National Institute for Health and Clinical Excellence

Borderline Personality Disorders scope consultation table – By Section

Type	Stakeholder	No	Section number	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	Arts Psychotherapies Service, Sutton Hospital	1	General	Linked to CMHTs, Art Psychotherapy services (offering assessment, individual and group work) are well used in the first instance by patients with BPD. The majority are referred by Consultants and CPNs in the CMHTs. Many of the referrals are young people with PD presentations but no diagnosis, who are given the diagnosis at a later stage. These people initially benefit from individual art psychotherapy where, through the art, they begin to find a language to express themselves, think symbolically and reflect. The majority of referrals go into groups, particularly group analytic art psychotherapy groups. Most engage and stay with the therapy (drop out is usually very early on or the assessment is never attended). Care pathways may be extended through referral (with the agreement of the CMHT) to specialist PD services, including TCs (residential and day services). Art Psychotherapy is a standard intervention within this range of NHS services.	Thank you for your comment. The guideline will evidence in the area of Art Psychotherapy. We have amended the scope to reflect your cor (please see section 4.3c)
SH	Arts Psychotherapies Service, Sutton Hospital	2	General	The image in art Psychotherapy provides a unique therapeutic dimension beyond those encountered in purely verbal psychotherapies. The most recent neuropsychological research makes it possible for us to recognise the complexity of some mental health tasks, indicating that art psychotherapy may help with long term healing rather than merely reducing current symptoms. For example, art psychotherapy is effective in the treatment of individuals who have suffered traumatic childhood abuse, where such experiences happened before the child was able to verbalise them. Art psychotherapy contains more than the therapeutic dimension of art itself, but specifically enables dialogues in depth, beyond that which can be easily verbalised.	Thank you for your comment . Art Therapy will b included in the guideline. (please see section 4
SH	Association for Psychoanalytic Psychotherapy in the NHS (APP)	1	General	We welcome this guideline. The general diagnostic and background description of this condition is accurate, clear and comprehensive – we would like to see inclusion of how it feels from the patient's perspective, as well as something more about the strains and typical effects upon families and carers in trying to provide support and services to this group of patients, due to characteristic patterns of interpersonal functioning. This has implications for treatment and	Thank you for your comment. The full guideline include evidence associated with the individual user perspective, including both published rese individual testimonies where appropriate. The e of service users will be used to inform the devel recommendations. Family and carer issues will included (please see section 4.3c)

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				management.	
SH	Association for Psychoanalytic Psychotherapy in the NHS (APP)	2	General	It would help in recognition and understanding of this condition if the scope included the inner experience of these patients: pervasive feelings of emptiness, disturbance of identity, unstable relations and perceptions of others – awestruck or contemptuous.	Thank you for your comment, however the guid cannot be a complete discussion of the disorde question; its purpose is to set down what will be and excluded in the final guideline. Service use experiences will be considered in the guideline.
SH	Association for Psychoanalytic Psychotherapy in the NHS (APP)	3	3b & 3h	There is a useful estimation of prevalence and some mention of service use. Could there be any estimate of treatment need, and current level of service provision? Could there be an indication of the usual range of services offered, and treatment gaps which have been identified? There is no mention of tertiary services, which have an important role in treatment provision.	Thank you for your comment. The existing level provision will be described in the guideline; whe exist the guideline may make recommendations Thank you, the text has been amended to reflec comment (please see section 4.2a).
SH	Association for Psychoanalytic Psychotherapy in the NHS (APP)	4	3 & 4.3g	In the descriptions of etiology, diagnosis and identification there should be a section on inter-generational transmission, which is an important aspect of the developmental picture, as well as the potential cycle of chronicity in families. There needs to be a section which deals with identifying risk factors for adults across the life span, and identifying preventive and protective factors and interventions for children and young people (as in the A-S scope). Section 4.3g doesn't fully cover this, and will lead to possible inconsistencies with the other PD guidelines if the above elements are not included, which will be unhelpful to clinicians.	Thank you for your comment. The consideration factors associated with the development of the beyond the remit of this guideline. The ASPD an remits from the DoH, emphasise different aspec disorder and it is not possible for them to mirror other in the way described. The difference in em reflects the tasks that can be completed within t year period as prioritised following the consultat exercise.
SH	Association for Psychoanalytic Psychotherapy in the NHS (APP)	5	4.3	Given the acknowledged strains on staff, and the propensity for iatrogenic harm and / or staff burnout, the scope needs to include more emphasis on supervision and support structures, reliable and consistent provision of services, by well qualified and experienced staff, and service models with proven durability where high patient drop-out and high staff turn-over can be mitigated. Services where staff morale is sustained should be used as best practice models – ie: how have they achieved this? – is a question which should be included within the guideline scope. It is important the guideline does not overlook these "good management" factors, which may not be the variables focussed on in RCT studies, but which may be key common factors for effectiveness, nevertheless. A range of evidence may be needed in looking at these issues, and making reliable recommendations.	Thank you, the text has been amended to reflec comment, (please see section 4.3h)
SH	Association for Psychoanalytic Psychotherapy in the NHS (APP)	6	General	In addition to making recommendations across common treatments with proven efficacy, and generally agreed 'good management' protocols, the guideline for this condition should also consider	Thank you for your comment. These issues will considered during development. In line with sta published NICE guideline methodology.

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				innovative treatment models, and newer service models, which may show promise of cost effectiveness / efficacy. The guideline should also consider treatments which have proven efficacy in Europe and the USA, and make recommendations for implementing these in the UK.	
SH	Association of Child Psychotherapists	1	4.1.1b	to make recommendations about preventative interventions for "people younger than 18 years with borderline symptoms or borderline PD". ***Has scope sufficiently considered the presence and functioning of CAMHS as distinct from AMHS?*** Point 4.2a) seems to be structured in relation to the settings of AMHS not CAMHS. The scope may need to clarify the developments with in CAMHS that have progressed beyond the 'interface' of NHS with other services and towards genuine integration in settings such as social and educational (4.2b): for example the shift of some CAMHS services into school settings and the relationship of the multi disciplinary CAMHS team to Children's services and CAMHS provision of supervision and consultation in settings both within and outside the NHS such as children's homes and foster carers.	Thank you for your comment. Where guidelines cover the clinical managemer people younger than 18 years, the guideline wil CAMHS issues.
SH	Association of Child Psychotherapists	2	4.1.1b	Scope BPD aims 4.1b): to make recommendations about preventative interventions for "people younger than 18 years with borderline symptoms or borderline PD". ***a. How will the scope recognise the limitations of CAMHS services which are over-stretched, and under funded?*** The BPD scope indicate that to meet the challenges of offering consistent NHS based treatment for PD there will be a need to develop the capacity and skills within CAMHS. Specifically that there will be a need for increased capacity within CAMHS specialising in adolescence if effective preventative treatment PD interventions are to be provided on a national basis. ***b. Will the NICE guidelines have access to audit data about CAMHS and specialist capacity within CAMHS for working with adolescents, particularly in the lead up to the transition into adult services at 16-17?***	Thank you for your comments. NICE clinical gu aim to set out a framework for best practice, rat directly addressing resource related issues. Thank you for your comment. The Guideline De Group will have access to appropriate sources information and where necessary, seek additior professional advice in the form of Special Advis NCCMH has links with CAMHS services which during the guideline development process. The will specifically address the transition to adult se (please see section 4.2a).
SH	Association of Child Psychotherapists	3	4.3	***Would it be more coherent for these sections (a)-j)) to separate out the points related to CAMHS from AMHS?*** BPD : Currently the aspects relating to CAMHS are buried in point g) and k);	Thank you for your comment. This section addr specific aspects of clinical management rather t service delivery issues.
SH	Association of Child	4	4.3	***How will the expert group involved in the BPD Scope ensure***	Thank you for your comments. The original rem

