherent treatment model/conceptual framework combined with an attachment focus with treatments which are relatively long in duration which no doubts explains the rise of both DBT and MBT as complex interventions. What is not clear is why is their a distinction between these two preferred treatments and that of psychosocial treatments?(the number of RCT's in one or two modalities should not dictate the treatment available to a hugely disadvantaged client group) Given that the common features of effective treatments for BPD are shared between those listed as psychosocial and DBT/MBT? Research needs to be conducted as to the non-specific aspects of any treatments offered within either of these modalities. In terms of the use of expressive therapies/arts therapies within TC's or partial day hospital programs we would recommend the need for research into the specificity of such interventions. A study by Karterud and Pederson (Karterud, Pederson, 2004) of the various therapeutic components of a short term day hospital treatment for personality disorder, found that the art group therapy was rated highest by all patient categories, e.g. personality disorders, mood disorders and anxiety disorders. They also found	Thank you for your comment. As our analysis of the available data in chapter 5 demonstrates, we found that interventions which were well structured and integrated showed benefit above treatment as usual across a wider range of outcomes than individual psychological therapies not offered within a structured framework. However, because of the overall paucity of evidence for particular therapies the GDG did not feel it appropriate to make a very specific recommendation about psychological therapies (see the amended recommendation in 1.3.5.4 draft NICE guideline numbering). Leading on from this analysis, the GDG felt that the next step should be to undertake RCTs to ascertain the relative efficacy of

							that the more severely disturbed patients "seemed to favour the pretend mode" of the art group therapy. Significantly, borrowing from the work of Bateman and Fonagy, they propose that the art group therapy "appears to be a safe method of exploring the mind in the presence of mentalising self objects". (Karterud, Pederson, 2004) They assert that their results should be considered when designing treatment programs for Personality Disorders. Johns and Karterud (Johns, Karterud, 2004) writing about guidelines for the Art Group Therapy reported in the above piece of research state that the most "successful day treatment programs being reported contain one mode or another of expressive group therapies", including the work of Bateman and Fonagy on the effectiveness of partial hospitalisation. Of note the model proposed by Johns and Karterud reflects aspects of group analytical practice and Kohut's self-psychology, and similar to the work of Bateman and Fonagy encourages a very structured and delineated treatment approach. "To this extent the therapy creates transitional objects and the therapists have to work at developing a transitional space within the group in which the created objects can be used to facilitate expression whilst maintaining stability of the self" (Bateman & Fonagy 2004). Whilst the theory of transitional objects is extremely credible and much has to be said in how it may be present in both DBT, MBT and other therapies more research is required as to its specific agency in any clinical change. Karterud S, Pederson G, (2004). 'Short term day hospital treatment for personality disorders: Benefits of the therapeutic components' Therapeutic Communities' Vol. 25, No. 1 pp 43-54. Bateman A, Fonagy P, (2004). Psychotherapy for Borderline Personality Disorder- mentalization based treatment. Oxford University Press. Johns S, Karterud S,(2004). 'Guidelines for Art Group Therapy as part of a day treatment for patients with personality disorders' Group Analysis. Vol. 37 No. 3. pp 419-430.	the two treatments which showed most benefit against the same standardised control treatment. In addition, it is NICE rubric to make only 5 research recommendations per guideline to improve chances of funding which the GDG prioritised based on an expert consensus view of which piece of research, if completed and published before the guideline is due to be updated (usually in 4 years time), would be most likely to improve the guideline.
125	SH	British Association	6	Full	General		RCT research paradigm: The relative limited evidence found by the GDG which is inconclusive for the effective treatment of BPD may	Thank you. We believe the recommendations as amended

		of Art Therapists			/Research		well be corollary of the difficulties associated with implementation research? (Fixsen et al. 2005;) Their research found that when interventions that succeed in one setting are moved to another setting the transitions and results are challenging, with much work required to achieve similar results. The researchers Weisz and Gray (2008) quoting the above propose a new model of intervention development and testing- a deployment –focussed Model (DFM) the goal of which is to ensure effective treatments match practice conditions, and that adaptations fit these conditions. Of note they suggest that research into what constitutes standard care, care as usual may well lead to new and effective treatments, we would recommend research into the standard care/usual care for BPD be undertaken straight away alongside the proposed research by the GDG. Good innovative clinical practice runs the risk of being obscured by the rush to implement Evidence based Treatments, the model proposed by Weisz and Gray shifts the focus to the Practice Based Evidence paradigm. Fixsen et al (2005). Implementation research, synthesis of the literature. Tamh34 FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231) Weisz, J. Gray, J. (2008) Evidence based Psychotherapy for Children and Adolescents: Data from the Present and a Model for the Future: Child and Adolescent Mental Health. Vol 13. No.2, 2008 pp 54-65.	during the stakeholder process accurately reflect the evidence base which is at a relatively immature stage of development (particularly since few pragmatic trials have been undertaken). It is NICE rubric to include up to 5 research recommendations per guideline which the GDG prioritised based on an expert consensus view of which piece of research, if completed and published before the guideline is due to be updated (usually in 4 years time), would be most likely to improve the guideline.
126	SH	British Association of Drama Therapists	1	Full	2.5.4 Line 42	30	Creative Arts Therapies should read Arts Therapies in line with the term used by the HPC, the regulating body for Arts Therapies.	Thank you – we have amended the text.
127	SH	British Association of Drama Therapists	2	Full	2.5.5 Lines 4-27	33	The title Art and creative therapies should be amended to Arts Therapies. The definition of Arts Therapies should be: 'Arts therapies are the creative use of the artistic media as vehicles for non-verbal and/or symbolic communication, within a holding environment, encouraged by a well-defined client-therapist	The term art and creative therapies has been replaced by the term ‘arts therapies’ throughout.

					Line 19		relationship, in order to achieve personal and/or social therapeutic goals appropriate for the individual.' Karkou and Sanderson (2006) Arts Therapies: A Research Based Map of the Field, Elsevier, p 46. Creative Arts Therapies should read Arts Therapies in line with the term used by the HPC, the regulating body for Arts Therapies.	
128	SH	British Association of Drama Therapists	3	Full	5.1.2 Line 26	187	Dramatherapy is one word.	Thank you. We have amended the text.
129	SH	British Association of Drama Therapists	4	Full	5.12.1 Lines 3-4	188	The unreferenced sentence 'drama therapists (sic) use games, storytelling and role play' is an inadequate description of dramatherapy as both an art form and a psychological therapy. In our correspondence to Rachel Burbeck in November 2007 we included the following definitions which are more appropriate for stressing that dramatherapy is a form of psychological therapy: The HPC defines Dramatherapy as: a unique form of psychotherapy in which creativity, play, movement, voice, storytelling, dramatisation and the performance arts have a central position within the therapeutic relationship (Standards of Proficiency for Arts Therapists, Health Professions Council) A BADth definition is: Dramatherapy has as its main focus the intentional use of the healing aspects of drama and theatre as the therapeutic process. It is a method of working and playing that uses action methods to facilitate creativity, imagination, learning, insight and growth. The therapy gives equal validity to body and mind within the dramatic context; movement, stories, myths, play texts, puppetry,	Thank you. We have amended the sentence.

							masks, symbolic play and improvisation are examples of the range of artistic interventions a Dramatherapist may employ.	
132	SH	British Psychological Society, The	1	Full	5.13.1.1 (1.3.5.4)	8	Clarkin et al, (2007) and Levy's (et al., 2006) significant findings regarding TFP would also necessitate the revision of the conclusion that "health professionals should offer one [a psychotherapy] that provides therapy in at least two modalities (for example, individual or group)" as this conclusion is not supported in view of the evidence presented here.	Thank you. Clarkin et al 2007 and Levey et al 2006 are publications of additional data from the Clarkin et al 2004 study. We generate a study-id based on the first author and publication year for each study, with follow-up data or data published in subsequent papers being added to the original study to avoid double-counting. The references of all publications relating to a trial can be seen in the reference section of the study characteristics tables (appendix 16 (draft appendix numbering) in the draft guideline).Therefore, the data from Clarkin et al 2007 was considered. However, there were few extractable data from these papers, and the authors have been asked to provide their data in a usable format. However, the authors did not wish us to use the data to publish between-group effect sizes calculated using the new data. No conclusions can be drawn about this study. It should be noted that we base our conclusions about studies on calculating effect sizes from data given in the papers rather than on the statistical analyses undertaken by study authors (usually with conclusions based on statistical significance rather than the clinical significance of the effect size). It rare that a strong recommendation specifying

								a particular therapy would be made from a single RCT), particularly one with relatively few participants. The best that can be said of the existing data for many psychological treatments in BPD is that they are still at an experimental stage. The recommendation has been amended in light of your and other stakeholders' comments.
133	SH	British Psychological Society, The	2	Full	1.1.2 and 1.1.5	10 & 11	The statements in 1.1.2 and 1.1.5 are contradictory. In 1.1.2, it is emphasised that 'Guidelines are not a substitute for professional knowledge and clinical judgement. They can be limited in their usefulness and applicability by a number of different factors: the availability of high-quality research evidence, the quality of the methodology used in the development of the guideline, the generalisability of research findings and the uniqueness of individuals with borderline personality disorder'. However, in 1.1.2, the document goes on to explain that 'Once a national guideline has been published and disseminated, local healthcare groups will be expected to produce a plan and identify resources for implementation, along with appropriate timetables'. This, along with the instructions for auditing the implementation of the guideline (1.1.6), clearly demonstrates how professional knowledge and clinical judgements will be overridden in order to be seen to implement the NICE guidelines.	Thank you for your comments. These sections are not contradictory or incompatible. Guidelines will only ever be applicable to 75% of patients being treated by the NHS. A corollary is that full implementation of the guideline would mean that 100% of patients were considered for recommendations in the guideline but less than 100% would receive treatment identified in the guideline.
134	SH	British Psychological Society, The	3	Full	1.2.1	12	The document does not state the numbers of the different members of the GDG. As such it is not as transparent as claimed to be in 1.1.3, line 10, p.11, as it does not highlight how membership of the GDG was heavily weighted towards the professional position, including seven psychiatrists, for example, and only two service users.	Thank you. The GDG members are listed on p2 of the full guideline and it is clear from this list, as you have demonstrated that it is easy to identify the professional backgrounds of individuals in the group. However, individuals are selected for their expertise and to ensure that the GDG can properly address the scope of the guideline. In this regard, their professional backgrounds are of secondary

								importance. It is a matter of routine that for the NCCMH we incorporate 2 service users and a carer into each GDG wherever possible (guidelines for paediactric populations excepted).
135	SH	British Psychological Society, The	4	Full	2.1	16 & 17	There are areas of the literature review where further references would be useful to support the general statements that are made.	Thank you for your comment. Without further detail we are unsure what you are specifically referring. The chapter has been substantially reordered and revised in light of comments from stakeholders and we hope this deals with your concerns.
136	SH	British Psychological Society, The	5	Full	2.2	17	It is helpful to read that the GDG acknowledge that 'Borderline personality disorder is one of the most contentious of all the personality disorder subtypes. The reliability and validity of the diagnostic criteria have been criticised, and the utility of the construct itself has been called into question (Tyrer, 1999). Moreover, it is unclear how satisfactorily clinical or research diagnoses actually capture the experiences of people identified as personality disordered (Ramon et al., 2001)'. This section would benefit, however, from a statement which makes explicit that the concept of personality disorder is so problematic that it is difficult to use it as a basis for effective treatment planning. (A similar statement is made in relation to depression in National Institute for Clinical Excellence (2004) Clinical Guideline 23 Management of depression in primary and secondary care. London: NICE)	Thank you for your comment. The text is intended to describe the view that BPD is not a personality disorder, not that the diagnosis is meaningless. However, the issue is outside the scope of the guideline and so is not expanded upon.
137	SH	British Psychological Society, The	6	Full	2.2	18	The GDG reports that 'Comparisons of DSM and ICD criteria when applied to the same group of patients have shown that agreement between the two systems is limited. For example, in a study of outpatients diagnosed using both systems, less than a third of participants received the same primary personality disorder diagnosis (Zimmerman, 1994)'. They conclude that 'Further modifications in the ICD and DSM are required to promote convergence between the two classifications'. The GDG also need to acknowledge here that the research quoted is another example of the problematic concept of personality disorder and that	Thank you. We have made some amendments to the paragraph.

							convergence between ICD and DSM will not address this.	
138	SH	British Psychological Society, The	7	Full	2.2	20	'First, agreement among clinicians' diagnoses of personality disorder has been shown to be poor (Mellsop et al., 1982)'. This once again demonstrates the need for a clear statement that the concept of personality disorder is problematic (as per points 3 and 4).	Thank you for your comment. We consider that this point is made. However, the guideline has to work within the current system and redefining the diagnosis is outside the scope of the guideline.
139	SH	British Psychological Society, The	8	Full	2.2	20	'A defining feature of all personality disorders is that they are stable over time'. This contradicts previous statement (2.1, p.15): 'The course of personality disorder is very variable...with at least 50% of people improving sufficiently to not meet the criteria for bpd 5-10 years after first diagnosis...evidence suggests that a significant proportion of improvement is spontaneous and accompanied by greater maturity and self-reflection'.	Thank you – we have amended the text.
140	SH	British Psychological Society, The	9	Full	2.2	20	(line 60) SUD can also mimic some of the symptoms of BPD (i.e. affective instability, impulsivity etc.)	Thank you – we have amended the text.
141	SH	British Psychological Society, The	10	Full	2.5.2.	26	Substance misuse is also more common in people with BPD	Thank you. We have amended the text.
142	SH	British Psychological Society, The	11	Full	2.5.2.	27	In addition, the high comorbidity of SUD with BPD (70%, Fyer 1988) further complicates the picture	Thank you, we have amended the text to include SUD as a comorbidity.
143	SH	British Psychological Society, The	12	Full	2.5.3	29	A key component of the therapeutic process is effective clinical supervision and support for carers; for example Cognitive analytic Therapy uses "contextual reformulation" to help care teams identify and modify unhelpful interaction sequences.	We agree, and refer specifically to the use of cognitive analytic therapy in this context.
144	SH	British Psychological Society, The	13	Full	2.5.4	32	One limitation of the therapeutic community concept is the selective nature of the service. The prevalence of co morbidity of disorders within this group, and ambivalence towards intervention can limit access.	Thank you for your comment.
145	SH	British Psychological Society, The	14	Full	2.5.5	34	Child….insert "it has also been used for adults with severe mental illness "	Thank you. We have said 'most commonly'. This section is not intended to be comprehensive.

146	SH	British Psychological Society, The	15	Full	2.6	35	Family …insert “or support network”	Thank you but we cannot work out to what this refers. We have checked occurrences of ‘family’in this section.
147	SH	British Psychological Society, The	16	Full	2.9	37	Demand on mental health insert “and emergency care resources”	Thank you for your comment. The suggested phrase has been inserted in the text.
148	SH	British Psychological Society, The	17	Full	5.2.9	45 & 117	Clarkin, Levy, Lenzenweger, Kernberg (2007). Evaluating three treatments for Borderline Personality Disorder: A Multiwave Study. American Journal of Psychiatry. 164:6, 922-8. Levy, Meehan, Kelly, Reynoso, Weber, Clarkin, Kernberg (2006). Change in Attachment Patterns and Reflective Function in a Randomized Control Trial of Transference-Focused Psychotherapy for Borderline Personality Disorder. Journal of Consulting and Clinical Psychology. 74:6, 1027-40 To request the inclusion in the NICE BPD guidance of the above cited studies (i.e. Clarkin et al., 2007; Levy et al., 2006) which reported findings from a randomised controlled trial (RCT) comparing Transference-Focused Psychotherapy (TFP), Dialectical Behaviour Therapy (DBT), and Supportive Psychodynamic Therapy (SPT) over the duration of one year with a sample of ninety patients. The results indicated patients treated with TFP demonstrated significant improvements in 10 of the 12 experimental outcome variables; these were suicidality, anger, facets of impulsivity, anxiety, depression, social adjustment, global functioning, irritability, verbal, and direct assault. DBT was associated with significant improvements in only five outcome variables: suicidality, depression, anxiety, global functioning, and social adjustment. SPT with significant improvements in six of the variables (depression, anxiety, global functioning, social adjustment, anger, and facets of impulsivity) (Clarkin et al., 2007). Moreover, patients who were treated with TFP showed a significant increase in the number classified as securely attached on the Adult	Thank you. Clarkin et al 2007 and Levy et al 2006 are publications of additional data from the Clarkin et al 2004 study. We generate a study-id based on the first author and publication year for each study, with follow-up data or data published in subsequent papers being added to the original study to avoid double-counting. The references of all publications relating to a trial can be seen in the reference section of the study characteristics tables (appendix 16 (draft appendix numbering) in the draft guideline). Therefore, the data from Clarkin et al 2007 was considered. However, there were few extractable data from these papers, and the authors have provided their data in a usable format. However, the authors did not wish us to use the data to publish between-group effect sizes calculated using the new data. No conclusions can be drawn about this study. It should be noted that we base our conclusions about studies on calculating effect sizes from data given in the papers rather than on the statistical analyses

							Attachment Interview (AAI) which was not demonstrated in the DBT or SPT groups (Levy et al., 2006). TFP patients also showed significant improvements in narrative coherence and Reflective Function (RF) (Levy et al., 2006). RCT's experimental design combines the most salient features of efficacy and effectiveness research rendering the results particularly meaningful with regard to extrapolation to clinical practice. In light of the positive and robust findings regarding the efficacy of TFP, the articles' inclusion would necessarily result in the amendment of the NICE BPD guidance to include and name TFP in the main guidance as at least a "psychosocial intervention," and preferably a "complex intervention," as TFP can and has also been delivered in group format	undertaken by study authors (usually with conclusions based on statistical significance rather than the clinical significance of the effect size). It also unlikely that a strong recommendation specifying a particular therapy would be made from a single RCT).
149	SH	British Psychological Society, The	18	Full	4.3.3	89	The six qualitative studies reported here, where diagnosis and stigma are discussed, clearly document many unhelpful aspects of receiving a diagnosis of Borderline Personality Disorder. It would be helpful if the Guideline acknowledges, perhaps in the introduction, that there is a need to find different ways of talking and thinking about people who have experiences which attract this label and that the overriding concept of producing guidelines, for something which is so diagnostically problematic, is flawed.	Thank you for your comment. You make a valid point. However, we were tasked with producing a guideline for people with BPD and diagnosis was outside the scope. We do make some comments on the diagnosis in chapter 2.
150	SH	British Psychological Society, The	19	Full	5.2.9	117	There is high comorbidity with BPD and SUD so to exclude studies looking at this client population seems to make little sense.	Thank you for your comment. This is an error – the studies were in fact looked at separately (see 5.3.1 p131 [draft document numbering]). The introductory paragraph has been amended.
151	SH	British Psychological Society, The	20	Full	5.3.1	123	This mirrors the experience of many clients with BPD and comorbid SUD; being excluded from personality disorder services due to their SUD and from addictions services due to their personality disorder. If not part of the remit of this Guideline, which guideline will it be addressed in?	Thank you for your comment. The treatment comorbid BPD and SUD is not in the scope for this guideline.
152	SH	British Psychologi	21	Full	5.3.1	128	This comment is misleading as it fails to highlight that this was a study of clients with comorbid opioid dependence (which was	Thank you. We have amended the paragraph to make this clear.

		cal Society, The					previously said to be outside the scope of this Guideline).	
153	SH	British Psychological Society, The	22	Full	5.4.2	153	This highlights the complexity of work with this client group. Engagement, which is problematic in a client group with BPD due to fears of abandonment is further exacerbated by SUD	Thank you. We are unsure to what you are referring in the text, but this is a good point.
154	SH	British Psychological Society, The	23	Full	5.4.3	155	Research does seem to indicate that comorbid SUD makes treatment of this client group with individual psychological interventions harder. The two studies that took SUD into account found it to be either associated with non-response (Ryle 2000) or drop-out (Markowitz, 2006). These were both significant findings and should be summarised here.	Thank your for your comment. This is a good point. However, the treatment of people with BPD and comorbid SUD is outside the scope, although we have reviewed two studies which specifically recruited such populations (see the section on DBT). Neither of the 2 studies you mention are RCTs.
155	SH	British Psychological Society, The	24	Full	5.8	173	"There is no convincing evidence that the individual psychological interventions are efficacious…" in the treatment BPD should be amended to reflect the findings of the research described herein (i.e. Clarkin et al, 2007; Levy et al., 2006).	Please see response to comment on paragraph 5.2.9.
156	SH	British Psychological Society, The	25	Full	5.10.1	180	Doesn't mention whether drug and alcohol dependence are exclusion criteria for the Cassel as they are for the Henderson. Clarification of this would be helpful.	Thank you. The Cassel excludes patients with current severe addition to alcohol or drugs, but includes those with substance-use disorders. The text has been amended.
157	SH	British Psychological Society, The	26	Full	5.14.1.1	189	This should also include individuals with comorbid SUD as many individuals with BPD will use drugs and alcohol to help them cope with their emotional dysregulation. There is some evidence of the efficacy of DBT with this client group, but not yet for mentalisation-based therapy.	Thank you. The tretament of people with borderline personality disorder and SUD was outside the scope of the guideline (although we did review 2 studies of DBT in this client group – see chapter 5).
158	SH	British Psychological Society, The	27	Full	7.4.1	262	Many of the recommendations reflect principles of ordinary good practice for all individuals requiring mental health care. Whilst staff may not always achieve these standards, providing more explicit guidance for how they could be achieved in relation to these clients would be more useful. We would be surprised if even the most inexperienced practitioner found anything of use within the clinical recommendations.	Thank you for your comment. We do not agree!

159	SH	British Psychological Society, The	28	Full	7.5.1.1	263	As there is a high comorbidity with SUD in people with BPD, it will also be important to specifically assess current drug and alcohol misuse as this will have a significant impact on efficacy and safety.	Thank you. We have amended the recommendation.
160	SH	British Psychological Society, The	29	Full	7.7.2 1.4	266	There should be explicit advice given to assess individuals' current drug and alcohol use before prescribing	Thank you. Prescribing has to take into account the use of other drugs – prescribed and non-prescribed.
161	SH	British Psychological Society, The	30	Full	8	267	The section, The Configuration and Organisation of Services, should include the clinical question 10: How can healthcare professionals involved in the care of people with borderline personality disorder best be supported? (which can be found in Appendix 6, p.360, within Service configuration for people with borderline personality disorder). However, this question does not appear to be answered or indeed asked, in the main body of the text here. This needs to be addressed. Furthermore, there is a significant overemphasis on attention to the behaviours and interactions of people given a diagnosis of personality disorder, and there is no attempt to examine the behaviours and interactions of staff when working with these people. Further questions needs to be examined, such as: • What effect does the diagnosis have on how professionals interaction with people who have received this diagnosis? • What are staff attitudes to people who have received this diagnosis and what influences does this have on staff behaviour? • What fears and prejudices to staff have about the label personality disorder?	Thank you for your comment. This was an oversight and we have amended the chapter to include this. The question has been answered in the section on teamwork and communication in chapter 8 [draft guideline chapter numbering], and is also considered in the provision of psychological therapies in chapter 5 (for example, see the recommendation 1.5.4.3 (draft NICE guideline numbering).
162	SH	British Psychological Society, The	31	Full	8.4.4	282	'There is some empirical evidence that tentatively suggests that brief planned admissions are, at least no more harmful than standard treatment (Van Kessel, Lambie and Steward, 2002)'. If there is evidence that management and treatment is in any way harmful, then this should be acknowledged and made explicit by the resulting recommendations, which should not include management and treatment which has been found to be harmful.	Thank you. There is no more evidence for harm than that discussed. The recommendations do not recommend anything which is known to be harmful.
163	SH	British Psychological Society,	32	Full	8.5 and 8.5.2	283-284	There is no evidence cited regarding the claims in 8.5, yet clinical practice recommendations for care pathways are made in 8.5.2.	Thank you. We searched for evidence but found none therefore the care pathway section and

		The						resulting recommendations are based on expert opinion. We have stated this at the end of 8.2.1 on page 271 [draft guideline numbering].
164	SH	British Psychological Society, The	33	Full	8.5.4.1	285	This is particularly true if the individual is also misusing drugs or alcohol.	Thank you.
165	SH	British Psychological Society, The	34	Full	8.5.11.2	295	Ideally, the individual would be able to receive treatment for Axis I and BPD in the same place e.g. several services exist (particularly within a DBT model) to treat BPD and comorbid SUD	Thank you. This is a matter for local implementation.
166	SH	British Psychological Society, The	35	Full	General		The clinical practice recommendations are unfortunately very poor and lack real substance.	Thank you for a comment. We are sorry you feel like this as we have had many comments praising the recommendations. The recommendations are based on the available evidence which is generally poor.
167	SH	British Psychological Society, The	36	Full	General		The material from the qualitative literature review could be better integrated within the appropriate other sections of the document in support of other contributions rather than singled out which contributes to a feeling that the document is poorly structured.	Thank you. We do not agree. Assuming you are referring to chapter 4, we believe this makes more impact as a stand-a-lone chapter. It is then clear which recommendations are based on this evidence.
168	SH	British Psychological Society, The	37	Full	General		The document could be more clearly put together in order to make clinical recommendations more readily identifiable.	Thank you. It is not clear to which version of the guideline you are referring. The full guideline will include a separate chapter containing all the recommendations as they appear in the NICE version. T his is not included in the draft since the recommendations are not yet finalised.
169	SH	British Psychological Society,	38	Full	General		It would be extremely useful in providing staff working within the area with a general overview of aetiology and treatment approaches.	Thank you. This is outside the scope of the NICE guideline, although some information is

		The						provided in the full guideline.
170	SH	British Psychological Society, The	39	Full	General		The authors identify some useful areas for future research to be completed.	Thank you
171	SH	British Psychological Society, The	40	Full	General		The inclusion of service user accounts is helpful in communicating the vulnerability of this client group in order to elicit a more nurturing response from service developers and this empathic consideration is generally reflected throughout the clinical recommendations.	Thank you
172	SH	British Psychological Society, The	41	Full	General		The inclusion of sections devoted to the management of crises and service configuration is essential as these are a necessary component of a robust service.	Thank you
173	SH	British Psychological Society, The	42	Full	General		Findings from the Transference-Focused Psychotherapy RCT would require the revision of the guidance's research recommendations for psychological interventions to include the call for further research into TFP	Please see response to earlier comment.
174	SH	British Psychological Society, The	43	Full	General		The 'personal accounts' over-represented therapeutic communities. It would have been useful to seek comments from service users who have had extensive experience with other approaches, particularly those that have more of an evidence-base (e.g. DBT).	Thank you. We agree with your comment. We tried to collect a broader range of testimonies but had a poor response to our requests. It is the nature of qualitative work that content cannot be controlled.
180	SH	Cassel Hospital, The	1	Full	General		This is a very impressive and thorough review of the evidence base. Recommendations are sober, informative and drawn clearly from the evidence base. Congratulations to all involved.	Thank you
181	SH	Cassel Hospital, The	2	Full	1.2.2	13	It is noted that BPD can affect the whole family. Can I specifically include the infants and children of those with a diagnosis of BPD? In complex family situations an infant may be at risk of physical, sexual or emotional abuse, or neglect when 'cared for' by an individual with severe BPD.	Thank you for your comment. The issue of dependent children is outside the scope of the guideline. However, this is a very good point which has been made by several stakeholders. We have amended recommendation 1.3.2.2 [draft NICE guideline numbering] to include an assessment of dependent children.

182	SH	Cassel Hospital, The	3	Full	2.6.3	35	Social Services are actively involved in situations of risk to children. A significant percentage of children at risk are at risk because of the behaviour of their parent(s) as a result of (undiagnosed) BPD. The Family Courts are involved in deciding on the future safety of these children. Specialised Services within the NHS (Cassel Family Service), within Local Authority and Independent sectors, work with such families to ensure the safety of the child. Expert Witness Services are now being piloted nationally to assist the courts in determining the safe future of such children.	Thank you. Although is an important issue, it is outside the scope of the guideline. (However, although your comment relates to the introduction, we have added the assessment of dependent children to the relevant recommendation in the NICE guideline 1.3.2.2 [draft guideline numbering].
183	SH	Cassel Hospital, The	4	Full	8.5.10.1 (1.3.3.1) general		Reference to suggestion 2 and 3 above could usefully be included more prominently in the guideline at 1.3.3.1. There needs to be an inclusion about actions to take to ensure the welfare of dependent children when a significant risk is identified. Such actions will include referral to Social Services Child Protection teams who may in turn seek the help of outpatient, day, or residential specialist assessment and treatment settings, such as the NHS Cassel Families Service.	Thank you for your comment. Children of parents with borderline personality disorder are outside the scope of the guideline (the topic has been reviewed by SCIE http://www.scie.org.uk/publications/briefings/files/briefing24.pdf).
184	SH	Cassel Hospital, The	5	Full	9.10.1.4 (1.4.1.5)		The evidence for Tier 4 Specialist Services for adults is currently stronger than the evidence for Tier 4 Specialist Services for young people. I therefore suggest an additional point after 1.4.1.5. "NHS trusts should ensure that all patients with severe borderline personality disorder have access to tier 4 specialist services if required, which may include • inpatient treatment tailored to the needs of patients with borderline personality disorder, • specialist outpatient programmes, • And home treatment teams."	Thank you – we cannot see what you are suggesting here, the text seems the same as the existing recommendation.
185	SH	Cassel Hospital, The	6	Full	8.5.14.2 (1.3.5.2)		When considering psychological treatment for a person with borderline personality disorder health care professionals need to consider, alongside the individual factors outlined in 1.3.5.2, the following systemic factors • The availability of appropriate effective and least intensive services within the trust or the local area • The availability of appropriate effective and least intensive services within the region ▪ The availability of appropriate effective intensive specialised tier 4 services as part of a managed care pathway to meet the needs of the patient, the needs of	Thank you for your comment. The guideline makes recommendations for best practice.

							the professional network, and the needs of commissioners of services for cost effective service delivery.	
845	SH	Chase Farm Hospital Enfield Borough in Barnet, Enfield and Haringey Mental Health Trust	1	Full	General		This is a reasonable document as far as it goes but it is difficult to understand why there is no mention of personality disorder in older people. It is widely, naively and erroneously believed that personality disorder "burns out" and does not manifest in later life. This is not the case although it's presentation changes. There is much information in the literature and I hope you will consult this before producing the final guideline.	Thank you. The guideline applies to adults of all ages and the GDG did not think it necessary to identify specific recommendations for older people.
188	SH	College of Occupational Therapists	1	NICE	Introduction	3	The breakdown in occupational functioning has not been named as a core part of the condition that brings people into services. 2nd paragraph, first sentence - suggestion of wording: 'Borderline personality disorder is characterised by significant instability of interpersonal relationships, self-image, affects and impulsivity, and is associated with substantial impairment which frequently impacts on occupational functioning.	Thank you. The introduction has been amended as a result of various comments from stakeholders. We have included your suggestion at the end of the paragraph.
189	SH	College of Occupational Therapists	2	NICE	Introduction	3	2nd paragraph, last sentence – suggestion of wording: 'Its course is variable and although recovery is attainable over time, some people may continue to experience social, interpersonal and occupational difficulties.'	Thank you. This has been included.
190	SH	College of Occupational Therapists	3	NICE	1.1.7	13	We would like to see the title: 'Managing endings and supporting transitions'.	Thank you – we have amended the heading as per your suggestion.
191	SH	College of Occupational Therapists	4	Full NICE	8.5.18.2 (1.5.1.1)	27	It would be useful for there to be an acknowledgement of the importance of occupational rehabilitation/functioning within the specialist teams as there has been mentioned in relation to the role of CMHTS (1.3.2.2 under assessment).	Thank you. Patients are usually helped to access this sort of occupational help during treatment rather than it being provided specifically in a treatment programme.
192	SH	College of Occupational	5	Full NIC	5.14.2.1 (4.3)	31	While the recommendation of medium-term outcomes in RCTs is welcomed, would it be possible to include other occupational measures such as formal and informal life roles in addition to	Thank you for your comment. The outcomes listed are intended as examples.

		Therapists		E			employment? – Since for many people with BPD formal employment may not be appropriate due to age or social circumstances.	
205	SH	Department of Health	1	Full	General		Whilst acknowledging the difficult task the NICE group had been set, it was noted that the group should be commended for the draft guidance in that it brings together the current evidence in a cohesive manner for the first time.	Thank you.
206	SH	Department of Health	2	Full	General		The consultation document needs a simple introductory statement defining personality disorder. Contextual comments should briefly outline the current exclusion from most health and social care service intervention and the absence of recognition within criminal justice settings. This should include an acknowledgement of the difficulty of finding services and therefore their often-inappropriate use of services such as A&E. It is felt that the reality of the social problems and difficulties in getting timely access to services, faced by this group that are not made clearly and this risks commissioners and services failing to understand the extent of the BPD issue.	Thank you. We have included a description of BPD at the beginning of the NICE guideline. There is not space, and it is not appropriate, to define personality disorder. We have included recommendations about access to services etc. It is not appropriate to describe the current state of services in the introduction to the NICE guideline.
207	SH	Department of Health	3	Full	8 General		There is an assumption in the document that, the principles applied to generic mental health services should be unequivocally applied to those with BPD. Whilst this is generally true the specific differences in management and the need for different treatment interventions is not emphasized enough. Service user participants noted that generally the language and assumptions made in the document reinforced this assumption that PD can simply be included in generic mental health provision. This risks avoiding the need for key differences in approach. The use of words such as “recovery” in Section 1.1.4.1 is confusing; presumably, the sense is that explanations should emphasise that BPD is treatable and people can improve their lives. However there is a risk of confusion with the “recovery model” which is not universally endorsed as a single approach fro BPD	Thank you for your comments. People with BPD will, in most cases, receive the bulk of their treatments from community-based teams most notably CMHTs. The GDG believe that the guideline should support this and provide recommendations to help CMHTs better undertake this work. After all, 40% of the work of an average CMHT is dealing with people with personality disorders. The GDG believed that specialist PD services should support CMHTs as well as to provide treatment for people with more severe and complex problems.

								We understand your concerns about the use of the term 'recovery'; the GDG were convinced of the need for services to remain optimistic in their engagement with people with BPD.
208	SH	Department of Health	4	Full	General		The absence of some key detailed guidance for practitioners is concerning, the full document contains considerable detail that is not reflected in the guidance. The language, direction and guidance used, at times, are not helpful. For example, language about care planning is very bland and most practitioners would say that they already do what is recommended. Statements could briefly link back to the evidence.	Thank you for your comments. The current rubric for the NICE guideline does not include links to the evidence. However, NICE is piloting ways to do this which maintain the usability of the document although this will necessarily be in an electronic format.
209	SH	Department of Health	5	Full	General		The concern remains that as a guidance document in some ways it has a lack of clarity. This might be seen as a lack of evidence but it would be helpful if the guidance could make a statement that it is not sufficient to leave things as they are and that service implementation plans are essential. Commissioners, for example, could feel validated that there is no need to commission anything differently; and practitioners may feel that CMHTs operating as usual are enough .An opportunity exists to ensure and endorse a robust way forward that uses the evidence currently available to require a review of service provision at national regional and local levels.	Thank you. There is undoubtedly a lack of evidence in this area. In the draft guideline we do now recognise some unnecessary vagueness which has been corrected in light of comments from stakeholders. However, we are unable to correct the lack of evidence! Evidence is needed to make more robust recommendations about services.
210	SH	Department of Health	6	Full	8 General		There remains an attitude that it is acceptable that existing mental health services simply incorporate BPD interventions within its service structures. The evidence offered, in the full review document, does not support this view. This has significant service delivery and practice impact, neither the evidence nor the guidance supports this view.	Thank you for your comment. The GDG disagrees. PD generally, and BPD in particular, should be predominantly dealt with within community services, with some backup from specialist services. To do this effectively, the guideline has set out a care pathway incorporating specific guidance and advice about treatments that have

								the best evidence for efficacy and how to avoid harm to service users.
211	SH	Department of Health	7	Full	8 General		A basic level of specialisation of staff (workforce) is necessary for those accessing services and it will effect whether those with BPD get appropriate, timely and effective interventions. Such a view would be consistent with both guidance and directions in other fields e.g. Dual Diagnosis and Gender Equality Issues, and ensure appropriately skilled staff (and therefore services) are always available based on expertise.	Thank you. We agree this is an important issue and we have addressed these in various recommendations about training and support. As a result of this and other comments we have also made a new recommendation about training and supervision in section 1.1 of the NICE guideline.
212	SH	Department of Health	8	Full	General		Eleven community pilots were commissioned by the Department of Health (2006). Some acknowledgement of the emerging evidence, including both formal and informal outcome publications, that supports views of increasing economic benefits to services and patients, the need for systemic approaches to this client group is significant.	Thank you. This guideline was restricted to the management and treatment specifically of people with borderline personality disorder rather than for personality disorder in general.
213	SH	Department of Health	9	Full	8 General		The need for de-escalation at times of crises rather than reliance on traditional generic CMHT or Mental Health Act assessments should be noted as an area for further consideration and research.	Thank you. We found this comment confusing and are not sure how to answer adequately. De-escalation is recommended in the management of imminent violence (existing NICE guideline), to which this guideline has referred. We also cover the role of generic CMHTs (central to the services recommended in this guideline) and we do refer to the need to follow the guidance on the use of the mental health act in the introductory section of the NICE guideline. We hope this has answered your questions.
214	SH	Department of Health	10	Full	8 General		In developing PD services emphasis is on the importance of pathways of care for those with borderline personality disorders. The concept of commissioning pathways as opposed to single service interventions is most important. This principle is not	Thank you. The GDG have developed this guidance around a care pathway from primary care through community mental health services to specialst services for

							recognised and incorporated in the guidance document. This under-pins a concern that there is little stated in the guidance pertaining to early intervention, early detection the need for longer term maintenance and support and how effective multi agency work is essential to coherent provision over time.	the treatment of PD. Early intervention services are currently recommended for psychosis not PD. The evidence for the effectiveness of these services for PD is almost non-existent and, in any case, was not within the scope of this guideline.
215	SH	Department of Health	11	Full	General		Engagement with those with BPD and therefore the decisions about intervention are centred on primary care. This is not clearly acknowledged in the guidance in its current format. This understates the reality of where most interactions are taking place and under values the contribution made at primary care level. It is therefore of concern that the focus of the guidance appears to take a mental health rather than health perspective. It can equally be stated that in criminal justice care BPD is direct concern for custody staff and therefore requires changes in practice in custody settings.	Thank you. The bulk of routine care (mental health) for people with BPD takes place in CMHTs and other parts of secondary care services. The GDG believes that the focus of the guideline is correct. There are clear recommendations in the guideline regarding the role of primary care, and we do make plain that all the recommendations in the guideline may be relevant to professionals dealing with people with BPD in other settings (criminal justice/forensic/acute physical health etc). Specific comments (i.e. Tied to a specific section or topic area) would have been more helpful here.
216	SH	Department of Health	12	Full	General		The full document notes, and acknowledges, that research on BPD is lacking at the RCT level. However, the guidance endorses some paradigms (notably a psychiatric medical model). It does not note the importance of psychosocial models and the need for further developments in this area where emerging evidence is encouraging. An approach with a dominantly psychiatric mental health orientation is not an appropriate way to progress evidence or practice.	Thank you. This is a guideline for the NHS and therefore is necessarily focused on health/mentalhealth. However, the GDG does not agree that the guidance endorses a psychiatric medical model; the guideline does examine the treatments available for people with BPD in a pragmatic (what works for whom) way.
217	SH	Department	13	Full	General		There is an underlying difficulty in the scope of the guidance which	Thank you. We disagree. The

		of Health					will affect implementation; namely that the scope explicitly excludes comment on interfaces between health and other services. While many of the recommendations can only be delivered with the active partnership with these other agencies. A clear acknowledgement that collaboration and joint work is necessary would be helpful.	recommendation 1.5.1.1 [draft guideline numbering] goes into some detail about multi-disciplinary working and multi-agency co-ordination/communication.
218	SH	Department of Health	14	Full	8 General		Every region has a Personality Disorder Capacity Plan specifically developed to ensure integrated service commissioning and interagency collaboration are in place across Tiers 1 to 6. This could be noted as being the required cornerstone of developments across health, social care and justice services.	Thank you. This is primarily an issue of policy within the DOH, and was not within the scope of the guideline and in any event, given its policy roots, should be dealt with as a matter of local implementation.
219	SH	Department of Health	15	Full	9 General		The comments relating to young people and services provided by CAMHs are welcome, although the distinction between those under 16 years using CAMHs, and adults using mental health services is arbitrary. As an implementation issue, young people from 16 to early 20s have much in common, and commonly express reluctance to use statutory services. Some reference to appropriate alternative models of service provision (i.e. in youth agencies/voluntary sector etc.,) not just community mental health teams, might be helpful.	Thank you. The guideline is for the NHS. We agree that the age cut-offs in the end are arbitrary but necessary for directing service users in a manageable way into services. However, we have added this point to the person-centred care section at the beginning of the NICE guideline.
220	SH	Department of Health	16	Full	General		There are a number of mental health initiatives around implementation that have been driven by central policy, that Trusts and PCTs are working on, where clear links to PD and the NICE recommendations need to be made. These should be signposted in some way because otherwise many people see these as separate policy streams and areas of activity and will not see the implications. Within mental health these include:- ➢ IAPT – ensuring that people with BPD are identified early and not offered inappropriate of harmful treatments. ➢ MHA – access to appropriate treatment by use of new legislation ➢ CPA – the new practice currently being implemented but many practitioners still find it hard to see that this applies to people with PDs ➢ Autumn Assessment processes – if these continue they	Thank you. IAPT is purely for the treatment of common mental disorders (depression and anxiety), and is not therefore a service for people with BPD. MHA – the new mental health legislation applies to a broad range of people, and not specifically to those with BPD. CPA – we have mentioned the CPA where appropriate in the recommendations (eg 1.3.2 care planning).

							would be the primary mechanism for monitoring access and service provision ➢ Dual diagnosis policy and action streams ➢ The implementation of The Comprehensive CAMHs which will provide the key monitoring framework regarding the relevant PSAs will also need reference to recommendations on young people with BPD	Autumn Assessment processes – please see comment regarding the MHA which are equally appropriate here. Dual diagnosis policy/action streams – dual diagnosis is not especially relevant expect in so far as a person with BPD either develops another mental disorder, or develops a substance misuse problem – both of these situations are dealt with in the guideline. CAMHs – please see comments on MHA which apply here. There is a great deal of policy that could be relevant to all of our guidelines; where these are directly relevant to a specific guideline (eg dementia and Everybody's Business) we have sometimes cross-referenced.
221	SH	Department of Health	17	Full	General		More widely within other health care areas there are important linkages to be made with the prison health agenda and these include:- ➢ Prison in-reach services and what they provide and who for – ensuring the BPD and implications for services provision are well understood ➢ Women's mental health strategy and ensuring that BPD is well understood within that context, and that initiatives regarding self-harm are properly linked with implementation of these NICE recommendations • Development and implementation of the women's mental health care pathway in the CJS/prisons with particular reference to the Corston Report. (2007) • Important to ensure linkages to the Alcohol and Drugs	The guideline is written for the NHS and specific recommendations for prisson staff are outside the scope. However, NHS healthcare professionals working with prison populations should follow these guidelines.