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	Psychotherapists			***that the strengths and experience within the CAMHS multi disciplinary team structure and its range of specialist approaches are recognised and nurtured in the context of what may well be an adult dominated expert group?***	guideline only included the clinical managemen with a diagnosis of BPD. The scope has been e include the treatment of people younger than 18 certain circumstances. As this is predominately guideline for adults, the composition of Guidelin Development Group will reflect this, however m will be appointed with experience of the clinical management of people under 18 and the contri CAMHS will be considered as is usual in the de of guidelines for those under 18.
SH	Association of Child Psychotherapists	5	4.3k	There is a need for: "support for families and carers" to be reframed in relation to CAMHS. The current SCOPE emphasis downgrades the importance of working with parents of under 18s (maybe because it is adult oriented). This is important because CAMHS has specialist expertise and understanding of integrating work with families and parents, and carers both individual and institutional.	Thank you, the current wording does not exclud of issue.
SH	Association of Child Psychotherapists	6	4.3m & 3e	**Will this BPD guidelines incorporate the evidence from the Trowell et al research study (London Child Sexual Abuse Psychotherapy Outcome Study) into its guidance regarding clinical treatment of children/teenagers who have experienced the trauma of sexual abuse?** NB: A previous NICE guideline 'treatment of post traumatic stress disorder' overlooked published outcome research (by Prof. Judith Trowell et al) about treatment interventions with children who had experienced sexual abuse. <u>One consequence of this was that psychoanalytic psychotherapy with traumatised children was specifically not recommended despite Trowell et al. clinically based research demonstrating positive outcome of individual time limited treatment particularly in relation PTSD.</u>	Thank you for your comment. The guidelines al adopt a systematic approach to searching for ev building up the evidence base, analysing and in the evidence considered. Prof Trowell's work ha incorporated into some of our guidelines (for ex Childhood Depression). However, we cannot pr advance what specific pieces of evidence a GD examine or include.
SH	Association of Child Psychotherapists	7	4.3m	**Will the expert group give fair and reasoned consideration for evidence of the efficacy of psychodynamic psychotherapy approaches in treating adolescents and young adults (Baruch), particularly disturbed young women, in relation to childhood trauma and emerging symptoms of BPD during adolescence.**	Thank you for your comment. NICE guidelines a evidence based and are developed systematica following rigorous NICE protocols. If the existing supports a particular clinical treatment recomme will be made on its use and vice versa.
SH	Association of Child Psychotherapists	8	General Backgroun d	How will the NICE guidance take account of and recognise the problems linked to establishing outcome evidence through clinical research (in the context of ordinary clinical practice and funding) in relation to the developing BPD disorder during childhood and	The NICE guideline will be developed based on rigorous protocol – the methods are available o NICE website. However, we are always limited outcomes reported in research studies. The fina

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				adolescence; particularly given the fact that the background evidence in the Scope highlights the complex and high co-morbidity of these emerging disorders?	will include recommendations for further researc this is lacking in important areas.
SH	Association of Professional Music Therapists	1	General	The proposals which focus on this diagnostic group, people with borderline personality disorder are broadly welcomed. We endorse an emphasis upon multi-disciplinary working, consideration of the links between medical, psychological, social and managerial issues, and suggest that these links should increase. Evidence should be explored that provides more weight to the need for treatments to be looked at collaboratively and from the individual patient's point of view, rather than professionally led. That being said, similarly to the response about anti-social personality disorder, this document will focus on unique points illustrating how Music Therapy can contribute to the care of this population, assuming that many other responses will focus upon generic issues. These responses should be considered alongside those submitted by other professions, in particular BAAT. The shorter response reflects the fact that until recently this group were not seen in special settings or treated specifically for their difficulties. Consultation has been through attendance at the Stake Holders meeting on Dec 5th, a brief survey of all members of the APMT, and liaison with BAAT. Organisations such as BAAT and FATAG have shared ideas and discussed their submissions. A literature list is set out below, which includes music therapy literature specifically on this subject and also some key references used for this response. Other experienced practitioners from the multi-disciplinary team have contributed including Doctors, Mangers and Psychotherapists. The Association of Professional Music Therapists (APMT) has over 400 qualified music therapist members in the UK. (500 members, but around 100 of these are in training or working in another country). Music Therapy is regulated by Health Professions Council in the UK, and a high percentage of music therapists registered with the HPC are employed in NHS settings (currently 50% of the membership,	Thank you for your comments. The guideline wi treatments available in the NHS and will consid evidence in the area of Music Therapy. We have amended the scope to reflect the inclu this and other allied health professions, (please section 4.3c).

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				although these are not all full time posts. Although there is less emphasis upon the Forensic services relevant in this response, it is clear from the Stakeholders meetings and from the FATAG and BAAT responses that BPD is also found in Forensic settings and might not necessarily come under purely an anti-social definition. As such reference is included here to the following (also found in the PDA response. The Forensic Arts Therapy Advisory Group (FATAG) is made up of experienced qualified Arts Therapists, and aims to provide support, advice and opportunities for continuing professional development for arts therapists working in forensic or secure settings and trainee arts therapists on clinical placement in forensics. The organisation has made a separate submission which APMT supports. A document entitled **Guidelines for Arts Therapists Working in Prisons** has been produced by members of FATAG in consultation with the four professional Arts Therapies Associations, The Standing Committee on the Arts in Prisons and the Prison Service Directorate of Healthcare (now renamed Healthcare Services for Prisoners). These Guidelines set out professional standards for arts therapists working in prisons and have been distributed throughout HM Prison Service, please contact us for details on how to obtain a copy	
SH	Association of Professional Music Therapists	2	2c	It is hoped that the NICE guidelines will take into account the fact that as yet there has not been adequate funding for the development of research in the whole field, and although the government funded pilot services will provide a source of data for the guidelines, not all services include the whole range of psychological treatments available, particularly arts therapies, although music therapy is included in the Cambridge and Peterborough pilot. (Denman 2006).	Thank you for your comment. Where there is a research evidence we can make recommendati upon consensus expert opinion. We may also m recommendations for further research in specifi
SH	Association of Professional Music Therapists	3	2e	As stated in the stakeholders' meeting, an emphasis upon early childhood and adolescent influences upon the cause of BPD particularly in terms of trauma, is advised. It is our experience that in the government funded pilot studies, people with BPD rather than feelings stigmaised by their diagnosis now welcome the diagnosis is the special attention previously denied by the psychiatric community is applied, with the specialist in-put needed provided.	Thank you for your comment. However the guid not address risk factors associated with the dev of BPD.

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SH	Association of Professional Music Therapists	4	3f	The response from BAAT is referred to here and included in order to emphasise the point that 'recovery not only involves treatment of symptoms but recovery of functioning and ability.' BAAT write in their response to the guidelines as follows: 'Again the bias, via this important omission is inherent in the initial composition of GDG is quite clear here. From a report by Prof Jackie Campbell, Chair, of the Research Forum for Allied Health Professions "Many of the allied health professions use long-standing non-pharmaceutical therapies or interventions that have had little or no research undertaken to establish their efficacy, and finding funding for this work is extremely difficult. Similarly, the work of AHPs includes a strong focus on the prevention of illness and health promotion as well as actively working in areas such as housing, safe environments, lifestyle and occupation, all of which have a strong impact on health. However, in a health economy which is increasingly evidence-driven, not only are these areas of practice threatened, but this in turn threatens the whole basis for some professions. Funding is required for allied health professionals to rigorously research the evidence-base for their profession, enabling them to develop their therapeutic and preventative interventions and provide a sound evidence-base for their professional practice. This evidence could have cost-benefits elsewhere in the NHS as such interventions have low unit cost and could prevent more expensive interventions elsewhere." The lack of research by AHP's is highlighted here but will no doubt be echoed in the guidelines, as RCT's (level 1 evidence) are often medically driven and extremely expensive, the lack of funding for research by AHP's is extremely worrying. Again, the lack of no evidence does not necessarily imply lack of effectiveness of treatments and support offered by AHP's.' (BAAT response to NICE guidelines Scoping paper Dec 2006).	Thank you for your comment. AHP evidence wi considered during the development of the guide Where an evidence base is lacking, the guidelir make recommendations which in the past, has research being commissioned.
SH	Association of Professional Music Therapists	5	4.1.1c	It is hoped that the currently under funded area of research and clinical psychologically based treatments for LD and BPD is taken into account, and attempts to redress this made. Currently there are specialist music therapy treatments provided in some units (Beech	Thank you for your comments. NICE clinical gu aim to set out a framework for best practice, rat directly addressing resource related issues. AH evidence will be considered during the develop

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				House, Suffolk for example) which show through anecdotal descriptions of case work that non-verbal interventions which involve spontaneous improvisation and the validation of a positive active reciprocal relationship with feelings action and behaviour recognised and worked with, is helpful to patients, particularly those who do not have access to spoken language.	the guideline.
SH	Association of Professional Music Therapists	6	4.3	Some specific music therapy comments resulting from research (Odell-Miller 2006) are included here in addition to cross referring again to the BAAT response. (BAAT 2006). Odell-Miller (2006), in a study about the relationship between diagnosis and approach and technique in 5 European psychiatric music therapy settings, carried out survey-based research with 23 music therapists in these centres. The Personality Disorder diagnostic section produced the highest amount of data demonstrating that this is increasingly a priority group for music therapy treatment. In three out of five centres personality disorders are a major percentage within the case load for the music therapy services (from 25% ~ 50%). Three out of the five centres were in the UK. An example of case work in the literature is as follows. The APMT perceives a need for this evidence to be cited at the outset because the Scoping paper does not refer to this treatment specifically. Hannibal (2003) links the significance of a music therapy approach to that of personality disorder of the impulsive type. There is less music therapy literature in this field because psychiatry itself has not previously regarded it as a diagnostic category which demands services and focus, until the last decade unless linked to another diagnosis. Hannibal makes several comments about the importance of free improvisation as helpful for one case example in particular, where there is an absent sense of self, common in this disorder. He describes how the phenomenon of musical improvisation, owing to its immediate 'sounding', enables the patient to feel more 'present' through playing music. Hannibal's musical interactions and his way of listening gave the patient a sense of respect she did not seem to have prior to this, which happened in his view though the concrete act of playing music. She experienced respect for her music and	Thank you for your comment. AHP evidence wi considered during the development of the guide

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				therefore towards her. Using free improvisation amongst other things enabled her to cut down her judging of herself, which diminished as she experienced Hannibal's acceptance and did not therefore fear rejection. For this person language was a weak way to communicate and establish an alliance. However while free improvisation is described as the preferred method, there is little description of the technique used in detail, linked to diagnosis, or therapeutic strategies.	
SH	Association of Professional Music Therapists	7	4.3d & 4.3e	More information about music therapy treatment is given here in order to argue for inclusion of all NHS regulated available treatments. The research mentioned above found several interesting phenomenon not yet published apart from in the research study, which are summarised here (Odell-Miller 2006). The roots of some of these disorders arise from early trauma and difficulty, and literature in the psychological therapies supports working through meaning, stressing the importance of understanding how to deal with present roles and emotions in the light of reflecting about this through role play, reciprocal roles (Ryle et al 1997), and Mentalisation (Bateman & Fonagy 2004). The latter was referred to by three centres in the study, and there is an emerging interest in this approach in the field of music therapy.	Thank you for your comment. AHP evidence wi considered during the development of the guide
SH	Association of Professional Music Therapists	8	4.3	Some further details about findings from the European music therapy survey are included below. Responses such as by BAAT and FATAG in respect of the importance of an inclusive approach to guidelines are supported. Active engagement in music therapy is seen as crucial with a psychoanalytic process. because some patients with BPD seem 'present' but with no active engagement with other patients in groups, for example. Music is therefore ideal in encouraging an interaction between thinking and emotions. Music-making through improvisation and interpretation is indicated with this group who need to address meaning and understand psychological frameworks for their mental state, in order to progress The fact that a Psychoanalytically Informed approach to music therapy is most used by the 5 centres in the research points to an approach where music might put people in touch with painful memories. These need to be analysed, but also supported and	Thank you for your comment. AHP evidence wi considered during the development of the guide

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				engaged with during the process of music therapy. A modified form of a Psychoanalytically-Informed Music Therapy is used, which provides structure and reciprocity between patient and therapist at the same time as being interpretative and analytic. This provides links with Cognitive Analytic Therapy (CAT) suggested by Ryle et al (1997) to be most useful for people with Personality Disorders. There is unanimous agreement by centres in the study that techniques involving structures such as themes are only useful if the themes come from the patients. It is the very aspect of creative control linked to relevant themes of character, emotions or life events that make it so useful. There is also agreement that this population can work symbolically. Results from the study, similarly to outcomes for other non-psychotic disorders, also show that composed music could act as a defence by having a holding function which might prevent patients working on their own issues. However, Odell-Miller (2006) also found that if people bring songs they have written, the therapists' role may include providing an accompaniment, and performance can help some patients explore or overcome feelings of shame. This can in turn build up feelings of self- worth if handled in the right way with a music therapist. This viewpoint is also supported by respondents, and it is noticeable that the BAAT response to the Scoping paper also mentions Art Therapy as helpful in individual work when dealing with issues of shame. (BAAT 2006). The results from Odell-Miller's survey support the use of structured improvisation, as three out of five centres suggest this is useful for similar reasons, particularly if a person is feeling stuck. The main focus of work with this population is in making links between emotion and more cognitive processes. This can happen in many different ways, but often involves patients wanting to use composed music which has meaning for them, as well as using improvisation. The use of free improvisation and also structured music techniques were often linked by respondents to common difficulties associated to this diagnosis, particularly borderline personality disorder. For	

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				example many people who self harm and have suffered abuse are found to have very low self esteem. A pilot research project, which aimed to look at some of these issues in a way that had not previously been undertaken. (Odell-Miller & Hughes 2005) aimed at evaluating what musical changes might occur in the playing of members of a weekly music therapy group for people with personality disorders, and at exploring a link between musical aesthetic development and improved self image. Hannibal's work supports this idea (Hannibal 2003), referring to a patient developing respect for music and therefore herself, through music therapy, which appeared to reduce the degree of negative self-concept. Odell-Miller & Hughes (2005) in their pilot study with BPD investigated how participants' music changes over time in a weekly music therapy group, and how this relates to changes in symptoms or in the way participants feel about themselves. The hypothesis for the study is that changes will occur which could be associated with more interaction between the members, and more expressive playing. This in turn might relate to increased self esteem and a wish to create something 'whole' or aesthetically satisfying, which is particularly crucial for this population who often self-harm. An example might be where a member of a group changed his/her playing from an overwhelming volume showing no regard for the other members of the group, to listening and playing music that shows regard for others and forms part of a whole creative act. If a clear progression emerges in terms of musical expression, and musical interaction with peers and the therapist, it is hoped that patients would be able to transfer these increased skills of positive expression and interaction, to their experiences in the outside world. The planned research will investigate this further, and the musical analysis, together with the psychological questionnaires measuring the patients' emotional state will be correlated within each subject. The results of the pilot study following detailed musical analysis showed that the musical improvisations developed, in terms of emotional expression and aesthetic quality, over a ten month period.	