							Strategies • The Offender Health Strategy and the Improving Health, Supporting Justice Consultation Documents (2007) • The Lord Bradley Independent Review of the diversion of individuals with Mental Health problems from and within the criminal justice system and prisons (2008)	
222	SH	Department of Health 2	1	Full NICE	5.13.1.1 (1.3.5.4)		The initial sentence appears to be a little unclear, and we wonder whether the word 'one' should be replaced by 'a service'.	Thank you. This recommendation has been amended.
223	SH	Department of Health 2	2	Full NICE	8.5.18.2 (1.5.1.1)		(Fifth bullet point): should the second use of the word 'advise' possibly be 'advice'? We would be grateful for clarification.	Thank you. The spelling has been corrected.
224	SH	Department of Health 2	3	Full NICE	8.7.5.2 (1.1.2.2.)	11	It is suggested that people with moderate learning disability and BPD should be treated in mainstream services. In our view, it is usually the case that those with mild learning disabilities are seen - and treated - in mainstream services, but those with moderate learning disability are cared for by the learning disability specialist services. We would be grateful for clarification.	Thank you. It has been clarified that people with mild LD only should have access to mainstream services while in all cases including moderate and severe LD there should be involvement of specialist services.
225	SH	Department of Health 2	4	Full NICE	5.13.1.3 (1.3.5.7)		Could you please clarify whether this recommendation not to use interventions of less than three months' duration needs to be cross-referenced to the guidelines that promulgate a stepped care approach, where brief interventions may well be offered in primary care for symptoms that someone with BPD may display (for example, anxiety-related symptoms).	Thank you. This recommendation is concerned with specific treatments for BPD and its symptoms rather than comorbid disorders which may benefit from brief interventions.
226	SH	Department of Health 2	5	Full NICE	5.13.1.3 (1.3.5.7) Originally 'general'		We feel that there is a potential conflict between the admirable goal of not excluding those with a diagnosis of BPD from services on the grounds of their diagnosis (please see 1.1.1.1), and the avoidance of brief psychotherapeutic interventions (as are offered via IAPT, for example [please see 1.3.5.7]).	Thank you for your comment. The evidence does not support the use of brief interventions in people with BPD (see chapter 5 of the full guideline). Psychological therapies should be provided based on the amended recommendation at 1.3.5.4 [draft NICE guideline numbering]. The recommendation in 1.1.1.1 refers to any service and

								not specific therapies.
228	SH	Derbyshire Mental Health Services NHS Trust	1	Full	8.5.18.2	302	Re: "Mental Health Trusts should consider developing multidisciplinary specialist teams/services for people with personality disorder." Following the extensive discussion re care pathways within primary and secondary services and the need for staff at all levels to be trained & supported in their work with people with personality disorder, the use of the term "consider" does not appear to be robust enough. Some source of expertise is clearly necessary in this area, for consultation as well as for the delivery of services to very complex clients; unless there are clear alternative ways of accomplishing this task, then we believe that specialist services should be developed. We recommend that the word "consider" be removed so that it reads "Mental Health Trusts should develop multidisciplinary specialist teams/services for people with personality disorder."	Thank you. As a result of this and other comments we have amended the recommendation.
229	SH	Derbyshire Mental Health Services NHS Trust	2	Full	8 General		Document could offer more detail on what should be offered by general Adult Services, as it does with the specialist / tertiary services. It is also helpful on what should be done in primary care, so it seems odd that the bit in between is missed out (other than recommending thorough assessment).	Thank you. The guideline does devote most of the recommendations to the management BPD within the community setting, usually undertaken by CMHTs.
230	SH	Derbyshire Mental Health Services NHS Trust	3	Full	9.8	282	We welcome the detailed consideration of the needs of young people with emerging personality disorder in this guidance, and the identification of the responsibility of CAMHS in meeting these needs. The required expertise fits well within the system of 'tiers'. We also welcome some consideration of the effective transition of young people from child to adult services, and the unique challenges that people with personality disorders face in developing new relationships and networks.	Thank you.
231	SH	Derbyshire Mental Health Services	4	Full	General		We welcome the service user centred approach, both in de-stigmatising and involving in care. Also, the view that "one size does not fit all" and that a variety of approaches, at different levels of service delivery, will need to be offered for effective care.	Thank you.

		NHS Trust						
254	SH	Henderson Hospital Services	1	Full	General		1 The guidelines efforts to generally improve access to services for people with BPD are welcomed. However, we also have serious concerns that strict interpretation of these guidelines will be used to deny access to some valued services, in particular residential Therapeutic Communities (TCs) and some out-patient psychotherapy services. 2 The highlighting of good clinical practice in all settings is welcome. 3 There is concern that there is so much emphasis on RCTs and an undervaluing of other types of research, including narratives (when service user views are also stated as being valued) and values-based practice (Woodbridge K and Fulford KWM 2004). Whilst the paucity of RCTs is highlighted, quite specific recommendations are being made on the basis of those cited, whilst the paper by Clarkin et al (2007) highlighting that a wider range of domains affected by TFT than DBT, is not mentioned. 4 It would be useful to explain in the guidelines that psychological treatments include various types of treatments.	Thank you for your comment – we have numbered the individual points to aid our response. 1 There is no good quality evidence for the effectiveness of therapeutaic communities in people with BPD and therefore a specific recommendation could not be included. Similarly, there is no evidence concerning the effectiveness of specific service models. 2 Thank you 3 Clarkin et al 2007 and Levy et al 2006 are publications of additional data from the Clarkin et al 2004 study. We generate a study-id based on the first author and publication year for each study, with follow-up data or data published in subsequent papers being added to the original study to avoid double-counting. Therefore, the data from Clarkin et al 2007 were considered. 4 The therapies are described in the introductory sections in the full guideline chapter 5.
255	SH	Henderson Hospital Services	2	Full	4.6.1.1 (1.1.1.1)		The issue of excluding someone from a service on the basis of self harm is complex. A service, or the other service users in it, may only be able to contain a certain level of self harm (whether frequency, type or severity) and a different service may be required for someone above that level. Self harm may be amongst a number of behaviours e.g. drug taking or violence to others, that someone contracts to try and abstain from, to be able to use a service, in	Thank you. We disagree. The recommendation is clear that people with borderline personality disorder should not be excluded from a service because they have BPD or because they have self-harmed. If somebody's self-harming

							order to keep both themselves and the other service users and staff safe. If this is used thoughtfully and collaboratively, and not punitively or impulsively, it can be containing for service users.	behaviour escalates beyond the ability of a service to adequately contain this or provide the right level of treatment for such a peson, then is would be encombant upon the service and healthcare professionals involved to find a service that better suited the individual concerned (ie that could contain with that level of self-harming behaviour). We do not think this would qualify as excluding someone from a service. We have also amended the recommendation to make it clear that we mean any health and social care service, not just mental health services.
256	SH	Henderson Hospital Services	3	Full	8.5.2.1 (1.1.3.1)	6	The principle of autonomy and choice sounds hollow to service users when they have been denied their treatment of choice on financial grounds; that this may be a constraint may need to be acknowledged	Thank you for your comment. The guideline is intended to reflect best practice based on the available evidence.
257	SH	Henderson Hospital Services	4	Full	4.6.2.1 (1.1.4.1)	12	Mention of the need for boundaries, limit setting and a clear indication of what can be expected from the service can help unrealistic expectations	Thank you. We think that the guideline deals adquately with these issues throughout.
258	SH	Henderson Hospital Services	5	Full	5.13.1.1 (1.3.5.4) 5.2	8 109-111	Is it clear from the research that the difference between complex interventions, which are considered to show some benefit, and single modality psychological treatments, which are not, is due to there being 2 modalities of treatment e.g. individual and group, or is it due to other factors e.g. a combination of psychological therapy and social therapy; of verbal and 'non-verbal' (e.g. art therapy or psychodrama); of formal therapy and informal e.g. responses to crises and peer support; or the greater number of contacts with professionals and peers? It may be more accurate to recommend at least two types of therapy, or therapy at least twice a week within a well structures programme and a coherent theory of practice.	Thank you. This recommendation has been amended in light of your and other stakeholders' comments.
259	SH	Henderson Hospital Services	6	Full	5.1, 5.2	109-111	It is not clear why therapeutic communities (TCs) are not considered complex interventions alongside DBT and MBT based partial hospitalisation. They share much in common with the	Thank you. The term 'complex therapy' has been replaced because of the confusion caused.

							description of partial hospitalisation; they have a variety of therapies, are well structured, have a coherent model and adequate supervision of therapists. How much of MBT's success is down to the psychosocial/partial hospitalisation/ (modified therapeutic community)?	The GDG considered therapeutic communities warranted a separate section since they provide a very different environment compared with that offered in studies of what were initially termed complex therapies.
260	SH	Henderson Hospital Services	7	Full NICE	5.13.1.1 (1.3.5.4)	8	One modality treatment may be appropriate in certain circumstances e.g. after intensive treatment (supported by Wilberg's 1994 data and also with the indication that they can help with general functioning and are liked by service users), particulary if there is also contact with e.g. a CMHT.	Thank you. This recommendation has been amended in light of your and other stakeholders' comments.
261	SH	Henderson Hospital Services	8	NICE	1.4 1.5	25-26	No mention is made of what provision should be made for people who canot be contained or treated in local services. This ignores the fact that some people with BPD are referred to residential services, mainly TCs in the NHS or locked private or independent facilities, even from some areas that have well developed local services. It is acknowledged that some specialist residential treatment is needed by NIMHE and NSCG. Distinction needs to be made between the crisis management described on inpatient units and treatment in specialist residential services, and principles to guide referral. Some local specialist services offer management only whereas some patients want/need psychological or psychosocial treatment.	Thank you. The guideline addresses services outlined in the scope and has made recommendations to primary, secondary and non-regional tertiary services, and this has involved examining the evidence for TCs. We have as a consequence not recommended TCs within local services and have not made recommendations regarding TCs providing regional/national services as these are outside the scope.
262	SH	Henderson Hospital Services	9	NICE	1.1.3.1 1.1.4.1 1.1.7.1 1.5.1.2 1.1.4.1	6 27	The milieu and peer emphasis within TCs powerfully encourages the development of people's autonomy (through democratic participation, equal voice) and the development of optimistic (through seeing others who have progressed) and trusting relationships, key priorities for implementationof the guidelines. Otherwise hope and optimism can feel inauthentic. TCs also show good practice in terms of developing user networks and groups; yet TCs are not mentioned in the guidelines. Recovery is not felt to be a good term for people with PD by some ex-residents who feel that the treatment gave them a life they never had before.	Thank you. We found no high quality evidence for the efficacy of TCs and therefore there is no specific recommendation about them. Re 'recovery' – we feel this is an acceptable term from a service user perspective given that many feel that the term PD is used as if it were a life sentence from which people never recover (and service users don't think this is the case).
263	SH	Henderson	10	Full	5.14.2.1	31	The difficulties in researching residential TCs are acknowledged,	The evidence base for the guideline

		Hospital Services			(4.3) 5.10.4	185	particularly in doing a RCT, yet no recommendation is made for further research into these; the Lees et al meta-analysis (1997) is not included. Day TCs have relied on the research done by the residential TCs.	comprises primary research studies (i.e., studies with outcomes from relevant patient populations) from which the GDG draw their own conclusions rather than relying on existing reviews.
264	SH	Henderson Hospital Services	11	Full	5.3.3	137	Mention of no 'high' quality evidence for efficacy of TCs but are considering 'moderate' quality of DBT and MBT; is this biased?	RCTs provide high quality evidence of effectiveness of treatments. The GRADE system which we use to assess the overall quality of evidence (see the methodology chapter) allows high quality evidence to be downgraded to moderate in certain circumstances. These include the existence of only a single trial (for example, there is only one RCT of MBT), poor generalisability to the relevant clinical population, significant unresolvable heterogeneity between effect sizes, or skewed data. This structured system allows data to be graded in an open and fair manner. The data for DBT and MBT is from RCTs but the overall quality of some of this evidence was downgraded because of some of these kinds of issues. Since there are no RCTs or even outcome studies of therapeutic communities it is fair to say there is no high quality evidence of their effectiveness.
265	SH	Henderson Hospital Services	12	NICE	1.3.5	8	Important role of psychoeducation too	Thank you. We found no evidence for the effectiveness of psychoeduction.
266	SH	Henderson Hospital Services	13	Full NIC	8.5.2.2 (1.3.3.4)	17	Importance of psychodynamic/reflective supervision at all times – not just an annual reviewing of a teams tolerance and sensitivity to working with risk	Thank you. We have included a new recommendation about support at the end of the general

				E				principles. However, there is no evidence to support specific models of support.
267	SH	Henderson Hospital Services	14	Full NICE	8.5.18.2 (1.5.1.1)	26	It seems that some Trusts are hiding behind the gestural and statemental - services need to be actual and resourced.	Thank you. The guideline is intended to describe best practice which should be implemented. It is a matter for local implementation how this is done and will depend on funding from PCTs.
268	SH	Henderson Hospital Services	15	Full NICE	8.5.18.3 (1.5.1.2)	27	Peer group support should be an integral part of services for people with severe BPD	Thank you.
269	SH	Henderson Hospital Services	16	Full	General		Henderson & Research. Independent Research Scientist and ex-resident. 1 The randomised controlled trial (RCT) is considered by many the 'gold standard' for evaluating simple medical interventions. However, for complex interventions such as a therapeutic community, it is difficult, and some say impossible, to meet the criteria necessary to perform such an experimental evaluation (Manning, 2004). Indeed, Manning quotes the Medical Research Council as advising that complex interventions are made less complex if they are to be subjected to a RCT (p.114) which in itself would alter the treatment being evaluated. An RCT requires that the research participants are randomly allocated ('randomised') to receive either the new 'experimental treatment' or the standard existing treatment, or control. For an RCT to be meaningful the treatments have to be able to be compared without other 'factors' in the way which bias the study for or against, and you have to be able to randomly allocate the participants to one of the arms. As admission to the Henderson is 2-stage (referral and then selection) it would be highly difficult to randomly allocate people to the Henderson treatment option and could only be done if you recruited people to the study after they'd been selected for admission. This raises obvious ethical and feasibility issues for study recruitment. Research studies require that the physical and mental health of participants is not jeopardised by participation: to get through referral and then selection and then be randomised to	Thank you for your comment – we have numbered the paragraphs to aid response. 1 Thank you. We appreciate that there are ethical difficulties in undertaking an RCT of therapeutic communities. 2 We do not consider the currently available research sufficiently robust to indicate clinical effectiveness of therapeutic communities over other treatments. 3 We do not consider the currently available research sufficiently robust to indicate clinical effectiveness of therapeutic communities over other treatments. There is insufficient evidence on which to undertake any kind of cost effectiveness analysis. Neither of the two studies cited were designed to provide an adequate comparison of TCs with other treatments or

							a weekly community group instead is likely to cause significant distress, or to result in a refusal to participate in the study. 2 Ivan Lewis' criticism of lack of RCT evidence for Henderson model and his justification for withdrawal of Henderson funding on the basis of no current RCT evidence is completely at odds with health policy decisions. It is well recognised by the Government (eg. the 2006 White Paper 'Best Research for Best Health') that RCTs are not always a valid method of comparing two treatments - ie. where there are methodological/ethical problems such as those outlined above. The British Medical Association has recently released the statistic that 85% of NHS treatments have not been evaluated by RCT. If one looks at the research evidence which underpins the treatment recommendations made by NICE, National Service Frameworks and specific White Papers, there is a consistent approach. This is that treatment decisions are made on the best available research evidence until new research suggests otherwise. Often this best available research evidence is not in fact in the form of an RCT. But most critically, specific treatment provision is not made vulnerable by a lack of RCT evidence (as Ivan Lewis MP suggests) but only by the existence of contrary evidence. If a study were conducted and the findings then indicated a comparable but cheaper (or a better) service to Henderson for that specific client group of complex PD then it would be right to call into question the research evidence which supports Henderson's funding. Until a study for the Henderson client group shows that there is a treatment which is either 1) as good as but cheaper than Henderson or 2) has better patient outcomes than Henderson, it goes in the face of research and health policy to remove an evidence based treatment and replace it with a different treatment for which there is no evidence to suggest the same client group will benefit to the same extent. 3 Current Henderson research evidence is sufficiently robust to indicate that the financial burden on the State of those with complex Personality Disorder is significantly reduced by a course of Henderson treatment, and that treatment costs are in fact recouped within a comparatively short period of time given the chronic and long-term nature of PD. This means it is not only cost-	'treatment as usual'. The first Dolan et al study takes outcome measures before admission and compares them with measures taken post-discharge. To be classified as a cross-over study would mean that participants would have to be randomised (or otherwise allocated) to receive treatment or 'control', and then after a period, be switched to the other treatment group, thus serving as their own controls. The Dolan study is therefore of a pre-post design, rather than a controlled study. The study is described in the review of evidence on p178 of the full guideline [draft guideline page numbering] The 2nd Dolan et al study compares those admitted with those not admitted. The GDG did not consider this a good comparison since those admitted are likely to have different clinical characateristics to those not admitted. The study is also described on p178. 4 Thank you. We understand that there is quite strong feeling amongst many professionals and service users about the closure of the Henderson Hospital. It is not the role of the GDG to comment on the Government view of the Henderson; rather, it is our role to consider the evidence such as it is.

							effective but actually cost-saving. Although the research base does not use an RCT to compare Henderson patients with a 'parallel' or 'control' arm of participants receiving an alternative treatment, two types of study have been employed which use different, but valid 'control' arms. ♦ In the first study (Dolan et al., 1991) a design called 'ABA' or cross-over has been used in which recruits act as their own controls, so that the period before an intervention is compared with one following. This is a valid method where there is considerable complexity and 'within-group' variance anticipated in a population. Follow-up of 62 patient eight months after discharge showed a highly significant improvement in psychological functioning compared with pre-admission scores. This change was also clinically significant for 55% of patients who now scored within a normal range. Additionally, a study was conducted (Dolan et al,1996) which compared patients admitted to Henderson with those who were refused funding. Although the element of randomisation (which reduces study bias) is not present, the two parallel study 'arms' were comparable on demographic and clinical features at the time of Henderson referral and at 1 year follow-up re-admission to hospital and criminal convictions were significantly lower in those who had been admitted to Henderson. 4 Evidence Cited by the Government against Henderson A study comparing two different models of treatment offered by The Cassel (Chiesa and Fonagy(2003)) is used by the Government to criticise the Henderson as a 1 year treatment model. However the validity of this inference is highly questionable. Primarily, the Henderson model is not comparable with the 1 year residential model at the Cassel which was found to be ineffective. They differ in the nature of the intervention, client group, and efficacy in improving patient outcomes. Importantly, the Henderson model incorporates outreach, where the Cassell model under question does not. The authors of the Cassell study themselves suggest that outreach may be of great therapeutic importance and	The GDG believe they have done this effectively.

							may be responsible for the lower success of the 1 year intervention 'The considerable difference.... between the two groups suggests that follow-up psychotherapy treatment after a period of hospitalisation is important to the stabilisation of these patients back into their community'p.360 'The absence of supportive after-care in the one-stage group seems to undermine the continuation of the healing process initiated while in in-patient treatment'. Furthermore, the Henderson does not use psychotropic medication or individual psychotherapy, providing a robust democratic milieu in which the power to change is seen to lie within the residents themselves. Although there has not been any direct comparison of the client groups, the Henderson has traditionally included more clients with antisocial behaviour, 30-50% having had previous convictions. In contrast with the significant improvement in the Henderson ABA study (Dolan et al.(1996)), this study also embedded an ABA study of the 1-stage Cassell group, which '….did not show any significant improvement in self-mutilation, parasuicide and acute re-admission compared with the year prior to admission to Cassel hospital'. This demonstrates how the Cassel and Henderson models differ in outcome as well as client group and model. Finally, the study itself does not provide conclusive evidence that a longer residential stay is associated with poorer patient outcomes. The two interventions in the Cassel study differ on two counts. The 1-stage model is both longer (1 year versus 6 months) and lacks outreach. So to attribute its lower performance clearly to the former is entirely conjecture, particularly as the attrition rate from the 1 year intervention was so great that this cohort only stayed an average of 8 weeks longer than the 6 month cohort. In addition, this view is at odds with the opinion of the research authors themselves. In contrast to the Cassel study, research on the Henderson model has consistently shown that those that stay longer improve most, with a plateau between 9 and the maximum 12 months. Despite this, the Henderson responded to the request of commissioners to offer a 6 month initial period of treatment, a point which makes the criticism of the minister rather irrelevant.	

							References: • Chiesa M. Fonagy P.(2003) Psychosocial Treatment for Severe Personality Disorder British Journal of Psychiatry Vol.183 pp.356-362 • Dolan B. Warren F. Norton K. Menzies D. (1996) Cost offset following specialist treatment of severe personality disorder Psychiatric Bulletin vol.20 (7) pp.413-417 • Manning, N. The Gold Standard. What are RCTs and where did they come from? Ch.6 in A Culture of Enquiry. Research Evidence and the Therapeutic Community. Eds. Lees, J., Manning, N., Menzies, D. and Morant, N. (2004). Jessica Kingsley. • Wilberg, T., Friis, S., Karterud, S. Mehlum, L., Urnes, O. and Vaglum, P. (1998). Outpatient group therapy. A valuable supplement to day treatment for patients with borderline personality disorder? A three year follow up study. Nordic Psychiatric Journal, 52, 213-21.	
270	SH	Hertfordshire Partnership NHS Trust	1	Full NICE	4.6.2.1 (1.1.4.1)	6	This guideline is most appropriate for a nursing ward, and does not clearly differentiate between roles and purpose. Although apparently an ordinary enough guidance, it may lead to an unhelpful emphasis on immediate post intervention outcomes of 'feeling positive' which may not reflect the need of for instance complex assessment or treatment. A complex assessment needs to allow the patient to express and be heard authentically, not interposing a particular attitude from the assessor; 'an atmosphere of hope and optimism' and 'explaining that recovery is possible and attainable' is something that remains to be seen in a serious assessment; as the patient with severe illness is aware. It is actually worker centred, leaving out the engagement with the reality that it is the patient who has to find hope within themselves which cannot be given by workers. It protects the assessor from exploring with the patient his actual experience which may be that there is a great deal to be concerned about and that many treatment options may already have failed with no immediate good reason for optimism. Allowing this to be explored openly is more likely to be helpful in identifying what the patient does want and can aim for and in finding their more authentic feelings than a self protective attitude which is quite different from a more neutral	Thank you. We disagree, the guideline is aimed predominantly at CMHTs (40% of their workload is with PD, of which, more than half will be people with BPD). We also disagree with the suggestion that services and healthcare professionals should not be hopeful or optimistic or, indeed, suggest that recovery is possible and attainable. It appears to be a very stigmatising approach to think that people with borderline personality disorder need to face their problems in an atmosphere which is neither hopeful nor optimistic. People with cancers no longer have to face this pessimistic prospect. We hope this guideline will go some way torwards

							approach which may then more convincingly take up why a patient might be negative about treatment options.	achieving a similar setting for people with borderline personality disorder, a setting in which hope and optimism may keep some people alive.
271	SH	Hertfordshire Partnership NHS Trust	2	Full NICE	5.13.1.1 (1.3.5.4) Psychological treatment	8	As the guidelines say elsewhere, there is an insufficient evidence base. The reasons for this do not principally have to do with lack of research but the mismatch between the actual delivery of therapeutic interventions and the assumption that psychological therapy for individual patients can be manualised and standardised as if it was a chemical. Complex interventions rely on the patient as well as the therapist. The attempt to impose the partial findings of studies is in violation of both this reality and the attempt to use an evidence base scientifically; there is no sufficient evidence base to make broad based guidelines such as this. The scarcity of what NICE is accepting as evidence is not only due to the lack of good research it is the narrowness of what is seen as scientific, and the unscientific refusal to take seriously why such scarcity and difficulty in establishing such an evidence base exist. There is sufficient evidence to say that a psychological treatment should be based on a highly complex assessment. This is likely to mean that the assessor is highly trained and able to conceptualise the patients needs in terms of a coherent theory of the mind and corresponding theory of practise. They will preferable be aware of and able to discuss and assess the relevant treatment options from a knowledge of them in and articulate why a particular choice is made in relation to a particular patient. In many cases, a structured and well boundaried programme will be most appropriate. A great deal of evidence of effectiveness outside RCTs' demonstrates how in psychoanalytic work the structure is provided by the coherence of the model of the mind and by adhering to a treatment within a very clear setting which includes regularity, consistency and neutrality. This allows very specific interactions between patient and therapist to take place which offers another way of providing the containing and effective framework for therapy, offered externally by therapies offering structure in terms of an active therapist programme. The complexity of these kinds of intervention with patients with very complex needs requires complex	Thank you for your comment. We cannot make a recommendation to the NHS without clear evidence of effectiveness (i.e., good quality RCTs). Since this is lacking for most psychological therapies in people with borderline personality disorder, we have made a less specific recommendation. As a result of comments from stakeholders, the version in the draft guideline has been amended. Thank you for your comment. As far as we understand the point you are making we would agree that psychotherapies of any kind are complex and share a great deal in common with surgical interventions and very much depend upon the skills of the therapist, the severity of the patient's problems, the very individual nature of many problems experienced by service users (etc). However, we are nevertheless bound to evaluate claims for efficacy using designs that allow direct comparisons either between treatments or between treatment and placebo (or standard treatment). Those designs currently centre around RCTs. As we are sure you are aware evaluation of psychological treatments is

							assessment which goes beyond the ability of guidelines to determine the best option for every patient. These guidelines are therefore misleading and unhelpful in giving the impression that a definitive delivery of therapy approach can be made which will lead to commissioning on the basis of an unfounded demand for 'structured' therapy understood in a simplistic way.	accessible to this design. The field of BPD and its treatment is at a very early stage with few trials available. We have therefore made our recommendations based on an evaluation of RCT evidence and consensus of a very broadly based guideline group.
272	SH	Hertfordshire Partnership NHS Trust	3	Full NICE	8.5.18.2 (1.5.1.1)	9	There is a failure to articulate the differences between diagnosis and management of a disorder, and psychological assessment and treatment of a disorder. This does not help teams recognise the differences and similarities between the medical model of intervention and psychological conceptualisations of disorder. A core part of these teams should be the individual complex assessment of psychological needs and treatment options, from highly specialist psychological services. The attempt to diagnosis and treat according to diagnosis alone is wholly invalid in psychological treatment and specifically dooms patients with more severe illness to treatments they have already tried or which do not address their needs. It is a recipe for a generalised, low level service aimed at mild to moderate severity.	Thank you. We do not agree. We have made the differences clear between diagnosis and management, and we have taken a standard model for BPD. This is not a recipe for a low level service at all but a recipe for a well organised service with a range of skills and not simply high level specialist psychological services.
273	SH	Hertfordshire Partnership NHS Trust	4	Full NICE	4.6.2.1 (1.1.4)		The hope needs to be located in the patient, or it risks crudely imposing something they do not feel and which increases exclusion and the sense that the professional cannot bear the pain of the reality the patient experiences or believes is true about their internal state.	Thank you. The guideline is not recommending that healthcare professionals should be unrealistic about treatment outcomes or, indeed, about the difficulties faced by people with borderline personality disorder. However, it is recommending that healthcare professionals should work in an atmosphere of optimism and hope as there is much to be hopeful about for people with borderline personality disorder if they receive the right help.
274	SH	Hertfordshire Partnership NHS Trust	5	Full NICE	8.5 (1.3.1/1.3.2)	15	There needs to be provision for highly specialised psychological assessment in the CMHT's. Treatment for patients with more severe illness who have not responded to other interventions need to be provided with treatment from specialist psychological teams	Thank you. The specialist teams referred to in section 1.5 [NICE guideline] are intended to explictly provide the specialist

							with specialist supervision.	interventions/contexts to which you refer. Their job is also to ensure that CMHTs become more skilled in undertaking less specialist but nevertheless important work in the general psychiatric context.
275	SH	Hertfordshire Partnership NHS Trust	6	Full NICE	5 (1.3.5) Psychological treatment	18	Written material should be considered where helpful. The main way of ensuring informed consent should be based in the assessment process. Complex psychological treatment is involves interpersonal issues which involve the engagement of a patient on an emotional basis. A defensive retreat to giving a patient a piece of paper which will not actually prepare them for the emotional impact of treatment is an evasion. A highly specialist psychological assessment will introduce a patient into a way of thinking and provide an experience on which to then discuss and decide treatment. By introducing such detail as written information as if it informs often severely ill or highly distressed patients militates towards a low level generalised service commissioned without due attention to complexity.	Thank you. The GDG disagree. It is important that service users and their families/carers where appropriate are able to read about treatments and services and not just be dependent on what they are told by professionals. Indeed, it is our view that all people with BPD should be given a copy of this guideline as well as information about treatments and their effectiveness. This is a specific additional point we make above that made in the person-centred care section.
276	SH	Hertfordshire Partnership NHS Trust	7	Full NICE	5.13.1.2 (1.3.5.5)	19	Evidence does not exist that DB therapy is the best option for an individual woman patient, merely that a study has shown some evidence that it can help. This does not serve as a sufficient indicator that DBT should have priority for studies or as a treatment option. By taking such limited evidence as if it was definitive the resulting commissioner led bias to this may come to inappropriately limit psychological services options.	Thank you for your comment. The bulk of the evidence behind this recommendation is specifically in women. DBT is specifically recommended where the reduction of self-harm is a priority. The recommendation suggests that DBT is 'considered' rather than given to all regardless.
277	SH	Hertfordshire Partnership NHS Trust	8	Full NICE	8.5 (1.4) Inpatient services		Psychological treatment can be extremely useful during inpatient admission, and for some patient who resort to frequent inpatient admission, can allow psychological work on issues that are not available outside such a supportive environment. Best practise would allow psychological specialist teams to continue working with patients during inpatient stays.	Thank you for your comments. A number of commentators have drawn attention to the possiblity of using psychotherapy within inpatient/TC settings, and at one level (dealing with risk) this has some face validity. However, as an evidence-based guideline, we cannot make recommendations at

								this level.
278	SH	Hertfordshire Partnership NHS Trust	9	Full NICE	5.14.3.1 (4.1) Research recommendations	29	This is a misleading recommendation for a study which evades the difficulty that establishing agreed outcome measures has to engage in. The measure are not agree and are different as a result of attempts to produce information taking into account the complexity of what is required of them. Instituting a study with qualified and non qualified research workers will not short circuit the difficulties which should instead be giving pause to NICE's simplistic attempts to use basic data that does not fit.	Thank you for your comment. The large number of outcomes used in the existing studies gave us considerable problems in assessing the evidence base. The aim of this recommendation was to reduce this confusion to improve future analyses.The GDG feel it is important to include 'non-qualified research workers' to ensure that outcomes are relevant to both service users and clinicians.
279	SH	Hertfordshire Partnership NHS Trust	10	Full NICE	5.14.1.1 (4.2)	30	The effect of trying to impose a simplistic and false conceptualisation of research evidence on psychological treatment leaves NICE paradoxically open to manipulation by therapies which can apparently conform to manualisation and standardisation for RCT's. These remain unconvincing across the field and do not provide the diagnosis to treatment results that NICE seeks. Mentalisation is a case in point, where hand picked therapists worked under close supervision of highly experienced psychoanalysts. The theory and practise was in reality informed by psychoanalytic ideas which were re-conceptualised within a model which could be apparently manualised and reproduced. However, the likely real benefits to patients may well have been a result of treatment by a motivated, very strongly led team meeting with close supervisions and able to help patient establish their own conceptualisation of their illness. The study which thus apparently shows mentalisation as better than psychoanalytic treatment in terms of study's available can thus be seen to reverse the actual benefit of being highly trained in psychoanalysis and its application with individuals, in favour of apparently less well qualified workers who actually relied on them. As is typical on NICE guidelines in psychological work, the reality of the individuality and complexity of treatment is disguised behind results which are misleading when generalised. It is as valid to say that the studies show a need for highly specialist teams with a clear and sophisticated understanding and conceptualisation of mental health and personality disorder than that they establish a base to roll out even	Thank you for your comment. We recognise that the research evidence currently available is at a relatively early stage in its development and, particulalarly, that there are no pragmatic trials in NHS settings. This is reflected in the clinical recommendations which mention specific therapies only where the evidence allows this.

							in the event of further successful RCTs.	
280	SH	Hertfordshire Partnership NHS Trust	11	NICE	General		There is an understandable wish to standardise and manualise and offer treatment following diagnosis based on a preferably RCT evidence base. Unfortunately, this aim in its practical effects is likely when applied through commissioning to become a series of artificial rigid demands that have very little to do with what the research or lack of it really shows. My principal concern is that NICE's approach may lead to general good practise at a primary care and basic, generalised level of service, but that as is so often the case, people with moderate/severe personality disorder will not be offered the complex and long term treatments that they may need. Very often these patients have had courses of different psychological therapies, and they deserve to have further treatment explored on the basis of both specialist psychosocial assessment and specific psychological therapy treatment which should include those treatments such as psychoanalytic which may be less well geared to outcome measures but which for a minority of patients following complex assessment, can be extremely effective as shown as the psychoanalytically informed Henderson etc.. This patient group would be very ill served by a joining of an overly simplified approach to evidence to the wish for commissioners to have an equalised generalised and standard service which does not offer much to people with severe illness.	Thank you for your comments. The evidence base in its current state does not allow us to make stronger recommendations. However, the recommendations as they stand (amended based on stakeholder comments) do not proscribe effective treatment to people with complex needs. We hope the recommendations will prevent people receiving ineffective psychological interventions. We found no evidence for the effectiveness of therapeutic communities, and little evidence for the effectiveness of psychoanaltyically informed therapies.
285	SH	Leeds PCT	1	Full	5.13.1.1 (1.3.5.4)	8	This recommendation seems to be at odds with 'stepped care' services for common mental health problems and access (point 1.1.1.1) It is possible that people with BPD may present in primary care with symptoms of depression or anxiety and access services that offer brief interventions first. To exclude people who are seeking this sort of help in primary care seems unhelpful in practice.	Thank you for your comment. This recommendation is about treatment specifically for borderline personality disorder rather than comorbid disorders. (It has been amended in light of other comments from stakeholders).
286	SH	Leeds PCT	2	NICE	General		The group (local project team involved in exploring alternatives to admission for women with BPD) felt that there is a lack of acknowledgement of the potential interpersonal difficulties for staff working with people with borderline personality disorder (may be described as transference issues, splitting etc) and the need for supervision/reflective practice. Particular guidance on building in capacity for appropriate levels of reflective practice time into contracts etc would be welcomed.	Thank you for your comment. As a result of this and other comments we have made a new recommendation about training and supervision in section 1.1 of the NICE guideline.
287	SH	Leeds PCT	3	NIC	General		Comment from manager of vol sector crisis service – would hope to	Thank you for your comment. As a

				E			see more emphasis on training and support of staff – particularly around survivors of trauma and abuse which would seem particularly relevant for this client group.	result of this and other comments we have made a new recommendation about training and supervision in section 1.1 of the NICE guideline.
290	SH	Managed Clinical Network for PD Leicestershire Partnership Trust	1	Full	6.11.1.1 (1.3.6.2)	20	The proscription of drug treatment for individual symptoms of BPD is questionable. Mood stabilisers such as Carbamazepine can be particularly helpful with mood and emotional instability, and antidepressants can be essential in treating the other common comorbid symptom of depression. Obviously, these treatments cannot be used to any purpose for just a week (1.3.6.3). In stipulating that healthcare professionals should refer to the appropriate NICE guidelines for the comorbid condition (1,3.7.3), and for therapeutic efficacy this would seem entirely appropriate, it does not seem appropriate to treat such comorbid conditions as separate from the borderline condition as the guidelines seem to imply.	Thank you for your comments. The week limit refers to the management of crisis. If during crisis, mood instability is the major problem and this lasts for only a short time, clinicians would not prescribe CBZ or other mood stabiliser, but if the mood instability lasted longer they might. At this point a diagnosis of co-morbid bipolar illness may be considered. However, if the criteria are not met, the facts are that RCTs show little benefit for individual symptoms that fall short of diagnostic criteria for a co-morbid disorder.Please see chapter 6 which examines the evidence for pharmacological treatments in this context. The treatment of comoribidities in the context of BPD is complex, depends on the specific comorbidities and their severity (please see the evidence chapter in the full guideline (chapter 6)). The recommendation 1.3.6.3 refers to the use of drugs in the management of 'crises'. It was the view of the GDG that, in the absence of evidence of benefit and the known harm associated with the

								medium to longer term use of sedative medication (and other psychtropics) that the use of medication in the context of a crisis should be for a limited period of time and should be reviewed at an early stage.
291	SH	Managed Clinical Network for PD Leicestershire Partnership Trust	2	NICE	General (intro)		The guidelines are helpful in their general pharmacological advice. We would support the strong stance on discouraging the indiscriminate use of medication, though we note that this is not conveyed strongly or clearly enough in the introduction.	Thank you. This is a good point but the introduction to a NICE guideline is meant to introduce the condition and its treatment in broad terms (focus on service users etc) but does not deal with the evidence or recommendations based upon these.
292	SH	Managed Clinical Network for PD Leicestershire Partnership Trust	3	NICE	General		The guidelines do not specifically or sufficiently address the fact the BPD is a broad spectrum disorder, not only in the permutations of its individual characteristics, but also in the degree of severity. This has major implications for the type and combination of treatments offered, whether psychological or pharmacological. For example, many with BPD attend for weekly out-patient psychotherapy, or may even manage with good social support networks. The guidelines need to emphasise the importance of tailoring and titrating the interventions to suit the individual, rather than prescribing interventions that are both narrow and sweeping.	We agree with you that BPD is a hetrogeneous and varied condition and, as with other psychiatric/mental health conditions, severity will vary from mild (not reaching a diagnostic label) through to very severe (when for PD this will merge with other PD categories). Where we have been able to remind practitioners of the need to consider severity we have done so (1.3.5.2 – draft guideline numbering). However the evidence for different treatment approaches for different levels of severity is pretty much non existent in the field of BPD (unlike depression and OCD for example). We also agree with you that it is important, especially in BPD which is such a heterogeneous and diverse condition, to tailor the

								treatment programme to individual needs and goals, and we do address this, for example in care planning (1.3.4.1) and in assessing for psychological treatments.
293	SH	Managed Clinical Network for PD Leicestershire Partnership Trust	4	Full NICE	5.13.1.1 (1.3.5.4)	19	There is no rationale given for the recommendation that therapy should be provided in at least two modalities. This again is a sweeping recommendation that may be appropriate for some, but certainly not for all people with BPD. It is the experience of many clinicians that people with BPD do derive benefit from individual psychotherapy, group psychotherapy, homogeneous groups e.g. for women who have been sexually abused. The NICE guidelines need to be open to considering practice-based evidence. Also, the term "modality" needs to be defined. Some modalities may be complex e.g. therapeutic community programme which may comprise individual and group psychotherapy, arts therapies etc.	Thank you for your comment. Please see the full guideline (chapter 5) which does explore the evidence for effectiveness of psychological treatments. In the meta-anlaysis of psychotherapeutic interventions, the best evidence for benefit appeared in therapeutic approaches which included an individual treatment alongside a group treatment, both delivered in the context of a well structured treatment programme. Once weekly therapy of any kind was not associated with improved outcomes. Nevertheless we do accept that the evidence of benefit in the former approaches maybe the result of twice weekly (ie higher intensity) treatments. This recommendation has been amended in light of your and other stakeholders' comments, and reference to modalities has been removed – see 1.3.4.3 [updated NICE numbering].
294	SH	Managed Clinical Network for PD Leicestersh	5	Full NICE	5.13.1.3 (1.3.5.7)	20	For some, a brief intensive psychotherapeutic intervention can be followed by a prolonged less intensive attachment to the service. Once again, it seems that the guidelines are too narrowly prescriptive. In our service, it is common for those with severe BPD to have open-ended contact but with short, intensive, focussed	Thank you for your comment. It may well be that in your service people do benefit from the approach you take. Unfortunately there is an absence of research

		ire Partnership Trust					interventions.	evidence to support this. The GDG came to the conclusion that there was some evidence to support higher intensity well strucutured and theoretically coherent approaches; but there was no evidence of benefit for low intensity treatment undertaken outside a well structured theoretically coherent approach. Moreover the GDG were concerned about the harm that may be associated with the lower internsity approach, especially outside of a well strucutured programme. We have amended the recommendation to reflect this.
295	SH	Managed Clinical Network for PD Leicestershire Partnership Trust	6	NICE	General		There is an overemphasis on outcome, and insufficient information on process and technique.	We do not agree. The research in BPD has produced a plethora of highly divergent outcome measures which cannot be meta-anlysed (in the main) and have not lead to many firm conclusions. Without these it makes it very difficult to make recommendations about process or technique without confidence in the outcomes.
296	SH	Managed Clinical Network for PD Leicestershire Partnership Trust	7	Full NICE	5.13.1.2 (1.3.5.5)	19	It is not clear why DBT is recommended only for women and not men.	Please see chapter 5 in the full guideline for the evidence which relates to this recommendation.
297	SH	Managed Clinical Network for PD Leicestersh	8	Full	4.6.4.1 (1.1.6.1)	13	The guidelines need to refer to prognosis and not just diagnosis. This is especially important in the historical context of the way psychiatry has viewed personality disorder. Some professionals still think of it as a chronic condition from which people cannot recover, and this therapeutic pessimism and fatalism needs to be strongly	Thank you for your comment. We feel we have addressed prognosis in recommendation 1.1.4.1 which emphasises the need for an optimistic approach to treatment

		ire Partnership Trust					challenged. The guidelines could usefully advise regular reviews of the diagnosis and outline a process whereby clinicians can determine that a patient no longer fits the criteria.	and that recovery is obtainable.
298	SH	Managed Clinical Network for PD Leicestershire Partnership Trust	9	Full NICE	8.5.14.2 (1.3.5.2)	18	It seems to be implied that frequency and extent of service use might be a reason for precluding someone from consideration for access to psychological treatment. Surely, such a decision has to be about individual needs and the likelihood of psychological intervention being efficacious. Indeed, it may be the case that the service user is an expensive consumer of services precisely because they have not been offered appropriate psychological intervention.	Thank you. This bullet point (frequency and extent of service use) was intended as a proxy for severity – the greater the severity the greater the need for a psychological treatment. However we agree that it can be confusing and there is in fact little evidence to support this, we have removed it.
299	SH	Managed Clinical Network for PD Leicestershire Partnership Trust	10	Full	4.6. (1.1.1.4 & 1.1.6.1)	10	In some urban areas, such as Leicester, it would not be realistic to provide information or therapy in every language, though, if available, an interpreter would of course be used.	Thank you. Whenever a guideline is launched there is always a gap between what is recommended and what is available, otherwise there would be little point in producing a guideline. This will also apply to the availability of interpreters and access to information in a full range of languages. Guidelines should always aspire to overcome inequalities.
300	SH	Managed Clinical Network for PD Leicestershire Partnership Trust	11	NICE	General		The summary does not seem to reflect accurately the full guidelines, but is likely nevertheless to be used selectively by some e.g. commissioners, to the detriment of clients.	Thank you. This is hard to answer without a specific example.The summary document contains only the recommendations – this is standard NICE rubric. The full guideline will be available on the NICE website.
301	SH	Managed Clinical Network for PD Leicestershire Partnership Trust	12	Full NICE	8.5.18.1 (1.3.1.1)	15	Training should also be offered to relevant inpatient staff teams.	Thank you. We have amended the recommendation to include this.

302	SH	Managed Clinical Network for PD Leicestershire Partnership Trust	13	Full NICE	8.7.5 (1.1.2.1 & 2)	11	It is unrealistic to expect all people with mild to moderate learning disability to benefit from mainstream psychological therapies, though there will always be exceptions where the LD is mild. It could seriously disadvantage people with a LD to deny them access to specially tailored services.	Thank you. It has been clarified that people with mild LD only should have access to mainstream services while in all cases including moderate and severe LD there should be involvement of specialist services.
305	SH	Mental Health Foundation	1	NICE	1.1.1		Services should provide clear and accessible information about the service provided for service users and carers.	Thank you. T his point has been made in the relevant sections including the introductory section 'person-centered care' and 1.3.6.1 [draft guideline numbering].
306	SH	Mental Health Foundation	2	NICE	1.1.1		Services should consider important accessibility issues – e.g. hours of service, location of service (e.g. distance to travel, ideally not based within hospital setting, environment within service etc), provision of transport etc.	Thank you. This is not specific to the care of people with BPD with which the guideline is concerned.
307	SH	Mental Health Foundation	3	Full	4.6.2.1 (1.1.4.1)		Important to ensure staff receive sufficient support and supervision	Thank you. Recommendations about staff support and supervision are made in 1.3.1.1, 1.3.3.4, 1.3.3.3 (relating to risk management), 1.3.5.4 (for therapists). We have also added a recommendation at the end of the general principles section. [All draft guideline paragraph numbering.]
308	SH	Mental Health Foundation	4	Full	8.5.9.1 (1.3.2.1)		Important to ensure throughout assessment period that appropriate support and information is available for service users and carers.	Thank you. This point is covered in the section on 'general principles of assessment' as it is relevant to assessment in any setting.
309	SH	Mental Health Foundation	5	FUll	5 (1.3.5.) The role of psychological treatment		Clarity on the rules and boundaries of psychological treatment is required.	Thank you for your comment. The guideline is not intended to replace treatment manuals or adequate therapist training.
310	SH	Mental	6	Full	8.5.18.		Ideally, specialist services should involve service users and carers	Thank you. We have amended the

		Health Foundation		NICE	(1.5.1) The role of specialist personality disorder services within Trusts		in the design and production of information about their service.	recommendation to include this [1.5.1.3 in the NICE guideline].
311	SH	Mental Health Foundation	7	Full	8.5.18. (1.5.1)		Specialist services should be flexible – offer a range of options and a degree of choice – not 'one model fits all'. Specialist services should also demonstrate a positive focus towards recovery.	Thank you. These points are covered by the recommendations in 1.1.3 and 1.1.4 (draft NICE guideline numbering).
312	SH	Mental Health Foundation	8	Full	8.5.18.1 (1.3.1)		Training programmes should take into account the needs and priorities of minority groups (Does the service have the capacity to respond to diversity and to address diversity issues when they arise?)	Thank you. The guideline expressly requires that those from minority ethnic grups have equal access to services (see 1.1.1.3 draft NICE guideline numbering). The recommendation to which you refer requires that treatment is provided 'in accordance with this guideline'.
313	SH	Mental Health Foundation	9	NICE	1.1.5		Specific support groups within specialist service for carers would be recommended.	Thank you. We have amended the recommendation to suggest that professionals should inform families/carers about local support groups. We cannot recommend that healthcare services should develop these as we have no evidence to support such a recommendation.
315	SH	Mersey Care NHS Trust	1	Full	General	NA	The commenting group found the draft proposals to be of high quality.	Thank you.
316	SH	Mersey Care NHS Trust	2	Full	General	NA	There was a strong consensus that the guidelines would be a very positive step forward for clients experiencing BPD and more generally personality disorder.	Thank you.
317	SH	Mersey Care NHS	3	Full	General	NA	The group felt that the reality of 'patchy'service provision for BPD was not reflected in the document. It was suggested that there was	Thank you. The guideline recommends best practice;

		Trust					some unreasonable assumptions made about the present capacity of services to meet the needs of this client group.	implementation is a local matter.
318	SH	Mersey Care NHS Trust	4	Full	General	NA	There was a general consensus within the group that the guidance may not be realistic with regard to the skills and competencies available within both specialist and mainstream services at present.	Thank you. The guideline is designed to reflect best practice. We have included recommendations about training.
319	SH	Mersey Care NHS Trust	5	Full	General	NA	There is a large differential between the size and content of the two draft documents. The group felt that a suitable balance needs to be struck with regard to any final document. Specifically that more detail is needed in the shorter version to on key areas.	Thank you for your comment. It is standard NICE rubric that the shorter document (NICE guideline) contains only the recommendations.
320	SH	Mersey Care NHS Trust	6	NICE	1.2 -1.3.4	14-18	We are pleased that the entitlement of service users to care and support both in primary and secondary services is recognised. However, commissioners and service providers will be helped by the guideline providing greater clarity about the level of need and other factors that would determine which level of care is appropriate. Doing this will guard against continuing ambivalence within services, often expressed in implicitly excluding access criteria.	Thank you for your comment.
321	SH	Mersey Care NHS Trust	7	Full	8.5.6.1 (1.2.3)	15	Broad areas of responsibility are identified for CMHTs such as assessment. However, you give little detail CHMT interventions and care. This may give the impression that the work of CMHT is limited with respect to BPD and/or fail to clarify the skills development that is needed/expected in order for mainstream teams to be responsive to this population.	Thank you. The whole of section 1.3 relates to CMHTs.This includes psychological treatment.
322	SH	Mersey Care NHS Trust	8	Full	5 (1.3.5)	18	There appears to be too sharp a distinction between the role of psychological 'treatment' and that of work carried out in the CMHT. This may suggest that psychological interventions are not within the remit of CMHT and are only permissible within the context of others specialist services. It should be emphasised that psychological interventions and the application of psychological knowledge may be appropriate in any service context.	Thank you for your comment. Section 1.3 deals with the assessment and management of BPD by community mental health services and includes the bulk of the guidance on psychological treatments under 1.3.4.
323	SH	Mersey Care NHS Trust	9	Full	8.7.1	304	The 'learning disabilities' section does not contain reference to 'person centred planning' or specific psychological interventions relevant to this area of provision.	Thank you for your comment. There is no evidence specifically in psychological interventions for people with learning disabilities and a diagnosis of borderline personality disorder. The group felt that there was no reason why this

								group should not have full access to services provided to others.
324	SH	Mersey Care NHS Trust	10	Full	General NICE 1.3.3.3 1.3.5.4 4.2	 17 19 30	Reference is made to 'adequate supervision arrangement'. The group felt that the important issue of supervision needed more clarity.	Thank you. In light of this and other comments we have added a recommendation at the end of section 1.1 on supervision and support.
325	SH	Mersey Care NHS Trust	11	Full	General	NA	There is very little reference made to the importance of psychological formulation. The issue is confined to descriptive accounts of DBT and CAT within the full document. The group suggested that case formulation should be better represented within the document as a whole; suggesting it to be a basic standard for needs led interventions within both mainstream and specialist services.	Thank you. The GDG has made a number of recommendations regarding assessment, care planning, care programming, risk assessment and overall long-term care management, rather than to elaborate the specific approaches to case formulation taken by some types of therapy. The former represent good practice within the NHS, and at present we do not have evidence to surplant this with an alternative approach derived from therapies which currently have little evidence to support such a change in practice.
326	SH	Mersey Care NHS Trust	12	Full	General	NA	There is little guidance with regard to addressing motivation or engagement issues, including responding to missed appointments etc.	Thank you for your comment. We believe we have made it clear that the two are distinct.
327	SH	Mersey Care NHS Trust	13	Full	9.5.2	322	Some concerns were expressed about the appropriateness and utility of formally identifying borderline personality in children and adolescents, even as a preliminary to their transition to adult services. It was felt that a more functional needs-based description could still highlight the kinds of services required, without prematurely applying a diagnostic label.	Thank you. This is a good point which we feel we have addressed adequately in this chapter, for example in the section on diagnosis in young people in the introduction and in the section specifically devoted to diagnosis. We have also addressed the issue of stability of diagnosis. However, we sympathise with your point of view.
328	SH	Mersey Care NHS	14	Full	General	NA	The group felt that there were some conflicting messages emerging with regard to drug interventions.	Thank you for your comment. The first recommendation relates the

		Trust					Recommendations suggest (6.1.1.1(2)) that drug interventions (and more specifically antipsychotic medication in the long and short-term) are not efficacious for BPD. However, this seems at odds with the suggested place for the pharmacological management of crisis with BPD (7.5)	use of medication for the on-going treatment of borderline personality disorder, whilst the second relates to short-term use during crises.
329	SH	Mersey Care NHS Trust	15	Full	9 General	NA	The group suggest that reference should be made to Government documentation concerned with children, adolescents and parents – 'Every child matters'; "Every parent matters' http://www.everychildmatters.gov.uk/	Thank you. The guideline is consistent with the principles of these documents and the NSF which emphasise comprhensice assessment and high quality treatment from well trained professional services.
330	SH	Mersey Care NHS Trust	16	Full	5.13.1.3 (1.3.5.7)	189 20	The document suggests that brief psychotherapeutic interventions (of less than 3 months' duration) should not be used specifically for borderline personality disorder or for the individual symptoms of the disorder. This would seem to be at odds with the notion that BPD is a complex psychological disorder and for this reason may require both long and short-term interventions. Would it not be better to state that 'brief psychotherapeutic interventions (of less than 3 months' duration) should not be used in isolation or to the exclusion of long-term interventions.	Thank you. We have amended the earlier recommendation (1.3.5.4 draft guideline numbering) which should make this clearer. There is no evidence that brief interventions are effective.
332	SH	Milton Keynes PCT	1	Full	8.5.15.1 (1.3.6.1)	20	The efficacy of many pharmacological interventions in Borderline Personality Disorder is poorly established and/or poorly evidenced. No interventions are licensed directly for this indication. No information leaflets neatly relate to use in this condition therefore, NICE should champion development of specific leaflet(s) if they are recommending this practice. Lots of different locally produced leaflets is not ideal, the UKPPG PALs are a good model.	Thank you for your comment. Information leaflets are sometimes produced as part of implementation support for a guideline, and will be considered for the implementation of this guideline.
333	SH	Milton Keynes PCT	2	Full	6.11.1.1 (1.3.6.2)	20	I feel that this comment will lead to people being given sub-diagnoses inappropriately in order to defend the choice to use pharmacological treatments. E.g. diagnosed with affective/psychotic disorders in order to justify use of antipsychotics/antimanic agents.	Thank you for your comment. The wording 'should not routinely be used' allows some flexibility that does not force defensive medicine. The reality is though, that for symptoms that fall short of criteria for a co-morbid disorder, there is little evidence that drug treatments truly help.
334	SH	Milton Keynes	3	Full	8.5.15.1	20	Would be good to reinforce the need for good husbandry of unlicensed medicines at this point. You could incorporate the need	Thank you. This is a good point but it is not specific to the treatment of

		PCT			(1.3.6.1)		for clear goals of treatment (for voices), how and when this will be evaluated (rating scale) and the physical monitoring that will take place.	borderline personality disorder.
335	SH	MIND	1	NICE	Key priorities	6	We welcome the key priorities and particularly support access to services and the principles for working with people diagnosed with BPD.	Thank you.
336	SH	MIND	2	NICE	Key priorities	6	However, the important messages about autonomy and choice should not be separated from support and validation of the person's experience.	Thank you. This section lists the key priorities for implementation and is limited in number. The guideline should be implemented as a whole.
337	SH	MIND	3	Full	4.3		We welcome the attention given to qualitative research into service users' experiences as well as the personal accounts, and the recommendations that follow from them.	Thank you.
338	SH	MIND	4	Full	4.6		However, the excellent recommendations at 4.6 do not quite cover the 'caring response' element that seemed to come out quite strongly in the qualitative research. As one person told Mind, 'Professionals always need to remember it isn't BPD they are treating but an individual in emotional pain'.	Thank you for your comment. We do not agree and consider that the recommendations encourage healthcare professionals to treat service users as individuals.
339	SH	MIND	5	Full	4.6.2.1		Not a problem with this section, but the sensitivity and non-judgmental manner that is described here needs also to be built into the language used in parts of the NHS around BPD and people diagnosed with it, which generates and reinforces negativity.	Thank you. We think the recommendations we have in the 'principles of care' section of the NICE guideline will help to improve this aspect of care.
340	SH	MIND	6	Full	General	105	The views on the diagnosis of BPD set out in the draft guideline reflect the mix of views expressed to Mind. While we would see the main issue as being to challenge the stigma associated with the diagnosis, people should be able to choose not to be associated with BPD without being rejected by services, particularly given the negativity around it.	Thank you. We hope recommendation 1.1.6.1 [draft NICE guideline numbering] will help here.
341	SH	MIND	7	Full	General	105	If a diagnosis is being used, there needs to be openness about it with the person diagnosed, and about what it means, which should be communicated with respect, understanding and empathy. Service users need better information about BPD.	Thank you for your comment. We have included these points in recommendations 1.1.6.1 and 1.1.4.1, and in the person-centred care section at the beginning of the NICE guideline (short version; draft guideline paragraph numbers).
342	SH	MIND	8	Full	General	105	There may also be value in reconsidering the terminology of the	Thank you. This is outside the

							diagnosis itself, to make it more descriptive and less stigmatising.	scope of a NICE guideline.
343	SH	MIND	9	Full	General		In addition to the intervention itself, one of the benefits of DBT for the person concerned was working with staff/therapists who 'get' BPD. This speaks to the importance of staff awareness and training, both by specialist provider teams and service users.	Thank you. A recommendation about training is included at 1.3.1.1 (draft NICE guideline paragraph number).
344	SH	MIND	10	Full	5.13.1.1 (1.3.5.4)		We welcome the recommendation of DBT (elsewhere in the guideline) which has been described as life-saving. Should it be made more explicit in the key priorities what currently available interventions meet the criteria set out?	Thank you. This recommendation has been amended. However, there is insufficient evidence to warrant specifically listing which therapies meet criteria. The guideline has been written to reflect the generally poor state of the evidence base.
345	SH	MIND	11	Full	5.13.1.1 (1.3.5.4)		We have also received testimony as to the life-saving nature of 'consistent, long-term support from an experienced community psychiatric nurse', the latter working with optimism, a range of therapeutic approaches and humanistic values. Greater availability of one-to-one therapy may also be helpful as long as the therapists have the skills, support and supervision.	Thank you. We have not specific evidence comparing contact with one therapist compared with other kinds of contact. The guideline recommends consistency in 1.1.4.1 and how to manage endings and transitions in 1.1.7 [draft NICE numbering]. There is no evidence to support stronger recommendations.
346	SH	MIND	12	Full	5.13.1.2 (1.3.5.5)		It is good to see the reference to men in the research recommendation about DBT. Pending research, consideration should be given to saying that men should not be excluded from this where there is a basis for thinking it may be helpful.	Thank you for your comment. The bulk of the evidence behind this recommendation is specifically in women.
347	SH	MIND	13	Full	7.6		We welcome the attention to follow-up and to avoiding the unnecessary and potential harmful use of drugs post-crisis.	Thank you.
348	SH	MIND	14	Full	7.7		While this may not affect the advice to follow the appropriate NICE guideline, it may be helpful to recognise the need people may have for medication to help with sleep. If someone experiences flashbacks and night traumas or is at particular risk of self harm during the night, then advice on sleep hygiene is unlikely to be adequate help.	Thank you. Further advice about this is given in 1.3.9.1 (draft NICE guideline paragraph numbering).
349	SH	MIND	15	Full	8.5.18.2		We would strongly support the development of specialist teams. People should also be able to be treated by CMHTs, but specialist teams would provide a source of expertise, consultancy, training and treatment for those with highest/most complex support needs.	Thank you. As a result of this and other comments we have amended the recommendation.

							Therefore we consider that the recommendation on the development of specialist teams should be worded more strongly. Part-time secondments would be one way of ensuring multidisciplinary input and developing learning.	
352	SH	National network for safeguarding children leads in mental health trusts in England	1	Full	General		Purpose of this response We welcome the opportunity to respond to this draft guideline. Although Borderline Personality Disorder should no longer be a 'diagnosis of exclusion' we believe that people receiving this diagnosis are still subject to inconsistent care and treatment from mental health services. The greater clarity of expectations around care planning and treatment provided by this guideline is, therefore, to be welcomed. However, we are concerned at a serious omission in the guideline: it completely fails to recognize the significance of people with a diagnosis of BPD who are parents. We believe that acknowledging and supporting mental health service users who are parents in their parenting role is critical, both to the care and treatment of current service users, and to the prevention of emotional and mental health difficulties among their children, many of whom are 'young carers'. Our response, therefore, focuses on this specific issue.	Thank you. The issue of parenting is outside the scope. However, the topic has been reviewed by SCIE http://www.scie.org.uk/publications/briefings/files/briefing24.pdf). We would suggest that it may make a suitable topic for suggestion to the NICE topic selection panel.
353	SH	National network for safeguarding children leads in mental health trusts in England	2	Full	General		People with BPD as parents The guideline highlights the contested nature of BPD as a diagnosis. It acknowledges that it has been difficult to determine a reliable and consistently applied diagnostic tool and that BPD is commonly co-morbid with other conditions such as depression, PTSD, substance misuse, bi-polar disorders and psychotic conditions. BPD remains a contentious diagnosis, frequently viewed as stigmatizing by service users and clinicians alike. The lack of consistent diagnosis makes estimates of prevalence among the general and clinical population difficult to reliably determine. However, we know that a BPD diagnosis is more likely to be applied to adults aged between 18 and 35, and to women,	Thank you. Thank you. This is a good point but is outside the scope of the guideline. The topic has been reviewed by SCIE http://www.scie.org.uk/publications/briefings/files/briefing24.pdf). We would suggest that it may make a suitable topic for suggestion to the NICE topic selection panel.

							whom comprise approximately 75% of those receiving a BPD diagnosis.[1]. The likelihood of people with a BPD diagnosis being parents (particularly mothers) is therefore considerable. We believe that the importance of the parenting role for the person with BPD (and for their child/ren) should always be taken into account as part of the service user's care plan.	
354	SH	National network for safeguarding children leads in mental health trusts in England	3	Full	General		Parenting and BPD The guideline acknowledges the psycho-social factors commonly associated with BPD. These include a history of childhood abuse and neglect, having parents with mood disorders and/or substance misuse issues, and emotional under-involvement by parents, frequently associated with ongoing relationship (attachment) difficulties. However, the guideline fails to make explicit three critical implications of these factors: i. that the service user's experience of being parented will not only have impacted on their mental health condition but is likely to impact on their own parenting capacity; ii. that difficulties in parenting are likely to compound the mental health problems of parents with BPD; iii. that children of parents with BPD are themselves more likely to experience emotional stress with implications for their ongoing mental well-being. This is not to imply that service users with BPD inevitably make 'bad parents'. Rather, we believe that support for parenting needs to be integral to plans for treatment and care, not only to promote the mental health of the service user, as well a means of preventing immediate distress and long-term difficulties for their children. This view is supported by the testimony of BPD service users who are parents, many of whom describe the stigma of their	Thank you. This is a good point but is outside the scope of the guideline. The topic has been reviewed by SCIE http://www.scie.org.uk/publications/briefings/files/briefing24.pdf). We would suggest that it may make a suitable topic for suggestion to the NICE topic selection panel. Please see the NICE website at: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp

[1] DSM IV, 1997, p 652

							diagnosis as affecting how professionals view them as parents, for example: I have given peer support/advocacy to a number of women with BPD diagnosis during care proceedings, and the courts seems to accept the assertion from the authorities that BPD and being a parent doesn't mix as an absolute truth though there is really no evidence base for this and real misconceptions about the nature of BPD within the child protection arena.[2] A social worker arrived on my doorstep saying she had received a phone call from a 'friend' stating she was concerned that I'd harm the children. Since then my son has remained in the custody of his father, who has a history of violence, and whose parenting abilities have never been assessed by the Local Authority. I did not need 'help' from Social Services on that day. It was forced on me. Previously, when I had asked for assistance, they had placed the children twice at my request. The point being that when I felt I needed help I had always asked for it…..[3]	
355	SH	National network for safeguarding children leads in mental health trusts in	4	Full	General		The needs of young carers of parents with BPD Although the guideline acknowledges the role of carers, it completely fails to recognise the part played by the children of service users with a BPD diagnosis. A recent research briefing produced by the Social Care Institute for Excellence[4] highlights that the resilience of both parents and	Thank you. This is a good point but is outside the scope of the guideline. The topic has been reviewed by SCIE http://www.scie.org.uk/publications/briefings/files/briefing24.pdf). We would suggest that it may make a suitable topic for suggestion to the

[2] Quote from a service user-activist (personal communication*)*

[3] Anon quoted in Haigh, 2006

[4] L. Parrott, G. Jacobs & D. Roberts, Stress and resilience factors in parents with mental health problems and their children, SCIE research briefing 23, March 2008

		England					children can be promoted by appropriate support. Organisations and individual practitioners need to adopt a whole-family approach in supporting parents with mental health problems. However, many mental health practitioners remain reluctant to take account of the needs of children, including young carers: a reluctance which will go unchallenged by the guideline as it stands. Primary care practitioners also need to improve practice in this regard as the majority of mental health care is provided by PCTs. Historically, the experiences of children caring for a parent with a mental health problem have gone undocumented. Recently, more attention has been given to their circumstances[5] and researchers have highlighted the need to address issues of stigma, the need for children to receive information and direct communication from practitioners, and for practical and emotional support. Children of parents with a BPD diagnosis have similar needs but, in addition, the following factors should be considered: • Stigma: the guideline acknowledges the stigma associated with a BPD diagnosis. The general public, and many practitioners, have a particularly negative view of people with BPD. The impact of this on the child of a BPD mother (or father) should not be under-estimated; • Information: the guideline recognises that the BPD diagnosis is poorly understood, even by professionals. Although it advocates caution in providing information for carers, in case it increases stress, we believe that the complete absence of information provided to children and young people presents a far greater risk of stress. We agree that information needs to be carefully and appropriately communicated and suggest that the guideline needs to signpost practitioners to sources of support for ensuring that this happens; • Assessment: The guideline recognises the need for assessment to take into account the possible risks posed to self and others, including the welfare of dependent	NICE topic selection panel.

[5] For an overview see D. Roberts, M. Barnard, G Misca & E. Head, Experiences of children and young people caring for a parent with a mental health problem, SCIE research briefing 24, May 2008

							children. However, it provides no guidance as to how the welfare of children should be assessed, what questions might be asked and who should be involved. We feel the absence of any clarity in this regard is a serious oversight: as we have noted, the negative view of BPD leads some practitioners to erroneously assume that any BPD parent poses a risk to their children. On the other hand, parents with BPD, particularly at times of crisis may manifest behaviour which causes distress to their children: these risks should neither be overstated nor ignored. • Treatment options: we note that the guideline advocates the exploration of alternative options before considering admission to a crisis unit or inpatient admission. Whilst we generally agree with this approach, we believe that whichever treatment plan is implemented, the impact on children needs to be taken into account. If treatment occurs at home, steps need to be taken to help children understand what is happening. Where parents are admitted to hospital, support needs to be provided to help parents and children to maintain their relationship.[6]	
356	SH	National network for safeguarding children leads in mental health trusts in England	5	Full	General		Implications for the guideline's recommendations In summary, we believe that the guideline's recommendations should explicitly recognize the importance of parenting for many service users with a BPD diagnosis. This can be achieved by including the following: • Developing an optimistic and trusting relationship: any such relationship between a healthcare professional and a service user needs to acknowledge significant factors in the life of the individual. For most parents with BPD, their parenting role is central to their lives and should not be ignored or viewed negatively. • Involving carers: any discussion about the involvement of carers needs to include an exploration of whether there is a	Thank you. Th is is a good point but is outside the scope of the guideline. The topic has been reviewed by SCIE http://www.scie.org.uk/publications/briefings/files/briefing24.pdf). We would suggest that it may make a suitable topic for suggestion to the NICE topic selection panel.

[6] See B. Robinson and S. Scott Parents in Hospital: how mental health services can best promote family contact when a parent is in hospital; Barnardo's/CSIP, July 2007

							child or young person in the family undertaking a caring role. • Principles for healthcare professionals undertaking assessment: these should include an acknowledgement not only of the service user's childhood trauma but also their current experience as parents. • Managing endings and transitions: the implications for children of service users need to be considered when services end or change • Managing crises: when considering treatment options in crisis, it is particularly important to consider the impact on children including their needs and potential risks to their welfare. Treatment plans for the service user should not be considered in isolation from the needs of their children.[7] • General principles to be considered when working with people with borderline personality disorder: these general principles of active participation, an assumption of capacity, being consistent and reliable, teamwork and communication and realistic expectations apply equally to the consideration of people with BPD as parents. It is particularly important to ensure effective teamwork and communication across adult mental health and children's services.	
363	SH	NHS Direct	1	Full	8.7.5.3 (1.1.2.3)	11	Insert: Care planning for people with a mild or moderate	Thank you. The recommendation is correct as it stands.
364	SH	NHS Direct	2	Full	8.7.5.1 (1.2.2.1)	15	Could include a bullet point about sign posting onto other services	Thank you. Guidance on referral is dealt with in the subsequent recommendation (now 1.2.3.1).
365	SH	NHS Direct	3	Full	8.5.9.1 (1.3.2.2)	16	As part of the full assessment – impact factors need to be assessed.	Thank you. We are unsure what you are referring to. The GDG understood the phrase 'impact factors' with regard to journal citation rankings, but not with

[7] See the CPA briefing, *Supporting Parents with Mental Health Problems*, published to *support Refocusing the Care Programme Approach*. http://www.nimhe.csip.org.uk/our-work/reviewing-the-care-programme-approach-cpa-.html

								regard to people with BPD.
366	SH	NHS Direct	4	Full	7.6.1.1 (1.3.8.5)	24	Suggest a bullet point – Agree with the service user a follow up contact within 5 working days to assess current situation, make suggestions/amendments to the plan.	Thank you. We have amended the recommendation.
367	SH	NHS Direct	5	Full	8.5.16.2 (1.4.1.2)	25	Replace detention under the Mental Health Act with the use of compulsion under the Mental Health Act 1983 as amended by the Mental Health Act 2007.	Thank you. 'Mental Health Act' without a date refers to all relevant legislation and helps to avoid the guideline becoming out-of-date.
368	SH	NHS Direct	6	Full	8.5.16.3 (1.4.1.3)	25	Suggest a bullet point – Age appropriateness of the service.	Thank you. We address CAMHS services under 1.4.1.5.
369	SH	NHS Direct	7	Full	General		Would like to see reference made re the importance of assessing and developing Social Systems of Support.	Thank you. You have not referenced a specific recommendation or section. We think your suggestions may be covered by the third bullet of 1.3.2.2 [draft NICE numbering] which mentions the need to assess social care and support.
372	SH	NHS Quality Improvement Scotland	1	Full	2.5.3	29	Inaccurate statement re training of psychologists. The facts are as follows: All clinical and counselling psychologists are required by the BPS to train in two evidence based psychological therapies.	Thank you for pointing out this inaccuracy which has been corrected. The BPS criteria however do not qualify these psychologists to register as practitioners of these therapies without further post-qualification training.
373	SH	NHS Quality Improvement Scotland	2	Full	8.5.16.2 (1.4.1.2)	25	Suggests that a person should only be admitted if detained under the MHA – does this mean detained for another mental health reason? Needs clarity	Thank you. We have amended the recommendation.
374	SH	NHS Quality Improvement Scotland	3	Full	8.7.5.4 (1.1.2.4)	11	People with severe learning disabilities… this term could lead to confusion. Is it severe in respect of IQ or level of challenging behaviour. Might be helpful if this was clarified.	Thank you. Severe LD refers to ICD10 classification criteria
375	SH	NHS Quality	4	NICE	Person-centred	5	Good communication between…It should be supported by evidence based written information tailored to the service user's	Thank you – we have amended to improve clarity.

		Improvement Scotland			care Para 4		needs This needs clarity. Are you referrin to evidence based practice, or to relevant research, which is then applied to practice, based on an individual's needs?	
376	SH	NHS Quality Improvement Scotland	5	NICE	General	6	Key priorities for implementation – not sure if these are priorities or principles.	Thank you. These are intended to be priorities.
377	SH	NHS Quality Improvement Scotland	6	NICE	General	7	Should Diagnosis be added here?	Thank you – we are not sure to what you are referring, but diagnosis was outside the scope of the guideline.
378	SH	NHS Quality Improvement Scotland	7	Full	8.5.11.1 (1.3.4.1) Care Planning in Communit mental health teams	7	Should patient consent to treatment be added here?	Thank you. This point is covered in the stem of the recommendation '…in collaboration with the service user…'.
379	SH	NHS Quality Improvement Scotland	8	Full	6.11.1.1 (1.3.6.2) Drug Treatment	8	Given the ICP standards, this might be better to acknowledge the other way round – ie where it is prescribed, how the medication and the associated risks should be managed	Thank you for your comment. We are not sure how it relates to the recommendation (and therefore what you are suggesting). However, we found no evidence for the use of medication for the specific symptoms of BPD.
380	SH	NHS Quality Improvement Scotland	9	Full	8.5.18 (1.5.1.1) Specialist personality disorder service	8	As per Glasgow Specialist Service, consultation and support should also be offered to voluntary sector providers. Contribute to the implementation and monitoring of the Borderline Personality Disorder ICP	Thank you. We have amended the recommendation to reflect your concerns.

					within trusts			
381	SH	NHS Quality Improvement Scotland	10	NICE	1.1.1 Access to services	10	Should include guidance on comorbidity and Borderline Personality Disorder as either primary or secondary diagnosis and access to treatment specific to Borderline personality disorder should be added here	Thank you. The issue of comorbidity is dealt with in section 1.3.7.
382	SH	NHS Quality Improvement Scotland	11	Full	8.5.2.1 (1.1.3)	10	It might be useful to recognise difficulties with engagement here, role of assertive outreach and / or feature of the potential for multi-engagements before really engaging	Thank you. These are good practice points developed through consensus by the GDG. We are not aware of any evidence for AOTs in the treatment of BPD (see chapter 8). However, the NICE self-harm guideline does suggest an assertive approach to people who have self-harmed.
383	SH	NHS Quality Improvement Scotland	12	Full	8.5.18.1 (1.3.1)	15	Changes to professional curriculums to recognise the changed status of personality disorders and to improve levels of diagnosis	Thank you, but this is outside the scope of the guideline. However, we believe that published NICE guidelines are used as the basis of CPD by relevant bodies.
384	SH	NHS Quality Improvement Scotland	13	Full	7.5.1.1 (1.3.8.2)	22	Should be some reference to re-evaluation of risk associated with prescribing during crisis	Thank you – we have added a bullet as you suggest.
385	SH	NHS Quality Improvement Scotland	14	NICE	4	29	Useful to see the potential areas for future research and happy that dialectal therapy options being considered as well as drug related research	Thank you.
392	SH	Northumberland Tyne & Wear NHS Trust 1	1	Full	2.1	16 line no.24/25	I have not seen significant evidence or research that says that some people with pd come from stable and caring families –they may have been at least one parent that was caring but the environment was in some way hostile/neglectful or abusive or the patient as a child may have experienced abandonment or neglect due to difficult circumstances such as for example the mother having post natal depression or the parents struggled to cope with the childs ongoing illness which made it difficult for them to attach to the child. Also the stats quoted for abuse have been high ie 80% (Gunderson) and it would be more reflective of the clinical picture	Thank you. It was the view of the GDG that there was no single cause for the development of BPD, although it was widely accepted that very significant numbers had experienced different types of abuse and significant neglect. It was also accepted that this was not absolutely universal.

							and effective for work with patients to state a figure. Much abuse as you know is not reported until a safe relationship has been established with a worker and as many of the patients are women and many psychiatrists are men abuse may be underreported if anything. Many service users have asked for a female psychiatrist and struggled to gain access to one. The reason for this is that empathy for patients is one of the keys to making a relationship and workers find this easier if they understand that patients behaviour is a way to cope with distressing past events. I know we cant say that all pd patients report abuse or neglect but lets not ignore the reality that most clinicians have patients with similar difficult abuse histories rather than patients who have had stable and caring families. This awareness that the issue of abuse in the childhood of mental health patients has been neglected and now needs to be addressed by staff is highlighted in the DOH document 'Refocusing the Care Programme Approach' This documents quoted a figure of around 50% of mental health patients with histories of abuse.	
393	SH	Northumberland Tyne & Wear NHS Trust 1	2	Full	2.3.1	P21	Zanarani has reported that 80% of people diagnosed with BPD are females and 80% of those diagnosed with ASPD are males –does an analysis of all the research represent this or that there is no statistical difference –again I would say the most clinical experience in mental health does show females to be more likely diagnosed with BPD. On line 34 you quote Zanarani in relation to 50% of patients having PD and of those the majority have BPD – how many of these are women? I would say from clinical experience the majority. This is an important issue that should be clearly presented with all data possible. Zanarini I believe has done significant work in this area of gender difference in diagnosis which should be reflected in the guidelines	Thank you. In community samples the prevalence of BPD is roughly equal male to female, whereas in services there is a clear preponderance of females who are more likely to seek treatment. It follows from the above and from your clinical experience that the majority of patients diagnosed with PD, the majority of whom will have BPD, will be women.
394	SH	Northumberland Tyne & Wear NHS Trust 1	3	Full	General	P21	Blank line on form!	
395	SH	Northumberland Tyne & Wear NHS Trust	4	Full	2.5.5	P33	Transactional Analysis is a system for understanding personality development from birth onwards and a way to understand and then change how a person then relates to themselves and to others. It is used in collaboration with the patient to help understand their	Thank you. As is the case with an evidence-based guideline, the psychological therapies described do not comprise a comprehensive

		1					relationship with the therapist and their relationship with themselves and others in their life. It is not only used in TCs but is widespread. TA does not have to be used solely as a therapy but we in our services use it to help CPN, Social workers, Psychiatrists, GP and voluntary sector staff to understand their patterns of relating to BPD patients and how they can get stuck in non effective ways of relating to the patient. Practical advice is then given to move into a healthier way of relating which has a positive impact and creates change not only within the patient but also and very importantly within the practitioner whether a Psychotherapist or a generic worker. This is an important aspect of TA as most other therapies you are talking about rely on their being a formal therapist patient relationship within a limited time period whereas TA can and does help with the ongoing therapeutic relationship management of generic mental health and social care staff. I supervise secondary and primary care staff in their work with pd patients where they are the people who have daily contact with the patients and much of the reparative relationship work is done. Also service users can use it as a way of understanding themselves and managing their responses to situations so that a shared understanding and language can be used with patient and practitioner. Sometimes the best therapy is that that is taken out of the consulting room and applied in ward and comm. Mental health settings. TA is a thorough and well used therapeutic system which is not limited to therapist-patients settings. Why focus on the new less used and tested therapies rather than those that have been used for years with patients. They may have not been tested in trials but they can be given a chance –if dismissed now you can end up with new untried therapies that are scantily tested or older well used therapies that could be tested. I also work across service boundaries using TA to help create consistency across services and staff group.	list of every therapeutic approach (of which there are many) but only those therapies where there is at least one published account of application to people with Borderline Personality Disorder. No such references to Transactional Analysis were retrieved by our search strategies.
396	SH	Northumberland Tyne & Wear NHS Trust 1	5	Full	General		BPD is not new to the Adult Psychotherapist across the country who have been recognising and treating BPD patients for years. There has been too few Psychotherapists accessible to patients and they have in the past not worked as part of a whole system with other mental health or social care workers. Adult Psychotherapists are the most experienced and relevantly trained professionals in working with the relational problems of BPD	Thank you for your comment. As you know the guideline starts with an examination of the evidence for effectiveness (and harm) of different treatments, including psychological treatments. When treatment is found to be effective

							patients. .They are often the ones providing supervision to staff due to this expertise and they should be categorised as a distinct profession whether they be psychoanalytic or Integrative/Humanistic. Adult Psychotherapy is often marginalised within a health service that only recognises psychiatrists, nurses and OT and then categorises Psychotherapists as others –this is not helpful to patients as no other profession are trained to have expertise in the therapeutic relationship with PD patients to the extent that adult psychotherapist are. I know this as I supervise and support these other professions who say they wish they did have more input in the training about managing therapeutic relationships particular with PD patients. PD is an adult psychotherapist bread and butter not an add on or skills training. Lets use adult psychotherapists not just for therapy but where they can be most useful and cost effective is in proving consultancy, supervision and training to staff.	for a particular condition, or in this case shows some promise, then we may be able to make recommendations about training, supervision etc. In this guideline we do recommend a structured approach within which therapy may be undertaken and in which supervision is recommended. However, we are unable to specify either the specific treatment type or the therapist best placed/trained to undertake this (with the exception of DBT for women with BPD where the reduction of self-harm is a clinical priority).
397	SH	Northumberland Tyne & Wear NHS Trust 1	6	Full	2.6.4		The issue of capacity and pd may has moved on since 2001 and should be looked at in relation to the experience of the DOH IMCA pilots and the new capacity guidelines. It is not good enough to quote out of date opinion as capacity is becoming an important issue within our wards and staff need clear up to date guidance on this.	Thank you. We have made some amendments to the paragraph.
398	SH	Northumberland Tyne & Wear NHS Trust 1	7	Full	3.4		RCTs are not always the best way to test the effectiveness of an intervention –what about qualitative research. If you only use RCT you limit the research to only those treatments that can be measured by that method therefore excluding other treatments that can be effective. RCT trials are from a tradition of measuring drugs not human relationships –we need to find an alternative to RCT and use it –what about grounded theory research –I have used this to measure and categorise the themes that emerge with BPD patients on a small scale during the course of a therapy session. I know you have looked at qualitative in regard to patient experience but here are alternatives to measuring outcome –if we don't find then we limit ourselves to researching and measuring only that which falls within our experience of what is measurable. The other thing that happens and is happening is that people begin to develop therapies and treatments around what is easily measurable rather than what may be most effective for client outcome.	Thank you. Whilst it is true that qualitative research provides valuable insight into hard-to-measure outcomes, such as patient experience, RCTs provide the best evidence source we have for making decision about the relative benefits of different treatments. They also allow data from large numbers of patients to be evaluated, whereas approaches such as grounded theory are only practical with a small number of patients. Also, reliable and robust methods for synthesising evidence from qualitative studies are still being developed. For clinical

								questions about the relative efficacy of treatments, the RCT is the best study design available and is recommended in the NICE handbook for developers (see http://www.nice.org.uk/media/052/6A/GuidelinesManual2008Consultation.pdf). For other clinical questions, such as patient experience, qualitative designs are more appropriate and we have used them where available. The question of which research design and which outcomes are reported by researchers is for the research community. We can only use what has been reported.
399	SH	Northumberland Tyne & Wear NHS Trust 1	8	Full	8.5	P 283 point 30	As someone who manages dynamics between staff teams and services working with pd patients I know that it is good advice given in the guideline in regard to teamwork and communication but that due to unconscious processes i.e. splitting staff do pull different ways and give patients different messages and starkly different levels of care. The problem is that these processes are unconscious and staff /organisations are not aware of what is happening. Team leaders and mangers are also not aware. It is important therefore that there are roles in services for organisational consultancy and supervision to help staff to become aware of these dynamics and work through them. This will be ongoing work and not a once or twice a year away day. Arbitration, facilitation of complex case meeting and analysis of Serious Untoward Incidents and risk management are also important roles of the organisational and staff dynamics consultation	Thank you. We have included an additional recommendation about support for staff (at the end of the section on general principles in the NICE guideline). However, we had no evidence on which to base recommendations about the specific nature of supervision and support.
400	SH	Northumberland Tyne & Wear NHS Trust 1	9	Full	8.5:3		My experience of supporting primary care staff is that they do not have information about whether a patient has been diagnosed with Pd and they ask me for advice on how to recognise PD as they find that half way through their time with a patient they realise something is not working and they feel stuck, confused and weary and they don't know why. They are then frustrated that they did not know about the diagnosis as they only have a limited time with the	Thank you for your comment. We have included 3 recommendations on recognition and management in primary care (see 1.2 in the NICE guideline – draft numbering). We also recommend that specialist PD services within Trusts should

							patient but cant do any satisfactory work in the time limit they have are often in the middle of a difficult process. GPs need training and support to recognise PD and be aware of how to manage a Pd patient as many Gps end up coping rather than actively manages these patients.	develop systems of communication with other services and provide advice and consultation to both primary and secondary care. We underand the difficult position GPs face, and think that these recommendations will help address their needs.
401	SH	Northumberland Tyne & Wear NHS Trust 1	10	Full	8.5.4	P286	Service users in our service user group have said that they feel that when they are listened to and understand when phoning crisis team they often feel better and get through the crisis period because they have felt held and not alone –often when workers do not give this empathy response and start by advising them on how to distract themselves from how they feel then patients feel not listened to an unimportant. That all anyone cares about is whether they hurt themselves or others not how they feel. It is important for crisis staff to understand and respond empathically before giving practical advice.	Thank you for your comment. We make this point in recommendation 7.4.1.1 (draft guideline numbering).
402	SH	Northumberland Tyne & Wear NHS Trust 1	11	Full	8.5.8	P288 point 22	If comm. Mental health teams are to routinely assess and treat Pd patients then they need to routinely be given enough supervision, support and time out and resources for ongoing training. Also their capacity in regards to how many patients they are expected to see should take into account how many complex pd patients they have otherwise they will try to avoid or discharge or resent these patients as they take up so much of their time. The debate on quality of work vs quantity of work needs to be addressed in CMHT.	Thank you. This is a matter for local implementation.
403	SH	Northumberland Tyne & Wear NHS Trust 1	12	Full	8.5.16.4 (refers to subheaded section on support'		Good point about reflective practice support/ supervision –needs to be a requirement not optional for trusts not to provide this and staff need time out to do it therefore there case load reduced to enable them to participate.	Thank you. This is a matter for local implementation of the guideline.
404	SH	Northumberland Tyne & Wear NHS Trust	13	Full	8.5.17	P3001 point 1	Excellent recommendation about specialist services providing support to CMHT and ward staff. Again these specialist services then need time to do this ans have it measured as part of their work –often only client contact hours are measured	Thank you. This is a matter for local implementation of the guideline.

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405	SH	Northumberland Tyne & Wear NHS Trust 2	1	Full	General		The suggestion that Mental Health Trusts should consider establishing central specialist PD teams is helpful and appears supported by available evidence and experience.	Thank you.
406	SH	Northumberland Tyne & Wear NHS Trust 2	2	Full	General		There is a disappointing absence of comment on means to achieve multiagency and multisectoral collaboration and coordination of both staff training and service planning. No doubt there is little firm evidence in these areas but summaries of expert opinion would be helpful	Thank you. We have amended 1.5.1.1 [NICE guideline draft numbering] to address your concerns.
407	SH	Northumberland Tyne & Wear NHS Trust 2	3	Full	General		We were surprised to see no mention of the forthcoming national knowledge and understanding framework (KUF) which should guide and support training for staff in all agencies who work with people with PD. The draft guideline recommends the development of training, and reference to the KUF would be an opportunity to prevent disconnected developments.	Thank you. There is a wealth of policy initiatives that will overlap with, address directly or indirectly, the work of mental health workers and other professionals who provide services for people with PD. We can only deal with those that are directly relevant to people with BPD and those that are currently published and in only so far as these enhance the understanding, integration or implementation of this particular guideline.
408	SH	Northumberland Tyne & Wear NHS Trust 2	4	Full	4.6.2.1 (1.1.4.1) Section on developing an optimistic and trusting relationship people with		This section does not sufficiently take into account the shifting self-states of working with people with BPD. There is the implication that the professional is working with someone who is stable and can be a constant and collaborative partner and this gives the wrong impression.	Thank you. Although we recognise that people with BPD often have “shifting self-states”, it is a key tenet of this guideline that services should remain positively engaged providing the sort of stability that quite often people with BPD have never had with caregivers previously. Services should therefore be stable and we believe they should also be optimistic.

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409	SH	Northumberland Tyne & Wear NHS Trust 2	5	Full	General		If professions are being mentioned by name the Guidance should include that of Adult Psychotherapists, as they are a professional group employed to work within PD services. It is not helpful to have psychotherapists grouped under 'other mental health professionals' as their training and expertise is particularly appropriate to working with people with BPD.	Thank you. The various lists of professional groups mentioned in the guideline are intended to provide examples since the precise groups working with people with BPD can vary between services.
410	SH	Northumberland Tyne & Wear NHS Trust 2	6	Full	5.14.1.1 (4.2) NICE Research		The guidelines are necessarily rather vague about treatment recommendations but seem to be overly influenced by not very robust research into DBT and mentalisation. These types of treatment can be standardised and therefore fit into current ways of determining an evidence base but they can also delimit practice in an unhelpful way if only these types of treatment are to be recommended.	Thank you. We have amended this recommendation.
411	SH	Northumberland Tyne & Wear NHS Trust 3	1	Full	8.5.18.1 (1.3.1)		There is as far as I can see no detail about level of training required to offer psychological therapy. I would be concerned that workers with little training may attempt schema therapy or DBT. Supervision is mentioned but level of psychological training and expertise should be also discussed.	Thank you. We do not have evidence to support recommendations about of level of training, paricularly in view of the fact that we do not recommend specific therapies other than a limited recommendation for DBT.
412	SH	Northumberland Tyne & Wear NHS Trust 3	2	Full	5	113 113 111	Schmit and Davidson 2002 (reference not found) Clarkin et al. 2000 (ref not found) Davidson (2002) (ref not found) These are ones that I looked for there may be others.	Thank you – we have searched extensively on relevant electronic databases for the references you mention but cannot find any which match. Without further details, it is not possible to check further. However, we are confident we have found all relevant studies.
414	SH	Nottinghamshire Healthcare NHS Trust	1	Full	General		The guideline represents an important opportunity for shaping the future of patient care in the field of Borderline Personality Disorder (BPD). It is estimated that 7.5% of psychiatric admissions may be as a result of BPD with a raised incidence of psychiatric morbidity and mortality. Currently, most patients with BPD in our clinical experience receive pharmacological treatment, despite uncertainty over the clinical role of such therapies, and research has supported this observation (Zanarini et al, 2004). Therefore we feel that this warrants further consideration in the proposed Guidance.	Thank you. We have made specific recommendations about the role of pharmacological treatments.