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				although progress was not linear. It was concluded that the increased level of group expression gave all members new possibilities, regardless of who may have initiated playing in that way. These findings indicate that there is a need for the new research study to be carried out, if funding is available. The amelioration of symptoms, for example the decrease of self harm and increase of self-value in patients, through their use of music has been reported anecdotally in the pilot study, so it is hoped that there may be more substantial results available for the NICE guidelines process. In summary the importance of music-making links to the pathology of personality disorders because music, like the illness, is affect-based. This implies that the music therapist's task for people with personality disorders is to help the person understand the meaning of the affect. This was suggested in Hannibal's case study (Hannibal 2003)and is supported by Pedersen (2003).	
SH	Association of Professional Music Therapists	9	4.3 cont.	Any psychological approach needs to be linked to activity of a different kind, that of getting involved in life events in order to help cope in social situations life events so that reflecting upon them and preparing for 'the outside world' with support where meaning can be addressed is crucial to successful outcomes.(Denman 2006). This has been introduced very recently as a 'Lifeworks' model in a government funded project in the Complex Cases service in Cambridge, UK as part of a therapeutic community model. Psychological therapies work alongside real life events so that reflecting upon them and preparing for 'the outside world' with support where meaning can be addressed is crucial to successful outcomes	Thank you for this information.
SH	Association of Professional Music Therapists	10	4.3 cont.	Finally, the research reports on the anecdotal benefits of music therapy for people with severe personality disorders.(Cluster B type mainly), some of whom have an additional diagnosis such as depression, and often more than one type of personality disorder. These groups are often complex, as is usual for such a unit (Bateman & Fonagy 1997, Gunderson 2005). The high risk of self harm, including regular severe cutting, or over-dosing, and a difficulty in dealing with high levels of emotion often so intensely felt that strong cognitive processes or physical rituals or self harm had developed to counter the feelings, or to express deep hurt in another	Thank you for this information.

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				way, were cited by music therapy services as areas where music therapy could help this population. Techniques and approaches which include both talking and music, with the possibility of moving between the two, encourage integration and access to thoughts and emotions.	
SH	Association of Professional Music Therapists	11	General	The elements of the Scoping paper which are not commented upon are supported by the APMT. This response has focussed upon drawing attention to as yet unpublished or little known evidence which is emerging at the time of the NICE Guidelines Scoping paper.	Thank you.
SH	Association of Professional Music Therapists	12	**General**	**References and Bibliography** Bateman, A & Fonagy, P. (2004) *Psychotherapy for Borderline PersonalityDisorders: Mentalization Based Treatment*. Oxford: Oxford University Press. Blake, R.L. & Bishop, S. (1994) The Bonny Method of BMGIM in the treatment of post-traumatic stress disorder (PTSD) with adults in a psychiatric setting. *Music Therapy Perspectives,* 12(2), 125-129. Denman (2006) Complex Cases Annual Report Cambridge and Peterborough Mental Health Partnership NHS Trust. Edwards, J. (2002) Using the Evidence Based Medicine framework to support music therapy posts in healthcare settings. *British Journal of Music Therapy* 16(1), 29-34. Fairburn C., Cooper, Z. and Shafran, R. (2003) Cognitive behaviour therapy for eating disorders: a "transdiagnostic" theory and treatment. *Behaviour Research and Therapy*, 41 (5), 509-28. Grant, A. (2004) *Cognitive Behavioural Therapy in Mental Health Care.* London: Sage. Grant, P., Young, P., DeRubeis, R., (2002) Cognitive behavioural therapies. In G.Gabbard, J.Beck & J.Holmes (eds.) *Oxford Textbook of Psychotherapy*. Oxford University Press: Oxford. p. 507-521. Gunderson, J.G., (2005) *Understanding and Treating Borderline Personality Disorder: a guide for professionals and families*. Washington DC: American Psychiatric Publications. Hadley, S. (ed.) (2003) *Psychodynamic Music Therapy Case Studies*. Philadelphia: Barcelona Publishers. Hannibal, N. (2005) Music Therapy and Personality Disorders. Personal Communication. Denmark: Aalborg University PhD course. Hannibal, N. (2003) A woman's change from being Nobody to Somebody: Music therapy with a middle–aged, speechless, and self-destructive woman. In S. Hadley (ed.) *Psychodynamic Music Therapy Case Studies* (pp. 403-413). Philadelphia: Barcelona Publishers. Odell-Miller, H. (2004b) *Music Therapy and Personality Disorders - Music Therapy and Schizophrenia. A Comparison in Group-Work*. Unpublished	Thank you.

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				Lecture Notes. Cambridge: Anglia Ruskin University. Odell-Miller, H., Westacott, M., Hughes, P., Mortlock, D. & Binks, C. (2001) *An Investigation Into The Effectiveness Of The Arts Therapies (Art Therapy, Dramatherapy, Music Therapy, Dance Movement Therapy) By Measuring Symptomatic And Significant Life Change For People Between The Ages Of 16-65 With Continuing Mental Health Problems.* Addenbrooke's NHS Trust & Anglia Polytechnic University Joint Publication. Odell-Miller, H. & Hughes, P. (2005) Summary of a Pilot Project : An investigation of musical change in a music therapy group for people with personality disorder. (Unpublished document. Appendix X PhD thesis 2006). Odell-Miller, H., Hughes, P. and Westacott, M. (2006) An investigation into the effectiveness of the arts therapies for adults with continuing mental health problems. *Pscyhotherapy Research* 16(1), 122-139. Odell-Miller, H (2006) *The practice of music therapy for adults with mental health problems: the relationship between diagnosis and clinical method*. PhD Thesis: Aalborg University Denmark. Pederson, I. N. (2003) *The Revival of the Frozen Sea Urchin: Music Therapy with a Psychiatric Patient.* Psychodynamic Music Therapy: Case Studies, ed Susan Hadley. Barcelona Publishers Rolvsjord, R (2001) *A case study exploring the dialectics between didactic and psychotherapeutic music therapy process – Sophie learns to play her songs of tears.* Nordic Journal of Music Therapy, vol 10 (1): 77-85 Ryle, A., Leighton and Pollock (1997) *Cognitive Analytic Therapy of Borderline Personality Disorders.* Chichester: Wiley. Schaverien, J. and Odell-Miller, H. (2005) The Arts Therapies. In G.Gabbard, J.Beck & J.Holmes (eds.) *Oxford Textbook of Psychotherapy* (p. 87-95). Oxford: Oxford University Press Stige, B. (1999) The meaning of music –from the client's perspective. In T. Wigram and J. De Backer (eds.) *Clinical Applications of Music Therapy in Psychiatry.* London: Jessica Kingsley.	
SH	Association of Therapeutic Communities	1	3a	Attention needs to be given to clarification of clinical threshold and range of severity encompassed in the guidance, also the heterogeneity of presentation. People frequently have more than one PD diagnosis particularly at the more severe end e.g. residents at Henderson Hospital have consistently been found to have an average of more than 7 on the PDQ. Cross-referencing with the Antisocial GDG will also be important. Although diagnosis does not imply causative facts most clinicians describe strong association with early development trauma and neglect. Many patients prefer more empathetic diagnostic label of complex post-traumatic stress disorder.	Thank you for your comment. Arrangements are to ensure good communication between the two during the development of the guidelines.
SH	Association of Therapeutic	2	3b	Concerns about the discrepancies in reported prevalence even in	Thank you for your comment. We acknowledge