415	SH	Nottinghamshire Healthcare NHS Trust	2	Full	6.12.1.1 (4.4) (research rec)	32	'An evidence base for the effectiveness of pharmacological treatments for people with personality disorder does not exist'. We now feel that this statement is out of date as there has recently been extensive research, including large studies into the use of olanzapine and also valproate in the treatment of Borderline Personality Disorder.	Thank you for your comment. The studies of olanzapine and valproate did not show any convincing effect in the treatment of BPD. We have amended the sentence to make it more accurate.
416	SH	Nottinghamshire Healthcare NHS Trust	3	Full	6 (general)		In 2006, two Cochrane Reviews were published, covering pharmacological (10 RCTs; 554 patients in total) and psychological interventions (7 RCTs; 262 patients). The pharmacological part of this review has recently been updated and publication is expected in September 2008. Submission has been invited to one of the major psychiatric journals and this is now imminent. The current draft can be obtained from the authors: Jutta M Stoffers, Birgit A Völlm, Gerta Rücker, Antje Timmer, Gitta A Jacob & Klaus Lieb 2008. The Cochrane Review update covers 27 available RCTs published between 1979 and 2008 with over 1600 patients and hence a much larger evidence base than the previous reviews. Some of the latest studies were also much larger than those included in the original reviews (over 300 patients).The authors conclude that second generation antipsychotics and mood stabilisers may be beneficial for the treatment of BPD, but that there is no evidence that first generation antipsychotics or antidepressants are effective. Outcome measures included overall BPD severity, severity of specific BPD symptoms and secondary associated symptoms which are not core symptoms of BPD.	Thank you. We have analysed the same evidence base and concluded that there the evidence was not sufficiently robust to warrant specific recommendations about 2nd generation antipsychotics or mood stabilisers. (See our summary of clinical evidence in section 6.10 p256 [draft guideline paragraph numbering].) Note that we did not draw conclusions from the studies by Nickel et al – see the chapter for reasons – which may account for the differences between the new Cochrane review and ours. We did not find the new studies with over 300 patients demonstrated the efficacy of the study drugs (olanzapine). It is usual that updates to Cochrane reviews are undertaken by the original authors and none of the authors mentioned by the stakeholder were involved in the original review. However, with regard to the evidence, it should be noted that we did not draw conclusions from studies by Nickel and associates since there was some doubt about their funding. We raised this with the authors and publishing journal but did not receive satisfactory responses. We

								have brought the matter to the attention of the relevant authorities who are investigating. The studies found very large favourable effects, far larger than other studies reviewed for the guideline. The effect sizes are also large compared with many studies in other mental health disorders reviewed for other guidelines. The authors have published studies finding similarly large effect sizes in a very large number of disease areas, not related to mental health, which is extremely unusual. Our discounting these studies may account for the discrepancy between our findings and those of the updated Cochrane review.
417	SH	Nottinghamshire Healthcare NHS Trust	4	Full	6.3.4 general		In terms of overall BPD severity, significant effects were found for olanzapine [in the updated Cochrane review]. In addition to this some drug interventions proved effective for specific symptoms, i.e. haloperidol for anger, aripiprazole in the reduction of interpersonal problems, impulsivity, anger, paranoia, depressive and anxiety related symptoms. Semi-sodium valproate (Divalproex®) for interpersonal problems and depression, lamotrigine for impulsivity and anger and topiramate for interpersonal problems, impulsivity, anger and anxiety. No differences were found in terms of tolerability between the drug and placebo. Given the advances in research over the past few years, we feel a statement suggesting that there is no evidence of any effectiveness of pharmacological treatment in BPD is no longer appropriate.	Thank you for your comment. We have analysed the same evidence base and concluded that there the evidence was not sufficiently robust to warrant specific recommendations about 2nd generation antipsychotics or mood stabilisers. (See our summary of clinical evidence in section 6.10 p256 [draft guideline paragraph numbering].) Note that we did not draw conclusions from the studies by Nickel et al – see the chapter for reasons – which may account for the differences between the new Cochrane review and ours. We did not find the new studies with over 300 patients demonstrated the efficacy of the study drugs (olanzapine).

418	SH	Nottingham shire Healthcare NHS Trust	5	Full	6.12.1.1 general		The Draft Guideline highlights the need for further research within this subject area. However, further Evidence Based Research on a large enough scale may not be conducted because the Guideline states that medication should not be used for long term treatment, and the pharmaceutical industry may be reluctant to invest in such research in view of this. The Guideline suggests that promising results had been obtained from some small scale studies, particularly regarding mood stabilisers, but that further larger scale studies will need to be undertaken to support this. There are in fact a number of large scale studies already available in this area. We do agree that more research is needed and that this may particularly be relevant for the use of clozapine.	Thank you for your comment. The research recommendations are made based on the evidence reviewed for the guideline and the consensus of the GDG. We found no large scale high quality studies in people with BPD.
419	SH	Nottingham shire Healthcare NHS Trust	6	Full	6.12 Pharm reseach recs [originally : general]		There are a number of small scale studies and case reports regarding the use of clozapine in the treatment of BPD, particularly with respect to suicide and self harm. A well known example of this would be Chengappa et al's work on clozapine reducing self mutilation and aggression in psychotic patients with BPD. This research concludes that 'clozapine deserves careful consideration for a controlled study in patients with borderline personality disorder and psychoses, especially if the clinical issues include severe self-mutilation, aggression, and violence. Until such studies are done, the risk-to-benefit ratio of clozapine treatment needs to be carefully evaluated on an individualized basis in such subjects'.	Thank you for your comment. The Chengappa 1999 (J Clin Psychiatry 60 (7); 477-484) study is a non-comparative study of 7 patients which we would not consider as providing high quality evidence of effectiveness. Given the side effect burden associated with antipsychotics their use could only be recommended where the treatment of a comorbid psychotic disorder was a priority.
420	SH	Nottingham shire Healthcare NHS Trust	7	Full	6.12 Pharm reseach recs [originally : general]		At Rampton Hospital, clozapine has been used very successfully in patients with BPD on a number of occasions. Once again, we feel that larger scale research needs to be undertaken of adequate duration before ruling out this important antipsychotic treatment, which can often reduce severe distress sufficiently for psychological treatments to be commenced.	Thank you for your comment. NICE rubric allows up to 5 research recommendations per guideline which the GDG prioritised based an expert consensus view of which piece of research, if completed and published before the guideline is due to be updated (usually in 4 years time), would be most likely to improve the guideline. The GDG did not consider one about antipsychotics to be a priority. Given the side effect burden associated with antipsychotics their use could only

								be recommended where the treatment of a comorbid psychotic disorder was a priority. The guideline is intended for the majority of patients presenting to the NHS, and there may be a very small number of patients who are admitted to forensic services with behavior that challenges who benefit from clozapine treatment.
421	SH	Nottinghamshire Healthcare NHS Trust	8	Full	6.11 [originally: general]		Clinicians at Rampton hospital feel that there are certain "brittle symptoms" for example poor impulse control including self harm, significant mood swings, paranoia and anger or hostility. These respond particularly well to treatment with antipsychotics and certain mood stabilisers and result in reduced inpatient stays. If we follow the draft NICE Guidelines, the use of these treatment options in our more challenging patient population would be unsupported. It is surely in everybody's interests that symptoms are alleviated by the most appropriate means and that length of hospitalisation is reduced to a minimum.	Thank you for your comment.
422	SH	Nottinghamshire Healthcare NHS Trust	9	Full	General		In our opinion, the draft Guideline does not distinguish between mild, moderate and severe degrees of BPD or give consideration to the patient setting, which can often have a large impact on treatment options available. It appears that in community settings, many patients are prescribed medication by their GP, partly as other treatments either are not available or have an extensive waiting list. This is another reason why we feel it would be appropriate to give guidance on the best pharmacological treatments available.	Thank you. There is very little evidence for the effectiveness of pharmacological treatments for people with BPD. We have made as many recommendations for the use of drugs as far as we can. There is no agreed definition of severity in BPD.
423	SH	Nottinghamshire Healthcare NHS Trust	10	Full	5.13.1.1 general		The guidance is particularly rigid in terms of generalising treatment options for all patients, i.e. "therapy in at least two modalities" for more than three months duration. This suggestion not only disregards aspects of service provision, but also fails to treat patients as individuals with variable needs.	Thank you. This recommendation has been amended.
424	SH	Nottinghamshire Healthcare NHS Trust	11	Full	General		According to data within the latest review, the prevalence of BPD within the general population is around 1.5%, but rises up to approximately 20% within psychiatric inpatient settings, and may even be as high as 75% amongst female inpatients. Most frequently, co-morbidities exist and BPD is rarely found as a single	Thank you.

							diagnosis.	
425	SH	Nottingham shire Healthcare NHS Trust	12	Full	General		Patients, by the very nature of their symptoms, often have a preference about their treatment options and may request medication to alleviate their distress, particularly if transient psychotic symptoms are suffered or extreme impulses to self harm.	Thank you. Drug treatments are recommended only for comorbid conditions or for short-term use in a crisis.
426	SH	Nottingham shire Healthcare NHS Trust	13	Full	8.5.15.1 general		The current Draft Guidance acknowledges that there is often a need for drug treatment during crises, but this appears to be somewhat contradictory if medication is not felt to have a place during long term strategies and it is proposed that medication is withdrawn within a week or so.	Thank you. The guideline recommends only the short-term use of drugs during crises.
427	SH	Nottingham shire Healthcare NHS Trust	14	Full	6 general		As quoted in the Maudsley Guidelines 'several "symptoms" of BPD may intuitively be expected to respond to drug treatment. These include affective stability, transient stress related psychotic symptoms, suicidal and self harming behaviours and impulsivity'. Perhaps it would be more beneficial to look at evidence for use of medication for specific symptoms in BPD, rather than treating the illness as an entirety since different patients invariably experience different combinations of symptomology.	Thank you. We looked at the data from the point of view of both the individual therapies used and individual symptoms for both the pharmacological treatments an psychological therapies. (See the evidence chapters in the full guideline.)
428	SH	Nottingham shire Healthcare NHS Trust	15	Full	General		Tyrer and Bateman discussed comparisons between psychological and pharmacological treatments and found them to be relatively comparable. Looking at the previous Cochrane reviews on BPD for both psychological and pharmacological treatments, a similar number of studies were reviewed in each, but patient numbers were much lower in the psychological studies and the quality of evidence was not superior for psychological interventions. Therefore we feel that it cannot be concluded that psychological treatments are supported by stronger evidence when looking at the Gold Standard Reviews.	Thank you for your comment. The GDG concluded that overall the evidence for any therapy (psychological or pharmacological) is relatively weak. However, there is a reasonable amount of evidence for the efficacy of DBT and some for MBT which led to specific recommendations. In considering the evidence, the GDG also took into account the not inconsiderable side-effect burden of many psychotropic drugs.
429	SH	Nottingham shire Healthcare NHS Trust	16	Full	General		Psychological treatments, whilst very important in treating BPD, are not always readily accessible in the community and long waiting lists for psychological interventions exist. Often patients with BPD are in states of extreme distress and are not in a position to engage with or retain psychological input, at least until their immediate distress has been reduced, frequently by using medication.	Thank you. Drug treatments are recommended only for comorbid conditions or for short-term use in a crisis.

430	SH	Nottinghamshire Healthcare NHS Trust	17	Full	5.13.1.2 general		Often one psychological treatment type cannot always be used to treat all and DBT may not always be an appropriate psychological approach in a BPD patient with other complicated personality issues.	Thank you. DBT is specifically recommended where the reduction of self-harm is a priority. The recommendation suggests that DBT is 'considered' rather than given to all.
431	SH	Nottinghamshire Healthcare NHS Trust	18	Full	General		There is an increasing weight of evidence that some second generation antipsychotics and mood stabilisers may be beneficial for the treatment of BPD. As clinicians and pharmacists working within the Personality Disorder Directorate at Rampton Hospital, we feel that certain aspects of the Draft Guideline should be revisited, and the points detailed above taken into consideration. We would urge the authors of the Guideline to contact the authors of the updated Cochrane review, the publication of which is expected for September 2008, for more details on this latest evidence.	Thank you. We have analysed the same evidence base and concluded that there the evidence was not sufficiently robust to warrant specific recommendations about 2nd generation antipsychotics or mood stabilisers. (See our summary of clinical evidence in section 6.10 p256 [draft guideline paragraph numbering].) Note that we did not draw conclusions from the studies by Nickel et al – see the chapter for reasons – which may account for the differences between the new Cochrane review and ours. We did not find the new studies with over 300 patients demonstrated the efficacy of the study drugs (olanzapine).
433	SH	Oxfordshire & Buckinghamshire Mental Health Partnership NHS Trust	1	Full	6.11.1.1 (1.3.6.2)		The guidance not to use drug treatment specifically for borderline personality disorder, appears particularly targeted at antipsychotic medication. This seems excessively prescriptive given the limited evidence and the fact that many patients are specifically requesting medication to help them and may not be particularly amenable to other interventions.	Thank you for your comment. Given that the side effects of antipsychotics are clinically significant, and the fact that there was no evidence of clear clinical effectiveness, the GDG did not consider that antipsychotics should be used in the absence of co-morbid psychotic illness.
434	SH	Oxfordshire & Buckinghamshire Mental	1	Full	4.2	6	The guideline does not make reference to the transition from adulthood to older adult in terms of service provision.	Thank you. The guideline is intended to apply to adults of all ages and therefore specific mention of older adults has not been made. All services for people with

		Health Partnership NHS Trust 2						borderline personality disorder whether general or specific should include people from any age group, and not descriminate on the basis of age.
435	SH	Oxfordshire & Buckingha mshire Mental Health Partnership NHS Trust	2	Full	7.5.1.4 (1.3.6.3)		The guidance suggests short term use (up to one week) of 'sedative medication' may be considered in a crisis. It may be that this includes antipsychotics, but might be suggesting benzodiazepines are used in preference though no evidence is given for their use. We would again suggest that the guideline is excessively prescriptive in this area.	Thank you. We have amended the recommendation to give sedative antihistamines as an example.
436	SH	Oxfordshire & Buckingha mshire Mental Health Partnership NHS Trust 2	2	Full NIC E	8.7.5 (1.1.2)		The guideline suggests an individual with moderate LD & BPD to be treated in a mainstream setting. Not aware of sufficient evidence supporting this, and is doubtful if someone with a moderate LD (IQ 35-50) would be likely to do well in a mainstream PD service; in the case of any other disorder someone with this range of IQ would be treated in LD services.	Thank you. We have amended the recommendation so that people with mild LD only should have access to mainstream services while in all cases including moderate and severe LD there should be involvement of specialist services.
437	SH	Oxfordshire & Buckingha mshire Mental Health Partnership NHS Trust	3	Full NIC E	8.5.16.2 (1.4.1.2)		The suggestions for consideration of inpatient admission, including detention under the Mental Health Act, do not contain an adequate warning about the possible adverse effects of admission, including a worsening of disturbed behaviour with a diminution in the level of personal responsibility being taken by the patient. Also there is no mention of the increased risk of suicide following admission (Geddes et al, 1997). Geddes, J.R., Juszczak, E., O'Brien, F., and Kendrick, S. Suicide in the 12 months after discharge from psychiatric inpatient care, Scotland 1968-92. Journal of Epidemiology & Community Health 51:430-434, 1997.	Thank you. We have added a further bullet point.
438	SH	Oxfordshire & Buckingha	3	Full	1.1.5		Use of the word 'carers' is not appropriate for the client group as it fosters dependency in the person. The use of more empowering terms like 'family and friends' is suggested.	Thank you. We have amended the term.

		mshire Mental Health Partnership NHS Trust 2						
439	SH	Oxfordshire & Buckingha mshire Mental Health Partnership NHS Trust 2	4	Full NIC E	5.13.1.1 (1.3.5.4)		The reference to therapy in 'at least two modalities (e.g. individual or group)' is confusing. This is not the usual use of the term 'modality'.	Thank you. This recommendation has been amended.
440	SH	Oxfordshire & Buckingha mshire Mental Health Partnership NHS Trust 2	5	Full NIC E	5.13.1.3 (1.3.5.7)		The reference to brief psychotherapeutic interventions not being used (less than 3 months) either for the disorder or for the symptoms. There is no sufficient evidence for this and will essentially exclude people with BPD from brief problem solving or solution focussed approaches that might benefit, for example, their self harming.	Thank you for your comment. The evidence does not support the use of brief interventions in people with BPD (see chapter 5 of the full guideline).
441	SH	Oxfordshire & Buckingha mshire Mental Health Partnership NHS Trust 2	6	Full NIC E	6.11.1.1 (1.3.6.2)		The guidance not to use drug treatment specifically for borderline personality disorder, which appears particularly targeted at antipsychotic medication, seems excessively prescriptive given the limited evidence and the fact that many patients are specifically requesting medication to help them and may not be particularly amenable to other interventions	DUPLICATE COMMENT – see previous response.
442	SH	Oxfordshire & Buckingha mshire Mental Health	7	Full NIC E	7.5.1.4 (1.3.6.3)		Guidance suggests that short term use (up to one week) of 'sedative medication' may be considered in a crisis. It may be that this includes antipsychotic, but might be suggesting benzodiazepines of preference though no evidence is given for their use	Thank you. We have amended the recommendation to give sedative antihistamines as an example.

		Partnership NHS Trust 2						
443	SH	Oxfordshire & Buckinghamshire Mental Health Partnership NHS Trust 2	8	Full NICE	8.5.16.2 (1.4.1.2)		The suggestions for consideration of inpatient admission, including detention under the Mental Health Act, do not contain an adequate warning about the possible adverse effects of admission, including a worsening of disturbed behavior with a diminution in the level of personal responsibility being taken by the patient. There is also no mention of the increased risk of suicide in the week following admission.	DUPLICATE COMMENT
446	SH	Partnerships in Care	1	Full	5.2.2	110	Some inconsistency in description of stages in relation to DBT treatment. If including pre-treatment as a stage (presumably stage 1) then the description of stage 1 in the document reads as though the behavioural control is achieved during pre-treatment stage. This is not the case and if a 5 stage process is to be described then behavioural control is achieved at stage 2. Also, the implication here is that behavioural control is linked to impulsive behaviours that are purely self-destructive when in fact they may also include homicidal behaviours, which is particularly relevant in a forensic setting.	Thank you for pointing out this inconsistency which has been corrected. The description is based on primary sources in relation to self-harming women, prior to the application of the method to forensic settings.
447	SH	Partnerships in Care	2	Full	5.13.1.2	189	There is scope for this recommendation to include women for whom any life-threatening behaviours (to self or others) are a risk	Thank you. This recommendation is based on the evidence which shows that of the outcomes measured during the available trials, the only one to significantly change was self-harm.
448	SH	Partnerships in Care	3	Full	General		Section 5 appears to focus specifically on addressing risks related to self whereas in fact BPD patients can post risks to others through impulsive behaviour linked to chronic experiences of anger/aggressive urges	Thank you. We are not sure to what you are referring, but we have made various recommendations about risk assessment.
449	SH	Partnerships in Care	4	Full	6		No mention of Clozapine as a treatment option?	Thank you. There is no evidence for the use of clozapine in borderline personality disorder.
450	SH	Partnerships in Care	5	Full	7.4.1.1	262	These recommendations appear to have a lot of practical value.	Thank you.
451	SH	Partnership	6	Full	8.5.1	282-284	There needs to be more explanation of the term ‘split’ as this	Thank you – we have adjusted the

		s in Care					assumes a knowledge of this behavioural strategy employed by those with BPD (or alternatively a reference). Note that this does come later in the report (page 293 under 8.5.10, so this explanation could be included at this earlier point	text in the earlier section.
452	SH	Partnerships in Care	7	Full	8.5.2.2	284	There should be more emphasis on healthcare professionals receiving adequate and relevant training and/or supervision on a regular basis.	Thank you. There is a recommendation about training in paragraph 8.5.18.1 (draft guideline numbering).
453	SH	Partnerships in Care	8	Full	8.5.10.3	292	As above	We are unclear to what this refers.
454	SH	Partnerships in Care	9	NICE	Introduction	3	Feel that this should say more explicitly who the guidance is for at the beginning of the document. Scope of the guidance is provided on page 28, but feel this would make more sense at the front of the document	Thank you. We think this is already clear. The scope gives more detail.
455	SH	Partnerships in Care	10	Full	8.5.18.2 NICE Key priorities	9	Training focus appears to be on diagnosis and management of BPD. Feel there is not enough emphasis on the need to have training programmes/supervision for health professionals working with this group, focusing on the impact it has on them in working with this difficult group. This does seem to be covered in the full report but a reference to it in the NICE seems to be lacking	As a result of this and other comments we have made a new recommendation about training and supervision in section 1.1 of the NICE guideline.
465	SH	Royal College of Nursing	2	Full NICE	5.13.1.1 (1.3.5.4)	8	The document ought to state the importance of and need for supervision for all clinicians working with this client group regardless of whether or not they are deemed 'therapists'.	Thank you. This recommendation is specifically concerned with the provision of psychological therapy. The issues of supervision and support are also covered in recommendations 1.3.4.3 and 1.3.4.4. as well as in a new recommendation at the end of the section on general principles.
466	SH	Royal College of Nursing	3	Full NICE	8.5.18.2 (1.5.1.1)	8	It is naïve to expect specialist personality disorder services to successfully develop communication systems and protocols to be used among different parts of mental health services. Such teams will probably have little impact upon the behaviour of other teams and little mandate to ensure that compliance to such systems is adhered to by others. The document needs to acknowledge that the successful accomplishment of such initiatives within Trusts would require the support and sanctioning at executive levels within management structures.	Thank you. The recommendations made by the Implementation Directorate at NICE include 'sign-up from the top' – in other words, executive leadership in implementation. We do not believe this recommendation is naïve, but will require significant commitment.

467	SH	Royal College of Nursing	4	Full NICE	8.7.5.3 (1.1.2.3)	11	The document should consider more explicit guidance re consulting with a specialist in learning disabilities e.g. under what circumstances a referral might be appropriate. Additionally the guidelines should incorporate the need to regularly review (e.g. bi-annually) whether specialist referral is necessary and a requirement that the rationale for referral or not are clearly documented within the MDT care plan.	Thank you. It has been clarified that people with mild LD only should have access to mainstream services while in all cases including moderate and severe LD there should be involvement of specialist services.
468	SH	Royal College of Nursing	5	Full NICE	8.5.16.1 (1.4.1.1)	25	Suggest add to end of sentence: as they may have access to crisis houses or other more appropriate alternatives.	Thank you. We have taken this into account in 8.15.6.1 [draft full guideline paragraph numbering].
469	SH	Royal College of Nursing	6	NICE	General		This guidance needs to make reference to self harm and dual diagnosis i.e. co-existing drug and alcohol use.	Thank you. T his is outside the scope and is the subject of a separate NICE guideline which has recently been commissioned.
470	SH	Royal College of Nursing	7	Full	General		We welcome the fact that there was a mental health nursing representation within the guideline development group. We would have liked the group to have had more mental health nursing representation. This is of particular concern given the ratio of 1 to 1 time that mental health nurses spend with this client group in comparison to other MDT members.	Thank you. Individuals are selected for their expertise and to ensure that the GDG can properly address the scope of the guideline. In this regard, their professional backgrounds are of secondary importance.
471	SH	Royal College of Nursing	8	Full NICE	8.5 (1.3.2, 1.3.4, 1.3.10)		Because of the importance of work and vocational activities in promoting sustaining recovery, we would welcome an explicit reference to this in sections 1.3.2, 1.3.4, and 1.3.10.	Thank you. We have amended the recommendation about care plans to include specific reference to employment and occupation in long-term goals.
472	SH	Royal College of Nursing	9	Full NICE	8.5.16 (1.4)		Whilst we welcome the recommendations on supervision and detailed care planning, we would value additional comments on what support and supervision inpatient or acute care teams should access (section 1.4). Such teams have a great deal of control over people with personality disorder, have staff with a range of knowledge, skills and attitudes towards people with borderline personality disorder, and have frequent changes in staff.	Thank you for your comment. We have included a new recommendation about support at the end of the general principles which applies to all staff working with people with BPD.
473	SH	Royal College of Nursing	10	NICE	3		In section 3 and the audit of services, we look forward to standards on work and vocation, and a recommendation that audit teams assess staff and service user experience in order to assess whether the standards have been met.	Thank you. This section does not contain recommendations. The audit criteria are prepared from the key recommendations for implementation by NICE.

474	SH	Royal College of Paediatrics and Child Health	1	Full	9 General		It is stated in chapter 9 that BPD has onset in adolescence. It would be helpful to know what those later diagnosed were like in childhood- did they have any behavioural or aggression problems? Had any neuropsychiatric diagnosis been made? In view of the fact that community paediatricians see so many children with challenging behaviour of varying sorts, some alerting guidance might be given for that group of professionals who are responsible for school health.	Thank you for your comment. This is an important issue but is outside the scope of this guideline.
475	SH	Royal College of Paediatrics and Child Health	2	Full NICE	8.5.11.1 (1341)	7	It is important to acknowledge the potential impact on the children of adults with BPD and in community planning consider their well being, possible role as carer and possible child protection issues.	Thank you. Although this issue is outside the scope of the guideline, we have included this point in the recommendation about risk assessment 1.3.4.1.
476	SH	Royal College of Paediatrics and Child Health	3	Full NICE	9.10.1.3 (1172)	14	The RCPCH welcome the flexible and sensitive approach to age limits regarding the timing of transfer of care from CAMHS to adult services. This is to be applauded.	Thank you.
477	SH	Royal College of Paediatrics and Child Health	4	Full	8.5.5.1 (1221)	14/15	It is important to acknowledge the potential impact on the children of adults with BPD in crisis management and consider their well being, possible role as carer and possible child protection issues.	DUPLICATE COMMENT
478	SH	Royal College of Paediatrics and Child Health	5	Full NICE	8.5.10.1 (1331)	16	We note the reference to dependent children in this section on risk management.	Thank you.
479	SH	Royal College of Paediatrics and Child Health	6	Full	General		This is a sensitive and coherent document which reads very well. There are no obvious omissions and the research recommendations are relevant. The importance of early presentations and diagnosis in children is important and therefore the role of CAMHS services is key.	Thank you.
480	SH	Royal College of Paediatrics and Child Health	7	Full	9	All	This is a very helpful chapter, but needs some improvement in organisation and clarity. The sections on organisation of treatment services are particularly good.	Thank you for this comment; we have edited the draft chapter, but are somewhat constrained by the need to include large amounts of evidence in a relatively short chapter. We hope responding to a

								number of stakeholder comments helps to improve clarity.
481	SH	Royal College of Paediatrics and Child Health	8	Full	9	Page 334, line 35	'Home base' should perhaps be 'home-based treatment'. More importantly, it is not clear which two home-based treatments the writer is referring to: this needs clarification.	We agree that home-based treatment is a more appropriate term and have changed this. We have also clarified which two types of home-based interventions we are referring to – services that focus on management of acute issues and those that treat chronic problems
482	SH	Royal College of Paediatrics and Child Health	9	Full	9	All	The issue of past sexual abuse is alluded to several times, but the only figure given is from a study finding that 30% of young people with a borderline personality disorder diagnosis have been sexually abused (page 321, line 14). Clinical experience suggests that the proportion is higher than this. Several mentions are made (e.g. page 328, lines 31-34) of the need to be cautious about addressing the experience of past trauma (including sexual abuse) at times when suicidal actions are frequent and risk is high. This is sensible caution. However, it would be helpful also to have advice on when (and how) such past trauma can be therapeutically addressed in a way that helps the young person.	The GDG did not look explicitly for evidence of the frequency of sexual abuse or indeed other forms of abuse specifically in young people as this did not fall within the scope. Nor were other risk indicators researched. Certainly the figure in the study cited does seem low from clinical experience and studies with adults. This study, however, was referenced as it reported on suicidal behaviours that were within the scope. Chapter 2 of the guideline discusses aetiological factors, including sexual abuse, more fully. The GDG gave consideration to adding in advice about when and how to address trauma but felt this went beyond the scope of the guideline.
483	SH	Royal College of Paediatrics and Child Health	10	Full	9.8	All	Mention is made (page 329, lines 35-36) of the need to avoid reinforcing self-harming behaviour by paying it too much attention. The context of this advice is that a supportive treatment package needs to be in place. It may be worth emphasising also that treatment packages have in the past emphasized a behavioural approach that involves trying not to pay attention to acts of self-harm. This can be counter-productive. If a supportive treatment	Thank you, we have amended this paragraph to take account of your comment.

							package is not in place, the self-harming behaviour is likely to escalate until attention has to be paid to it.	
484	SH	Royal College of Paediatrics and Child Health	11	Full	9.8.1 and elsewhere	Especially managing acute and chronic risks	It is often self-harm that brings young people with borderline personality disorder to professional attention: usually cutting or overdose. A reduction in self-harming behaviour is often made a principle target of treatment. The guideline should, we feel, recognise that this may not always be the most important goal of treatment. For instance, it may be more important to help the young person find ways of being aware of their distress and expressing it. As part of such an approach, a permissive attitude to cutting and other non-life-threatening self-harm may be more supportive than an emphasis on reducing self-harming acts (Spandler, Helen and Warner, Sam. Beyond Fear and Control: working with young people who self-harm. PCCS Books, Ross-on-Wye, 2007.)	The guideline makes no recommendations about what should be the principle goal of treatment only that professionals must consider the management of risks and care plan these appropriately. Any intervention for young people with BPD is likely to involve alternate ways of expressing distress. As there is no evidence on the relative benefits and risks of a permissive approach to self-harm it is not possible to recommend it.
485	SH	Royal College of Paediatrics and Child Health	12	Full	General Children of BPD parents	All	There doesn't seem to be any mention of the needs of children whose parents have a diagnosis of borderline personality disorder. This condition is likely to have a significant impact on the child. Possible concerns may include, for instance: lack of parental emotional availability, the parent being unable to prioritise the needs of the child, the parent-child relationship may amount to emotional abuse or neglect.	Thank you. The issue of parenting is outside the scope of the guideline. The topic has been reviewed by SCIE http://www.scie.org.uk/publications/briefings/files/briefing24.pdf). We would suggest that it may make a suitable topic for suggestion to the NICE topic selection panel.
487	SH	Royal College of Psychiatrists 1	1	NICE	1.1.1 Access to services Children of BPD parents		Agreed with all the principles, but we would emphasize on the importance of access for parents with personality disorders, and the needs to take dependent children's needs into account. It is possible that access to mental health services needs to be facilitated for referrals arising out of social services and schools, where children are noted to be affected by personality difficulties in their parents.	Thank you. This issue is outside the scope of the guideline but has been reviewed by SCIE http://www.scie.org.uk/publications/briefings/files/briefing24.pdf). It may make a suitable topic for a future short guideline and can be suggested to NICE via the topic selection process (see http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp.) .
488	SH	Royal	2	Full	8.7.5		Patients should be managed in the service that best meets their	Thank you.

		College of Psychiatrists 1		NICE	(1.1.2.) PD and Learning disabilities		needs. For some patients these will be mainstream services whilst for others these will be learning disability services. Patients with severe learning disabilities should not be usually diagnosed with borderline personality disorder.	We have said that people with severe learning disabilities should not be diagnosed with BPD (8.7.5.4 draft guideline numbering) It has been clarified that people with mild LD should have access to mainstream services while in all cases including moderate and severe LD there should be involvement of specialist services.
489	SH	Royal College of Psychiatrists 1	3	Full NICE	8.5.2.1 (1.1.3.) Autonomy and choice		We would add here the possibility of encouraging patients to seek support from PD self help groups.	Thank you. There is no evidence about the usefulness of self-help groups for people with BPD. There may be a suggestion, particularly if badly managed, that they may be harmful.
490	SH	Royal College of Psychiatrists 1	4	Full NICE	4.6.2.1 (1.1.4) Trusting relationship		In order for staff to achieve this they will need appropriate training and ongoing supervision, as these patients can be very demanding, anxiety provoking, and provoke staff rejection.	Thank you for your comment. As a result of this and other comments we have made a new recommendation about training and supervision in section 1.1 of the NICE guideline.
491	SH	Royal College of Psychiatrists 1	5	NICE	1.1.5 Involving carers		Here we would emphasize the need for confidentiality, the fact that carers also require a great deal of support, but also that the relationship with the carer might be part of the problem which needs addressing. Special attention needs to be given to the needs of young carers in these circumstances.	Thank you. The issue of confidentiality is not specific to BPD and is relevant all interactions between healthcare workers and clients. The GDG did not consider there to be a particular issue with people with BPD. The needs of dependent children are addressed in recommendations about assessment. The wider issue of dependent children is outside the scope.
492	SH	Royal College of Psychiatrist	6	Full NIC	4.6.4.1 (1.1.6)		Assessment principles Agreed	Thank you.

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493	SH	Royal College of Psychiatrists 1	7	NICE	1.1.7		Managing transitions Agreed. Be aware of interface difficulties between in-patient, community and specialist services, particularly at times of crisis. Need to openly discuss criteria for involvement in each particular case, so that different teams know exactly will be expected of them, and when to be and not to be involved. If there is any indication that the patient's needs are challenging the ability of the service to meet with them, this should be openly acknowledged and discussed, and alternative solutions found. If more than one service is involved at the same time, be aware of splitting, idealization, disengagement or other threats.	Thank you.
494	SH	Royal College of Psychiatrists 1	8	NICE	1.1.7		Managing self harm and suicide threats Agreed but recognize that these incidents enquire special efforts to clarify involvement, recognize patient's use of self harm/suicidal behaviour as attempts to control unbearable feelings, and opportunities to discuss alternative strategies. There is no mention in this section of the need for in-patient admission, which requires special management arrangements, with the principle that it should be a brief admission, an opportunity to discuss the crisis that led to the admission, the use of in-patient groups and one to one counselling, judicious use of medication for short, specific objectives, and an opportunity to revisit the CPA arrangements and involve all the necessary agencies. (Please see my papers on this subject: FAGIN, L (2004) Management of personality disorders in acute in-patient settings Part 1: Borderline personality disorders. Advances in Psychiatric Treatment, vol 10, Issue 2, 93-99. March 2004 FAGIN, L (2004) Management of personality disorders in acute in-patient settings Part 2: Less common personality disorders. Advances in Psychiatric Treatment, vol 10, Issue 2, 100-106. March 2004)	Thank you. The existing NICE guidance deals with these issues. The issue of inpatient admission is also dealt with in section 1.4 [draft NICE guideline numbering].

495	SH	Royal College of Psychiatrists 1	9	Full NICE	8.5.4.1 (1.2.1)		Recognition of Borderline Personality Disorder in Primary Care Agreed. We would add here the need for training and close cooperation with community mental health services/specialist when both agencies are involved.	Thank you. We have inserted a new recommendation about training at the end of the section on general principles which includes the option for primary care staff to be trained where they opt to be involved in assessment and treatment.
496	SH	Royal College of Psychiatrists 1	10	Full NICE	8.5.18.1 (1.3)		Assessment and management by Community Mental Health Services 2.3.1 Training Be aware of the Department of Health Personality Disorder Knowledge Frameworks, a national training programme which is being rolled out by the Tavistock Clinic and the Open University.	Thank you.
497	SH	Royal College of Psychiatrists 1	11	Full NICE	8.5.9 (1.3.2) Assessment (children of parents with BPD)		Assessment should also take into account the needs of dependent children when that is appropriate.	Thank you. This is included in recommendation 1.3.4.1.
498	SH	Royal College of Psychiatrists 1	12	Full NICE	8.5.10 (1.3.3)		Risk assessment and management Agreed	Thank you.
499	SH	Royal College of Psychiatrists 1	13	Full NICE	8.5.11 (1.3.4)		Care planning Agreed	Thank you.
500	SH	Royal College of Psychiatrists 1	14	Full NICE	8.5.14 (1.3.5)		Psychological treatment There is no evidence base for the suggestion that psychological treatments should be in two modalities. Given the limits on	Thank you for your comment. We found no evidence for the effectiveness of individual

							resources a psychological treatment in one modality would be better than none. Psychological treatment needs to be provided to patients with BPD, but treatment in one modality can be very helpful. During crisis admissions psychological treatments started in out-patient settings should be continued. Brief psychological interventions are useful and evidence based. Some BPD patients may benefit from short term interventions for specific co morbid problems. It would be a pity if these guidelines were to deprive them of these. Perhaps the guidelines should state that in BPD patients the psychological intervention should not be restricted to brief interventions. It would be helpful here also to delineate the different psychological modalities used in the management of PD, and especially BPD (behavioural, dialectical behavioural, cognitive , psychodynamic) and some suggestions of when to use which modality. If there is no strong evidence to make a choice then this needs to be stated.	psychological therapies, but some evidence for therapies delivered in 2 modalities (eg DBT, MBT – termed 'complex interventions' in the draft full guideline evidence chapter but revised to psychological therapy programmes). Please see our reviews in chapter 8 (draft guideline chapter numbers). The recommendation 1.3.5.4 has been revised. We found no evidence for the effectiveness of brief psychological interventions specifically for the symptoms of BPD. The guideline does not suggest that brief interventions for comorbid conditions should not be given where appropriate. There is insufficient evidence to give the specific advice you suggest. This may be available when the guideline is revised.
501	SH	Royal College of Psychiatrists 1	15	NICE	1.3.6		Drug treatment Recent literature suggests that medication may have a very modest, but helpful contribution to make during crises and in the medium term. The important thing is to develop a rationale of why, for what and how long the medication will be used, whether behavioural control, mood instability, fleeting psychotic symptoms, etc. There is some evidence that SSRIs, low dosage atypical antipsychotics, anticonvulsants (sodium valproate) and lithium, but all of these medications must used with caution and be provided for short-term treatment in conjunction with psychological approaches.	Thank you for your comment.
502	SH	Royal College of Psychiatrist	16	Full NIC	8.5.12 (1.3.7)		Co-morbidities We would add here the problems of managing depression and PD.	Thank you for your comment. The management of comorbidities is dealt with in 1.3.6 and it will be the

		s 1		E			There is still some controversy as to whether antidepressant management should be used when these conditions co-exist, as it is very difficult to ascertain whether we are dealing with the same condition or different entities. Personality pathology affects outcome in depression, with a suggestion that BPD have worse outcomes. Best studies indicate that no significantly different response to treatment for those PD with and without depression: therefore always worth treating. Mulder RT, Joyce PR, Luty SE. The relationship of personality disorders to treatment outcome in depressed outpatients. J Clin Psychiatry 2003; 64:259–276 Mulder RT. Depression and personality disorder. Curr Psychiatr Rep 2004; 6:51–57	responsibility of the depression guideline therefore to advise on whether or not the treatment of depression should be modified in the presence of borderline personality disorder, if such evidence exists. Of course, if it doesn't exist, this along with other comorbidities in health generally proves to be a problem.
503	SH	Royal College of Psychiatrists 1	17	Full NICE	7.5.1.1 7.4.1 (1.3.8)		Management of crises The comment that there should be a team consensus before starting drug treatment in a crisis is unhelpful. This is not a realistic requirement, in particular given the fact that BPD patients often split teams. It would be better to suggest that prescribing should be properly integrated within and consistent with the team formulation of patient problems, and , over time, is consistent in approach to prescribing and decision making, keeping all informed.	Thank you. There should be consensus before prescribing if at all possible to avoid the splitting you mention. But if this is not possible at the point of prescribing then consensus should be sought as soon afterwards as possible. We do not consider that the recommendation should be changed.
504	SH	Royal College of Psychiatrists 1	18	Full NICE	7.7 (1.3.9)		management of insomnia Agreed	Thank you.
505	SH	Royal College of Psychiatrists 1	19	Full NICE	8.5.13.1 (1.3.10)		Discharge to Primary care Agreed. I would emphasize on the importance of direct communication with the GP and other primary care professionals, an awareness of their capacity to manage with future crises and their training needs in this area, and the guarantee that support will be available from secondary services when required.	Thank you. We hope that implementation of the guideline with provide this.
506	SH	Royal College of Psychiatrist	20	Full NIC	8.5.16 (1.4)		In-patient services Agreed, but please comments above	Thank you.

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507	SH	Royal College of Psychiatrists 1	21	Full NICE	8.5.18 (1.5)		Organization and planning of services Agreed, with additional comments made above.	Thank you.
508	SH	Royal College of Psychiatrists 1	22	Full NICE	5.14.3.1 (4.1)		Outcome research Agreed, with the addition of criteria that takes into account ethnic differences.	Thank you. This is a valid point but would be too much detail for an initial study (which is already a large undertaking).
509	SH	Royal College of Psychiatrists 1	23	Full NICE	5.14.1.1 (4.2)		Dialectical behavioural and mentalization approaches Agreed	Thank you.
510	SH	Royal College of Psychiatrists 1	24	Full NICE	5.14.2.1 (4.3)		OP psychosocial intervention research Agreed.	Thank you.
511	SH	Royal College of Psychiatrists 1	25	Full NICE	6.12.1.1 (4.4)		Mood stabilizers See comments above	Thank you but we cannot answer this comment due to the way that it is structured.
512	SH	Royal College of Psychiatrists 1	26	Full NICE	8.6.1.1 (4.5)		Care pathway Agreed	Thank you.
513	SH	Royal College of Psychiatrists 1	27	Full	General		Final Comments Our final comments are the usual ones, associated with 1. The need for a proper funding infrastructure for these services. The condition is a protracted one, that requires stability of services, and patients will suffer if they are not assured that the provision of care and treatment will be there when it is required. Many PD services have recently been threatened with cuts, which affects staff who are at the forefront as well as their patients. 2. Special attention must also be given to support and supervise staff and to pick up early signs of burnout when working with this client group	Thank you. 1 This is a matter for local implementation 2 As a result of this and other comments we have made a new recommendation about training and supervision in section 1.1 of the NICE guideline. 3 T his is outside the scope and is the subject of a separate NICE guideline which has recently been

							3. There is very little mention of good coordination with substance misuse teams, that have a high proportion of patients with PD in their client lists, and how to manage the difficulties of co-morbidity in this area.	commissioned.
514	SH	Royal College of Psychiatrists 1	28	Full NICE	8.5.12.1 8.5.14.1 General		Comments from the Forensic Psychiatry Faculty There is no doubt that a huge amount of work has gone into writing this Guideline and, for example, clarity about which drugs to and not to prescribe. However, there are glaring omissions which I will refer to. Professor Peter Hobson has sent detailed comments on behalf of the Tavistock & Portman NHS Foundation Trust where I work and which I have supported. I will therefore not repeat these but rather emphasise points which I find of particular importance. Firstly, given that BPD is frequently accompanied by co-morbid disorders, it is worrying to see that "the Guideline does not cover the separate management of co-morbid conditions" (introduction, page 3). To separate the management of co-morbid conditions produces an artificial situation and is therefore not in keeping with the accepted aim for 'person-centred care' in the treatment of people who suffer from a wide range of psychopathology and rarely from 'pure' forms of disorder – which is especially true for personality disorders. But actually, as Professor Hobson has pointed out, there is evidence for the value of psychodynamic psychotherapy for patients presenting with complex disorders who have much contact with psychiatric services (e. g. Guthrie et al. 1999). This complexity cannot be appropriately reflected in RCT conditions. It has therefore been argued that field studies are at least equally if not more relevant for the research of the treatment of patients as it actually happens in clinical practice (eg. Leichsenring & Rueger, 2004). This brings me to my second main comment which is that it is of great concern how the role of transference-based psychodynamic psychotherapy in the treatment of BPD sufferers is omitted in the Guideline. Professor Hobson has referred to studies such as the RCT of Clarkin et al. (2007) which concludes "A structured dynamic treatment, transference-focused psychotherapy was associated	Thank you. First point: the separate management of cormorbid conditions is outside the scope of the guideline. We appreciate the difficulties of undertaking RCTs of psychotherapy in client groups with complex problems, but there are no high quality data showing the efficacy of psychodynamic psychotherapy versus standard treatment in BPD, and therefore it is difficult to justify a recommendation to the NHS. Second point: Clarkin et al 2007 and Levy et al 2006 are publications of additional data from the Clarkin et al 2004 study. We generate a study-id based on the first author and publication year for each study, with follow-up data or data published in subsequent papers being added to the original study to avoid double-counting. The references of all publications relating to a trial can be seen in the reference section of the study characteristics tables (appendix 16 (draft appendix numbering) in the draft guideline). Therefore, the data from Clarkin et al 2007 was considered. However, there were few extractable data from these

							with change in multiple constructs across 6 domains; DBT and supportive treatment were associated with fewer changes". It does not seem to be well known that transference-focussed psychotherapy (TFP), as developed by Clarkin and Kernberg, is a very specific and manualised treatment and which allows for research into its specific effects. Furthermore, the study of Chiesa and Fonagy (2000) also provides evidence for the effectiveness of psychodynamic psychotherapy in mixed in- and out-patient settings. My third comment is to stress how critical it is for the multi-disciplinary teams caring for patients suffering from BPD to be provided with appropriate training and supervision. This should be conducted from a psychodynamic point of view in order to make use of the knowledge about the developmental conditions and structural conditions found in patients suffering from BPD. This is not emphasised in the guideline. Patients suffering from BPD provoke strong emotional reactions in others and this includes those caring for them. Experts in organisational dynamics and psychoanalytic understanding are essential if units caring for these patients are to function. Professionals working with them, providing treatment and management must be able to acknowledge and understand this and this is addressed by providing experts to regularly train and supervise members of the multi-disciplinary teams. Another way of putting this is to say that the psychoanalytic understanding can provide an 'immunisation' for the 'contagiousness' of these disorders. Such disorders are considered to be developmental failures that require understanding of the complex nature of the psychopathologies. Psychodynamically trained experts can provide the complex diagnoses in the context of inter-personal relatedness as well as a developmental perspective necessary to address prescribe the treatment plans required. A long-term perspective is also essential if these developmental aspects are to be given the opportunity to be addressed and a more integrated mental structure rendered possible. Lastly, I would like to re-iterate Professor Hobson's point regarding	papers, and the authors have provided their data in a usable format. However, the authors did not wish us to use the data to publish between-group effect sizes calculated using the new data. No conclusions can be drawn about this study. It should be noted that we base our conclusions about studies on calculating effect sizes from data given in the papers rather than on the statistical analyses undertaken by study authors (usually with conclusions based on statistical significance rather than the clinical significance of the effect size). It is rare that a strong recommendation specifying a particular therapy is made based on a single RCT which does not have a treatment as usual comparator. Third point: As a result of this and other comments we have made a new recommendation about training and supervision in section 1.1 of the NICE guideline.However, there is no evidence to suggest this be conducted from a psychodynamic point of view. Last point: Although is an important issue, it is outside the scope of the guideline. The topic has been reviewed by SCIE http://www.scie.org.uk/publications/briefings/files/briefing24.pdf). We would suggest that it may make a suitable topic for suggestion to the

							the guideline only briefly mentioning the potential effects of BPD in adults on the well-being of their off-spring. There is evidence now available indicating the impact of BPD in mothers on the development of their infants (Crandell et al, 2003 and Hobson et al. 2005) and the danger of trans-generational transmission of the psychopathology. Very early interventions are required to help parents suffering from BPD and the impact of this on their babies. I hope that these comments will be read by the NICE BPD working group. Dr Carine Minne References: Chiesa, M., & Fonagy, P., (2000) Cassel personality disorder study: Methodology and treatment effects. British Journal of Psychiatry, 176, 485-491 Clarkin, J., Levy, K., Lenzenweger, M., & Kernberg, O., (2007) Evaluating three treatments for BPD: A multi-wave study. American Journal of Psychiatry, 164, 922-928 Crandell, L., Patrick, M., Hobson, R.P., (2003) “Still-face” interactions between mothers with BPD and their 2-month-old infants. British Journal of Psychiatry, 183, 239-247 Guthrie, E., Moorey, J., Margison, F., et al., (1999) Cost-effectiveness of brief psychodynamic-interpersonal therapy in high utilizers of psychiatric services. Archives of General Psychiatry, 56, 519-526 Hobson, R. P., Patrick, M., Crandell, L., et al., (2005) Personal relatedness and attachment in infants of mothers with BPD. Development and Psychopathology, 17, 329-347 Leichsenring, V. F., Ruger, U., Psychotherapy and Evidence Based Medicine (EBM) – Randomised controlled versus naturalistic studies: Is there only one gold standard? Psychosomatische	NICE topic selection panel.

							Medizin und Psychotherapie, 50, 203-217	
515	SH	Royal College of Psychiatrists 2	1	Full	General		The guideline's attempt to encompass the full scope of clinical responses to this often disadvantaged client group, and associated research needs, is extremely welcome. We highlight below the minority of areas in which we feel the draft advice is incorrect or incomplete, as well as an additional area (training) where specific advice might usefully be added.	Thank you.
516	SH	Royal College of Psychiatrists 2	2	Full	General		A common weakness across the recommendations (and in the assimilation of research evidence) is the relative lack of attention paid to differences in social inclusion or social adjustment as factors that influence the choice of and outcomes from interventions of all kinds. This is likely to be particularly relevant to this client group.	Thank you. A major problem in the development of this guideline was our inability to meta-analyse any of the datasets regarding any of the treatments, especially psychological therapies, since very few studies had outcome measures in common. Also, measures of social inclusion or adjustment are rarely reported.
517	SH	Royal College of Psychiatrists 2	3	Full	5.2 , 5.3 and 5.9 General and sections		The classification of psychological therapies into 'complex' and 'individual' is seriously flawed. We cannot support its retention as set out here. There are three principal reasons for this. 1. Relevance to outcomes. Defining 'complex' interventions in this way appears to isolate a set of interventions that collectively lead to better outcomes than non-complex interventions. This is not proven. It reflects the complete omission of key RCT evidence comparing outcomes from 'complex' and individual psychological therapies. Clarkin, Levy, Lenzenweger & Kernberg (2007), uncited throughout the guideline, demonstrate significant improvement across a broader range of outcomes after 12 months from an 'individual' intervention, transference focused therapy (TFT) than with DBT. We comment below on where proposed statements on treatment choice are invalidated as a result. The simplest way to infer a characteristic common to interventions whose efficacy has been relatively well supported by RCT evidence would be a statement that attending regularly at least twice per week to receive an extended, theoretically coherent intervention appears to be associated with better outcomes than attending once per week or less.	Thank you for your comments. 1 We have not omitted the Clarkin study. Clarkin et al 2007 and Levy et al 2006 are publications of additional data from the Clarkin et al 2004 study. We generate a study-id based on the first author and publication year for each study, with follow-up data or data published in subsequent papers being added to the original study to avoid double-counting. The references of all publications relating to a trial can be seen in the reference section of the study characteristics tables (appendix 16 (draft appendix numbering) in the draft guideline). Therefore, the data from Clarkin et al 2007 were considered. However, there were few extractable data from these

							2. Future application. Defining a category of interventions as loosely as that proposed for 'complex' interventions here, and then making this the basis for the most significant single recommendation of the guidelines (1.3.5.4) means that untested interventions that appear to fit the description could claim to have more authority than ones for which there is evidence of effectiveness. NICE's growing international influence widens the scope for misinterpretation of this kind. We strongly recommend that guidelines on psychological treatments are revised and, instead of referring to 'complex' interventions, are confined to traceable statements about the relative strengths and weaknesses of named interventions (MBT, DBT, TFT etc.) 3. Consistency. Equating 'complex' therapies with DBT and MBT alone is inconsistent with the description that 'complex' interventions offer treatment in more than one modality and are provided by a team. As the guidelines recognise, therapeutic community programmes (TCPs) provide both social and group interventions through a dedicated team. Moreover, as these can be delivered through partial hospitalisation as well as full hospitalisation, they are no more different in kind from one of the two models being labelled here as 'complex' – MBT – than the other 'complex' model – DBT . DBT remains at least as distinct from MBT in its theory and practice as TCPs, and is not associated with partial hospitalisation.	papers, and the authors were then asked to provide data in a usable format. However, the authors did not wish us to use the data to publish between-group effect sizes calculated using the new data. No conclusions can be drawn about this study. It should be noted that we base our conclusions about studies on calculating effect sizes from data given in the papers rather than on the statistical analyses undertaken by study authors (usually with conclusions based on statistical significance rather than the clinical significance of the effect size). It rare that a strong recommendation specifying a particular therapy would be made from a single RCT), particularly one with relatively few participants. The best that can be said of the existing data for many psychological treatments in BPD is that they are still at an experimental stage. 2. We have amended the recommendation. We do not think it is appropriate to name specific interventions as the current evidence base is still at a developmental stage. 3. We have removed the term 'complex' in light of this and other comments.
518	SH	Royal	4	Full	5.2		The use of 'individual psychological therapies' to refer to those that	Thank you. As a result of this and

		College of Psychiatrists 2			General and section, 5.4		are not 'complex' is confusing. The term refers to group treatments as well as those provided on a one-to-one basis. We do not find the distinction as used here justified (above: comment 3). If it is to be resurrected or redefined in a revision of the guidelines, the term 'simple' would be a better designation for interventions of relatively less complexity.	other comments we have restructured the chapter and removed the term 'complex'.
519	SH	Royal College of Psychiatrists 2	5	Full	General training		Provision of clinical interventions for people with borderline personality disorder poses special challenges, because the working alliance between clinician and patient is more likely to be unstable and emotionally charged. This imposes particular demands on clinicians that need to be addressed in the process of training. However, training needs specific to working with people with this disorder are hardly addressed. We recommend that a dedicated section of the revised guideline addresses essential training requirements.	Thank you. We have included a separate section on training (and support) in the NICE guideline to give this issue appropriate emphasis.
520	SH	Royal College of Psychiatrists 2	6	NICE	General		The table of contents does not marry up with the enumeration of sections in the main text. 'Organisation and planning of services' appears as 1.4 and 1.5 respectively, for instance.	Thank you. This has been corrected during the editing process.
521	SH	Royal College of Psychiatrists 2	7	Full NICE	5.2 (1.3.5.4)	8 109-111	The neglect of evidence supporting the effectiveness of individual psychological therapy (above, comment 3) means advice that 'healthcare professionals should offer one that provides therapy in at least two modalities ……' should be replaced by a recommendation drawing attention to MBT, DBT and TFT as therapies having the strongest evidence from RCTs, each requiring attendance at least twice per week. The use of the term 'complex' in this context is unhelpful, for reasons already given. However, a statement that treatment choice is also likely to need to take into account patients' social circumstances and the degree of support available between sessions would be clinically appropriate.	Thank you for your comment. This recommendation has been amended in light of comments from other stakeholders. In addition, we have amended the term 'complex therapies' as it was causing confusion. It would not be appropriate to make a specific recommendation about MBT based on only 1 study. We have made a specific recommendation about DBT based closely on the evidence. We do not agree that the TFP study (Clarkin et al, 2004, 2007, Levy et al, 2006) shows the superiority of TFP. The between-group effect sizes calculated from the Clarkin et al data shows no advantage for TFP

								over the other therapies. In addition, there is no treatment as usual control group in this study making it hard to evaluate.
522	SH	Royal College of Psychiatrists 2	8	Full NICE	5.13.1.2 (1.3.5.5)	8	Any recommendation of DBT as an intervention for females only is potentially unhelpful. While this may reflect a selectivity in early evaluations, there is no evidence DBT is less effective for men than women. When the evidence for other psychological interventions (eg. IPT for depression) has been drawn from female populations, this has not been reflected in NICE's recommendations. If DBT was routinely offered as a female only option, this is likely to restrict future options for male patients and contravene general principles of access set out in Guidelines 1.1.1.1. We recommend this guideline refers to 'people', 'patients' or 'individuals' who chronically self-harm.	Thank you for your comment. The bulk of the evidence behind this recommendation is specifically in women.
523	SH	Royal College of Psychiatrists 2	9	Full NICE	8.5 (1.4)		In-patient recommendations make no reference to criteria for referral to specialist rather than generic in-patient units. (These include some units providing therapeutic community programmes). The guidelines need to address this, including the principles that should govern referral, assessment and treatment in these circumstances for adults, as they already do for young people.	Thank you. We have set out the criteria for referral to generic inpatient units (1.4.1.2 draft guideline numbering). Referrral from generic acute inpatient units to other more specialist inpatient facilities (such as regional secure units) is not to BPD and will be wholly dependent on the patient's behaviour and the extent to which the generic inpatient unit can manage their behaviour without referral. It therefore lies outside the scope.
524	SH	Royal College of Psychiatrists 2	10	Full NICE	8.5.18 (1.5)		Advice on service organisation also needs to address the interface between local and regionally organised services for people with PD. Principles of good practice would include a statement of the considerations likely to make such provision necessary (recently defined by DH as amenability to treatment; risk; need for residence; uncontainability in local settings) and of the responsibility of commissioning bodies to facilitate referrals consistently and rapidly on the basis of expert clinical advice.	Thank you. The guideline does not specifically deal with regional or national services as there is little or no evidence for these. The guideline, instead, supports the DH policy to set up specialist PD services at a local level within Trusts. Many Trusts do not have such services, and their actual or potential relationship with regional

								services is beyond the scope of the guideline. We do recognise, nevertheless, that there may be some worth in referral guidance of the kind you describe being developed at a later stage when local tertiary services have been developed.
525	SH	Royal College of Psychiatrists 2	11	Full	5.3 5.10.3	123-142	The unresearched possibility that part of MBTs success reflects the 'partial hospitalisation' context in which it has been provided in the evaluations cited, rather than the content of its interventions, make it puzzling that insufficient attention appears to have been paid to studies of therapeutic communities indicating positive benefit from partial hospitalisation (5.10.3).	Thank you for your comment. There is no high quality evidence for the effectiveness of therapeutic communities. Making inferences about part of a treatment package is not appropriate given the current evidence available.
526	SH	Royal College of Psychiatrists 2	12	Full	5.9 & 5.10	174-186	It is not clear why therapeutic community programmes might not be 'complex' psychological therapies in the terms set out by the guideline, nor why they account for a disproportionate number of the published studies excluded from consideration (as well as an uncited systematic review – Lees (1997)).	Thank you for your comment. The term 'complex therapy' has been replaced by 'psychological therapy programme' in the full guideline because of the confusion it caused. However, the GDG considered therapeutic communities warranted a separate section since they provide a very different environment compared with that offered in studies of what were initially termed complex therapies. The review by Lees et al was not considered high quality – it used an unclear outcome measure to calculate effect sizes and also aimed to review non-UK therapeutic communities which were considered too different from the UK setting to be useful.
527	SH	Royal College of Psychiatrists 2	13	Full	8.4	279-282	The assessment of evidence concerning 'in-patient services' excludes residential therapeutic communities These units in the UK should provide a point of comparison with the Finnish unit that was reported on, and prove a better basis for generalisation.	Thank you. This section is concerned with psychiatric inpatient care. Therapeutic communities are reviewed elsewhere (chapter 5).

528	SH	Royal College of Psychiatrists 3	1	Full NICE	4.6.1.1 (1.1.1.1)	10	should race and sexual orientation be added to diagnosis and gender (although black and minority ethnic groups are mentioned in 1.1.1.3.)?	Thank you for your comment. The GDG considered that the groups specifically mentioned in this section are those for which there is evidence that there may be descrimination in those with a diagnosis of BPD – i.e., it should be specific to BPD not any mental health problem. Services are already required not to discriminate on grounds of ethnicity or sexual orientation.
529	SH	Royal College of Psychiatrists 3	2	Full NICE	8.7.5.2 (1.1.2.2)	11	People with mild or moderate learning disability may have difficulties in understanding information imparted in therapy, and therefore may need dedicated interventions taking this into consideration.	Thank you. It has been clarified that people with mild LD only should have access to mainstream services while in all cases including moderate and severe LD there should be involvement of specialist services.
530	SH	Royal College of Psychiatrists 3	3	Full NICE	4.6.4.1 (1.1.6.1)	13	“offer post-assessment support” the assessing professional may not be equipped to do so, but would be appropriate to arrange for this.	Thank you. The GDG think that a professional able to provide a proper assessment will also have the skills to be able to offer post-assessment support.
531	SH	Royal College of Psychiatrists 3	4	Full NICE	8.5.10.2 (1.3.3.2)	16	Explicitly agreeing the risks being assessed might not be possible as additional risks may emerge during the assessment. Wording could possibly be changed to “should explicitly agree the risks being assessed, as far as is possible, …”	Thank you. This addition would make the recommendation vaguer rather than less vague. We have therefore not changed it.
532	SH	Royal College of Psychiatrists 3	5	Full NICE	8.5.14.1 (1.3.5.1)	18	Detailed discussion of therapy should be placed ahead of written/other medium information - just giving people written information & the opportunity to discuss this doesn't work.	Thank you for your comment. This recommendation should be read alongside those in the section on Autonomy and Choice (1.1.3 in the NICE guideline).
533	SH	Royal College of Psychiatrists 3	6	Full NICE	5.13.1.1 (1.3.5.4)	19	Not all therapeutic interventions include group and individual therapy.	Thank you. This recommendation has been amended.

534	SH	Royal College of Psychiatrists 3	7b	NICE	1.3.6.1 & 1.3.6.2		Paragraph 1.3.6.2 seems to conflict with 1.3.6.1. The first says that patients should be given written information about the effectiveness of a drug in BPD (as well as drugs for co-morbid conditions) while the second says that drug treatment should not be used specifically for BPD or for the individual symptoms or behaviour associated with the disorder.	Thank you. The information supplied to patients should make it clear that drugs are not effective in the treatment of symptoms of BPD but may be effective in the management of comorbid conditions. There is very little evidence for the management of comorbid conditions in people with BPD.
535	SH	Royal College of Psychiatrists 3	7a	Full NICE	5.13.1.3 (1.3.5.7)	20	Some parts of interventions for BPD do last for less than three months. This wording is ambiguous.	Thank you. This recommendation is concerned with specific treatments for BPD and its symptoms rather than comorbid disorders which may benefit from brief interventions.
536	SH	Royal College of Psychiatrists 3	8	Full NICE	8.5.15.1 (1.3.6.1)	20	Evidence is limited; therefore giving written evidence may be difficult.	Thank you for your comment. The written evidence should make the limits of the current evidence base clear.
537	SH	Royal College of Psychiatrists 3	9	Full NICE	6.11 (1.3.6.2 1.3.6.4)	20	There appears to be no mention of use of low dose Clozapine. Sometimes medication is necessary for high arousal, and transient psychotic symptoms. Gold standard evidence base may be lacking but there is certainly some evidence and probably a lot of clinical anecdotal experience suggesting that treating mood instability and psychotic symptoms is worthwhile. We have certainly seen very impressive improvements for some people with clozapine (including dramatic reductions in self harm). RCTs may still need to be done but the potential usefulness of medication should at least be mentioned. To dismiss it in the way this guideline does is depriving some individuals of effective treatment (and the effectiveness of the psychological interventions is limited anyway) It will be difficult for clinicians to get hold of appropriate written information.	Thank you. There is no high quality evidence for clozapine in the treatment of borderline personality disorder, and therefore it could not be recommended. Also, the side effects associated with antipsychotics are considerable.
538	SH	Royal College of Psychiatrists 3	10	Full NICE	7.5.1.4 (1.3.6.3)	20	Whilst this might be an ideal, for some service users, particularly those with high risk behaviours, medication may be required for longer periods of time.	Thank you. We have no evidence that this will be helpful and it will need to be justified if a longer period is used.

539	SH	Royal College of Psychiatrists 3	11	Full NICE	7.4.1.1 (1.3.8.1)	21	Principles and general management of crises This guidance is very general, and there are likely to be situations where this could even be counter therapeutic, and at worse dangerous (episode of self harm). Ideally this should be care planned and outlined in crises plans, specific to the service user and likely crisis situations they may experience.	Thank you. We suggest consulting the crisis plan and this should contain information related to episodes of self harm. Please see sections on care planning and risk assessment and management which adequately cover your concerns, in our view.
540	SH	Royal College of Psychiatrists 3	12	Full NICE	8.5.16 (1.4)	25	Consideration needs to be given to people with BPD, who require longer term inpatient treatment, in a variety of settings, and levels of security. These guidelines refer only to acute admissions.	Thank you for your comment. We have no evidence to suggest who, if any, these people are or why they should need it.
541	SH	Royal College of Psychiatrists 3	13	Full	General		Specific management is mentioned for insomnia, however there are likely to be other specific problems, e.g. past trauma, that might also benefit from there being specific guidelines.	Thank you. The GDG felt that insomnia warranted specific mention but that other topics eg past trauma was outside the scope. If patients meet criteria for PTSD, recommendation 1.3.7.2 [draft NICE guideline numbering] should be followed.
542	SH	Royal College of Psychiatrists 3	14	Full	General		Recovery – one of the principles of recovery is allowing service users to make mistakes, and to learn from these mistakes. This can be applied to treating people with borderline personality disorder.	Thank you. The guideline does not proscribe this!
543	SH	Royal College of Psychiatrists 3	15	Full	General		Use of term borderline personality disorder and not making a reverence that this is the same as emotionally unstable personality disorder could lead to confusion.	Thank you. We have added a footnote to help avoid confusion.
544	SH	Royal College of Psychiatrists 3	16	Full	General		Principles of staff support needed to work with this group of people, and the need to good and clear communication, should be emphasized at the beginning, as this may make more specific guidelines clearer, and underpinned by an obvious rationale.	Thank you. We have added a recommendation about staff support at the end of the general principles. Communication between staff (which is what we assume you are referring to) is mentioned at several points in the recommendations (eg 1.5.1.1) and implicit in recommendations about whole team working. It is also mentioned in the section on person-

								centred care.
545	SH	Royal College of Psychiatrists 4	1	Full NICE	4.6.1.1 (1.1.1.1)		People should not be excluded “by reason of their personality disorder”. It may be entirely reasonable to exclude them for other reasons, e.g. a man should not be admitted to a Women’s Service	Thank you – we agree. This is what the recommendation says.
546	SH	Royal College of Psychiatrists 4	2	Full NICE	8.7.5.2 (1.1.2.2)		Those with moderate LD will need a different treatment programme to those of normal IQ. It would therefore be difficult to treat them successfully in mainstream services.	Thank you. It has been clarified that people with mild LD only should have access to mainstream services while in all cases including moderate and severe LD there should be involvement of specialist services.
547	SH	Royal College of Psychiatrists 4	3	Full NICE	8.7.5.3 (1.1.2.3)		Healthcare professionals should consult ….remove consider.	Thank you for your comment. The wording of the recommendation reflects the evidence base.
548	SH	Royal College of Psychiatrists 4	4	Full NICE	8.7.5.4 (1.1.2.4)		Add in……Efforts should be made to exclude confounding physical illness (especially epilepsy) or difficult to diagnose mental illnesses in people with all levels of learning disability	Thank you. There is no evidence that people with leraning difficulties and possible BPD might have increased rate of epilepsy and physical illness
549	SH	Royal College of Psychiatrists 4	5	Full NICE	4.6.4.1 (1.1.6.1)		Need to make people aware of support options as it may not be practicable for the individual themselves to offer this support.	Thank you. The GDG think that healthcare professionals undertaking assessment of people with BPD will/should have the skills to provide post-assessment support.
550	SH	Royal College of Psychiatrists 4	6	Full NICE	9.10.1.3 (1.1.7.2)		Commissioning arrangements sometimes preclude transfer at the time best for the young person. There needs to be greater flexibility.	Thank you. The guideline is intended to encourage this.
551	SH	Royal College of Psychiatrists 4	7	Full NICE	8.5.10.2 (1.3.3.2)		Risk must be assessed collaboratively as far as possible, but agreement may not always be possible.	Thank you for your comment.
552	SH	Royal	8	Full	8.5.14.1		Such material will need to be developed if this is to be retained in	Thank you for your comment. We

		College of Psychiatrists 4		NICE	(1.3.5.1)		the Guidance. There is not a great to deal of research to indicate that such an approach is necessarily helpful.	have amended the recommendation to say that written information about the treatments should be given, rather than information about effectiveness of treatments. Providing writing information is required by NICE (see person-centred care section). It means that patients have material they can take away with them to read outside of consultations with doctors to allow fully informed consent.
553	SH	Royal College of Psychiatrists 4	9	Full NICE	5.13.1.1 (1.3.5.4)		Other therapies mentioned later in the Guidance do not offer therapy in 2 modalities, and whilst this may be desirable, many services will not be able to meet this requirement and many therapeutic interventions use only one.	Thank you. This recommendation has been amended.
554	SH	Royal College of Psychiatrists 4	10	Full NICE	5.13.1.2 (1.3.5.5)		Why not for men? And DBT can be helpful many of the presentations of BPD, not just self harm.	Thank you for your comment. The bulk of the evidence behind this recommendation is specifically in women.
555	SH	Royal College of Psychiatrists 4	11	Full NICE	5.13.1.3 (1.3.5.7)		When addressing specific symptoms brief interventions can be helpful, especially when co-coordinated in an overall treatment programme. Such interventions are helpful, e.g. distress tolerance, and will in themselves be brief.	Thank you for your comment. The evidence does not support the use of brief interventions in people with BPD (see chapter 5 of the full guideline). However, note that the recommendation is concerned with specific treatments for BPD and its symptoms rather than comorbid disorders which may benefit from brief interventions.
556	SH	Royal College of Psychiatrists 4	12	Full NICE	8.5.15.1 (1.3.6.1)		There is no such material. Patients rely on the expertise and experience of their doctors, and this is not necessarily a bad thing.	Thank you. This is a matter for local implementation.
557	SH	Royal College of Psychiatrists 4	13	Full NICE	6.11 (1.3.6.2 and		The evidence considered is selective and applies to a limited population group. Follow up periods are often measured in weeks. The evidence ignores some the work on arousal, use of clozapine and other aspects considered in the treatment of severe BPD. This	Thank you. The evidence considered is the best available. There are no high

					1.3.6.3 and 1.3.6.4)		recommendation in no way takes account of the breadth of presentations in this disorder and the levels of distress and disturbance often seen for prolonged periods e.g. in secure settings. Evidence is limited and many of this population do not have a pure disorder, indeed co-morbidity is the norm in severe personality disorder. If the evidence is insufficient to allow for evaluation then no recommendation should be made. There is a consensus amongst a knowledgeable clinical peer group that these treatment modalities can be extremely effective in a small sub group of patients with severe BPD.	quality comparative studies of clozapine in people with borderline personality disorder. There are separate recommendations for the use of drugs in people presenting in crisis (section 1.3.8 in the draft).
558	SH	Royal College of Psychiatrists 4	14	Full NICE	8.5.12.4 (1.3.7.4)		Complex co morbidity is common in certain services and one service should be responsible for providing care to the "whole person". This may however differ, for example in a community setting, but the Guidance should address all patients and this section would not be appropriate for many. Indeed, multi-agency working can facilitate primitive mechanisms such as splitting. Significant risk issues can arise when services compartmentalise the patients problems.	Thank you. The GDG have made their recommendations based on best practice and the logic of treating the most serious problem first (as would happen in any other medical speciality). Clearly it is advantageous to provide a whole service for a whole person, but not all PD services will be able to deal with, for example, a Class A drug addiction.
559	SH	Royal College of Psychiatrists 4	15	Full NICE	7.4.1.1 (1.3.8.1)		Crises in some services include significant threat to life, limb or property. This should be recognised by the Guidance. This formulaic approach cannot be applied, and indeed will reinforce certain presentations and is not compatible with certain therapeutic approached e.g. DBT	Thank you. The suggest approach is not formulaic and clearly states suggested principles. They are compatible with any approach. The principles apply to presentations commonly outside a specialist treatment approach.
560	SH	Royal College of Psychiatrists 4	16	Full NICE	7.5.1.1 (1.3.8.2)		Treating professionals should read prescribers. Some professionals have little training on medication, especially in this complex area. Whilst it would be good practise to consult with team members, achieving consensus might not be possible, and ultimately a decision may be taken by those responsible for prescribing.	Thank you – we have amended the text to include prescribers and all those involved.
561	SH	Royal College of Psychiatrists 4	17	Full NICE	7.5.1.3 (1.3.8.4)		Such matters need to be recorded in a pre agreed crisis plan, not debated at the time of crisis.	Thank you. We agreed but this section is related to prescribing in a crisis and we suggest that the crisis plan is then revisited and amended accordingly. We have no evidence

								that this will be helpful and it will need to be justified if a longer period is used.
562	SH	Royal College of Psychiatrists 4	18	Full NICE	7.6.1.1 (1.3.8.5)		Again, this will depend on the definition and severity of the crisis. There is also a need to conduct an analysis of the crisis and the antecedents.	Thank you. We have added a bullet to the recommendation to cover your point.
563	SH	Royal College of Psychiatrists 4	19	Full NICE	7.7 (1.3.9)		Why just pick out insomnia? Issues of trauma and the common co morbidities should also be addressed if insomnia is to be considered.	Thank you. Insomnia was thought by service users to be of particular importance.
564	SH	Royal College of Psychiatrists 4	20	Full NICE	8.5.16 (1.4.)		There should be separate consideration of all potential in patient services, given the variety e.g. acute, PICU, low, medium and high secure, therapeutic communities, and healthcare wings in prisons. Other teams should continue to offer services to those with BPD and they should not necessarily be referred to crisis resolution. Such fragmentation can be particularly unhelpful for this group.	Thank you. The recommendation has been amended in light of this and other comments.
565	SH	Royal College of Psychiatrists 4	21	Full NICE	8.5.16.3 (1.4.1.3)		This refers to patients in the community being admitted to general services. It does not consider all the other types of services outlined above. Voluntary management may not be possible if the individual is subject to Part 3 of the MHA.	Thank you. This is why we have put 'at the earliest opportunity'.
566	SH	Royal College of Psychiatrists 4	22	Full NICE	8.5.16.4 (1.4.1.4)		Stating frequency is unhelpful, clinical judgement should be used.	Thank you. The guideline is not intended to replace clinical judgement. However, the GDG felt that some guidance was necessary.
567	SH	Royal College of Psychiatrists 4	23	Full NICE	8.5.18 (1.5)		Missing from this section is the provision of PD services in low and medium secure settings. Most existing PD provision in high and medium secure is aimed at antisocial PD or DSPD, not BPD.	Thank you for your comment. The guideline is written for the NHS and specific recommendations for prisson staff are outside the scope. However, NHS healthcare professionals working with prison populations should follow these guidelines.
568	SH	Royal College of Psychiatrists 4	24	Full	General		In general there should be acknowledgement that this group of patients can be particularly challenging, and that staff should be involved in regular supervision and training, and the challenges working intensively with this group recognised, and resources allocated accordingly.	Thank you. We have several recommendations which cover these points adequately.

569	SH	Royal College of Psychiatrists 5	1	Full	General		I couldnt find any specific evidence for the effect of setting on effectiveness. in particular whether treatment delivered in a coercive/ secure setting where the individual has very limited choice over the services they access and treatment they receive (which the NICE guidleines identify as very important) is as effective as treatment delivery in the community or in voluntary inpatient settings. Given the fact that most forensic practititioners will be delivering care to people in priosn or secure institutions it would be helpfu to know if there was any evidence out there to guide us as to whether this is liklely to be effective. I also thought that we need to be very cautious in applying these guidelines in real life given the high rates of comorbidity in our patient population (partic with drug substance misuse for which no spevifci guidance on how treatment should be modified) and the high rates of past abuse/victimisation/deprivation which may require more specific trauma focussed psychotherapy (where evidence of good effectiveness for CBT) and where symptoms may have considerable overlap with the symptoms profile of BPD	Thank you. There is very little evidence on the effect of setting, and no evidence of treatment delivered in a secure setting as you rightly suggest. The guideline gives recommendations about comorbidities, but comorbid drug and substance misuse was outside the scope and will be considered in a separate guideline on this specific topic.
570	SH	Royal College of Psychiatrists 6	1	Duplicate comment	Duplicate comment		NICE consultation on Personality Disorders **1.1.1.** Access to services Agreed with all the principles, but we would emphasize on the importance of access for parents with personality disorders, and the needs to take dependent children's needs into account. It is possible that access to mental health services needs to be facilitated for referrals arising out of social services and schools, where children are noted to be affected by personality difficulties in their parents. **1.1.2.** PD and Learning disabilities Patients should be managed in the service that best meets their needs. For some patients these will be mainstream	DUPLICATE COMMENT (Royal College of Psychiatrists 1)

							services whilst for others these will be learning disability services. Patients with severe learning disabilities should not be usually diagnosed with borderline personality disorder. 1.1.3. Autonomy and choice We would add here the possibility of encouraging patients to seek support from PD self help groups. 1.1.4 Trusting relationship In order for staff to achieve this they will need appropriate training and ongoing supervision, as these patients can be very demanding, anxiety provoking, and provoke staff rejection. 1.1.5 Involving carers Here we would emphasize the need for confidentiality, the fact that carers also require a great deal of support, but also that the relationship with the carer might be part of the problem which needs addressing. Special attention needs to be given to the needs of young carers in these circumstances. 1.1.6 Assessment principles Agreed 1.1.7. Managing transitions Agreed. Be aware of interface difficulties between in-patient, community and specialist services, particularly at times of crisis. Need to openly discuss criteria for involvement in each particular case, so that different teams know exactly will be expected of them, and when to be and not to be involved. If there is any indication that the patient's needs are challenging the ability of the service to	

							meet with them, this should be openly acknowledged and discussed, and alternative solutions found. If more than one service is involved at the same time, be aware of splitting, idealization, disengagement or other threats. 1.1.7 Managing self harm and suicide threats Agreed but recognize that these incidents enquire special efforts to clarify involvement, recognize patient's use of self harm/suicidal behaviour as attempts to control unbearable feelings, and opportunities to discuss alternative strategies. There is no mention in this section of the need for in-patient admission, which requires special management arrangements, with the principle that it should be a brief admission, an opportunity to discuss the crisis that led to the admission, the use of in-patient groups and one to one counselling, judicious use of medication for short, specific objectives, and an opportunity to revisit the CPA arrangements and involve all the necessary agencies. (Please see my papers on this subject: FAGIN, L (2004) Management of personality disorders in acute in-patient settings Part 1: Borderline personality disorders. Advances in Psychiatric Treatment, vol 10, Issue 2, 93-99. March 2004 FAGIN, L (2004) Management of personality disorders in acute in-patient settings Part 2: Less common personality disorders. Advances in Psychiatric Treatment, vol 10, Issue 2, 100-106. March 2004) 1.2. Recognition of Borderline Personality Disorder in Primary Care Agreed. We would add here the need for training and close cooperation with community mental health	

							services/specialist when both agencies are involved. 2.4 Assessment and management by Community Mental Health Services 2.4.1 Training Be aware of the Department of Health Personality Disorder Knowledge Frameworks, a national training programme which is being rolled out by the Tavistock Clinic and the Open University. 2.4.2 Assessment Assessment should also take into account the needs of dependent children when that is appropriate. 2.4.3 Risk assessment and management Agreed 2.4.4 Care planning Agreed 2.4.5 Psychological treatment There is no evidence base for the suggestion that psychological treatments should be in two modalities. Given the limits on resources a psychological treatment in one modality would be better than none. Psychological treatment needs to be provided to patients with BPD, but treatment in one modality can be very helpful. During crisis admissions psychological treatments started in out-patient settings should be continued. Brief psychological interventions are useful and evidence based. Some BPD patients may benefit from short term	

								interventions for specific co morbid problems. It would be a pity if these guidelines were to deprive them of these. Perhaps the guidelines should state that in BPD patients the psychological intervention should not be restricted to brief interventions. It would be helpful here also to delineate the different psychological modalities used in the management of PD, and especially BPD (behavioural, dialectical behavioural, cognitive , psychodynamic) and some suggestions of when to use which modality. If there is no strong evidence to make a choice then this needs to be stated. 2.4.6 Drug treatment Recent literature suggests that medication may have a very modest, but helpful contribution to make during crises and in the medium term. The important thing is to develop a rationale of why, for what and how long the medication will be used, whether behavioural control, mood instability, fleeting psychotic symptoms, etc. There is some evidence that SSRIs, low dosage atypical antipsychotics, anticonvulsants (sodium valproate) and lithium, but all of these medications must used with caution and be provided for short-term treatment in conjunction with psychological approaches. 2.4.7 Co-morbidities We would add here the problems of managing depression and PD. There is still some controversy as to whether antidepressant management should be used when these conditions co-exist, as it is very difficult to ascertain whether we are dealing with the same condition or different entities. Personality pathology affects outcome in depression, with a suggestion that BPD have worse outcomes. Best studies indicate that no significantly	

							different response to treatment for those PD with and without depression: therefore always worth treating. Mulder RT, Joyce PR, Luty SE. The relationship of personality disorders to treatment outcome in depressed outpatients. J Clin Psychiatry 2003; 64:259–276 Mulder RT. Depression and personality disorder. Curr Psychiatr Rep 2004; 6:51–57 2.4.8 Management of crises The comment that there should be a team consensus before starting drug treatment in a crisis is unhelpful. This is not a realistic requirement, in particular given the fact that BPD patients often split teams. It would be better to suggest that prescribing should be properly integrated within and consistent with the team formulation of patient problems, and , over time, is consistent in approach to prescribing and decision making, keeping all informed. 2.4.9 Management of insomnia Agreed 2.4.10 Discharge to Primary care Agreed. I would emphasize on the importance of direct communication with the GP and other primary care professionals, an awareness of their capacity to manage with future crises and their training needs in this area, and the guarantee that support will be available from secondary services when required. 2.5 In-patient services Agreed, but please comments above.	

							2.6 Organization and planning of services Agreed, with additional comments made above. 4.1 Outcome research Agreed, with the addition of criteria that takes into account ethnic differences. 4.2 Dialectical behavioural and mentalization approaches Agreed 4.3 OP psychosocial intervention research Agreed. 4.4 Mood stabilizers See comments above. 4.5 Care pathway Agreed Our final comments are the usual ones, associated with 4. The need for a proper funding infrastructure for these services. The condition is a protracted one, that requires stability of services, and patients will suffer if they are not assured that the provision of care and treatment will be there when it is required. Many PD services have recently been threatened with cuts, which affects staff who are at the forefront as well as their patients. 5. Special attention must also be given to support and supervise staff and to pick up early signs of burnout when working with this client group 6. There is very little mention of good coordination with	

							substance misuse teams, that have a high proportion of patients with PD in their client lists, and how to manage the difficulties of co-morbidity in this area.	
571	SH	Royal College of Psychiatrists 7	1	Full	General		Hopefully these brief comments still reach you in time before 4th August deadline – sorry they are late but I am on maternity leave and was only recently forwarded Dr. Kim Fraser's e-mail to my home address asking me to be one of the respondents for the forensic executive. There is no doubt that a huge amount of work has gone into writing this Guideline and, for example, clarity about which drugs to and not to prescribe. However, there are glaring omissions which I will refer to. Professor Peter Hobson has sent detailed comments on behalf of the Tavistock & Portman NHS Foundation Trust where I work and which I have supported. I will therefore not repeat these but rather emphasise points which I find of particular importance. Firstly, given that BPD is frequently accompanied by co-morbid disorders, it is worrying to see that "the Guideline does not cover the separate management of co-morbid conditions" (introduction, page 3). To separate the management of co-morbid conditions produces an artificial situation and is therefore not in keeping with the accepted aim for 'person-centred care' in the treatment of people who suffer from a wide range of psychopathology and rarely from 'pure' forms of disorder – which is especially true for personality disorders. But actually, as Professor Hobson has pointed out, there is evidence for the value of psychodynamic psychotherapy for patients presenting with complex disorders who have much contact with psychiatric services (e. g. Guthrie et al. 1999). This complexity cannot be appropriately reflected in RCT conditions. It has therefore been argued that field studies are at least equally if not more relevant for the research of the treatment of patients as it actually happens in clinical practice (eg. Leichsenring & Rueger, 2004). This brings me to my second main comment which is that it is of	DUPLICATE COMMENT (Royal College of Psychiatrists 1)

							great concern how the role of transference-based psychodynamic psychotherapy in the treatment of BPD sufferers is omitted in the Guideline. Professor Hobson has referred to studies such as the RCT of Clarkin et al. (2007) which concludes “A structured dynamic treatment, transference-focused psychotherapy was associated with change in multiple constructs across 6 domains; DBT and supportive treatment were associated with fewer changes”. It does not seem to be well known that transference-focussed psychotherapy (TFP), as developed by Clarkin and Kernberg, is a very specific and manualised treatment and which allows for research into its specific effects. Furthermore, the study of Chiesa and Fonagy (2000) also provides evidence for the effectiveness of psychodynamic psychotherapy in mixed in- and out-patient settings. My third comment is to stress how critical it is for the multi-disciplinary teams caring for patients suffering from BPD to be provided with appropriate training and supervision. This should be conducted from a psychodynamic point of view in order to make use of the knowledge about the developmental conditions and structural conditions found in patients suffering from BPD. This is not emphasised in the guideline. Patients suffering from BPD provoke strong emotional reactions in others and this includes those caring for them. Experts in organisational dynamics and psychoanalytic understanding are essential if units caring for these patients are to function. Professionals working with them, providing treatment and management must be able to acknowledge and understand this and this is addressed by providing experts to regularly train and supervise members of the multi-disciplinary teams. Another way of putting this is to say that the psychoanalytic understanding can provide an ‘immunisation’ for the ‘contagiousness’ of these disorders. Such disorders are considered to be developmental failures that require understanding of the complex nature of the psychopathologies. Psychodynamically trained experts can provide the complex diagnoses in the context of inter-personal relatedness as well as a developmental perspective necessary to address prescribe the treatment plans required. A long-term perspective is also essential if these developmental aspects are to be given the opportunity to be	

							addressed and a more integrated mental structure rendered possible. Lastly, I would like to re-iterate Professor Hobson's point regarding the guideline only briefly mentioning the potential effects of BPD in adults on the well-being of their off-spring. There is evidence now available indicating the impact of BPD in mothers on the development of their infants (Crandell et al, 2003 and Hobson et al. 2005) and the danger of trans-generational transmission of the psychopathology. Very early interventions are required to help parents suffering from BPD and the impact of this on their babies. I hope that these comments will be read by the NICE BPD working group.	
572	SH	Royal College of Psychiatrists 7	2	Full	General Refs		References: Chiesa, M., & Fonagy, P., (2000) Cassel personality disorder study: Methodology and treatment effects. British Journal of Psychiatry, 176, 485-491 Clarkin, J., Levy, K., Lenzenweger, M., & Kernberg, O., (2007) Evaluating three treatments for BPD: A multi-wave study. American Journal of Psychiatry, 164, 922-928 Crandell, L., Patrick, M., Hobson, R.P., (2003) "Still-face" interactions between mothers with BPD and their 2-month-old infants. British Journal of Psychiatry, 183, 239-247 Guthrie, E., Moorey, J., Margison, F., et al., (1999) Cost-effectiveness of brief psychodynamic-interpersonal therapy in high utilizers of psychiatric services. Archives of General Psychiatry, 56, 519-526 Hobson, R. P., Patrick, M., Crandell, L., et al., (2005) Personal relatedness and attachment in infants of mothers with BPD. Development and Psychopathology, 17, 329-347 Leichsenring, V. F., Ruger, U., Psychotherapy and Evidence Based	DUPLICATE COMMENT (Royal College of Psychiatrists 1)

							Medicine (EBM) – Randomised controlled versus naturalistic studies: Is there only one gold standard? Psychosomatische Medizin und Psychotherapie, 50, 203-217	
575	SH	Royal Liverpool Childrens NHS Trust	1	Full	General		We are pleased to have the opportunity to comment on the draft guideline and welcome the opportunity to engage in the process of developing appropriate services and treatment pathways for a group of clients who have significant need	Thank you
576	SH	Royal Liverpool Childrens NHS Trust	2	Full	General		As a child and adolescent mental health service our response is in the context of privileging the needs of children and their families	Thank you
577	SH	Royal Liverpool Childrens NHS Trust	3	Full	General		We therefore are concerned about a lack of attention to the wider familial context within the guidelines and the omission of a comprehensive systemic perspective.	The family context as an aetiological factor is discussed in chapter 2 and involvement of families and carers in the treatment of young people in chapter 9. We found no specific references to the use of systemic perspective in the treatment of BPD.
578	SH	Royal Liverpool Childrens NHS Trust	4	Full	General		The diagnosis of BPD is privileged over other potential explanations of symptoms and functioning such as trauma. These alternative hypothesis are viewed as co-morbid disorders rather than causal experiences.	NICE guidelines do use diagnosis as a starting point. This is inevitable as most research into treatments is based on diagnostic groupings. The guideline does not consider that the diagnosis explains the symptoms and functioning of individuals who meet criteria, it merely describes the symptoms of the disorder. The role of trauma in aetiology is discussed in chapter 2 but not all individuals who meet criteria for a diagnosis of BPD have a history of trauma. Anecdotal reports indicate that service users without a trauma history feel side-lined by explanations that privilege trauma as an explanatory variable.
579	SH	Royal	5	Full	General		We consider this to be limiting on professionals working with	The GDG were unclear about what