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	Communities			information presented here (0.7%) and at stakeholder group (2%). No consideration of co-morbidity or dual diagnosis, front a clinical viewpoint this is an important omission and needs to be rectified. This section implies a strong link with criminality, which may add to the stigma associated with diagnosis of BPD.	of estimates associated with the prevalence of t disorder. The text has been amended to reflect comment (please see section 3b). Common comorbidities have been included in the scope (see 4.3j). The objective is not to highlight criminality per s reflect the importance of intervention irrespecti setting in which this takes place in either the NH example in the prison service.
SH	Association of Therapeutic Communities	3	3c	Reservations about the classification system, which can confuse the picture.	Thank you for your comment. ICD is used by NI DSM by researchers. We will be outlining the di features which trigger the use of this guideline.
SH	Association of Therapeutic Communities	4	3d	We have serious concerns about use of BPD as diagnosis in those aged under 18. Guidelines should emphasize importance of early recognition of personality difficulties and scope for preventative interventions but avoid attaching life long stigmatising diagnosis.	In ICD-10, which is used by the NHS, BPD is no diagnosed in under 18s, but DSM-IV which is us some research permits a diagnosis under 18. W not wish to exclude relevant evidence simply be participants under 18 had a (DSM) BPD diagno therefore the scope must reflect this.
SH	Association of Therapeutic Communities	5	3e	Attention should be paid to discovering and describing protective factors, which can lead to preventative interventions. Specific interventions should be developed where transgenerational factors are a high probability and whole system interventions developed, this is likely to involve multiple agencies working together.	Thank you for your comment.
SH	Association of Therapeutic Communities	6	3f	In order to reduce suicide there needs to be a range of accessible, non-stigmatising services across primary, secondary and tertiary provision to respond to differing levels of severity and treatment resistance.	Thank you for your comment.
SH	Association of Therapeutic Communities	7	3g	BPD is often overlooked when presenting later in life, often following traumatic events, which lead to decomposition (this may involve childbirth or age specific parenting transitions especially when there is personal significance, for example a child reaching age when parent was abused). A section of people with BPD do not recover and become chronic, guidance about their treatment and care is required in order that they are not inappropriately treated leading to iatrogenic deterioration or discharged from services when they may benefit (or deterioration may be prevented) through long term supportive interventions.	Thank you for your comment. The guideline will anyone with a BDP diagnosis irrespective of the onset. Issues around the longer term clinical ma will also be addressed.
SH	Association of Therapeutic	8	3h	Developing clinical intervention for this high usage group requires	Thank you for your comment. The guideline will

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	Communities			clinical resources, expertise, skills and a whole system approach. In order to maximise cost effectiveness and cost offset the guidance should consider resource utilization across a range of agencies and reinvest in prevention and treatment, including for the most severely disturbed, who may require intensive speciality treatment including access to residential therapeutic community treatment. Alongside this public education programs should be developed to raise awareness and assist people in seeking early interventions, in order to prevent disturbance becoming chronic.	Health Economic evidence across the range of interventions where it is available. Pathways to care will also be considered during development of the guideline.
SH	Association of Therapeutic Communities	9	4a	We are extremely concerned about the manner in which the Guidance Development Group has been convened, specifically the process lacks transparency, appears to have been centrally developed and representation lacks appropriate diversity. We call for this to be reconsidered, with the GDG being stood down and re-convened in an open, transparent process. Specifically we recommend that specialist treatment providers, including therapeutic communities, are represented on the GDG. Given the considerable investment by the Department of Health in developing increased provision of residential TCs and also through the pilot service development, Day TCs it is extraordinary that this was questioned by the stakeholder panel (investment is probably well in excess of £100 million from the public purse) The panel are cautioned against developing a simplistic naive approach to BPD, which does not usually respond well to short-term specific interventions, these interventions being by their nature relatively easy to research as compared to complex interventions where research is more challenging.	The process that has been followed conforms t current process that has been set out by NICE, been subjected to public consultation. Not all m have been recruited so your comments will be c in recruiting the remaining members and expert You will be pleased to note that a new process recruitment of GDG members will be implement NICE from March 2007 onwards. This will requi appointments to be made via open advertiseme GDG will include AHP representation.
SH	Association of Therapeutic Communities	10	4.1.1	a. As diagnosis is underutilized this would be better described as "clinical presentation consistent with BPD". This should include complex presentations and co-morbid conditions. b. We Strongly consider it is unethical to use diagnosis of BPD in those aged under 18, and probably should be used with caution in those under 25. The use of diagnosis of BPD can in itself be iatrogenic, it is important to guard against provocation of life-long disability. Guidelines need to consider patients who may decompensate and present with BPD at any age. c. Needs also to include people with BPD and autistic spectrum disorder with normal intelligence.	a) Thank you for your comment, we are happy v current wording. b) In ICD-10 which is used by the NHS BPD is n diagnosed in under 18s, but DSM-IV which is us some research permits a diagnosis under 18. W not wish to exclude relevant evidence simply be participants under 18 had a (DSM) BPD diagno therefore the scope must reflect this. c) Thank you for you comment. The guideline w the management of common comorbidities, as t

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					these conditions affect the treatment of BPD.
SH	Association of Therapeutic Communities	11	4.2	a. Guideline needs to be broadened to include tertiary services, this is often where diagnostic expertise resides. Limiting this to primary and secondary services will reduce access to appropriate diagnosis care and treatment, which is inconsistent with effective clinical practice. b. The guidelines should include therapeutic communities, specifically those which are within the NHS. c. Include tertiary care and also TCs.	a. Thank you, the text has been amended to ref comment (please see section 4.2a) b. Thank you, the text has been amended to ref comment, (please see section 4.3g)
SH	Association of Therapeutic Communities	12	4.3d	This should also include complex, multi-faceted interventions including TCs, creative therapies and psychosocial interventions. Clinical management of whole system is of particular importance in BPD, where splitting of service elements is part of the presenting problem. Supervision of individuals and teams together with team focussed training, across agencies, is an essential part of the interventions required. This often gets neglected because of the narrow medical model approach, which is inappropriate as a sole intervention for BPD, a complex and multifaceted disorder.	Thank you for your comments. Changes to the text in section 4.3 have address issues you raise.
SH	Association of Therapeutic Communities	13	4.3j	We again underline the importance of women, those with alternative lifestyles together with cultural issues. In order to ensure these are considered the guideline development group needs to represent all diverse elements of population. This is not currently the case.	Thank you for your comment. The Guideline Development Group recruits not only clinical an experts; it also recruits three service user and c representatives. Wherever possible we seek to population being considered when recruiting.
SH	Association of Therapeutic Communities	14	4.3k	Patients who are themselves carers need appropriate clinical interventions, specifically focusing on assessment of risk to themselves and others and inputs to manage their risk. This may include parenting skills groups and groups for women caring for elderly dependants, as currently provided by several PD services.	Thank you for your comment. We will be includi assessment.
SH	Association of Therapeutic Communities	15	4.3 Areas that will not be covered	a. This contradicts L above, referring to complimentary therapies, the guidelines should be consistent. b. The guidance needs to attend to management of combined conditions or a separate guideline should be developed to cover this area.	Thank you for your comment; however we have revised the scope to exclude complementary th not normally provided within the NHS. b. The guideline will address the management c comorbidities in people with BPD *as far as thes conditions affect the treatment of BPD* (please s section 4.3j) Consideration of comorbidity per s beyond the remit of this scope.
SH	British Association for Psychopharmacology	1	3f	The clinical need for the guideline does not specifically refer to the substantial comorbidity of borderline personality disorder (BPD) with	Thank you, we have amended the text to reflect comment, (please see sections 3c).