		Liverpool Childrens NHS Trust					children in such family systems by reducing the opportunity to address issues of trans-generational transmission of trauma. These issues will impact on the parenting capacity of the person with BPD	you considered to be limiting on professionals. There is no proscription on professionals working with parents and young people together on trauma issues if this is indicated after a comprehensive formulation / assessment
580	SH	Royal Liverpool Childrens NHS Trust	6	Full	General		Children and young people may be thrust into the role of carer. This may result in them developing mental; health difficulties. We would ask the guidelines increase the focus on whole family approaches when the individual with BPD is a parent. Taken together with the 'psychosocial factors' (2.4.4) it appears likely that parental BPD carries a direct risk of producing BPD in the children as an outcome. So from a preventative perspective a parenting dimension is crucial to include.	Thank you. This is a very important point but outside the scope and is being addressed by SCIE in a review they are currently undertaking on parents with mental health problems. The topic has been reviewed by SCIE http://www.scie.org.uk/publications/briefings/files/briefing24.pdf). We would suggest that it may make a suitable topic for suggestion to the NICE topic selection panel.
581	SH	Royal Liverpool Childrens NHS Trust	7	Full	General		We would welcome consideration being given to the use of mentoring as an intervention. In addition interventions adopting an approach increasing mentalisation skills in parents could be flagged as a area for research. Thought needs to be given to the appropriate configuration of services which should be provided for parents, peri-natal services, clinical practice considerations re risk should include reference to the parental role, co-morbidity should explicitly include peri-natal issues such as 'baby blues'.	Thank you. This was outside the scope. The issue of parents with BPD was also outside the scope although the topic has been reviewed by SCIE http://www.scie.org.uk/publications/briefings/files/briefing24.pdf). Issues relating to antinatal and postnatal mental health have been addressed in a separate NICE guideline.
582	SH	Royal Liverpool Childrens NHS Trust	8	Full	General		If the parenting dimension is to be included in the guidance in principle it would also be useful to include something on thresholds. Often diagnostic and service thresholds may not be meeting children's needs when parent may have a sub-threshold mental health condition.	Thank you. The issue of parents with BPD is outside the scope.
583	SH	Royal Liverpool Childrens	9	Full	General		The guidelines could benefit from an increased focus on agencies who manage risk in families where a parent is diagnosed BPD. Consideration of abuse and parenting is minimal except for a brief	Thank you. The issue of parents with BPD is outside the scope. We have mentioned the issue of

		NHS Trust			Children with BPD parents		item on risk assessment. It could invoke the impression that the link between PD and abuse is not known, and that we cannot understand it in individual cases. This does not reflect the growing body of literature to take into account, both of a narrative and a scientific kind.	assessing the needs of and risks to families in the relevant recommendations.
584	SH	Royal Liverpool Childrens NHS Trust	10	Full	General		There are several layers of social service provision that could be included here as essential stakeholders: a. Child protection b. Child in need Voluntary sector (children-focussed, e.g. NYAS, NCH, Barnardo's Young Carers and many others)	Thank you .It is not clear to what you are specifically referrring. It is a matter for individual organisations to register as stakeholders.
585	SH	Royal Liverpool Childrens NHS Trust	11	Full	General		The family court system has a considerable experience with a BPD in parents. They should be consulted as an essential stakeholder. The guideline also acknowledges the significant proportion of BPD diagnoses in the prison population. The vast majority of women in the criminal justice system and the majority of men are parents, so the parenting dimension is important but difficult to deal with within the criminal justice system.	Thank you for your comments. We agree this is a complicated area, especially when people with BPD are also parents. We also acknowledge that many people within the criminal justice system can be so diagnosed. Nevertheless, both parents and the criminal justice system are outside the scope of this guideline.
586	SH	Royal Liverpool Childrens NHS Trust	12	Full	General		Evidence and Cost: It would be helpful for the guideline development group to assist in providing models for calculating the cost-effectiveness of interventions with parents. This is a methodologically demanding field where published work is variable in standards. This would facilitate work to progress faster and families to receive better and more evidence based interventions.	Thank you for your comment. Interventions with parents is outside the scope of the guideline.However, NICE provides a costing template based on the key recommendations. This can be downloaded from the NICE webside from roughly 6 weeks after the guideline is published.
587	SH	Royal Liverpool Childrens NHS Trust	13	Full	General		The guidelines acknowledge the contested nature of BPD as a diagnosis and the negative experiences associated with diagnosis for client. We believe this is vital when considering the appropriateness of the guidelines in adolescents.	Thank you.
588	SH	Royal Liverpool Childrens NHS Trust	14	Full	General		Primary diagnosis of BPD according to the guidelines can only be made in the absence of any other psychiatric or physical illness. This raises the whole question of diagnostic systems and labelling which has not been adequately addressed in the guideline development. There is a risk that a large proportion of the	Thank you for your comment. The scope restricted this guideline to address the treatment and management of BPD (but not the validity of diagnosis or related

							professional community will be in disagreement with the guidance, as they privilege more functional ways of looking at complex mental health issues and providing services.	issues such as labelling). There is another guideline developed in parallel on ASPD. These guidelines inevitably overlap just as the patient populations do. Both guidelines take a pragmatic approach and are based on the evidence of effectiveness for different treatments.
589	SH	Royal Liverpool Childrens NHS Trust	15	Full	9.	308	As a child and adolescent mental health service we have serious concerns about this section (young people) of the document	The GDG appreciate you taking the time to express your concerns. We provide a response to each concern individually.
590	SH	Royal Liverpool Childrens NHS Trust	16	Full	9.1	308	We note that reluctance to diagnose is portrayed as a consequence of uncertainty about criteria, timing of diagnosis, or the consequence of labelling. All of these may contribute	The GDG agrees that all of these may contribute.
591	SH	Royal Liverpool Childrens NHS Trust	17	Full	9.1		However we think it should be recognised that many clinicians will not diagnose as they do not consider such a diagnosis will add to the understanding of the client, their difficulties or the treatment plan	This is a valid point. We have added a sentence to this effect in section 9.1.
592	SH	Royal Liverpool Childrens NHS Trust	18	Full	9.3		The evidence presented does not support the hypothesis that BPD is a stable disorder in young people.	Thank you – we agree, but nor does it clearly indicate that the disorder is unstable in all cases. As discussed in section 9.3 commentators have argued both perspectives from the same data. The GDG are not arguing that the disorder is stable only that the evidence seems to indicate that in some cases it is but that this judgement is based on limited evidence. We have added a further sentence to 9.3.6 to emphasise this point.
593	SH	Royal Liverpool Childrens NHS Trust	19	Full	9.3.3	314	The prospective studies highlight stability rates over 2-3 years of 21-40%. Therefore in 60-79% of young people diagnosis is not stable.	This is a valid point. We have added a sentence to this effect in section 9.1.

594	SH	Royal Liverpool Childrens NHS Trust	20	Full	9.3.3		This suggest a lack of specificity in the diagnostic criteria and measures, leading to a significant risk of misdiagnosis.	Indeed, nor does it clearly indicate that the disorder is unstable in all cases. As discussed in section 9.3 commentators have argued both perspectives from the same data. The GDG are not arguing that the disorder is stable only that the evidence seems to indicate that in some cases it is but that this judgement is based on limited evidence. We have added a further sentence to 9.3.6 to emphasize this point.
595	SH	Royal Liverpool Childrens NHS Trust	21	Full	9.3.3		Although the principle of early intervention is privileged within the document, early diagnosis carries the risk of iatrogenic effects given the pejorative nature of the label. A diagnosis of BPD is frequently life limiting and the consequences are enduring	This is a valid point. We have added a sentence to this effect in section 9.1
596	SH	Royal Liverpool Childrens NHS Trust	22	Full	9.3		Many of the diagnostic criteria for BPD may be viewed as more extreme representations of adolescent development. This concept could be highlighted more in the guidelines	This is a valid point. We have added a sentence to this effect in section 9.1
597	SH	Royal Liverpool Childrens NHS Trust	23	Full	9.4.4	321	The guidelines would benefit from highlighting that self harm and suicide attempts have many different functions. Conceptualising DSH as a consequence of BPD is erroneous and may prevent appropriate intervention.	Indeed, nor does it clearly indicate that the disorder is unstable in all cases. As discussed in section 9.3 commentators have argued both perspectives from the same data. The GDG are not arguing that the disorder is stable only that the evidence seems to indicate that in some cases it is but that this judgement is based on limited evidence. We have added a further sentence to 9.3.6 to emphasize this point.
598	SH	Royal Liverpool Childrens NHS Trust	24	Full	9.44		Conceptualising BPD as a risk factor for self harm when it is a diagnostic criteria is a circular argument which won't create clinical contexts privileging the unique nature and function of the young person who engages in self harm. BPD has no explanatory power	This is a valid point. We have added a sentence to this effect in section 9.1.
599	SH	Royal	25	Full	9.5	323	The guidelines again return to clinicians' reluctance to diagnose.	The GDG did feel that considering

		Liverpool Childrens NHS Trust					This seems to convey an implicit pressure for early diagnosis. It should be recognised that "failure to diagnose" by clinicians often reflects a desire to reduce the impact of iatrogenic effects of a diagnosis and the lack of added value to the treatment plan.	the diagnosis early would be beneficial but acknowledge that this was based on collective clinical judgement. The GDG were also extremely aware of the iatrogenic effects of diagnosis but also had extensive experience of the iatrogenic effects of failure to consider the diagnosis, along with others and a comprehensive understanding of the young person's difficulties, in formulating treatment plans. We have modified this section, however, to more clearly reflect the dilemma 'To diagnose or not to diagnose' and to emphasise the importance of thorough and comprehensive assessments and formulation of young people's difficulties.
600	SH	Royal Liverpool Childrens NHS Trust	26	Full	9.5	323	It is our view that a formulation based approach can clinically meet the needs for early intervention and is likely to actually increase the opportunity for appropriate and efficacious treatment.	We have added in references to a formulation of the young person's difficulties.
601	SH	Royal Liverpool Childrens NHS Trust	27	Full	9.6.1	324	We do not agree with proposal that treatment recommendations and general principles in working with adults with BPD should be applied to young people. There is no evidence to support this view. The construct of BPD in young people is highly questionable and the diagnosis is neither stable nor specific in clients of this age	The applicability of the BPD diagnosis in young people is still highly controversial. The GDG took the view that the caveats in DSMIV in relation to the diagnosis (problems have been pervasive and persistent, not limited to periods of an Axis 1 disorder or a particular developmental stage) are sufficiently cautious. That for young people who do meet the criteria for diagnosis the range of services suggested for adults should be available to them. Clearly we need far more studies

								specifically of young people with BPD or the behaviours and experiences suggestive of the diagnosis to establish what is most effective for them.
602	SH	Royal Liverpool Childrens NHS Trust	28	Full	9.6.3	325	We would like to see greater emphasis on the issue of family treatment. We see this as different to involving the family in the treatment of the young person.	Thank you. We found no research trials of family treatment in our search of the literature so it was not possible to specifically recommend or particularly emphasise family treatment. We do mention modification of problematic family interactions where possible (9.6.3), the use of home-based treatment and the importance of involving families in treatment – this would include family treatment if indicated.
603	SH	Royal Liverpool Childrens NHS Trust	29	Full	9.8.1	328	While we accept that working with young people who have intense interpersonal difficulties can be challenging for teams, we would like the guidelines to highlight that all systems and agencies should privilege the rights of the service user. We are concerned that commensurate with a diagnosis of BPD is a significant reduction in the right to typical levels of confidentiality. Inter and multi agency approaches should not be viewed as justification for infringing on this right to confidentiality.	Thank you for your comment. This is indeed a risk and we have added a statement that procedures to improve multi-agency communication must not compromise the young person's right to confidentiality.
604	SH	Royal Liverpool Childrens NHS Trust	30	Full	9.8.1	329	We feel this is particularly pertinent in multi agency work with young people. The degree of information needed to provide an appropriate service in different contexts such as health, social care and education varies greatly. Often information shared is applied to meet the needs of the organisation rather than the individual and the risk of social exclusion is exacerbated. We would like the guidelines to reflect this risk.	We agree this is particularly important with young people have address it (see above).
605	SH	Royal Liverpool Childrens NHS Trust	31	Full	9.8.1	329	Additionally given the clients potential difficulties with interpersonal relationship asking them to manage the fact that many different professionals in different organisations hold information about them can be overwhelming. The multi agency "thickening" of BPD narratives can be limiting at a time of developmental change and also iatrogenic	We have amended the guideline to include this point.
606	SH	Royal	32	Full	9.1	309	We also wish to highlight the approach to trauma and trauma	Thank you for your comment. All

		Liverpool Childrens NHS Trust					focussed therapy in the guidelines. Such traumatic histories are constructed as co-morbid disorders rather than differential explanations. We are also concerned that the guidelines stress the contra-indication of trauma work at times of instability.	NICE guidelines are based on the treatment of a specific diagnosis to provide a degree of clarity to clinicians about when to use the guideline. Using NICE guidelines does require clinicians to take a diagnostic approach in the first instance although that does not obviate the need for a comprehensive needs assessment or a formulation of the client's difficulties (both of which are referred to elsewhere in the guideline). The contribution of trauma to aetiology is discussed in chapter 2 of the guideline. On reflection the GDG agree that the statement that trauma work is contra-indicated at times of instability was too strong. This has been modified and the possibility that trauma work may facilitate stability added.
607	SH	Royal Liverpool Childrens NHS Trust	33	Full	9.1	309	While we acknowledge the difficulties inherent in treating traumatic material, often the instability observed is a consequence of the trauma. In our experience creating greater internal and external stability is both a necessity for and a consequence of trauma work. They should not be regarded as sequential interventions. We are concerned the guideline conveys this message, which will act to prevent clinical engagement with traumatic experiences and material.	Thank you. While we acknowledge the difficulties inherent in treating traumatic material, often the instability observed is a consequence of the trauma. In our experience creating greater internal and external stability is both a necessity for and a consequence of trauma work. They should not be regarded as sequential interventions. We are concerned the guideline conveys this message, which will act to prevent clinical engagement with traumatic experiences and material.

608	SH	Royal Liverpool Childrens NHS Trust	34	Full	9		We do not feel there is sufficient evidence for diagnosis of BPD in young people. Receiving such a diagnosis has many enduring negative consequences and is likely not to be in the interest of young people. We would suggest services do not diagnose young people. We privilege the use of formulation based approach which encompasses a lifespan developmental perspective and incorporates transgenerational influences on current difficulties.	Thank you for your comment. We were required by the guideline scope to make recommendations for the treatment and management of young people. However, the scope did not include making recommendations about the diagnosis in young people per se. Both DSM-IV and ICD-10 allow the diagnosis with certain caveats which we describe in chapter 9 [draft guideline numbering]. We feel the coverage of young people in the guideline is appropriate. Additional comments have been added to the full guideline chapter, however, to encourage caution in using the diagnosis and to ensure that this only follows a thorough assessment and formulation of the young person's difficulties (section 9.3.6 & 9.5).
609	SH	Royal Liverpool Childrens NHS Trust	35	Full	General		Carers for people with BPD: The NIMHE/CSIP Northwest Development Centre sponsored a research conference with carers in 2005 There were over 100 participants, perhaps the findings could be acknowledged in the guidance.	Thank you. Guidelines are based on the best available evidence of effectiveness. This is usually RCTs published in peer-reviewed journals. Conference proceedings are often focused on preliminary research results and unpublished findings.
610	SH	Royal Liverpool Childrens NHS Trust	36	Full	General		Social exclusion/social inclusion: The impression is given that there is a simplistic notion of economic impact of BPD. The fact that it is a socially excluding condition, especially when it is parents who are having to cope with BPD (see Social Exclusion Report, especially action 16) does not seem to be adequately reflected.	Thank you. The economic impact is specifically dealt with in section 2.9 [full guideline draft numbering] the broader impact of BPD is also discussed throughout the introduction to the full guideline. For example, section 2.6 discusses the range of services for people with this diagnosis and the burden

								placed upon them, and section 2.3.2 specifically looks at the impact of the disorder on individual functioning.
611	SH	Royal Liverpool Childrens NHS Trust	37	Full	General		Crisis management guidance should include up-to-date CPA guidance, especially with the recently published specific supplementary guidance on parents as patients. There is of course the question of the usefulness of a whole family approach which has been discussed above.	Thank you. Guidelines are not intended to repeat Department of Health policy. Although the issue of parents as patients is important, it was outside the scope of the guideline and therefore we did not look at the relevant evidence.
612	SH	Royal Liverpool Childrens NHS Trust	38	Full	General		On balance the literature review was narrowly focussed on work that was utilising rigorously diagnosed people with BPD. Although understandable this may potentially build in a source of bias e.g. against parents since adult mental health research literature in its sampling and outcome standards tends to exclude any information about parenting roles. It would be good to at least acknowledge in the literature review that other work, (e.g. with families under the Respect Agenda, or the work of the Marlborough Family Service) will likely include a proportion of parents with a diagnosis of BPD. Also, there are opportunities to research the parenting dimension from a user perspective, e.g. Borderline UK has a parents' group that could be accessed. The issue of the absence of high-quality research is specifically addressed in the draft and should be expanded to include parenting.	Thank you. Although the problems of patients as parents is outside the scope of the guideline (and has been reviewed by SCIE http://www.scie.org.uk/publications/briefings/files/briefing24.pdf) we have amended the recommendation on assessment to include assessing the needs of and risks to children in the family.
615	SH	Sainsbury Centre for Mental Health	1	NICE	1.1.1 -1.1.2	10-11	Access to services for people in custody may be difficult. There is a greater proportion of people with BPD in prison vs the general population. Co-morbidity with other MH problems and especially LD compounds this problem for those incarcerated, esp as the morbidity of LD and BPD is very high in the prison population. Consideration needs to be made as to how services can be made accessible to this very vulnerable group in prison.	Thank you. This applies to the whole prison population having a high rate of mental health problems and not only to those with LD
616	SH	Sainsbury Centre for Mental Health	2	Full NICE	8.5.2.1 (1.1.3)	11	Autonomy and choice are very limited for those people who are in prison – this may restrict the therapeutic alliance that is strongly advocated in this guidance.	Thank you. We agree, due to the nature of the prison service, autonomy and choice are unlikely to be widespread. Unfortunately this is beyond the control of this guidance which is aimed at primary and secondary care in the NHS.

								However, medical services in prisons are part of the NHS and therefore the guideline is applicable.
617	SH	Sainsbury Centre for Mental Health	3	Full NICE	4.6.2.1 (1.1.4)	12	Developing a trusting relationship is a challenge for the therapist when working with this group of clients [prison populations]. This is compounded when the client is subject to a prison sentence.	Thank you. We agree. Short of altering the criminal justice system to accommodate the needs of people with borderline personality disorder, there is little that the guideline can do in this context.
618	SH	Sainsbury Centre for Mental Health	4	NICE	1.1.7	13.	Managing endings and transitions is a particular challenge for prisoners on remand or short term sentences. Given the importance of transitions and endings for this client group, working within the prison environment could prove challenging.	Thank you. We agree. Short of altering the criminal justisce system to accommodate the needs of people with borderline personality disorder, there is little that the guideline can do in this context.
619	SH	Sainsbury Centre for Mental Health	5	Full NICE	8.5 (1.2 et seq)	18-20	Identification, assessment and training. Identification of BPD amongst the prison population should be included here as a specific subject, given the high morbidity and risk. Giving prison staff appropriate training would help identification on admission and clerking-in, and would help appropriate referral to healthcare staff, or encourage a watchful waiting approach to be adopted by wing staff.	Thank you. The guideline is written for the NHS and specific recommendations for prisson staff are outside the scope. However, NHS healthcare professionals working with prison populations should follow these guidelines.
620	SH	Sainsbury Centre for Mental Health	6	Full NICE	5 (1.3.5)	18-20	The Sainsbury Centre welcomes the recommendation of the use of psychological interventions for people with BPD, especially the use of DBT for women who are at a risk of self-harming (a high risk group in the prison population). However, the transient nature of many of the people in prison means that the recommendation that longer-term psychological interventions are offered (using more than one modality) greatly reduces the chance of these being available in a prison setting. This may need to be flagged at this point and a cross-reference made to the NICE guidance for self-harm.	Thank you. We recognise the significant difficulties of people with borderline personality disorder within the prison system.
621	SH	Sainsbury Centre for Mental Health	7	Full NICE	7 (1.3.8)	21-24	Management of crisis is particularly important for BPD prisoners, where these everyday difficulties may be compounded by the penal environment. Reference here should be made to the importance of developing crisis plans for prisoners with BPD.	Thank you. The guideline is written for the NHS and specific recommendations for prisson staff are outside the scope. However, NHS healthcare professionals working with prison populations

								should follow these guidelines.
622	SH	Sainsbury Centre for Mental Health	8	Full NICE	8.5.18 (1.5)	26-27	The organisation and planning of services should pay more attention to the delivery of services within prison settings. The proportion of people with BPD in prison is far greater than the general population.	Thank you. The guideline is written for the NHS and specific recommendations for prisson staff are outside the scope. However, NHS healthcare professionals working with prison populations should follow these guidelines.
623	SH	Sainsbury Centre for Mental Health	9	NICE	2	28	Scope of the guidance – this categorically states that no recommendations will be made specifically for the delivery of services in prisons. Given the high proportion of people in prison with the diagnosis of BPD, this is a significant impediment to them receiving acceptable (and possibly life-saving) services. As many of these people will only be in prison for a short period of time, the greater proportion of the management of their condition would fall to their primary care provider or CMHT (where engagement with primary care is a significant issue for the prisoner population). Not being able to knit together services to meet the needs of this population would be regressive.	Thank you. The guideline is written for the NHS and therefore applies to NHS healthcare professionals working with prison populations. However, making specific recommendations for non-NHS prison staff is outside the scope.
624	SH	Sainsbury Centre for Mental Health	10	NICE	4	29 et seq	The Sainsbury Centre welcomes the research recommendation set out in this guidance. However, there would be great potential in recommending more research in the delivery of services for prisoners with BPD, and area which has not been covered.	Thank you. The guideline is written for the NHS and specific recommendations for prison staff are outside the scope. However, NHS healthcare professionals working with prison populations should follow these guidelines. We are restricted to 5 research recommendations per guideline which the GDG prioritised based on an expert consensus view of which piece of research, if completed and published before the guideline is due to be updated (usually in 4 years time), would be most likely to improve the guideline.
631	SH	Sheffield Health and Social Care	1	Full NIC	8.5.12.4 general	many	The general outline of this paper seems to be a valuable one since it attempts to describe in enough detail of what psychiatric care should be composed of and how it should work. However, the	Thank you for your comments which we have numbered to aid response.

		Foundation Trust		E			terms laid out are fairly unspecific, if not to say generic, and one could claim that this model of care should apply to any psychiatric condition. 1 The care for a borderline personality disorder client may demand a more accurate way of communicating in order to avoid splitting but even that should be a general principle applicable to any level of meaningful care for all conditions. Many sections are describing what should already be in place as good psychiatric care but perhaps can do no harm to re-emphasise this. 2 Despite that the draft's emphasis on good communication and co-operation between services it contains from my point of view some contradiction as mentioned in paragraph 1.3.7.4 when an either-or approach is proposed. It seems that either treatment for the personality disorder should take place or for a co morbid condition. It would be better if the various treatment aspects can be integrated and treatment should not be interrupted by referrals to other services which incur a long waiting time. A closer knit care package needs to be considered with all contributors talking the same language.	1 This is covered by the recommendation at 1.1.4.1 [draft guideline numbering] 2 The GDG did not consider the approach you suggest suitable for those with major psychosis, drug/alcohol dependence, or a severe eating disorder, for which well developed services exist. However, for depression, PTSD and anxiety what you suggest was recommended – see 1.3.7.2 [draft numbering]. The whole guideline aims to provide a closer knit care package as you suggest.
632	SH	Sheffield Health and Social Care Foundation Trust	2	Full NICE 5 of full draft	5 General and introduction of summary		Given the very limited evidence, according to NICE criteria, for effective treatments, psychological treatment recommendations seem rather concrete and over prescriptive and miss the opportunity to bring in the many resources and treatment approaches currently used into the structure for evaluation and research in order to see what is already “out there” that works and just needs support for research and risks limiting and stifling development and innovation in an area that is still at a stage of mostly developing theoretical models and piloting treatments in small trials. It would be helpful if the final document can support this	Thank you. We have amended the psychological recommendations in light of various stakeholder comments. We think they accurately reflect the current evidence base which, we agree, is relatively immature compared with that in other mental health disorders.
633	SH	Sheffield Health and Social Care Foundation Trust	3	Full NICE	5.13.1.2 (1.3.5.5)	19	The paper also specifically mentions “Dialectic behaviour therapy” as part of the interventions that should be offered in a treatment programme for a specific target group of women who self harm. It certainly needs to be looked into however training could be offered to capable individuals in order to either broadening of our first approaches	Thank you for your comment. The guideline is required to be evidence-based and that for DBT in the prevention of self-harm is sufficiently strong to warrant a recommendation. There is no such

							Also other specific interventions can prevent self harm.	similar evidence for other interventions.
634	SH	Sheffield Health and Social Care Foundation Trust	4	Full NICE	5.13.1.1 (1.3.5.4)	8	Important to clarify if modalities are within the same model of therapy or a coherent programme, also it would seem a good CPA could form a "containing" and coherent context in which to provide a range of treatments/interventions some of which may be shorter than three months but evaluated in relation to the CPA rather than as stand alone treatments.	Thank you. This recommendation has been amended in light of your and other stakeholders' comments.
635	SH	Sheffield Health and Social Care Foundation Trust	5	Full NICE	5.13.1.1 (1.3.5.4)	8	Within the role of psychological treatment, as stated on page 8 of the draft, therapy should be offered in two modalities. I believe this will have some significant practical implication for us within this trust since one may claim that there is some patchy individual therapy available to people with (borderline) personality disorder but little in terms of a group therapy apart from groups with a very specific focus like in your service provisions at the Central Department. I am sceptical whether such a therapy should be delivered centrally (unless co-ordinated as part of robust care programme) despite valuing the work that happens within the Central Department.	Thank you. This recommendation has been amended in light of your and other stakeholders' comments.
636	SH	Sheffield Health and Social Care Foundation Trust	6	Full NICE	6.11.1.1 (1.3.6.2)	8	The role of medication within a treatment package for borderline personality disorder as outlined in the draft is more than contradictory. No clear line is drawn between the innate symptomatology of emotionally unstable personality disorder and co morbid conditions. To say that "drug treatment should not be used specifically for borderline personality disorder or for the individual symptoms or behaviour associated with the disorder" seems a bit out of touch with day to day practice. Even when accepting a critique of the overuse of medication/polypharmacy in some patients (reflecting some level of despair in dealing with the behavioural consequences of the condition) treatment solely based on social intervention and talking therapy is totally unrealistic.	Thank you for your comment. We have clarified a number of the recommendations following consultation. However, we disagree with the remainder of your comments regarding drug treatment – there is no evidence that we could find to support the use of drug treatments as a direct treatment for the core symptoms of BPD or for individual symptoms/symptom clusters for people with BPD.
637	SH	Sheffield Health and Social Care Foundation	7	NICE	Person centred care	5	It is extremely questionable whether a diagnosis of BPD should be made in young people as the age would mitigate against some of the important diagnostic criteria, however it may be that patterns of behaviour	Thank you for your comment. The guideline does not give recommendations about the use of the BPD diagnosis in young people

		Trust					That are similar may respond to similar interventions.	as this was outside the scope, but it does make recommendations about their care based on their meeting criteria as described by DSM-IV and ICD-10 which are cautious in applying the diagnosis.
638	SH	Sheffield Health and Social Care Foundation Trust	8	Full NICE	4.6.2.1 (1.1.4)	12	Evidence would suggest that an appropriate realistic about the uncertainties and attuned sensitivity is more important than being unrealistically optimistic and given the limited evidence base what is NICE suggesting the evidence is based on? Good therapeutic alliance is the important factor and this is more difficult in this often challenging group of people and requires high levels of training, skill and support. Being able to discriminate good therapeutic alliance from inappropriate boundaries is also an important and high level skill and there should be a duty on providers/commissioners to ensure this is provided through training, supervision and consultation. There is a case for generic training and supporting the development of this capability widely in the workforce and not just for BPD	Thank you. The GDG do not believe that approaching patients in an atmosphere of optimism and hope, and being able to explain that recovery is possible, is unrealistic. In terms of the development of the therapeutic alliance, the GDG think that this is adequately addressed throughout the guideline especially in the general principles (1.1 to 1.2 NICE guideline) and again in care planning (1.3.2 NICE guideline).
639	SH	Sheffield Health and Social Care Foundation Trust	9	Full NICE	8.5.5.1 (1.2.2)	15	Crisis and risk management is ideally part of a comprehensive CPA regardless of which particular level of service ethe patient is currently managed in. This will also almost certainly need to be an iterative process that can respond to the needs and demands of individual patients and with experience. It should be developed with input from experienced staff both in psychological/psychodynamic functioning as well as psychiatry.	Thank you. This section is specifically about crisis management in primary care and is therefore directed at primary care staff. However, risk assessment and management in community teams are dealt with in 1.3.4 and the management of crises in community teams is dealt with in 1.3. 8 [draft numbering]. We do make it clear throughout the guideline, particularly in the sections on care planning, that the response to crisis and risk should be coordinated across services and be undertaken within a CPA approach.
640	SH	Sheffield	10	Full	8.5	16	Very important to have the comprehensive care plan and this is a	See response to comment 9.

		Health and Social Care Foundation Trust		NICE	(1.3.2 1.3.3 1.3.4)		skilled and iterative process. see comment 9.	
641	SH	Sheffield Health and Social Care Foundation Trust	11	Full NICE	8.5.12.1 NICE 1.3.5 1.3.7.1, 1.3.7.2, 1.3.7.3, 1.3.7.4, 1.3.8.1 1.3.8.2	19/20/21	Useful to discriminate between specific treatments(psychological) and a "therapeutic" care programme that can offer a consistent approach over a long period of time whilst specific interventions are undertaken in this context the therapeutic care plan is the long term treatment with other interventions that could be short term (and evaluated in terms of whole care plan and not just the treatment itself) with the overall goal of improvement of functioning and reduction of symptoms/harm. Using this framework would make the recommendations in 1.3.7.1, 1.3.7.2, 1.3.7.3, 1.3.7.4, 1.3.8.1, seem less contradictory with some of the other recommendations' on duration of treatments and drug treatments.	Thank you for your comment. You do not specify which recommendations appear contradictory so it is difficult to respond more specifically. However, we have made a number of amendments to the recommendations in these sections in light of various comments from stakeholders which we hope address your concerns.
642	SH	Sheffield Health and Social Care Foundation Trust	12	Full NICE	7.4.1.1 (1.3.8.1)	21	Seems a little over prescriptive and describing an essential mental health skill at all times.	Thank you. We do not consider that the principles are over-prescriptive.
643	SH	Sheffield Health and Social Care Foundation Trust	13	Full NICE	8.5.13.1 (1.3.10.1)	24	Primary care would ideally be involved in the care planning from the start. GP's are often an essential part of providing the consistency required as part of long term management and treatment.	Thank you. We have amended the recommendation.
644	SH	Sheffield Health and Social Care Foundation Trust	14	Full NICE	5.14.2.1 (4.3)	31	Would be interesting to know evidence for discrimination between a psychological/psychotherapeutic intervention and psychosocial intervention.	We would define psychosocial as having a social component in addition to a psychological component (eg milieu therapy and some therapeutic community treatment). Psychological/psychotherapeutic interventions do not have a social component (eg psychoanalytic therapy, systemic therapies). Social therapies only include social interventions (eg nidotherapy). These classifications obviously have their limitations. Hope this is

								helplful.
645	SH	Sheffield Health and Social Care Foundation Trust	15	Full NICE	8.6.1.1 (4.5)	32	Guidelines for evaluation of care pathway would be very useful.	Thank you. This is outside the scope of the guideline.
650	SH	Somerset Partnership NHS and Social Care Trust	1	Full	General		Somerset Partnership NHS Foundation Trust welcomes the NICE Borderline Personality Disorder (BPD) guideline draft for consultation and, eagerly awaits the release of the final version. We are impressed with the detail and rigour in which it has been developed considering the complexity and diversity of the subject. The guidelines also struck us as compassionate and sensitive to the needs of the people who experience BPD, which in part is perhaps a reflection of the strong service user and carer involvement in its development.	Thank you.
651	SH	Somerset Partnership NHS and Social Care Trust	2	Full	General		There is some concern about the nature of the evidence supporting the guidelines in that it tends to rely heavily upon quantitative data, namely randomised controlled trials (RCT's). Although this is understandable in terms of validity and reliability, it is at the expense of reinforcing a hierarchy in an area where there is little consolidation and great uncertainty where grounded, qualitative methods may be more insightful and meaningful.	Thank you for your comment. Despite the fact that there are relatively few RCTs in people with BPD, this research designs remains the gold standard for determining treatment efficacy. This is recommended in the NICE handbook for developers (see http://www.nice.org.uk/media/052/6A/GuidelinesManual2008Consultation.pdf).
652	SH	Somerset Partnership NHS and Social Care Trust	3	Full	5 General		As with any guidelines they are open to interpretation and it is our view that the guidelines referring to the use of psychological therapies will be perceived as supporting specific modalities (due to the research supporting the guidelines) such as DBT and MBT. This would be at the expense of other modalities with potential benefits that have not as yet undergone RCTs and, perhaps more importantly at the expense of the well recognised guiding principles of the psychotherapeutic treatment of BPD.	Thank you for your comment. The guideline has to be evidence based and the bulk of the existing evidence base is in DBT and MBT.
653	SH	Somerset Partnership NHS and Social Care Trust	4	Full	5 General		Although we welcome the guidelines promoting relatively long-term treatment and no psychological therapy of less than 3 months duration, we are concerned that this may exclude people from accessing short-term psychological therapies in primary care, such as practice counselling.	Thank you for your comment. We only recommend psychological therapies in the context of structured care. There is no specific evidence for the effectiveness of

								counselling in borderline personality disorder and therefore we were unable to recommend it.
654	SH	Somerset Partnership NHS and Social Care Trust	5	Full	5.13.1.1 General		There is some confusion about what is meant by 'providing therapy in at least two modalities'.	Thank you. This recommendation has been amended.
655	SH	Somerset Partnership NHS and Social Care Trust	6	Full	8.5.16.1 General		There is concern that the guidelines for inpatient services may reinforce current exclusive practice and contradicts that 'people with BPD should not be excluded from any service because of their diagnosis'. The guideline is understandable considering the iatrogenic effects of historical inpatient admissions. However, with the development of specialist PD services it can be argued that planned admission might be a beneficial part of a treatment package. This was particularly voiced by CAMHS.	Thank you. We have taken this into account.
656	SH	Somerset Partnership NHS and Social Care Trust	7	Full	8.5.5.1 (1.2.2)	P13	Line 1 – 12 appear contradictory in the light of partnership Trusts.	We do not understand. Whether services are delivered under the auspices of a partnership trust, a primary care trust or other healthcare organisation, all will have primary care/general practice services, which will function as the front line. It is to these that we make the recommendation.
657	SH	Somerset Partnership NHS and Social Care Trust	8	Full	2.1	P17	Line 2 impairment not impartment.	Thank you. We have amended this.
658	SH	Somerset Partnership NHS and Social Care Trust	9	Full	5.14.2.1	P190	Line 5 analytic not analytical.	Thank you. We have amended this.
659	SH	Somerset Partnership NHS and Social Care	10	Full	General		The application of the guidelines for older people (rather than just adults) needs to be more explicit	Thank you. The guideline is intended to apply to adults of all ages and therefore specific mention of older adults has not been made.

		Trust						All services for people with borderline personality disorder whether general or specific should include people from any age group, and not descriminate on the basis of age.
660	SH	Somerset Partnership NHS and Social Care Trust	11	Full	General		We welcome that these guidelines are very much work in progress and will be subject to review	Thank you.
662	SH	South London and Maudsley NHS Foundation Trust - Referee 1	1	NICE	General		Overall these guidelines are very welcome, delineating as they do principles of good practice in managing patients with fragmented mental states who typically generate chaos and often splitting within teams. The stress on continuity of care, in planning endings and breaks, and in devising care plans with the participation of the patient, all involved services, and where appropriate the carer, is also to be welcomed. The idea of specialised teams with particular expertise in managing this patient group is also a step forward, as is the stress on adequate supervision and support for those who are most directly involved, particularly at the level of the CMHT.	Thank you.
663	SH	South London and Maudsley NHS Foundation Trust - Referee 1	2	Full NICE	General		The guidelines concentrate on the more moderate-severe end of the spectrum. There is a large group of patients with less severe borderline PD that is seen in primary care or psychological therapy units. Many of these people with borderline personality disorder hold down jobs, and function in the community, but their relationships may be very significantly disturbed. Because they often do not present with severe and acute risks they may not be eligible for treatment in CMHTs. Some more specific guidance on their management would be helpful. In particular, clarity about which of the recommendations applies only to more severe borderline pathology. This will be an issue when it comes to interpreting recommendations about the provision of psychological therapies (see comment*).	We agree with you that BPD presents with a range of severities. Where we have been able to remind practitioners of the need to consider severity we have done so (1.3.5.2 – draft guideline numbering). However the evidence for different treatment approaches for different levels of severity is pretty much non existent in the field of BPD (unlike depression and OCD for example).
664	SH	South London and Maudsley	3	Full NICE	5 General		The recommendations for psychological therapies, derive from RCTs done with the more severe end of the borderline spectrum. It would appear in section 1.3.5 that these findings are applied to the broader population of people with a borderline disorder. Thus the	Thank you. There is no specific evidence for treatments for difference severities of BPD (or even agreement on how severity

		NHS Foundation Trust - Referee 1					stress on including two modalities of therapy, and in not carrying out brief interventions for symptoms / characteristics of the disorder is appropriate for those severely affected, but probably not for patients with a milder affliction.	should be defined). However, the recommendations have been amended in light of various stakeholder comments, and there is now no mention of modalities. There is no evidence for the efficacy of brief interventions and therefore we cannot recommend them for those with milder disorder.
665	SH	South London and Maudsley NHS Foundation Trust - Referee 1	4	NICE	Introduction	3	The issue of not covering the separate management of comorbid conditions is problematic in the case of alcohol and drug misuse. It would be helpful to at least include a paragraph about the timing of psychological treatments in relation to substance abuse. There is, for example, often a psychologist in an Addictions service who will provide a short-term intervention specifically aimed at the substance abuse, but most longer-term therapy services, and many CBT services, require a period of abstinence before other, more general therapy is considered, and it would be useful for this to be explicated in some form for Primary Care and CMHT colleagues.	Thank you for your comment. This is a good point, but we think this is covered by 1.3.5.2 [draft guideline numbering] which addresses suitability for offering psychological treatment. Also, section 1.3.7 directly addresses the issue of the management of comorbidities. However, we do not agree that these issues should be dealt with in primary care.
666	SH	South London and Maudsley NHS Foundation Trust - Referee 1	5	Full NICE	4.6.1.1 (1.1.1.1)	6	Depending on the nature, extent, chronicity and severity, it may be appropriate to exclude certain forms of psychological treatment, at least for a time.	Thank you. This point is covered by the recommendation at 1.3.5.2 [draft guideline numbering].
667	SH	South London and Maudsley NHS Foundation Trust - Referee 1	6	Full NICE	4.6.2.1 (1.1.4.1)	12	The word 'recovery' is problematic, as it implies return to a previous level of functioning that may in fact never have been attained.	Thank you. This is the preferred term of service users both with borderline personality disorder, but also with a range of other mental health problems.
668	SH	South London and	7	Full NIC	4.6.4.1 (1.1.6.1)	13	Assessors are not necessarily in a position to 'provide post-assessment support'. Suggest 'ensure that the person has access to support post-assessment' would be preferable.	Thank you. The GDG think that a professional able to provide a proper assessment will also have

		Maudsley NHS Foundation Trust - Referee 1		E				the skills to be able to offer post-assessment support.
669	SH	South London and Maudsley NHS Foundation Trust - Referee 1	8	Full NICE	8.5.11.2 (1.3.4.2)	18	This may be better expressed as “enhanced CPA should normally be used.” The degree of care co-ordination depends on the services involved e.g. dietician for problematic eating + group therapy would not require enhanced CPA.	Thank you for your comment. We have amended the recommendation in light of this and other comments.
670	SH	South London and Maudsley NHS Foundation Trust - Referee 1	9	Full NICE	8.5.14.1 (1.3.5.1)	18	Not all patients would want to have ‘individual written material about the treatment model and evidence for its effectiveness’. Perhaps should read “should be available.”	Thank you – we have amended the relevant recommendations to say ‘offer’ rather than ‘give’ so that this can be refused.
671	SH	South London and Maudsley NHS Foundation Trust - Referee 1	10	Full NICE	5.13.1.1 (1.3.5.4)	19	The report does not commit itself to recommending specific psychological therapies yet is quite prescriptive about psychological therapies being provided in at least 2 modalities. This is based on moderately strong evidence base for DBT and a single RCT for mentalisation plus partial hospitalisation. While there would seem to be evidence to support the recommendation that DBT (which has a package that combines outpatient groups and individual therapy) be provided in this way, mentalisation therapy does not yet have an evidence base for individual plus outpatient group. There is also not evidence that other therapies are effective if delivered in dual modalities.	Thank you for your comment. This recommendation has been amended in light of your and other stakeholders’ comments.
672	SH	South London and Maudsley NHS Foundation Trust -	11	Full NICE	5.13.1.1 (1.3.5.4)	19	The clinical consensus within the South London and Maudsley Trust is that patients who have BPD traits but are able to function at a reasonable level can be treated in one modality with collective support and understanding between involved professionals. For instance, some patients can be seen in once or twice weekly individual or group psychotherapy, with a collective understanding within the group of professionals they normally rotate around (GP,	Thank you. This recommendation has been amended.