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				common mental disorders such as depressive illness, the range of anxiety disorders or alcohol dependence. The role of these common comorbid conditions needs to be considered, when describing the impact of BPD on patient-rated quality of life, morbidity and mortality, health service use and wider societal costs.	Comorbid conditions will be covered during the development of the guideline (please see sectio
SH	British Association for Psychopharmacology	2	4.3e	In the clinical management section, when discussing use of pharmacological interventions, it should be recognised that sole reliance by the NICE working group on licensed indications would severely restrict the scope of this section and probably reduce its potential utility in clinical practice. It would be better for the working group to focus on the findings of published (and unpublished, but available) randomised placebo-controlled trials (RCTs) in BPD, which represent the only reliable source for evaluations of the efficacy of psychotropic drug treatment. The group would need to focus on those RCTs that either exclude patients with primary comorbid conditions (such as major depressive disorder), or perform a sub-group analysis of the effects on treating BPD in patients with or without comorbid conditions.	The section (4.3 (e)) states that the guideline w recommend unlicensed indications where there evidence to support use. We will focus on RCTs appropriate sub-analyses) when considering dif treatment efficacy.
SH	British Association for Psychopharmacology	3	4.3h	It is certainly a good idea to comment on the management of common comorbid conditions in BPD, as far as those conditions affect the treatment of patients with BPD. It would also seem sensible to extend this through a consideration of the effects of BPD on the management of these comorbid conditions (such as depressive illness and anxiety disorders) as this has not been covered in earlier NICE guidance.	Thank you for your comment. It is not possible to extend the consideration co conditions in the way suggested as this is beyo remit of the scope and this would almost certain demand a new guideline.
SH	British Association of Art Therapists	1	2a & 2b	The Title reflects the clinical management of personality Disorder, it also states the guideline will provide recommendations for good practice that are based on the best available evidence. As stated at the stakeholder meeting we would endorse the views discussed, that the clinical management of BPD involves whole team organisational and environmental factors which include the supervision of teams and staff and organisations to prevent and minimise any iatrogenic affect of upon this client group. "The guideline will provide recommendations for good practice that	Thank you for your comment. Issues around "g management" such as environmental factors wi considered during the development of the guide (please see section 4.3h) Thank you for your comment. The guideline will the full range of care routinely available on the N shortened version of the guideline (NICE) conta recommendations and the Quick Reference Gu carefully edited to ensure that the meaning cont

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				are based on clinical evidence and cost effectiveness" following commissioning by the NCCMH. Given the work already achieved by NIMHE and their document "personality disorder – no longer a diagnosis of exclusion" how will the published guideline sit alongside the recommendations as made by NIMHE? This must be made clear as despite the stated aim of providing recommendations, current services are very much dependent on NICE recommendations/compliance as to whether they survive or not. Any summary of guidelines often loses the complexity of the original document once published; Service managers and commissioners always read the shortened version. There is a real risk that service users will be denied the benefit of a range of established services, through the rigid application of the guidelines. The views from stakeholders at the meeting reflected a collective concern with the conceptually reductive format of the current guidelines and lack of a systemic approach.	within the full / NICE versions is not lost or obsc Therefore although the format differs there shou any difference in underlying meaning of the diffe versions of the guideline. Implementation of the therefore reflects local priorities rather than the the guideline referenced.
SH	British Association of Art Therapists	2	2c	Again when we examine the CDG's and processes that contribute to the development of guidelines, whilst supporting multi disciplinary work and support of clients, the under representation of AHP's in CDG's remains a concern. There is bias towards the Psychology and Psychiatry professions within Mental Health GDG's, both these professions are also research resource rich ie MRC funded, the majority of research scoped is for level 1 which is a preserve of these professions and conducted by research/academic clinicians and as such translating such research findings to poorly resourced psychiatric settings away from centres where the research has been conducted is problematic. Can you manualise a treatment that is essentially dependent on the internal resources of the treating therapist (and team)? You cannot bypass experience with knowledge.	Thank you for your comment. AHP evidence w considered during the development of the guide (please see section 4.3c)
SH	British Association of Art Therapists	3	3b	See Coid et al in BJP 2006 their research suggests a link between cluster B diagnosis and early experience of institutional care and criminality.	Thank you for your comment.
SH	British Association of Art Therapists	4	3c	The ethnicity mix of the clients diagnosed as having a BPD is a moot point and is not mentioned here and should be reviewed, it is likely that clients from diverse ethnic groups may well be misdiagnosed where a history of trauma may well be indicated but overlooked. See editorial Acta Psychiatrica Scandinavica 2004, Critique of the	Thank you for your comment. These issues are in the scope and will be included in the guidelin see 4.3l). Thank you for your comment.

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				BPD and its kinship with bipolar spectrum. Mood lability and cyclothymia are present in both diagnosis and represent a diagnostic overlap. Affective instability and impulse control are clearly present in Bi-polar illness, "BPD is actually the most promiscuous of all mental disorders both as a symptom and as a nosologic construct." Of note, this editorial rightly points out that BPD is often a countertransferance diagnosis, given to individuals in which it is hard to like. See also Sarkar and Adshead in Advances in Psychiatric Treatment 2006, they suggest that personality disorder be best understood as disorganisation of the capacity for affect regulation mediated by early attachments. See also Colin Ross (USA) work on the trauma model for BPD.	
SH	British Association of Art Therapists	5	3e	Noticeable degree of hesitancy in ascribing causation, whilst clearly multi factorial, research conducted by numerous clinicians have increasingly postulated the link of damaged affectionate bonds, neurobiological deficits. (trauma, abuse, institutional care) and the subsequent emergence of borderline pathology, Again see Sarkar and Adshead 2006. See also Allan N, Schore "The effects of a secure attachment relationship on right brain development, affect, regulation and infant mental health" in infant mental health journal 2001. The NICE guidelines might be a useful opportunity to di-stigmatise BPD and re conceptualise the illness, both these authors take a more pragmatic heuristic approach describing a conceptual framework that is more clinically pertinent than a list of impulsive/maladaptive behaviours.	Thank you for your comment.
SH	British Association of Art Therapists	6	3f	Whilst the diagnostic, symptomatic difficulties are pointed out here, obviously derived from the ICD and DSM. As pointed out by Gwen Adshead at the stakeholder meeting, not only are the symptoms burdensome for an individual but also have a disabling impact on lifestyle and functioning. Such disabilities can be rated by the ICF the International Classification of functioning and disability (Like the ICD it has also has an extensive research base and comes from the WHO family of diagnostic clusters). It is used mainly by AHP's principally occupational therapists but has implications for all therapists including the arts therapists. Recovery not only involves treatment of symptoms but recovery of functioning and ability. Again the bias, via this important omission inherent in the initial composition of GDG is quite clear here. From a report by Prof Jackie Campbell, Chair, of the Research Forum for Allied Health	Thank you for your comment. AHP evidence wi considered during the development of the guide Where an evidence base is lacking, the guidelin make recommendations which in the past has l research being commissioned.