		Referee 1					CMHT, voluntary agencies etc) on containing strategies for their management. Some acknowledgement of this would be helpful.	
673	SH	South London and Maudsley NHS Foundation Trust - Referee 1	12	Full NICE	5.13.1.2 (1.3.5.5)	19	The recommendation for a DBT intervention service prescribed for the subgroup of women who self-harm, seems to arise from a distillation of the evidence, but as it stands, it lacks a realistic sense of gradation. It treats these women if they belong to an isolated group with the condition. Dialectical behaviour Therapy is the only named therapy given this degree of emphasis. It also suggests more confidence in DBT than is reached by a reasonably convincing analysis of the same studies in a recent Am J Psych Editorial (May 2008).	Thank you for your comment. The recommendation was specific because the only convincing evidence was for DBT in the reduction of self-harm. Almost all the patients in the studies were women.
674	SH	South London and Maudsley NHS Foundation Trust - Referee 1	13	Full NICE	5.13.1.3 (1.3.5.7)	20	A CBT for depression / anxiety may well be an appropriate first intervention, as may a year of individual outpatient psychodynamic psychotherapy, with or without the back-up of a CMHT.	Thank you. This recommendation is concerned with specific treatments for BPD and its symptoms rather than comorbid disorders which may benefit from brief interventions.
675	SH	South London and Maudsley NHS Foundation Trust - Referee 1	14	Full NICE	8.5.12.3 (1.3.7.3)	21	There is some concern about the assumption that the NICE guidelines for the comorbid conditions, derived from populations in which comorbidity for borderline personality disorder has often been screened out, would necessarily apply directly.	Thank you for your comment. The separate management of comorbid conditions was outside the scope of the guideline, and the GDG felt it was reasonable to use existing NICE guidance where appropriate. In our experience (based on developing the existing published NICE mental health guidelines), exclusion criteria in studies forming the evidence base of guidelines for Axis I disorders rarely specifically exclude Axis II disorders (whilst other Axis I disorders are frequently excluded). It is also fair to say that axis II comorbidities in included populations in such studies are on the whole poorly reported.
676	SH	South London	15	Full	8.5.16.1	25	It may be obvious that inpatient admission is needed, and then the CRT or HTT involvement would be superfluous. Perhaps might	Thank you. We disagree. Crisis Resolution and Home Treatment

		and Maudsley NHS Foundation Trust - Referee 1		NICE	(1.4.1.1)		read “should usually.”	Teams should gatekeep all admissions to the inpatient unit, and provide alternatives whereever they can, unless there are very specific reasons to prefer an inpatient admission (such as the use of the Mental Health Act). This does not mean to say that the CRHT will put everybody into home treatment or send them to a crisis house; on the contrary the CRHT may deem inpatient admission as most appropriate without any intervening home treatment.
677	SH	South London and Maudsley NHS Foundation Trust - Referee 1	16	Full NICE	8.5.18.2 (1.5.1.1)	26	There is some confusion about whether this team is primarily consultative or for treatment. These two functions need very clear delineation. If a service tries to be both there are risks of things going wrong in a crisis, when lines of responsibility can be blurred.	Thank you. We do not agree. The recommendation state what the team should offer.
678	SH	South London and Maudsley NHS Foundation Trust - Referee 2	1	Full	5		The South London and Maudsley NHS Foundation Trust (SLaM)has responded to the Draft Guidelines for Borderline Personality Disorder. As a member of the Trust Psychological Effectiveness Committee, I had a remit to respond particularly as a psychodynamic psychotherapist. The submitted comments were, I thought, an accurate representation of our views with one exception, which is that myself and other psychodynamic colleagues were exercised by the omission of any reference to Transference-Focussed Therapy in the draft, and that comment was not included in the submitted SLaM response. I understand that the Committee had a remit only to consider studies for which the authors were willing / able to provide the raw date and / or the Committee could work out from the publication what the intervention consisted of in some detail. I understand that the authors of the TFT paper did not respond to requests for further information and so the trial was not included. Whilst I can (of	Thank you for your comment. We base our conclusions about studies on calculating effect sizes from data given in the papers rather than on the statistical analyses undertaken by study authors (usually with conclusions based on statistical significance rather than the clinical significance of the effect size).In the case of the Clarkin et al 2004 trial (and subsequent publications) there are no extractable data for relevant outcomes in the published papers. Merely taking the results of the statistical tests undertaken by the authors would leave us open to criticisms of unfair evaluation

							course) see the value of examining the raw data where available, it seems quite dubious to exclude an RCT published in a high impact journal (in this case the American Journal of Psychiatry) because the raw data is not supplied. I don't think that researchers from another country can necessarily be expected to respond to such requests, however reasonable they may seem to us in the UK. It remains a fact that TFT has been shown in an RCT to be effective in the treatment of BPD and this should be reflected in some way in the final published guidelines, as to omit it is to misrepresent the state of knowledge. It is also the case that Kernberg has published widely on the TFT approach, albeit maybe not in the detail needed in this particular paper - but certainly in sufficient detail for therapists across the globe to have followed his method.	compared with other studies. The study authors supplied their data in a more usable format but these were still problematic because of the statistical procedures they used. Clarkin et al 2007 and Levy et al 2006 are publications of additional data from the Clarkin et al 2004 study. We generate a study-id based on the first author and publication year for each study, with follow-up data or data published in subsequent papers being added to the original study to avoid double-counting. The references of all publications relating to a trial can be seen in the reference section of the study characteristics tables (appendix 16 (draft appendix numbering) in the draft guideline). Therefore, the data from Clarkin et al 2007 was considered. However, there were few extractable data from these papers, and the authors were then asked to provide data in a usable format. owever, the authors did not wish us to use the data to publish between-group effect sizes calculated using the new data. No conclusions can be drawn about this study. It should be noted that we base our conclusions about studies on calculating effect sizes from data given in the papers rather than on the statistical analyses undertaken by study authors (usually with

								conclusions based on statistical significance rather than the clinical significance of the effect size). It rare that a strong recommendation specifying a particular therapy would be made from a single RCT), particularly one with relatively few participants. The best that can be said of the existing data for many psychological treatments in BPD is that they are still at an experimental stage.
688	SH	Sussex Partnership NHS Trust	1	Full	General		Our response reflect consultation with a range of experts in the organisation including, Psychologists, Psychiatrists, Nurses and Pharmacy advisors. The document was liked overall, 'it is an unusual NICE guideline in its generality, and good basic advice.	Thank you.
689	SH	Sussex Partnership NHS Trust	2	NICE	Introduction		May need to add something about different people with a diagnosis of personality disorder experiencing a range of symptoms with not everybody with the diagnosis presenting as very labile, changeable etc. (consultant Nurse).	Thank you. The introduction has been amended as a result of various comments from stakeholders. Its length is limited so we have not included all the details suggested.
690	SH	Sussex Partnership NHS Trust	3	Full	Introduction		Could add a bit about the suicide rate of people with BPD (Consultant Nurse).	Thank you. We have added a sentence to the introduction.
691	SH	Sussex Partnership NHS Trust	4	Full	General	5	Appropriate that age 16-17 remain with CAMHs (Consultant Nurse).	Thank you.
692	SH	Sussex Partnership NHS Trust	5	Full	Person Centred Care	5	'Family and carers, the support they need'. Needs to go further in describing the best type of support and intervention for families, such as consultation family sessions; pscho-education. (Consultant Nurse).	Thank you. We found no evidence on which to base recommendations for specific therapies with families.
693	SH	Sussex Partnership NHS Trust	6	NICE	1.1.1.1 – 1.1.41	6	Good focus on optimistic care (Consultant Nurse).	Thank you.
694	SH	Sussex Partnership NHS Trust	7	Full	9.10.1.3 (1.1.7.2)		Liked the specific stating of the helpfulness for the individual if all treatment could be completed within CAMHs, even if that goes beyond 18 years (Psychiatrist)	Thank you.

695	SH	Sussex Partnership NHS Trust	8	Full	8.5.11.1 (1.3.4.1)	7	Needs to add a bit about relapse plans, identifying early signs of relapse – thereby trying to avoid a crisis (Consultant Nurse)	Thank you for your comment. This point is covered in the earlier recommendation at 1.3.3.1, final bullet about potential triggers.
696	SH	Sussex Partnership NHS Trust	9	Full	5.13.1.1 (1.3.5.4)		Disagreed with the phrasing, and perhaps the intent, of this paragraph. An individual may not need therapy in at least two modalities, for example, one 24 session individual Cognitive Analytic Therapy may be all that is required for some people with BPD. However, I would agree that a PD SERVICE should offer psychological treatment in at least two modalities. At least two modalities should therefore be potentially available for each individual with BPD but not that every individual will require treatment in more than one modality.The definition of the term 'modality' as used here could be usefully expanded on. The example given, 'individual or group' is potentially misleading and too restrictive. A PD service should potentially have different modalitiesof therapy available as defined by the number of people being treated (individual, group, couple or family) AND different modalities of therapy available as defined by theoretical and clinical model (psychodynamic, CBT, CAT, systemic, DBT, BMT, STEPPS, IPT, schema-focussed etc. etc.) This is needed because different individuals connect with different models of therapy, that is, some with one model (e.g. cognitive) and others with another (e.g. psychoanalytic), so to have an overly restricted choice within a service or geographical area would seriously disadvantage some people with BPD. It would be helpful if this was spelt out more. (psychiatrist)	Thank you for your comment. The guideline is evidence based and, as yet, there is no high quality evidence for many of the psychological therapies you mention. The recommendation has been amended as a result of stakeholder comments.
697	SH	Sussex Partnership NHS Trust	10	Full	8.5 (1.3.5.7 and 1.3.7.3)	8	At first and fast reading, these two recommendations (both of them good ones) seem to contradict each other. Again, might benefit from spelling out for clarity i.e. don't try and treat the BPD or any symptoms thereof with brief psychotherapy, but brief psychotherapy may be appropriate for treating a co-morbid axis 1 condition – any decision needs to be thought through carefully, to be clear what you are treating and why, and whether it is safe to 'compartmentalise' like that. (Psychiatrist)	Thank you. The first recommendation is about the treatment of BPD not comorbid conditions as you point out. This is already clearly stated in the recommendatin.
698	SH	Sussex Partnership NHS Trust	11	Full	8.5.12.2 (1.3.7.2)		A good recommendation (Consultant Nurse).	Thank you.
699	SH	Sussex	12	Full	8.5.10.3	17	Could add about not minimising risk when they know people very	Thank you. We have already made

		Partnership NHS Trust			(1.3.3.3)		well. Could add about positive risk taking. Could add about needing to complete a good baseline assessment of risk, understanding of the person's usual functioning. (Consultant Nurse)	this point in the first bullet of the recommendation.
700	SH	Sussex Partnership NHS Trust	13	Full	8.5.14.4 (1.3.5.6)	19	Terminology 'enhanced CPA' no longer used (June 2008) [Consultant Nurse]	Thank you. We have amended the relevant recommendations.
701	SH	Sussex Partnership NHS Trust	14	Full	8.5.16.1 (1.4.1.1)	26	CRS – all admissions (nationally) should now be gate-kept by CRS teams (Consultant Nurse).	Thank you. We agree.
702	SH	Sussex Partnership NHS Trust	15	Full	8.5.16.3 (1.4.1.3)	26	Agreeing length of stay prior to admission. Although this is ideal, it is not always possible to stick to. The guidance could go further and say that respite in acute inpatient units is not appropriate. (Consultant Nurse – CAMHs)).	Thank you. Given the complex nature of BPD, its overlap with other conditions and presentations, and the fact that it is frequently comorbid with a range of other serious mental health problems, we suggest that we would be unwise to proscribe in the way you suggest. Rather, our aim is to limit the unthoughtout use of inpatient services.
703	SH	Sussex Partnership NHS Trust	16	Full	2.2	20	Suggestion that you change the title to 'Some instruments used in the assessment…' as instruments not included are MMPI, MCMI-III, ZAN-BPD. The implications of the way it is currently written could be that these are the recommended instruments. (Psychological therapies).	Thank you – we have amended the heading to indicate that these are the main instruments available.
704	SH	Sussex Partnership NHS Trust	17	Full	2.5.3	28	1. STEPPS has only recently been introduced into the UK, but originated in the USA in the early 90s and has been used in the Netherlands since 1998. The programme is now expanding world-wide. The programme has suffered from a lack of publicity and marketing, but two RCTs have been published, one of which is discussed in this document (Blum2008), but the other not (Van Wel, 2006). Clinicians have been trained in 80% of clinics in Holland, and around 7500 people have gone through the programme (called VERS). A pilot on emotional regulation training based on VERS with adolescents is also currently underway in the Netherlands, and they have developed material on parenting skills for people who have gone through STEPPS training. In addition to the pilot study being run in Sussex, initial groups have also recently been run or are being planned in Kent, Surrey and Scotland. This	Thank you for this information, much of which gives useful background but is not possible to include in the guideline itself. The Van Wel 2006 paper is a review of STEPPS and not an RCT.

							would suggest that it is a significant treatment approach with a growing following. 2. The programme follows a skills development, CBT based model, but includes a systems component. There is considerable overlap with DBT, but with significant differences to make it distinctive, and likely to provide advantages in certain settings. 3. STEPPS is characterised in the guideline document as a stand-alone, 'individual' therapy. This is inaccurate. It is intended to be used to supplement/ complement other treatments for BPD, and as such, should be characterised as 'complex'. 4. At Sussex Partnership Trust we are involved in of a pilot study, using non RCT quantitative and qualitative methodology. Early indications are that it is effective in reducing symptoms of BPD and has other positive benefits. It has been very favourably received by service users and clinicians. To date it has brought about significant change in attitude amongst staff, and has raised levels of understanding, acceptance and willingness to work with BPD, as staff feel more involved and part of the programme as a result of directly engaging them through the systems element of STEPPS. It is relatively easy to train, easy to understand and considerably less expensive to train, implement and run than DBT. Research is at a very early stage, and more time is needed to ascertain relative advantages of the two models. A pilot with young people (16 to 22) is being planned for early 2009. (Psychological therapies).	The GDG considered the specific point about whether to include STEPPS as a 'complex' therapy. As it is used to complement other treatments we have amended the description of STEPPS to acknowledge this. In this respect it is covered by the recommendation about best practice, but it does not of itself meet our criteria for a complex intervention (now termed therapy programme). We are pleased to hear about the plans for further research on this model, and we anticipate future revisions of this guideline will be reviewing a rapidly developing research base.
705	SH	Sussex Partnership NHS Trust	18	Full	2.5.3	28	(Following from previous comment)We would therefore request that STEPPS be mentioned specifically in this paragraph and in other places in the document (which will be highlighted in the comments), so that readers are made aware that DBT is not the only skills development approach or 'complex' therapy that might work together with other therapies like MBT. (In fact we are in the early stages of planning a 3-day intensive day programme pilot, using	Thank you. This section is intended as an introduction and outline history of the development of therapies for BPD.

							STEPPS plus MBT or another longer term psychological therapy model like CAT). This will provide flexibility and choice, and keep the research and commissioning agenda more open to alternatives. (Psychological therapies).	
706	SH	Sussex Partnership NHS Trust	19	Full	2.5.5	33	Line 5 – The division of art therapy into analytic and creative does not correspond with current clinical practice or literature. A more up to date definition is provided by the following quotation: Arts therapies are the creative use of the artistic media as vehicles for non-verbal and/ or symbolic communication, within a holding environment, encouraged by a well defined client-therapist relationship, in order to achieve personal and/ or social therapeutic goals appropriate for the individual.' Karkou and sanderson (2006) Arts Therapies: A Research Based Map of the Field, Elsevier, p46. Additionally it is important to recognise within the guidelines that the arts therapies - art therapy, dance movement therapy, dramatherapy and music therapy – are psychological therapies. Within our services they form part of specialist psychological therapy provision. In this way the following definition is of value. The arts therapies are forms of psychotherapy that uses arts media (visual art, dance, drama or music) as its primary mode of communication. Patients are assessed for group or individual therapy. The primary concern is to effect change and growth through the use of the art form in a safe and facilitating environment in the presence of a therapist. It differs from other psychological therapies in that it is particularly helpful for those who find it hard to express thoughts and feelings verbally. (LINE 17-18) Local evidence shows that where arts therapists are employed, people with borderline personality disorder are routinely referred. There is substantial anecdotal evidence/expert opinion in local settings of the value of these approaches. Where arts therapists are employed they are a key part of multi-disciplinary approaches. To address the current lack of RCT evidence for arts therapies with people with borderline personality disorder we request that NICE	Thank you. We have amended this section to remove the description of art therapy as divided into two, and to use some of the material you have suggested. We are limited to 5 research recommendations per guideline which the GDG prioritised based on an expert consensus view of which piece of research, if completed and published before the guideline is due to be updated (usually in 4 years time), would be most likely to improve the guideline. We would urge you to publish any evidence you have of efficacy where this can be collected in a rigorous manner which would stand up to scrutiny. This would help improve the evidence base.

							supports research for the arts therapies given both their historic and current involvement in this area of work. The lack of RCT evidence should not be taken as evidence that these approaches are not effective. (Psychological therapies)	
707	SH	Sussex Partnership NHS Trust	20	Full	2.9	37	Uncomfortable with phrases such as 'borderline personality disorder presents an excessive health and economic burden to people with the condition, families, healthcare workers, hospitals and society as a whole (37 /44). Do you use the word 'burden' with other service user groups. Terms such as 'challenge, difficulty or problem' are used in other contexts where services are having their resources drained. (Psychological therapies)	Thank you. The term 'economic burden' is well established – cf 'disease burden' in line 4.
708	SH	Sussex Partnership NHS Trust	21	Full	4.4	102	Although the guidance recognises links between factors from the individual's social context and their diagnosis of borderline personality disorder (page 102 /17, for example), these are not explained and the document then filters out these social influences in its theoretical modelling. (Psychological therapies).	Thank you. In the introductory chatper (chapter 2) there are substantial sections on psychosocial factors, attachment processes, and the need to take a broad multi-agency perspective because of the social context within which people with borderline personality disorder both live and receive treatment. This is approached froma slightly different angle in the chapter to which you are referring (the service user and carer perspective). The rest of the guideline necessarily takes a pragmatic, evidence-based approach to what works in treatment and management. The GDG is content with the balance the guideline holds regarding individual social context.
709	SH	Sussex Partnership NHS Trust	22	Full	4.5	105	The central role of socioeconomic status in aetiology and outcome (Cohen, Chen, Gordon, Johnson, Brook & Kasen, 2008) is pushed to the background. This individualism is expressed in statements such as; "When assessing people with borderline personality disorder it is important to recognise that physical expressions such as self-harm are usually indicative of internal emotions" (page 105 / 1). Cultural differences in self harm presentation are ignored and	Thank you. We refer you to our response to your comment #21 about p102.

							this kind of thinking requires that we bracket off the social context and imagine that the service user is an isolated individual. We are asked to understand the causes of their behaviours as primarily internal processes. Our experience suggests this individualistic approach hinders our use of empathy and can sabotage the formation of a therapeutic alliance. Where the service user has suffered neglect, abuse or discrimination it may be important to validate the significance of this and it is often helpful to observe that there are problems in society. It is also helpful to promote the reality that people are not alone in their suffering and that change is needed not just in their personal adjustment to their experiences, but in society in general. A holistic assessment (as might be expected under C.P.A.) should bridge disciplines to include an appreciation of social, cultural, moral, and religious domains. So rather than just providing individual therapy, interventions which are founded on multidisciplinary assessment can have a 'social inclusion' impact at cultural or societal levels (James & Prilleltensky, 2002). Cohen, P., Chen, H., Gordon, K., Johnson, J., Brook, J. & Kasen, S. (2008) Socioeconomic background and the developmental course of schizotypal and borderline personality disorder symptoms. Development and Psychopathology. 20, 633-650. James, S. & Prilleltensky, I. (2002) Cultural diversity and mental health: Towards integrative practice. Clinical Psychology Review. 22, 1133-54. (Psychological therapies)	
710	SH	Sussex Partnership NHS Trust	23	Full	5.2	109	For reasons outline in Comment no 2, we request a mention of STEPPS in this paragraph. (from line 36) (Psychological therapies)	As is the case with an evidence-based guideline, the psychological therapies described do not comprise a comprehensive list of every therapeutic approach (of which there are many) but only those therapies where there is at least one published account of application to people with Borderline Personality Disorder. No such references to Transactional Analysis were retrieved by our

								search strategies.
711	SH	Sussex Partnership NHS Trust	24	Full	5.2	109	Line 23 : STEPPS lasts 6 months.	Thank you. The chapter has been redrafted in light of various comments from stakeholders, and this sentence has been deleted.
712	SH	Sussex Partnership NHS Trust	25	Full	5.2.1	110	Complex therapies are distinguished from 'single modality' therapies, both individual and group. After this point, all single modality therapies appear to be referred to as 'individual' whether 1:1 or group. This seems confusing. (See comment 1, point no. 3). STEPPS is designed as a 'complex' therapy in these terms. It has been stated in this document that DBT is sometimes not applied as intended, because of resource issues (page 29 line 24), and in some instances this relates to DBT being provided without another therapy such as MBT or even without group DBT therapy. This means that DBT in such instances, becomes a single-modality therapy. In the Sussex pilot of STEPPS, we have aimed to provide 1:1 therapy and skills reinforcement in addition to the skills group, and also intend combining STEPPS with MBT in our future pilot day service, making it by current definition, a 'complex' therapy. MBT is presented as 'complex' because of being provided with a day hospital programme. Where MBT is provided outside of this, does it become 'individual'? Perhaps the GDG could reconsider this categorisation of therapies, especially in the light of the repeated principle that the whole treatment package for BPD should be 'complex', i.e. involving many different kinds of input, for it to be effective. (Psychological therapies).	Thank you for your comment. We have revised our use of the term 'complex' to make our meaning clearer. We have also revised the clinical recommendation relating to this evidence (1.3.5.4 in the draft NICE guideline). The terms are designed to describe the research evidence rather than how these treatments may have been implemented.
713	SH	Sussex Partnership NHS Trust	26	Full	5.2.3	111	Line 44 This section omits the systems component in STEPPS. Suggested change: 'STEPPS is a CBT-based skills development package presented in 2 hour sessions over a period of 20 weeks. It includes a 2 hour session for family members and significant others, including members of the treatment team, to introduce them to the concepts and skills to enable them to provide support and reinforcement of skills for participants. The programme comprises three phases…' (Psychological therapies)	This has been amended in line with your suggestion.

714	SH	Sussex Partnership NHS Trust	27	Full	5.2.9	119	1. Table headings 'Complex' and 'Individual' is misleading (see Comment 4). If this classification of therapies is to be retained, could the names be changed to 'complex' and 'single modality' to avoid confusion around 'group' vs 'individual' therapy. 2. It is difficult to place STEPPS in either column, since some people would have received STEPPS plus another kind of therapy included in their 'TAU'(Psychological therapies).	Thank you for your comment. We have revised our use of the terms 'complex' and 'individual' to make our meaning clearer. The addition of a specific intervention to TAU does not necessarily create a structured and theoretically coherent programme.
715	SH	Sussex Partnership NHS Trust	28	Full	5.8	173	Line 27: 'single modality' as opposed to 'individual'.	This has been revised to omit the term 'individual'.
716	SH	Sussex Partnership NHS Trust	29	Full	5.14 Research recs	189	In order to keep options open regarding research of other therapy approaches, and potential pressure on services to invest in expensive therapies where cost-effectiveness has not clearly been demonstrated: 1. This paragraph heading would more equitably be 'Complex interventions for people with borderline personality disorder' 2. Line 19 : 'A randomised trial of complex interventions (for example, dbt… 3. line 36: A pragmatic trial comparing two complex… ' (i.e. omit 'these') (Psychological therapies)	Thank you for your comment. We have amended the heading of this paragraph. These recommendations have been reworded.
717	SH	Sussex Partnership NHS Trust	30	Full	5.14.2.1	190	Please include STEPPS	Thank you. The list of therapies is intended to give examples and has been amended to make this clearer.
718	SH	Sussex Partnership NHS Trust	31	Full	6.12	258	Please insert a caveat around the prescribing of medication of any kind being used as a substitute for psychological therapy/psychosocial interventions. There is a potential risk that medication reduces the individual's motivation to work in therapy by making emotions less accessible, and by increasing dependency on a medical solution. (Psychological therapies)	Thank you. We consider that this point is covered in 1.3.8.2 (draft NICE guideline numbering).
719	SH	Sussex Partnership NHS Trust	32	Full	8.1	268	Line 12 '…least costly intervention…' In West Sussex, the current level of investment in STEPPS is at around 10-15% of the cost of implementing DBT for the same population. More time to thoroughly research the cost-benefit ratio would be helpful, so that a stepped care model can be implemented. Cf. comment 29 above) (Psychological therapies)	Thank you for your comment. There are currently insufficient data to provide accurate cost-benefit data for different psychological therapies.
720	SH	Sussex	33	Full	8.5.8	288	Line 33. There is a risk that where professionals are required as a	Thank you. We feel we have

		Partnership NHS Trust					routine to ask about a history of sexual abuse that the service user begins to elaborate and may become retraumatised or have emotional levels become so aroused as to precipitate a crisis. Professionals need to understand the limits of what should be dealt with during an assessment, and how to contain this issue. Also, some services routinely refer service users to groups or other therapies specifically for childhood sexual abuse, without checking first whether there is BPD, and referring for more appropriate and less risky management. (Psychological therapies)	covered the point you make in 1.1.4.1 [draft NICE guideline numbering].
721	SH	Sussex Partnership NHS Trust	34	Full	8.5.10.3 Section on 'management'	292	L 39 This line risks professionals telling or implying to service users that they should make changes that might be precipitous and unwise, e.g. change their job. Therapeutic wisdom is that it is not a good idea to make major decisions while in the process of therapy or while in crisis. (Psychological therapies)	Thank you. This has been amended in light of this and other comments.
722	SH	Sussex Partnership NHS Trust	35	Full	8.5.16	299	The issue of respite or planned admissions is not clearly discussed throughout the document, and here it looks as though admission for this purpose is specifically excluded. Service users have specifically requested access to respite (Page 94, line 26) and there is anecdotal evidence that it is helpful. Ideally this should not be in an acute psychiatric ward, but should be in a crisis house. However, in the absence of the latter, and in the light of the potential averting of a crisis (page 94 line 27), should this be recommended as a possible option in certain circumstances? Reference: Kessel (van), K., Lambie, I. & Stewart, M.W. (2002) The impact of brief planned admissions on inpatient mental health unit utilisation for people with a diagnosis of borderline personality disorder. New Zealand Journal of Psychology. 31/2, 93-7. (Psychological therapies)	Thank you for your comment. This would be covered by averting a crisis. This is likely to be done via crisis teams who have access to crisis houses if available. We have amended the recommendations 1.4.1.3 and 1.4.1.1 [draft NICE guideline numbering].
723	SH	Sussex Partnership NHS Trust	36	Full	8.5.17	302	Line 1 does not make sense(Psychological therapies).	Thank you for your comment. We believe the sentence to be clear as it is.
724	SH	Sussex Partnership NHS Trust	37	Full	9.2	310	It might be helpful when considering terms if the document referred to alternative terms such as 'emotional intensity'(Psychological therapies).	Thank you for your comment. We are not sure to what you are referring as this section describes the issue of diagnosis of BPD in young people.
725	SH	Sussex Partnership	38	Full	9.5.2	322	High levels of functional impairment are noted within this section on Assessment also later in the document. There is no mention of the	Thank you. When the GDG searched the literature for

		NHS Trust					value of Occupational Therapy Assessment and Treatment and research based models such as the Model of Human Occupation (Gary Kielhofner, 2008) developed over the last 30 years which provides a sound evidence based framework and standardised assessments which can provide an essential basis for addressing these problems. Also as mentioned be extremely effective in addressing volitional/motivational and engagement issues. (Psychological therapies)	assessment tools these measures did not appear.
726	SH	Sussex Partnership NHS Trust	39	Full	9.8.3	335	The recommendations still refer to diagnosis, is it correct to encourage early diagnosis and labelling, rather than recognition of areas of difficulty and working with a young person (and providing a service) on that basis. It needs to be acknowledged that young people are refused help in adult mental health without formal diagnosis. This impedes effective transition as discussed on page 335. (Psychological therapies)	Thank you. We have added in some qualifying statements about the potential risks of labelling. On balance the GDG felt that a consideration of the diagnosis early in the context of a comprehensive assessment was to be preferred. We have also added in some statements about developing a formulation of the young person's difficulties.
727	SH	Sussex Partnership NHS Trust	40	Full	General		1. Insufficient mention of gender and sexuality. 2. There seems to be very little reference to gender in the guidance and given the strong connections between this diagnosis and sexual abuse I wonder why there is no mention of gender appropriate services, as recommended in other guidance (Owen & Khalil, 2007). East Sussex has a very successful Women's Service and some recommendations related this would be helpful. Owen, S. & Khalil, E. (2007) Addressing diversity in mental health care: a review of guidance documents. International Journal of Nursing Studies. 44, 467-78. (Psychological therapies)	Thank you for your comments. 1 There is very little evidence specifically relating to these issues in people with BPD. 2 There is no evidence for the effectiveness of these services specifically in people with BPD. Indeed, we found no evidence for services in this client group.
728	SH	Sussex Partnership NHS Trust	41	Full	General		Not enough on the importance of risk management, and connected with this, teamwork. Also not enough on staff support and supervision which is emphasised in the "no longer a diagnosis of exclusion" paper. (Psychological therapies)	Thank you for your comment. As a result of this and other comments we have made a new recommendation about training and supervision in section 1.1 of the NICE guideline.
729	SH	Sussex	42	Full	5		In the meta-analysis of studies DBT is represented more than other	Thank you for your comment. Since

		Partnership NHS Trust			General		treatment modalities, as there have been more studies on outcome using this therapeutic technique. There is insufficient evidence at this stage for other forms of treatment, and in particular psychodynamic forms of treatment, is it presumptuous to say that such forms of therapy cannot be recommended. Experience and anecdotal evidence suggests these forms of therapy are often sought by people with a diagnosis of BPD. Shorter forms of therapy, when combined with other modalities, can be effective in our experience. (Psychological therapies)	the guideline is evidence based it can only make recommendations for treatments that have good quality evidence of their effectiveness.
730	SH	Sussex Partnership NHS Trust	43	Full	5	109-89	There is some suggestion that the guidance relies too heavily on a 'disease model' and it glosses over distinctions between different kinds of therapeutic outcome. Therapeutic communities for example, might enable service users to identify and experience challenging existential problems, such as facing their vulnerability, their need to give meaning to confusing experiences and the effects of their behaviour on others. These opportunities lead to outcomes such as self-awareness, maturity and feelings of connectedness to others. Yet the guidance confuses these outcomes with the treatment of disease. A therapy which enables the body to overcome an invasive biological disease process has an outcome of returning the person (to some degree) to a previous state of good health, but does not necessarily change their philosophical views, or their habitual ways of interacting with others. By failing to observe these distinctions, the guidance homogenises a diverse range of treatments and it promotes the notion of a suffering 'individual' who has an 'illness' which causes 'challenging behaviours', leading to social and relationship problems. This emphasis neglects complex flows of causality, which are likely to run both ways between the individual and their communities. Rather than just working with individuals, some therapeutic approaches include extensive work with friends and relatives (Pincus, 2004). The guidance observes that emphasising the notion of abuse within a family might lead to greater stigmatisation of carers, but it fails to observe the positive outcomes of more complex interventions, such as the STEPPS programme, which include work with carers (both family and friends). Treating a social network is not the same as treating an individual.	Thank you for your comment. The GDG fully understand the limitations of a disease model in the context borderline personality disorder. As a consequence the guideline takes a more pragmatic approach to what works, rather than what cures. They carefully examined the available evidence for a wide range of treatments and treatment models including therapeutic communities and STEPPS. It found no high quality evidence for therapeutic communities, so was unable to recommend them. Similarly, the evidence for STEPPS was not convincing (i.e., it did not significantly improve outcomes across a range of mesures compared with treatment as usual, although there was some improvement on a few outcomes). Since there was so little evidence, the guideline makes a general recommendation that therapy should be provided as part of structured care and have a

							Pincus, A.L. (2004) A contemporary integrative interpersonal theory of personality disorder. In M.F. Lenzenweger & J.F. Clarkin (Eds.), Major theories of personality disorder 2nd ed. (pp. 282-331) London, The Guilford Press. (Psychological therapies)	integrated theoretical base (see recommendation 1.3.5.4 draft NICE guideline numbering). To do more than this was not possible given the weak evidence base. We attempted to review evidence for interventions specifically with carers but there were few data (see chapter 5) and none strong enough for a specific recommendation.
731	SH	Sussex Partnership NHS Trust	44	Full	General		In general the guidance is vulnerable to the sociological criticism that by seeking to change individuals, we are treating the symptoms and ignoring the cause; which might be largely societal in its origins (Cromby etal., 2007). Thinking again about treatment models, the disease model includes an assumption that individuals are disadvantaged by their diagnosed condition (Tyrer & Steinberg, 1993). However Gottschalk (2000) argues that suffering form Borderline Personality Disorder might make it easier for people to fit into an impoverished and socially disconnected Modern western society. Recognising cultural difference is important here, because in promoting particular understandings of 'wellness' we might be promoting a narrow view of how people should be in our society. Also, considering the prevalence of a dual diagnosis with substance misuse, the use of approaches such as Motivational Interviewing and harm minimisation strategies might be included in the guidance. In these approaches, the responsibility for achieving therapeutic change rests mainly with the service user. While in contrast, within the disease model this responsibility is transferred to the medical worker. Unrealistic expectations might be generated if the guidance lacks clarity on these issues. Cromby, J., Diamond, B., Kelly, P., Moloney, P., Priest, P. & Smail, D. (2007) Questioning the science and politics of happiness. The Psychologist. 20/7, 422-425. Gottschalk, S. (2000) Escape from insanity: 'Mental disorder' in the postmodern. In D. Fee (Ed.), Pathology and the postmodern: Mental illness as	Thank you. Although these points are interesting, they are outside the scope of the guideline which is focused on specific advice for the treatment and management of BPD for the NHS. The issue of dual diagnosis is the topic of a separate guideline which has been commissioned by NICE.

							discourse and experience (pp. 18–48). London, Sage. Tyrer, P. & Steinberg, D. (1993) Models for Mental Disorder, Conceptual Models in Psychiatry. Chichester, John Wiley & Son. (Psychological therapies)	
732	SH	Sussex Partnership NHS Trust	45	Full	General		The guidance includes some limited acknowledgement of the key therapeutic component of contracting, but fails to recommend the use of this within a whole systems approach. A lot of effective clinical practice is grounded on the ability of service providers to require that their service users accept help in engaging in 'positive health promoting' activities, which are a more effective form of therapy than attempting to contain the service user in their escalating patterns of risky and challenging behaviours. In general the document creates confusion in glossing over the debate as to whether it is the responsibility of service provider to manage challenging behaviours, as if they were an outcome of a treatable disease entity, which has an existence separately from the person, or whether it is the person themselves who is 'the problem'. Implicit messages might be transmitted by the attempt to frame interventions within a RCT research model; that there is a medical intervention that works and that service users are entitled to be provided with it. (Psychological therapies)	Thank you. Unfortunately, because your comments are very general and do not refer to a specific section of the gudieline, it is difficult to answer or respond. The GDG believes it has got the balance right between support and individual responsibility, and has put a great deal of effort into making sure that that balance is explicity within the guideline, and to point out the harm that can be done by getting this balance wrong. The inclusion of service users in the GDG helped to ensure that this was done appropriately.
733	SH	Sussex Partnership NHS Trust	46	Full	General		We could not find any comments on the 'zero tolerance' campaign which is designed to protect staff from violence and abuse. Some advice on the use of police action against service users might be helpful. Some advice on the use of Safeguarding Vulnerable Adults legislation to manage conflict, neglect or abuse in adult relationships would also be beneficial. Meanwhile, contention can be neatly avoided in a recovery oriented approach as attention is drawn to the solution; which usually involves many mutually held responsibilities as the service user, their informal carers and a number of different kinds of workers from different agencies work together.	Thank you. This is a good point but is not specific to borderline personality disorder so lies outside the scope of the guideline. NICE has issues guidance on the management of imminent violence.
734	SH	Sussex Partnership NHS Trust	47	Full NICE	5.14.1.1 (4.2)	30	Heading: 'Complex interventions for people with borderline personality disorder' Middle of paragraph 'Why this is important' …A pragmatic trial comparing complex interventions such as these	Thank you for your comment. We have amended the term 'complex interventions' (see chapter 5 full guideline).

							against high quality…. This enables services to research equivalent therapies which may be used in combination. (Psychological therapies)	
735	SH	Sussex Partnership NHS Trust	48	Full	General		Needs a section on supporting staff/ supervision. Although it is there it needs to be more explicit that it should be for all staff (Consultant Nurse)	Thank you for your comment. As a result of this and other comments we have made a new recommendation about training and supervision in section 1.1 of the NICE guideline.
736	SH	Sussex Partnership NHS Trust	49	Full	General	23	The guidance should recognise more that people with BPD frequently have co-existing substance misuse problem which is secondary to BPD. When this is the case, CMHTs should have some expertise in working with people with BPD and the substance problem as it will not always be appropriate to refer to specialist substance misuse services. This is in line with Dual Diagnosis guidance. (Consultant Nurse)	Thank you. The guideline mentions the issue of comorbidity with substance misuse. The recommendation to refer to specialist services states 'consider referrring'.
737	SH	Sussex Partnership NHS Trust	50	Full	General		The guideline is disappointing for those of us who were hoping for official backing for our particular type of therapy (in my case CAT and group analysis), amid current fears that such treatments may not be funded in the NHS anymore unless they are specifically named as being recommended in some NICE guideline somewhere – and for many traditional as well as promising new psychotherapies, the BPD guideline was and is our best hope for that. It is a sad (and skewed, unintended) consequence of the existence of NICE guidelines that some useful therapies may become unavailable in the current political and commissioning climate, unless they are specifically recommended – however it is a reality on the 'frontline' of the NHS. (Consultant Psychiatrist)	Thank you. The guideline is based on the best-available evidence. There is insufficient evidence for a recommendation to the NHS for CAT at the present time.
739	SH	Tavistock and Portman Foundation Trust	1	Full	General	Guideline Introductio n, p 4 p 5 and p 11	We are pleased that the Guidelines have framed the recommendations to reflect the limitations of the evidence regarding the effectiveness of treatments for individuals with borderline personality disorder (Guideline Introduction, p 4). In addition, variability among individuals with the disorder, not only in relation to psychopathology and personal circumstances, but also with regard to preference of therapeutic approach (Guideline Person-centred care, p 5 and p 11) means that it is very important to sustain diversity in available interventions that can ameliorate the disorder and the suffering it entails.	Thank you.

							However, we are seriously concerned that the Guideline is not balanced in its appraisal of the role that transference-based psychodynamic psychotherapy should play in the management of borderline personality disorder. Therefore we urge that it be amended as follows:	
740	SH	Tavistock and Portman Foundation Trust	2	Full	General	Pg 448	We strongly suggest that the Guideline should recognize the potential importance of psychodynamic psychotherapy (both group and individual) in the treatment of individuals with borderline personality disorder. It is dismaying that the references in the full version of the Guideline [see references, p 448] fail to include a study yielding critical evidence for the value of such therapy, as this emerged from the substantial randomized controlled trial conducted by Clarkin et al (2007) and published in the American Journal of Psychiatry, for which the conclusions were as follows: 'A structured dynamic treatment, transference-focused psychotherapy was associated with change in multiple constructs across six domains; dialectical behaviour therapy and supportive treatment were associated with fewer changes'(Abstract). This evidence should be given due weight (as also that from Chiesa & Fonagy, 2000, for the effectiveness of psychodynamic psychotherapy in mixed in- and out-patient settings), and its implications reflected in the recommendations for treatment and future research.	Thank you for your comment. The Clarkin et al 2007 paper is part of the Clarkin et al 2004 study as is therefore referenced as such to avoid double-counting. The reference can be seen in the study characteristics in Appendix 16 (draft appendix numbering) [draft guideline appendices]. It should be noted that we base our conclusions about studies on calculating effect sizes from data given in the papers rather than on the statistical analyses undertaken by study authors (usually with conclusions based on statistical significance rather than the clinical significance of the effect size).In the case of the Clarkin et al 2004 trial (and subsequent publications) there are no extractable data for relevant outcomes in the published papers. Clarkin et al 2007 and Levy et al 2006 are publications of additional data from the Clarkin et al 2004 study. We generate a study-id based on the first author and publication year for each study, with follow-up data or data published in subsequent papers being added to the original study to avoid double-counting. The references of all publications relating to a trial can

								be seen in the reference section of the study characteristics tables (appendix 16 (draft appendix numbering) in the draft guideline). Therefore, the data from Clarkin et al 2007 was considered. However, there were few extractable data from these papers, and the authors were then asked to provide data in a usable format. However, the authors did not wish us to use the data to publish between-group effect sizes calculated using the new data. No conclusions can be drawn about this study. It should be noted that we base our conclusions about studies on calculating effect sizes from data given in the papers rather than on the statistical analyses undertaken by study authors (usually with conclusions based on statistical significance rather than the clinical significance of the effect size). It rare that a strong recommendation specifying a particular therapy would be made from a single RCT), particularly one with relatively few participants. The best that can be said of the existing data for many psychological treatments in BPD is that they are still at an experimental stage.
741	SH	Tavistock and Portman Foundation Trust	3	Full	5 General		Even if it is argued that there are an insufficient number of randomized controlled trials to recommend conventional psychodynamic outpatient treatment for patients with borderline personality disorder considered as a group (ie., simply in virtue of falling into this diagnostic category), both clinical reports and	Thank you for your comment. Please see response to previous comment regarding the Clarkin trial. The issue of the separate

							studies such as that of Clarkin and colleagues indicate there are strong grounds for considering the benefits of such treatment for selected individuals. The Guideline (in any short as well as long version) should reflect this. In addition, borderline personality disorder is frequently accompanied by comorbid depression and other disorders. The evidence that currently recommended treatments are effective in these respects is scant. It is inadequate to argue (as the Draft Guideline does in the Introduction, p 3) that the 'guideline does not cover the separate management of comorbid conditions'. If we are to have truly 'person-centred care', then the indications for treatment should relate not only to evidence from research on relatively 'pure' cases of borderline personality disorder, but also to evidence that relates to individuals with a range of psychopathology. Indeed, there is evidence for the value of psychodynamic psychotherapy for such patients presenting with complex disorders and high utilization of psychiatric services (e.g., Guthrie et al, 1999).	management of comorbidity is outside the guideline scope.However, the management of comorbidities is partially dealt with in section 1.3.7 [draft guideline numbering]. Thank you for your reference to Guthrie et al (1999). There are a number of studies which claim benefit for patients, but these are not randomised or properly controlled. It is not possible to determine superiority of one treatment over another, or indeed of any treatment over treatment as usual without undertaking a proper RCT.
742	SH	Tavistock and Portman Foundation Trust	4	Full	8.5 (1.3.4 1.5.1)	Page 17	We strongly suggest that professionals trained in psychodynamic psychotherapy should be involved in the proposed teams managing borderline personality disorder. [Guideline p 17, section 1.3.4, and p 26, section 1.5.1].	Thank you. We had no evidence on which to base recommendations about the specific nature of teams.
743	SH	Tavistock and Portman Foundation Trust	5	Full	General		The Guideline focuses upon the importance of effective communication among those professionals involved in the management of affected individuals. In many cases, such communication may be adversely influenced by the effects of these patients' psychopathology, for example through 'splitting' and opposing the stances and functions of different professionals. Although such processes are recognized by a range of professionals, psychodynamic psychotherapists have training and experience in paying special attention to, and to manage, these broader anti-therapeutic effects of borderline personality disorder.	Thank you. We do not have any specific evidence on the effectiveness of different models of managing effective communication between staff.
744	SH	Tavistock and Portman Foundation	6	NICE	1.3 , p 15	Guideline pp 8-9	We strongly suggest that professionals with training in psychodynamic psychotherapy should be involved in training and supervising professionals who will be managing patients with borderline personality disorder. It should be emphasized in the	Thank you. There is no specific evidence for this and we have not made recommendations relating to the nature of training and

		Trust					document that individuals with borderline personality disorder may evoke strong emotional reactions in others, including the professionals with whom they work, and that acknowledgment and understanding of this will prevent unhealthy organizational dynamics occurring such as splitting. The document alludes to this in places (eg 1.3.5.6 - 'to ensure clarity of roles among different services', or 1.3.3.4 when they mention reviewing a team's tolerance to working with risk) but we believe this needs to be spelt out and potential solutions described more clearly.	supervision, although we have made a new recommendation about support towards the end of the section covering general principles.
745	SH	Tavistock and Portman Foundation Trust	7	Full	General General	Guideline p8 p 6 p 12	The Guideline stresses the importance of involving and training therapists who understand the nature of borderline personality disorder (Guideline pg 8). To date, psychodynamic psychotherapists (e.g., Kernberg, 1996; Stone, 1986) have played major roles in characterizing as well as devising treatments for individuals with borderline personality disorder (and as already cited, RCT evidence is now emerging on the basis of such theoretical and clinical contributions). Beyond this, there is formal evidence from controlled studies that psychodynamic concepts such as 'paranoid-schizoid' forms of intrapsychic and interpersonal functioning (Hobson, Patrick, & Valentine, 1998), 'hostile-helpless' and 'confused, fearful, and overwhelmed' internal representations of attachment relationships (Lyons-Ruth et al, 2007; Patrick et al, 1994), constitute core features of the disorder. These forms of mental representation are played out in the interpersonal lives of affected individuals. Psychodynamic psychotherapists have expertise in conceptualizing and identifying, as well as managing and changing, such clinically important aspects of patients' mental functioning. They can make special contributions in training and supervision, not least by providing a theoretical and developmental framework for understanding the disorder, and translating what this means for clinical intervention. In-depth theoretical and therapeutic experience of relevant developmental issues hones therapeutic sensitivity both towards the nature of patients' experience (a matter stressed in the Guideline e.g., Key priorities to implementation, p 6, and Section 1.1.4, p 12) and towards the conditions necessary for promoting therapeutic change. We believe this needs to be given	Thank you. We have no specific evidence on the form supervision should take and therefore detailed recommendations of the kind you are suggesting are inappropriate.