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				Professions "Many of the allied health professions use long-standing non-pharmaceutical therapies or interventions that have had little or no research undertaken to establish their efficacy, and finding funding for this work is extremely difficult. Similarly, the work of AHPs includes a strong focus on the prevention of illness and health promotion as well as actively working in areas such as housing, safe environments, lifestyle and occupation, all of which have a strong impact on health. However, in a health economy which is increasingly evidence-driven, not only are these areas of practice threatened, but this in turn threatens the whole basis for some professions. Funding is required for allied health professionals to rigorously research the evidence-base for their profession, enabling them to develop their therapeutic and preventative interventions and provide a sound evidence-base for their professional practice. This evidence could have cost-benefits elsewhere in the NHS as such interventions have low unit cost and could prevent more expensive interventions elsewhere." The lack of research by AHP's is highlighted here but will no doubt be echoed in the guidelines, as RCT's (level 1 evidence) are often medically driven and extremely expensive, the lack of funding for research by AHP's is extremely worrying. Again, no evidence does not necessarily imply lack of effectiveness of treatments and support offered by AHP's.	
SH	British Association of Art Therapists	7	4a	Following on from above and 2c) the lack of AHP involvement in CDG's is extremely worrying and compromises statements in support of multi disciplinary working. It is welcome to hear that GDG panels are to be recruited to, it is important to bear in mind that the expertise belongs to the profession whose opinion is sought and it is from within their ranks that experts within clinical fields be sought, as it is no doubt the case for psychology and psychiatry.	Thank you for your comment. AHP evidence wi considered during the development of the guide
SH	British Association of Art Therapists	8	4.1.1b	It is worth considering that family members/partners can act in ways that either contribute or diminish the patient's difficult affect laden behaviours or thoughts; working within the family system is often helpful and at times even essential. Again we would agree with the discussions at the stakeholder meeting that preventative early identification of families (children) at risk be a priority prior to a	Thank you for your comment. This will be includ guideline.

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				diagnosis being made.	
SH	British Association of Art Therapists	9	4.1.1c	This represents a huge area of research; the psychiatry of LD is often under- researched and under- resourced.	Thank you for your comment. We will be drawin consensus expert opinion where there is insuffi evidence.
SH	British Association of Art Therapists	10	4.2b & 4.2c	There remains a population of LD that is managed at various private health care settings up and down the country which are funded by ECR's, from the NHS but not employing NHS professionals, the families of these individuals would need to understand the clinical accountability for the care of their relatives and the care they may well be entitled to or not in terms of the guidelines.	Thank you for your comment. This may be a qu for commissioning.
SH	British Association of Art Therapists	11	4.3c & 4.3h	Art therapists, (Art Psychotherapy) along with drama and music therapists are the only psychotherapies to have been granted State Registration with the Health Professions Council (HPC). Membership of this body demands high standards of education and clinical practice and ensures public protection. To practice as an art therapist practitioners are bound by law to be registered with the HPC. The British Association of Art Therapists (BAAT) is the professional organisation for art therapists in the United Kingdom and has its own Code of Ethics of Professional Practice. Comprising twenty regional groups and a European and International section, it maintains a comprehensive directory of qualified art therapists and works to promote art therapy in the UK. http://www.baat.org/art_therapy.html As Art Therapists we work extensively with the clients group described within the scope, importantly we have extensive involvement within a variety of settings both primary care and secondary care: prisons, forensic and specialist, both for LD and within Adult mental Health. We are also work as part of Child and adolescent services. Part of the clinical specialism we contribute involves providing individual sessions and groups for clients with BPD. As stated in the scope document, clients with BPD have chronic unstable internal working models which are often hidden by false and overly compliant behaviours, the diagnosis of BPD often goes missed within secondary mental health settings, the work that arts therapists undertake is often helpful in the assessment of BPD. Care pathways may be extended through referral (with the agreement of the CMHT) to specialist PD services, including TCs (residential and day services). Art Psychotherapy is a standard	Thank you for your comment. The scope now ir and Music therapy.

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				intervention within these ranges of services. These people benefit from individual art psychotherapy where, through the art, they begin to find a language to express them, think symbolically and reflect. The dynamics of shame and humiliation often dictate that such clients are often difficult to maintain working alliances with, the image can take some of the heat out of these feelings and make a therapeutic alliance feel safe. A recent survey of art therapists within the NHS and other settings found high percentage of severity within caseloads of arts therapists. Often this reflects maintaining chronic (co- morbid conditions) clients within the community and as such whilst no research has been undertaken we would suggest that this reflects a cost saving within these chronically presenting clients, who as it is known represent the second highest users of mental health beds. The image in art psychotherapy provides a unique therapeutic dimension beyond those encountered in purely verbal therapies. As stated in 3e) the recognition of neurological impairments associated with BPD should make it possible for us to recognise the complexity of some mental health tasks. This could be an indication that art psychotherapy may make connections that have the potential for long term healing rather than merely reducing current symptoms. When considering early intervention for example, art psychotherapy is effective in the treatment of individuals who have suffered traumatic childhood abuse, where such experiences happened at pre-verbal stages of development. Art psychotherapy contains more than the therapeutic dimension of art itself, but specifically enables dialogues in depth, beyond that which can be easily verbalised. Clinical observation (Marr 2002) suggests that the tactile qualities of art materials can help to access split-off bodily experiences associated with trauma, making them more available to cognitive processes. Significantly art therapists contribute essential supervisory skills for other disciplines within clinical settings, again supervision and the watchful management of countertransferance enactments are essential to the clinical treatment and management of BPD, and this should also be covered in the scope of the guideline.	