					Section 1.1.4		explicit recognition in the Guidance.	
746	SH	Tavistock and Portman Foundation Trust	8	Full	5.14 (4.2 and 4.3)	p 29	Effort should be expended in research on whether there are forms of psychodynamically configured, transference-based psychodynamic psychotherapy that are effective in promoting the development of individuals with borderline personality disorder towards more adaptive functioning. The NICE Guideline [especially p 29, Section 4.2 and 4.3] needs to be modified in its section on recommendations for research, to specify the need for research on the effectiveness of psychodynamic psychotherapy (for which initial formal evidence of benefit is already available).	Thank you. It is NICE rubric to include up to 5 recommendations per guideline to increase the probability of research funding being available and, therefore, the GDG prioritised carefully.
747	SH	Tavistock and Portman Foundation Trust	9	Full	General		There is only passing mention of the potential effects of borderline personality disorder in adults upon the well-being of these adults' offspring. For example, the Guidance does not give recognition to the potential impact of borderline personality disorder in mothers, upon the development of their infants. Research confirms poor outcomes for children exposed to poor parenting and associated repeated trauma. There is emerging evidence that from early in infancy (Crandell et al, 2003), and specifically in the shaping of dysfunctional ('disorganized') attachments at the end of the first year of life (Hobson et al, 2005), there is a danger of trans-generational transmission of psychopathology. We believe clinicians should be alerted to this issue, and the Guidance should suggest consideration is given to intervention (and research on intervention) in helping parents with borderline personality disorder to relate to their infants sensitively and parent more effectively.	Thank you. Th is is a good point but is outside the scope of the guideline. The topic has been reviewed by SCIE http://www.scie.org.uk/publications/briefings/files/briefing24.pdf). and it may be worth suggesting as the topic of a short guideline via the NICE topic selection process.
748	SH	Tavistock and Portman Foundation Trust	10	Full	General		1 The inclusion of under 18's and CAMHS is welcome. The full guidelines reflect comprehensively the different developmental needs of young people with borderline personality disorder, including thinking about working alongside parents and carers and the need for good multi agency working. These issues could be better represented in the NICE of the guidelines. 2 The current difficulties in transition from CAMHS to CMHT's are addressed in both guidelines. Work by Trusts on transition arrangements between services is recommended. An important addition in the guidelines would be the recommendation that	Thank you for your comments which we have numbered to aid response.We believe we have included recommendations in the NICE guideline which cover your points (eg 1.1.5.2 [draft NICE numbering]. 2 This is a useful suggestion and has been added in along with your next point to section 9.8.3 on

							commissioners of CAMHS and Adult Mental Health services are encouraged to work together and address service gaps. 3 This guideline accepts the current division of mental health provision for the under and over 18's. Given that the onset of borderline personality disorder is usually in late adolescence and early adulthood there is surely grounds to further explore the development of jointly commissioned services that works across the age range (as in Early Intervention Services). There could be recommendation for pilot services working across the age range that are researched in their effectiveness.	transition to adult services. 3 This is beyond the scope of the guideline. This could be a pilot funded by the DoH but it is beyond our role to recommend it.
749	SH	Tavistock and Portman Foundation Trust	11	Full Full Full	5.1 , 5.2 1.3.5.4 1.4, 1.5 1.1.3.1 1.1.4.1 1.1.7.1 1.5.1.2	109-111 8 25-26 6 27	1 It is not clear why therapeutic communities (TCs) are not considered complex interventions alongside DBT and MBT based partial hospitalisation. They share much in common with the description of partial hospitalisation; they have a variety of therapies, are well structured, have a coherent model and adequate supervision of therapists. 2 One modality treatment may be appropriate in certain circumstances e.g. after intensive treatment (supported by Wilberg's 1994 data and also with the indication that they can help with general functioning and are liked by service users), particularly if there is also contact with e.g. a CMHT. 3 No mention is made of what provision should be made for people who cannot be contained or treated in local services. This ignores the fact that some people with BPD are referred to residential services, mainly TCs in the NHS, even from some areas that have well developed local services. It is acknowledged that some residential treatment is needed by NIMHE and NSCG. Distinction needs to be made between the crisis management described on inpatient units and treatment in specialist residential services. TCs address the key priorities for implementation and show good practice in terms of developing user networks and groups. 4 The difficulties in researching residential TCs are acknowledged, particularly in doing a RCT, yet no recommendation is made for further research into these.	Thank you for your comments which we have numbered to aid response. 1 The term 'complex therapy' has been replaced because of the confusion caused. The GDG considered therapeutic communities warranted a separate section since they provide a very different environment compared with that offered in studies of what were initially termed complex therapies. 2 This recommendation has been reworded following comments from several stakeholders. It no longer refers to modality. 3 We have distinguished between the routine care of people with borderline personality disorder (by CMHTs) and more specialist care provided by specialist teams based within each Trust. It was outside the scope of the guideline to address

				Full	4.3 5.10.4	31 185		tertiary services with the exception of TCs for which we found no evidence supporting their use. 4 The guideline is limited on the number of research recommendations it can make. The GDG did not consider a recommendation about TCs to be as important as recommendations about other areas.
750	SH	Tavistock and Portman Foundation Trust	12	Full	5.13.1.1 1.3.5.4		The guidance is not clear about whether the two modalities of therapy offered should be provided concurrently or one after the other or whether this refers to a choice of treatments available.	Thank you. This recommendation has been amended.
751	SH	Tavistock and Portman Foundation Trust	13	Full	General References		Chiesa, M., & Fonagy, P. (2000). Cassel personality disorder study: Methodology and treatment effects. British Journal of Psychiatry, 176, 485-491. Clarkin, J.F., Levy, K.N., Lenzenweger, M.F., & Kernberg, O.F. (2007). Evaluating three treatments for borderline personality disorder: A multiwave study. American Journal of Psychiatry, 164, 922-928. Crandell, L.E., Patrick, M.P.H., Hobson, R.P. (2003). “Still-face” interactions between mother with borderline personality disorder and their 2-month-old infants. British Journal of Psychiatry, 183, 239-247. Guthrie, E., Moorey, J., Margison, F., et al. (1999). Cost-effectiveness of brief psychodynamic-interpersonal therapy in high utilizers of psychiatric services. Archives of General Psychiatry, 56, 519-526. Hobson, R.P., Patrick, M., Crandell, L., Garcia-Perez,R., & Lee, A. (2005). Personal relatedness and attachment in infants of mothers with borderline personality disorder. Development and Psychopathology, 17, 329-347. Hobson, R.P., Patrick, M.P.H., & Valentine, J.D. (1998). Objectivity in	Thank you.

							psychodynamic judgements. British Journal of Psychiatry, 173, 172-177. Kernberg, O. (1996). A psychodynamic theory of personality disorders. In J.F.Clarkin and M.F.Lezenweger (Eds.), Major theories of personality disorder, pp. 106-140. New York: Guilford. Lyons-Ruth, K., Melnick, S., Patrick, M., & Hobson, R.P. (2007). A controlled study of Hostile-Helpless states of mind among borderline and dysthymic women. Attachment and Human Development, 9, 1-16. Stone, M.H. (Ed., 1986). Essential papers on borderline disorders. New York: New York University Press. Patrick, M., Hobson, R.P., Castle, D., Howard, R., & Maughan, B. (1994). Personality disorder and the representation of early social experience. Development and Psychopathology, 6, 375-388.	
752	SH	Tees, Esk & Wear Valleys NHS Trust	1	NICE	Introduction	3	Commended for inclusion of comorbid condition.	Thank you.
753	SH	Tees, Esk,and Wear Valley NHS Trust	2	Full NICE	4.6.1.1 (Key Priorities & 1.1.1.1)	6	Agree with this comment. However in this client group there is a possibility of self perpetuating cycles of self harm and readmissions. An explicit contract of treatment may be necessary to prevent unnecessary admissions and treatments.	Thank you. We think you may have misunderstood the recommendation. The recommendation is about not excluding people from services as a result of the diagnosis or self-harming behaviour, which is quite different from regulating the use of services for people who recurrently self-harm.
754	SH	Tees, Esk,and Wear Valley NHS Trust	3	Full NICE	8.5.2.1 (Key Priorities & 1.1.3.1)	6	As with above, explicit treatment contracts would be useful for clients, carers and multiagency working. Some of this is implicit in page 7 and section 1.3.4.1.	Thank you. The GDG did not wish to make a recommendation about the use of formal contracts, but rather to capture the need to have very reliable arrangements for inter-professional and multi-agency

								working. This does not preclude the careful use of contracts, but the GDG did not feel they could specify for whom and/or when contracts could/should be used.
755	SH	Tees, Esk,and Wear Valley NHS Trust	4	Full NICE	8.5.11.1 (Key Priorities & 1.3.4.1)	7	The community teams must undertake specific training (mentioned) and seek supervision (not mentioned) to work with borderline personality disorder. The training and supervision should be evidence based and authors are commended for including this.	Thank you. A recommendation about staff supervision is included in a new section on staff training, supervision and support at the end of the general principles section in the NICE guideline.
756	SH	Tees, Esk,and Wear Valley NHS Trust	5	Full NICE	8.5.18.2 (Key Priorities & 1.5.1.1)	9	Role of specialist teams commended. Liaison with CAMHS has been mentioned which is important.	Thank you.
757	SH	Tees, Esk,and Wear Valley NHS Trust	6	Full NICE	8.5.5.1 (1.2.2.1)	14	It is unclear who should manage these clients in primary care. Should it be the primary care mental health team, link workers, graduate workers etc? Should there be appropriate training and supervision (currently this is mainly in the area of anxiety and depression) similar to recommendations for secondary care team.	Thank you for your comment. It is NICE rubric that guidelines do not generally specify job roles, but leave this to local implementation.
758	SH	Tees, Esk,and Wear Valley NHS Trust	7	Full NICE	8.5.2.2 (1.3.3.4)	17	Could there be a place for supervision and review?	Thank you. The issue of supervision is covered by several recommendations.
759	SH	Tees, Esk,and Wear Valley NHS Trust	8	Full	General		Can there be some specific pointers for specialist assessment e.g. Diagnostic Assessments (SCID, IPDE), outcome measurements which are generic and specific. Clinical outcomes (reduced self harm admissions etc). This will help service develop some common benchmark standards.	Thank you, but this was outside the scope of the guideline. In any event, the issue of outcomes is relevant to all people within health/mental health, and is not specific to those with BPD.
760	SH	Tees, Esk,and Wear Valley NHS Trust	9	Full	General		This is clearly a comprehensive review with a lot of information. However the authors have decided to not use trials in alcohol and substance misuse population. Since one of the core feature of BPD is impulsivity, in clinical practice substance misuse and alcohol use in this population is the norm. Can these trials be included or excluded on the strength of their design? If they are worthy then a	Thank you for your comment. Although this topic is outside the scope of the guideline, and we therefore did not formally review evidence for the treatment of cormobidities although we did

							subsection on personality disorder and substance/alcohol misuse recommendations (or recommendations for future research) could be created.	include 2 studies on DBT in this client group. Can we recommend that you suggest this topic (i.e., the management of comorbid PD and substance misuse) to the NICE Topic Selection Consideration Panel?
761	SH	Tees, Esk,and Wear Valley NHS Trust	10	Full	5.3.4	138	The information on health economics is very useful for service planning and could be included in the summary of recommendations	Thank you. NICE produce costing tools which are available on the NICE website within a few weeks of the guideline's publication. These are intended to help service planning.
762	SH	UK Council for Psychotherapy	1	Full	General		To include guidelines for high standards of training, supervision and clinical support: Therapeutic relationships with borderline personality disorder (BPD) patients are commonly experienced as challenging by practitioners of all health related professions. Ruptures in the often intense therapeutic relationship are a common occurrence in the work with BPD and regularly contribute to its failure. Strong countertransference responses and counter-transference enactments in therapeutic settings and the frequency with which such responses are destructive to therapies of all kinds are notable in all reports about working with BPD. On occasions, ruptures occur when unresolved personality aspects of the practitioner to which borderline patients appear particularly sensitive (Bateman and Fonagy, 2004) become evoked in the therapeutic relationship. The material presented in the full guideline document confirms the fact that there is currently no single superior theoretical model or treatment approach to BPD identifiable. The NICE full guideline also highlights (2.2 page 17 – 19) the prevalence of cluster B personality disorders, comorbid symptoms and the variations between individuals diagnosed with BPD. The challenging nature of therapeutic relationships with borderline patients and the complexity of presenting symptoms present a compelling case for the provision of the highest standards of initial and further training, supervision and clinical support for practitioners.	Thank you. In light of this and other comments we have included a separate recommendation about this issue at the end of the section on general principles in the NICE guideline.

							Practitioners' competencies contribute to the success of complex BPD treatments in variety of ways. Patients benefit from practitioners' abilities to integrate and make use of multiple theoretical models and clinical approaches. Multi modality work has led to the development of composite therapy approaches to BPD (e.g. DBT, MBT) which aim to combine skills and resource work with addressing identity diffusion and instability of interpersonal relationships through depth psychology work. In BPD literature, practitioners' capacities to work with the intensity and extremity of emotional and behavioural disturbance are seen as crucial to successful work with BPD patients (Warnecke 2008). Bateman and Fonagy (2004) refer to the need of BPD patients for a flexible, thinking but consistent therapist. Gunderson (2001) identifies good affect tolerance, empathic ability and self-sufficiency as the main qualities required from professionals working with BPD. We would like the NICE guideline to acknowledge and emphasize the requirements for high standards of further training, provision of clinical supervision by accredited supervisors, and good access to consultation, case discussions and support as these factors contribute crucially to successful treatments of BPD (Gunderson, 2001). Bateman A. W. Fonagy P. (2004) - Psychotherapy for Borderline Personality Disorder; Oxford: Oxford University Press Gunderson J.G. (2001) - Borderline Personality Disorder: A Clinical Guide; Arlington, VA: American Psychiatric Publishing. Warnecke T. (2008) - The Borderline Relationship; In: Contemporary Body Psychotherapy: The Chiron Approach; Ed. Hartley, London: Routledge	
763	SH	UK Council for Psychotherapy	2	NICE	General	5 & 6 of 39	We recommend the commitment to person-centred care, autonomy and choice.	Thank you.
764	SH	UK Council for Psychother	3	Full	2.4.5 & 2.4.6	25 & 26 of 476	To include specific references to identity disturbance, self regulation and the 'disorder of self' construct:	Thank you. The introduction chapter is meant to set the scene so that readers can understand

		apy					Functional impairment associated with identity disturbance or unstable sense of self (DSM IV) has emerged as one of the most commonly recognised features in BPD studies. Most theoretical models of BPD associate this aspect of BPD with attachment failures or attachment trauma. Masterson's influential BPD construct identified impaired self functions in BPD arising from arrested development and defined BPD as a 'disorder of the self'(2000). Gunderson (2001) describes identity disturbances in BPD as pathological disorders of self associated with early attachment failures. Bateman and Fonagy (2004) refer to incoherent self-representation associated with disorganized attachment trauma and identify the formation of a more robust and coherent sense of self as a central aim of treatment. DBT is based on biosocial theory which suggests that BPD is a disorder of self-regulation (Lineham, 1993). Kernberg emphasized the centrality of 'identity diffusion' in borderline pathology from early on (1984) and continues to write about how to conceptualize it and treat it (Clarkin et al 2006). His model links identity diffusion with the individual's difficulty in integrating positive and negative affects. Professor Allan Schore's theoretical work on the enduring impact of early trauma on brain development is highly relevant and applicable to BPD and supported by his research on the neurobiology of attachment and his studies of BPD. Schore, citing from numerous studies, emphasises self-regulation impairment as a crucial aspect of BPD. Schore (1994, 2003, 2006) developed a psychoneuro-biological model of 'implicit self' development based on a brain/mind/body system which constitutes the dynamic core of the implicit self. In Schore's conception, affective processes lie at the core of the self as they are bodily-based phenomena of an intrinsic psychobiological nature. Implicit self-functions appear to be crucial for the ability to maintain an integrated, coherent, continuous and unified sense of self. Research cited by Schore suggests that the implicit self is disorganized and dysfunctional in BPD (Schore, 2006). Bateman A. W. Fonagy P. (2004) - Psychotherapy for Borderline Personality Disorder; Oxford: Oxford University Press Clarkin J.F., Yeomans F.E. & Kernberg O.F. (2006)/ -	what is involved in the disorder and something about epidemiology, currently available treatments and the burden of care etc. What you refer to is important but probably too detailed for this part of the guideline. We have amended the text to indicate the breadth of opinion that exists on the relationship between attachment processes and borderline personality disorder.

							Psychotherapy for Borderline Personality/; Washington, D.C.: American Psychiatric Publishing. Gunderson J.G. (2001) - Borderline Personality Disorder: A Clinical Guide; Arlington, VA: American Psychiatric Publishing. Kernberg O.F. (1984) - /Severe Personality Disorders; /New Haven, CT: Yale University Press. Lineham M. M. (1993), Cognitive-Behavioral Treatment of Borderline Personality Disorder, New York: Guilford Masterson J. F. (2000), The Personality Disorders; Phoenix, AZ: Zeig, Tucker & Co. Schore A. N. (1994) - Affect Regulation and the Origin of the Self: the Neurobiology of Emotional Development; Hillsdale, NJ: Erlbaum. Schore A. N. (2003) - Affect Regulation and the Repair of the Self, New York: W. W. Norton & Company. Schore A. N. (2006) - The Science of the Art of Psychotherapy; Key note presentation at the 4th Biosynthesis Congress, 1-3 June 2006, Lisbon, Portugal.	
765	SH	UK Council for Psychotherapy	4	Full	4.4.1 - 3	101 - 103	The inclusion of carers experience in the NICE guideline is applaudable. The inclusion of carers in treatment plans should make a positive contribution to outcomes.	Thank you.
766	SH	UK Council for Psychotherapy	5	Full	4.6 ff	107 - 108	The clinical practice recommendations emphasise a person-centred care approach, inclusiveness, access and autonomy which in itself address some of the core issues in BPD.	Thank you.
767	SH	UK Council for Psychotherapy	6	Full	5.2	109 ff	The guidance makes reference to individual psychotherapy specifically Transference-Focused Psychotherapy (TFP). This is a form of therapy based on object relations theory developed by Otto Kernberg and others in the USA. The guidance contains a number of errors and omissions in relation to TFP. 1. The guidance suggests regular checks were made for up to date research evidence. They managed to find some reports from 2008 but not the results of the Multiwave Study into TFP written by Clarkin et al and published in the American Journal of Psychiatry in June 2007 (issue 164:6). The multiwave study was a Random	Thank you for your comment. The Clarkin et al 2007 paper is part of the Clarkin et al 2004 study as is therefore referenced as such to avoid double-counting. The reference can be seen in the study characteristics in Appendix 16 (draft appendix numbering) [draft guideline appendices]. It should be noted that we base our conclusions about studies on calculating effect

							Controlled Trial- RCT. 90 patients were randomly assigned to one of three treatments TFP, Dialectical Behaviour Therapy or Supportive Psychotherapy. All the clinicians involved were highly experienced in their own field. The results of this study are very positive in terms of TFP. NICE should have looked at this research and have incorporated the results into the Guidance. Clearly in the interests of balance they need to do this and they will no doubt reach their conclusions as to the validity of the research. However I can point out that patients treated with TFP showed improvements across a number of domains. There was significant improvement in terms of depression, anxiety, global functioning and social adjustment. TFP patients also showed improvement in anger, impulsivity. In fact of the three treatments TFP showed most improvement in the area of irritability and both verbal and direct assault. Patients also showed improvement in terms of suicidality.	sizes from data given in the papers rather than on the statistical analyses undertaken by study authors (usually with conclusions based on statistical significance rather than the clinical significance of the effect size).In the case of the Clarkin et al 2004 trial (and subsequent publications) there are no extractable data for relevant outcomes in the published papers. It should also be noted that it is unlikely that a strong recommendation specifying a particular therapy would be made from a single RCT.
768	SH	UK Council for Psychotherapy	6 (continued)	Full	5.2	109 ff	2. With specific references to the Guidance: a. Section 5.2 point 36 on psychological therapies mentions the Manual for TFP written by Clarkin et al giving a publication date of 2001. In fact there is a significantly updated manual that was published in 2006 entitled 'Psychotherapy for Borderline Personality Disorder Focusing on Object Relations' by Clarkin, Yeomans and Kernberg published by American Psychiatric Publishing. b. On page 113 there is a reference to TFP but they call it Transference Focused Therapy which is both sloppy and inaccurate. c. Section 5.2.8 8 point 6 refers to the Multiwave study but not the overall results and NICE in this section do not mention that it was a three armed study. d. Table 7 which is a list of RCTs does not mention the Multiwave study published in 2007. e. Page 173 point 27 says there is no clinical evidence that individual psychodynamic psychotherapy is efficacious which is patently inaccurate. The guidance is limited to treatments available on the NHS. TFP will shortly be offered by me [Frank Denning] in my NHS Trust and in fact there is no reason why any experienced psychodynamic psychotherapist working in the NHS can not offer TFP with some	Thank you for your comments. Point a Thank you. The GDG preferred to reference the earlier work. Point b. We have amended the text Point c. We cannot find the section to which you refer. However, we have ensured that this trial is labelled as a 3-armed study where appropriate. Point d. The 'multiwave' study was originally published as a protocol in 2004. We use the Cochrane study identification system which refers to studies by their original publication date, regardless of further papers published. The data published in 2006 and 2007 are from the 2004 study. This is clear in the

							training and proper supervision. This, of course, is the same principle as any therapy offered in the NHS. Glen Gabbard wrote in his editorial in the June 2007 American Journal of Psychiatry: "In a recently published report on a different dimension of these findings [those reported by Clarkin et al], Levy et al. [JCCP 2006; 74:1027-1074] demonstrated that transference-focused psychotherapy produced additional improvements that were not found with either dialectical behavioral therapy or supportive psychotherapy. Participants who received transference-focused psychotherapy were more likely to move from an insecure attachment classification to a secure one. Moreover, they showed significantly greater changes in mentalizing capacity (measured by reflective functioning) and in narrative coherence compared with those in other groups." (AJP, 164:6, 854).	references to the reviewed studies in the appendices. Point e. We found no evidence that individual psychodynamic psychotherapy. The between-group effect sizes calculated from the Clarkin et al data shows no advantage for TFP over the other therapies. There is no treatment as usual control group in this study making it hard to evaluate.
769	SH	UK Council for Psychotherapy	8	Full	8.5.1	282 - 284	To include Experienced and well-trained professionals in the clinical practice recommendations BPD patients often form intense relationships with practitioners. Professionals working with BPD patients should have completed a clinical psychotherapy training in one of the depth psychology approaches, ideally at masters level and above. Practitioners require the capacity to balance validation and nurturing with limit setting around both the frequency and type of contact. Frequently the intensity and extremity of emotional and behavioural disturbance in these patients combined with the contextual variability in their functioning can impact practitioners or groups of staff in bewildering ways. Professionals should be alert to the impact of clinical work on individual practitioners and staff teams and seek supervision from a qualified clinical supervisor and specialist consultation or further training in such circumstances. To include Monitoring the type and intensity of treatment in the clinical practice recommendations: Careful monitoring of the impact of interventions is warranted to review the type and intensity of clinical treatment. Too little but also too much treatment may be unhelpful. In circumstances where BPD patients are highly unstable (e.g. frequent, severe suicidal	Thank you for your comments. The points you make are coverd by the recommendations. For example, we have included recommendations about training and support (eg 1.3.1.1, 1.3.4.4, 1.3.5.2 and 1.5.1.1 [draft NICE guideline numbering]). As a result of this and other comments we have also made a new recommendation about training and supervision in section 1.1 of the NICE guideline. We have added a recommendation to deal with your concerns relating to monitoring of outcomes.

							and / or self-harming behaviour, severe substance abuse or other psychopathology) trauma processing work or exploratory approaches are contra-indicated. In circumstances where a patient in addition to borderline personality disorder also meets criteria for PTSD, professionals should exercise caution in offering trauma focused work where the patient presents with high levels of risk. Interventions aimed at resource and skill development should be considered.	
770	SH	UK Council for Psychotherapy	9	Full	8.5.8	290	to include the following questions in Text Box 4: 3. Fear of abandonment and invasion 9. Presenting episodes of hyper anxiety or anxiety induced semi psychotic states	Thank you - the suggestions in the text box are based recognised diagnostic criteria and were discussed with service users and providers prior to their inclusion in the document.
771	SH	UK Council for Psychotherapy	10	Full	8.5.13.1	296	Many BPD patients benefit from access to BDP literature which can also provide opportunities to discuss the diagnosis with practitioners (Moskovitz, 2001). Moskovitz R. (1996) - Lost in the Mirror, an Inside Look at Borderline Personality Disorder; Lanham ML: Taylor Trade Publishing.	Thank you. This may be the case for some patients but we cannot recommend specific texts. However, NICE publishes a version of the guideline for the public including patients. This includes suggested questions patients may find helpful to ask healthcare professionals at different stages of diagnosis and treatment, as well as information about the diagnosis and NICE recommendations for care. This is published with the guideline.
772	SH	UK Council for Psychotherapy	11	Full	8.5.16.4 8.5.17	299 - 303	Access to regular and frequent clinical supervision with supervisors sufficiently qualified to supervise clinical work with BPD should have the highest priority. The risks to patients and staff of working either without or with insufficient supervison and clinical support should be emphasised. (See Comment No. 1)	Thank you. We have included recommendations about support. See 1.3.4.4, 1.3.5.2 and 1.3.5.4 [draft NICE guideline numbering].
773	SH	UK Council for Psychother	12	Full	8.7	304 - 306	The special considerations for people with learning difficulties in the NICE guideline are recommendable	Thank you.

		apy						
774	SH	UK Council for Psychotherapy	13	Full	8.8	306 - 307	To include a research recommendation	Thank you. It is NICE rubric to include only 5 recommendations per guideline in order to increase the chance of research funding. The GDG prioritised carefully from amongst a number of recommendations.
775	SH	UK Council for Psychotherapy	14	Full	9.8	327 - 330	Most of these recommendations are equally appropriate for adult BPD patients and should also feature in the care pathway for adults. An 'absence of supervision', especially in the work with young people, should be viewed as inadequate and irresponsible. The following are extracts from the current UKCP policy and practice Standards of Education and training in relation to supervision of Psychotherapy with Children (and young people): "The primary purpose of supervision is to enhance the professional development of the supervisee so as to ensure the best possible psychotherapy practice for their client. To this end supervision should perform the functions of education, support, and evaluation against the norms and standards of the profession and of society. This is the case irrespective of employment arrangements and applies both in private and public service. Supervision can also contribute towards a gate-keeping process which allows for the recognition of certain situations, e.g. burnout, where because of the supervisee's physical, mental or emotional state it is unsuitable for them to work with clients." AND "Child Psychotherapists may have greater therapeutic, professional, ethical and legal sets of duties than towards their adult clients. Given the extra dimensions of working with children, it is mandatory that Child Psychotherapists have supervision whatever level of experience they have." (Extracts from UKCP SETs document STANDARDS OF SUPERVISION FOR CHILD PSYCHOTHERAPISTS Copyright UKCP July 2008.)	Thank you. This is text to support the specific recommendations for young people.

776	SH	UK Council for Psychotherapy	15	Full	10	337	To include recommendations for high standards of training, supervision and clinical support in the summary of recommendations (see Comment No. 1).	Thank you for your comment. As a result of this and other comments we have made a new recommendation about training and supervision in section 1.1 of the NICE guideline.
777	SH	UK Psychiatric Pharmacy Group (UKPPG)	1	Full	General		Guidance is very useful. The section on prescribing will be invaluable to begin to tackle high levels of inappropriate prescribing in this area. The personal accounts are also an extremely useful reminder of the human side of the disorder.	Thank you.
778	SH	UK Psychiatric Pharmacy Group (UKPPG)	2	NICE	1.3.6.2	20	Welcome this statement. Would appreciate more on how tensions between this and the desire by some patients to be medicated by choice can be managed.	Thank you. This is a good point and we feel we have adequately covered it in other recommendations – for example, 1.3.8.1 and 1.3.8.2 together with general recommendations about reviewing treatments.
779	SH	UK Psychiatric Pharmacy Group (UKPPG)	3	Full	6.1	192	Welcome the explicit clarification of APA guidance in this helpful way	Thank you.
780	SH	UK Psychiatric Pharmacy Group (UKPPG)	4	Full	6.1.1	193	Zanarini et al 2004 - is this the service utilization study? These figures look lower than those quoted. Not all 362 patients had borderline PD. Of those that did 20% took 4 or more medications and 40% 3 or more according to abstract.	Thank you for your comment. You arre correct and the figures quoted are for the full 362 patients followed not to the 264 with BPD. The text has been corrected.
781	SH	UK Psychiatric Pharmacy Group (UKPPG)	5	Full	6.1.2	194	Is it true that most people with BPD have axis I disorder? Elsewhere guidance suggests that these may be over diagnosed in times of crisis eg 6.2.1	Thank you. We have amended the text.
782	SH	UK Psychiatric Pharmacy Group (UKPPG)	6	Full	6.1.4	195	Line 35 – table is numbered 52 not 6	Thank you. This has been amended.

783	SH	UK Psychiatric Pharmacy Group (UKPPG)	7	Full	6	196	Table – borderline personality disorder doesn't exist in ICD10 – would search include emotionally unstable PD?	Thank you. Yes, the search string included all relevant terms. We have amended the table where this appears throughout the guideline. Borderline personality disorder is included in ICD10 as a subdivision of emtional unstable personality disorder.
784	SH	UK Psychiatric Pharmacy Group (UKPPG)	8	Full	6.1.4	197	Table labelled 53 text says 7.	Thank you. This has been amended.
785	SH	UK Psychiatric Pharmacy Group (UKPPG)	9	Full	6 General		Helpful clear description of trials and conclusions.	Thank you.
786	SH	UK Psychiatric Pharmacy Group (UKPPG)	10	Full	6.2.3	204 - 209	Is this in the wrong place? Talks about evidence for complex interventions in the middle of valproate therapy.	Thank you. This has been amended.
787	SH	UK Psychiatric Pharmacy Group (UKPPG)	11	Full	6.3.3	215	Table labelled antipsychotic trials but amitriptyline labelled.	Thank you. We have removed this column which was included in this table by mistake.
788	SH	UK Psychiatric Pharmacy Group (UKPPG)	12	Full	6.3.4	217	Line 10 says xx% women.	Thank you. We have added the percentage (71%).
789	SH	UK Psychiatric Pharmacy Group (UKPPG)	13	Full	6.3.6	221	Line 9 – not sure why EPSE's specifically mentioned here especially as aripiprazole generally causes few (apart from akathisia).	Thank you – you are, of course, correct and we have amended the text.

790	SH	UK Psychiatric Pharmacy Group (UKPPG)	14	Full	6.4.2	228	Typo line 5 although? but?	Thank you. This has been amended.
791	SH	UK Psychiatric Pharmacy Group (UKPPG)	15	Full	6.4.2	228	Not all people with PD self harm by overdose. This statement could potentially deny those with depression and PD access to non SSRI antidepressant therapy. Caution would however be well advised.	Thank you. We have amended the text.
792	SH	UK Psychiatric Pharmacy Group (UKPPG)	16	Full	6.4.3	230	Table says “to do” in it.	Thank you. This has been amended.
793	SH	UK Psychiatric Pharmacy Group (UKPPG)	17	Full	6.4.3	230	Line 15 typo of	Thank you. We have amended the text.
794	SH	UK Psychiatric Pharmacy Group (UKPPG)	18	Full	General	259	Very helpful guidance especially stressing importance of longer term plans and review. A big question is how to avoid polypharmacy when someone is already on lots of medication historically. Would be useful if guidance considered this.	Thank you for your comment. This is a good point and we have added a recommendation about this.
795	SH	UK Psychiatric Pharmacy Group (UKPPG)	19	Full	7.6	264	Line 30 typo “on the use of medications is used for other reasons”	Thank you – the text has been corrected.
798	SH	University of Liverpool	1	Full	General		The guideline is written from the point of view of the individual patient only, excluding the needs of families and children except for minimal attention to risk for children and some attention to carers. Probably this is a gap created by the scope of the guideline & original clinical questions not including the impact on children at the outset. This needs addressing as an issue of importance.	Thank you. Th is is a good point but is outside the scope of the guideline. The topic has been reviewed by SCIE http://www.scie.org.uk/publications/briefings/files/briefing24.pdf). and it may be worth suggesting as the topic of a short guideline via the NICE topic selection process – see

								http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp.
799	SH	University of Liverpool	2	Full	General		Diagnosis: While the draft acknowledges some of the complexities of the issues surrounding the diagnostic system of personality disorder, and specifically borderline personality disorder we felt that it does not cover sufficiently the whole breadth of mainstream opinion. This risks leaving significant parts of the professional community behind who are essential contributors to mental health care and research who will not feel supported by these guidelines. We would recommend that all research contributions to the classification debate are reviewed including those that question the very nature of classification of personality disorder and propose to replace it by other systems of formulating personality based mental health issues such as dimensional or functional approaches. We are not proposing that the system of classification should be changed now but the arguments should be inclusive and contribute to a process of change in the future if that were to be better for patients and service provision when the evidence is clearer on these issues. This is of particular relevance because of the stigmatising effect of the label 'personality disorder' for which there is some research support including from Appelby's work.	Thank you for your comment. Although this is a pertinent topic, it lies outside the scope of the guideline.
800	SH	University of Liverpool	3	Full	8.5.18.1 general		We also felt that the clinical practicality of requiring CMHT's to make diagnoses of BPD in daily practice was not clearly evidence based and there were concerns whether the guidelines spelled out in enough detail how this is meant to work on the ground, on the basis of existing evidence. What is clear from the text so far is that the instruments used in research practice have become more reliable in their diagnostic accuracy but it is not clear that this is the case in daily clinical practice.	Thank you. 40% of the work of CMHTs is with people with PD, the greatest number of whom have BPD. No service within the NHS providing treatment for people should initiate that treatment without having come to a diagnosis. It is therefore necessary for CMHTs to be able to properly diagnose BPD.
801	SH	University of Liverpool	4	Full	5.14		Research recommendation on psychological treatment: Point 3: The development of outcome measures: We are acutely aware that the guidelines have not included the parenting	Thank you. Although the issue of patients as parents is an important one, it is outside the scope of the guideline and therefore it is

							dimension, i.e. what works with people with BPD and their families who are parents. We propose that there should be separate item included in the research recommendations proposing the development of outcome measures for parents with BPD, which does not just focus on the symptom level but more on parenting function, the parent-child relationship and relevant aspects of child development and child welfare.	inappropriate to amend the research recommendation. (However, we have added the assessment of dependent children to the relevant recommendation in the NICE guideline 1.3.2.2 [draft guideline numbering].)
802	SH	University of Liverpool	5	Full	5.14		Point 2: We are aware that there is a whole range of treatment facilities available for families with parents who may have BPD though they may not be formally diagnosed (see above). That provision ranges from inpatient provision to day treatment provision to outpatient provision. Specific treatment for parents with BPD and their families should have its own set of recommendations because the evidence base for such interventions is relatively meagre, yet the clinical need and relevance are very great.	Thank you. This issue is outside the scope of the guideline. A review of the literture has been undertaken by SCIE (http://www.scie.org.uk/publications/briefings/files/briefing24.pdf). It may be appropriate to suggest the topic for a short guideline via the NICE topic selection panel process (see http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp.) .
803	SH	University of Liverpool	6	Full	5.14		Point 2: BPD is a clinical issue that also arises in people of non-working age. In fact the process of retirement can bring these issues to the fore and trigger clinical exacerbations. Also the issue of co-morbidity is of great relevance in the clinical work of our services for people of non-working age. The research evidence in this area is very limited and it would be of great benefit if this could be addressed as a specific recommendation. The guideline development is a unique opportunity to do so.	Thank you for your comment. The guideline is intended to apply to adults of all ages and therefore specific mention of older adults has not been made. All of the recommendations are relevant to the care of older adults.
804	SH	University of Liverpool	7	Full	6.12		Research recommendations regarding psychopharmacological intervention: Research evidence indicates that for some parents with complex mental health needs their specific states of mind; their mood instability and their capacity for rapid state shifts can be associated with child abusive actions. These are difficult-to-treat conditions and it would be timely for the	Thank you for your comment. Although this is an important issue it was outside the scope of the guideline. A review of topic has been undertaken by SCIE, (http://www.scie.org.uk/publications/briefings/files/briefing24.pdf) and it may be worth suggesting it as a topic for a short guideline via the

							above issue and other similar considerations to inform pharmacological research. Clinical experience suggests that not all pharmacological intervention that is symptomatically effective is beneficial in support of the parenting role of patients such treated. It would be really helpful if this was made an explicit part of the pharmacological research agenda.	NICE topic selection process (see http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp.) .
805	SH	University of Liverpool	8	Full	8.6		Research recommendation on care pathway development: It would be timely and appropriate for care pathways to explicitly address the needs of parents because of their differing role requirements compared with individual adult patients who may strive to fulfil other roles. The reasons are self-evident: service structures are not always easily compatible with parenting needs, do not always address sufficiently the needs of the family, and therefore contribute to the process of social exclusion for parents and children. This in turn increases the likelihood of stigmatisation, makes services inaccessible and ineffective for a subgroup of people very much in need. Inclusion of care pathway development specifically for parents and their children as a specific recommendation would facilitate service development that is inclusive, non-stigmatising to parents and children, and more effective.	Thank you. This is a good point but is outside the scope of the guideline. However, The topic has been reviewed by SCIE http://www.scie.org.uk/publications/briefings/files/briefing24.pdf). Also, it may be worth suggesting it to NICE as a topic for a future guideline via the NICE topic selection procedure (see http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp.) .
806	SH	University of Liverpool	9	Full	General		Implications for medical education: The guidelines have obvious and significant implications for medical education. Medical education in the past has not always been optimal in equipping doctors with the right skills for dealing with personality disorders and BPD in particular. It would be helpful if the guidelines included recommendations for training doctors with a specific set of skills that are useful in all walks of medical life where BPD patients may be encountered. That should include the skills required for dealing with parents with BPD and their children.	Thank you for your comment. This is a matter for medical education. The question of parents with BPD is outside the scope of the guideline, but T has been reviewed by SCIE http://www.scie.org.uk/publications/briefings/files/briefing24.pdf).
811	SH	West London Mental	1	Full	General		There is an additional comment from WLMHT, which I have received, which I pass on, as Borderline PD Lead Clinician. Namely that there is a concern about the lack of appropriate PD-related	Thank you for your comment. We have included recommendations which we hope will address your

		Health NHS Trust					expertise, ie expertise in the relevant psychological therapies, within the general psychiaric community teams. In the absence of specialist hubs or day hospitals, it is difficult to imagine that the secondary care level, as envisaged by NICE, would be equipped to cope with diagnosing and treating. If so, this would mean that there was still a need to place some reliance on tertiary level provisions for older adults as well as for adolescents/younger adults, as is described in the guidance. It is likely that secondary care CMHTs , in the absence of other expertise or access to specialist services external to their local Trusts, would have little option but to resort to 'over-medication', ie to contarvene the guidance with relation to psychopharmacological interventions.	concerns – for example, 1.3.1.1 and 1.5.1.1 [draft NICE guideline numbering].

The following stakeholders were approached but did not respond

No	Stakeholder
1	ADDEPT
2	Adults Strategy and Commissioning Unit
3	Afiya Trust, The
4	Ambulance Service Association
76	Association of Child Psychotherapists
77	Association of Dance Movement Therapy UK
78	Association of Family Therapy
79	Association of Professional Music Therapists
93	Avon and Wiltshire Mental Health Partnership NHS Trust
94	Avon and Wiltshire MHP NHS Trust
95	Barnet and Enfield Mental Health NHS Trust
108	Bolton Salford & Trafford Mental Health
109	Borderline UK
110	Bournemouth and Poole PCT
111	BPDWORLD
113	British Association for Counselling and Psychotherapy
130	British National Formulary (BNF)
131	British Paediatric Mental Health Group
175	Broadmoor Hospital
176	Bro-Morgannwg NHS Trust
177	Calderdale PCT
178	Calderstones NHS Trust
179	Cambridgeshire & Peterborough Mental Health Trust
186	CIS'ters
187	College of Mental Health Pharmacists
193	Commission for Social Care Inspection
194	Community Risk Assessment & Case Management (CRACMS)
195	Connecting for Health
196	Conwy & Denbighshire Acute Trust
197	Cornwall Partnership Trust
198	Counselling Haverhill
199	Counsellors and Psychotherapists in Primary Care
200	County Durham & Darlington Priority Services NHS Trust

201	Critical Psychiatry Network
202	Cumbria Partnership NHS Trust
203	David Lewis Centre
204	Department for Communities and Local Government
227	Department of Health, Social Security and Public Safety of Northern Ireland
232	Det Norske Veritas - NHSLA Schemes
233	Doncaster PCT
234	Drinksense
235	East & North Herts PCT & West Herts PCT
236	East London and The City Mental Health Trust
237	Eastern Specialised Mental Health Commissioning Group
238	Eli Lilly and Company Limited
239	EMDR UK and Ireland Association
240	Ex-Services Mental Welfare Society
241	Faculty of Dental Surgery
242	First Steps to Freedom
243	Food for the Brain Foundation
244	Forensic Arts Therapies Advisory Group
245	Foundation for the Study of Infant Deaths
246	General Adult Psychiatrists
247	General Chiropractic Council
248	Gloucestershire Partnership NHS Trust
249	Hampshire Partnership NHS Trust
250	Haven Project
251	Health and Safety Executive
252	Healthcare Commission
253	Heart of England Acute Trust
281	Home Office
282	Howard League for Penal Reform
283	Humber Mental Health NHS Trust
284	Kirklees Primary Care Trust
288	Liverpool PCT
289	Lundbeck Ltd
303	Medicines and Healthcare Products Regulatory Agency (MHRA)
304	Mental Health Act Commission
314	Mental Health Nurses Association
331	Merton CAMHS

350	MK ADHD
351	National Institute for Mental Health in England (NIMHE)
358	National Patient Safety Agency (NPSA)
359	National Public Health Service - Wales
360	National Self Harm Network
361	National Treatment Agency for Substance Misuse
362	NFA Primary Healthcare Team for Homeless Persons
370	NHS Plus
371	NHS Purchasing & Supply Agency
386	North East London Mental Health Trust
387	North East London Mental Health Trust
388	North Staffordshire Combined Healthcare NHS Trust
389	North Tees PCT
390	North Yorkshire and York PCT
391	North Yorkshire and York PCT
413	Nottinghamshire Acute Trust
432	Nutrition Society
444	Oxleas NHS Foundation Trust
445	Partnerships for Children, Families, Women and Maternity
456	Pembrokeshire and Derwen NHS Trust
457	Peninsula Primary Care Psychology & Counselling Services
458	PERIGON Healthcare Ltd
459	Pottergate Centre for Dissociation & Trauma
460	Primary Care Pharmacists Association
461	Rethink
462	Royal College of General Practitioners
463	Royal College of Midwives
486	Royal College of Pathologists
573	Royal College of Speech and Language Therapists
574	Royal Free Hospital NHS Trust
613	Royal Society of Medicine
614	SACAR
625	Sandwell & West Birmingham Hospital NHS Trust
626	Sandwell PCT
627	SANE
628	Schering-Plough Ltd
629	Scottish Intercollegiate Guidelines Network (SIGN)

630	Service for People with Personality Difficulties
646	Sheffield PCT
647	Sheffield Teaching Hospitals NHS Foundation Trust
648	Social Care Institute for Excellence (SCIE)
649	Social Perspectives Network
661	South Central Ambulance Service NHS Trust
679	South West London & St George's Mental Health Trust
680	Southampton City Council
681	St Andrew's Healthcare
682	Staffordshire Moorlands PCT
683	State Hospitals Board For Scotland
684	Stockport PCT
685	Surrey and Border Partnership Trust
686	Surrey PCT
687	Survivors Trust
738	Sustain: The alliance for better food and farming
796	UK Specialised Services Public Health Network
797	Unite / Mental Health Nurses Association
807	Victim Support
808	Walsall PCT
809	Welsh Assembly Government
810	Welsh Scientific Advisory Committee (WSAC)
812	Western Cheshire Primary Care Trust
813	Western Health and Social Care Trust
814	Wiltshire PCT