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				See Karterud and Perderson 2004 whose research suggests that art therapy is a safe method of exploring the mind in the presence of mentalizing self objects. They conclude that their results should be considered when designing treatments for PD.	
SH	British Association of Art Therapists	12	General	Included with this submission is a selection of evidence both from local audit of specialist clinicians (including testimonies) and a literature search. It is increasingly apparent that within Art Therapy departments across the country a large percentage of clients seen have a personality disorder and or co-morbid conditions. Consequently research is beginning to take place in the context of personality Disorders within the art therapy profession. • Mahony, J. (1992) **The organizational context** , in Waller, D. and Gilroy, A., eds. *Art Therapy: A Handbook,* Buckingham/Philadelphia: Open University Press. (A study of Art therapy at the Henderson Hospital Therapeutic Community). • Brooker, J., Cullum, M., Gilroy, A., Mahony, J., McCombe, B., Ringrose, K., Russel, D., Smart, L. and Waldman, J. (forthcoming), **Clinical Guideline: the use of art in art psychotherapy with people prone to psychotic states***,* Oxleas NHS Trust and Goldsmiths College, forthcoming publication. **ISBN 13: 978-1-904158-78-3, ISBN 10: 1-904158-78-1- see zipped attachment.** • Mahony, J. (2007)**'Reunion of broken parts': The role of the artmaking associated with an art psychotherapy group for people with severe and complex mental health problems***.* PhD, submission pending, Goldsmiths, London University. • Mahony, J. (2007) Artefacts related to an art psychotherapy group, in Gilroy, A. , ed, **'Illuminations from the field: practitioner research'***,* forthcoming book. • Mahony, J. and Waller, D., (1999) Eds, **Treatment of Addiction - Current Issues for Arts Therapies***,* Routledge, London. • Gilroy, A., (2006) *Art Therapy, Research and Evidence-based Practice,* Sage, London. • McNeilly, G. (2006) **Group Analytic Art Therapy***,* Jessica Kingsley, London. • " **Is There One Model of Art Psychotherapy That is Practiced by Art Psychotherapists Working in Therapeutic Communities With Adults With a Diagnosis of Personality Disorder ?**" Marion Wilds, September 2005. Unpublished Research project, Goldsmiths. Research findings show how well established and widespread Art Therapy is in this area. • Franks, M. Whitaker R (2007) **"The Image, Mentalization and Group Art Psychotherapy"** in Press. *International Journal of Art Therapy. Inscape*. A combined treatment approach art therapy and psychotherapy,	Thank you.

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				found reduced symptoms of distress on completion of treatment and at follow-up. A report conducted by Avon and Wiltshire Mental Heath Trust following a conference on the management of BPD (2000) found a consensus of opinion on the treatment options for very high risk patients following case discussion/presentation. Both DBT and Art Therapy rated highest in the treatment of this client group. (Bill Jerrom & Andrew Clark)	
SH	British Association of Art Therapists	13	General	Art Therapists have presented at this years Windsor Conference, an event hosted by the Association of Therapeutic Communities on behalf of mental health professionals working within therapeutic communities worldwide. The presentation was called **'Thinking outside the Picture; Imagery, Art Therapy and Group Process in a Personality Disorder Unit'**. Caroline Burgess and Sheila Butler, Co-ordinator for Research in Psychological Services for West Kent NHS Trust outlined the programme offered by the Brenchley Unit, its client group, their clinical symptomatic severity, risk, prognosis and outcomes based on data measures such as CORE-OM, PDQ4 and GAF (Global Assessment of Functioning Scale). They were able to show that clients referred to their service were likely to have a ' long term significantly disordered pattern of functioning over several life areas with unstable interpersonal relationships, intense emotionality with mood fluctuations, impulsive behaviours of self damaging nature and marked identity disturbance with a chronic feelings of emptiness'. They presented the images from the art therapy groups. These showed evidence of authentic communication, an enactment of feelings without threat to self or others enhanced self-awareness and improved social cohesion and group relatedness. They were able to establish that art therapy as one of the core therapeutic interventions at the Brenchley Unit, **an award winning NHS service**, contributed significantly to the integration and stability of this volatile and concerning client group. The presentation was warmly received by a large audience; Their findings will hopefully be published in the ATC yearly publication and invited to present the following year. Whilst the active ingredients of Arts Therapies remains as yet unproven, it is safe to assume that the successful maintenance of a therapeutic alliance contributes to positive outcomes, as is the case	Thank you. Art Therapy will be included in the g see section 4.3c).

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				for other modes of psychological/psychosocial treatments. The activation of episodic memory, autonomic sensation and affect are apparent in the use of imagery, whilst this is not unique to Art Therapy, it affords a unique contribution to the treatment of PD. Research from Neurobiology/Neuroscience, notably the Perception-Action –Model outlined by Preston and de Wall (2002) *Behavioural and Brain Sciences:* begin to suggest the likely mechanisms at play within treatments offered by Arts Therapies. Ie that internal representations, (empathy and mentilzation) can change through a shared experience.	
SH	British Association of Art Therapists	14	4.3d	It was noted at the stakeholders meeting that the identification of psychological treatments excluded any delineation of the psychosocial aspects inherrent in the application of treatment models (eg TCs) and care pathways. Psychosocial interventions include clinical practice as performed by psychiatric nursing, occupational therapists, social workers, arts therapists, systemic family therapists, all areas of practice no doubt informed by the vast literature on the aetiology of BPD, psychodynamic and other. Again we would endorse the opinion raised at the stakeholder meeting that treatment is inherent in the very fabric of the treating team and institution, actual physical surrounding, the focus of all treatments with BPD centres around attachment not only to clinicians but to teams.	Thank you for your comment. Thank you for your comment, the scope has be amended to reflect these comments (please se 4.3h)
SH	British Association of Art Therapists	15	General	Why is it that the guidelines cover adults with a diagnosis of ASPD in the NHS and prison system, whilst the BPD guidelines do not extend to include treatment in Prisons, BPD is equally a destructive condition, the suicide rates in prisons testify to this. (NSF?)	Thank you for your comment. The care provide prisons will be covered by the guideline please section 4.a.
SH	British Association of Art Therapists	16	General	Given that there is often a high drop out rate from treatments for BPD (between 42% & 67%), drop-out from therapies is very much a symptom of BPD in terms of attachment avoidance (& threats to alliance which are not successfully repaired) how will the guidelines approach this? Does this necessarily indicate poor treatment, where treatment protocol is "as usual" and not part of a research cohort? As long-term follow-up of interpersonal functioning is probably the best indicator of recovery, capturing the evidence for therapies, which are not part of a research cohort, would be difficult.	Thank you for your comment. Issues of treatme adherence and outcomes will be considered as guideline.
SH	British Association of Art Therapists	17	General	Not all clinicians can work with this client group, Bateman and Fonagy identified factors in clinicians which where not helpful, ie being controlling and faye. Constant projections both from and	Thank you for your comment.

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				between clinicians and clients combined with increased risky behaviour can often and do lead to increasing attempts by clinicians to rescue clients from their difficulties. These problems rather than be solved need to be lived with and tolerated, a fear in creating guidelines specifically for BPD is that you inadvertently fall into the trap that is core to the dilemma faced by clients who want their problem to be taken away, that action will lead to relief – with a medicalised/ diagnostic approach you suggest, ie that it is a solvable problem. Uncertainty is difficult to tolerate both for clients and clinicians alike, to live with uncertainty, doubt and anxiety is an immutable fact of contemporary life and is not a treatable symptom but part of the solution.	
SH	British Association of Art Therapists	18	General	From a report entitled "THE DEVELOPMENT OF THE EVIDENCE BASE ABOUT THE SOCIAL DETERMINANTS OF HEALTH" produced by Michael P Kelly, Josiane Bonnefoy, Antony Morgan, Francisca Florenzano and the The National Institute for Health and Clinical Excellence (NICE) (UK) andthe Universidad del Desarrollo (UDD) (Chile). We would fully endorse the comments made below whilst guidelines are clinically focused, for the protection of the public, (an important and necessary function) preventative interventions lead to health policy change, de facto! health policy is being shaped by the creation of NICE guidelines, how then can NICE reconcile itself with its own statements…. *"Therefore the strength of evidence alone should not drive the strength of policy recommendation"* We would ask that evidence hierarchies be used flexibly.. "There are of course some important caveats about the evidence based approach.There will be gaps in this evidence and some parts of it will be more powerful than other parts. There will have to be a recognition that strength of evidence alone is not sufficient as a basis for making policy (NHMRC, 1999) and that it is possible to have very good evidence about unimportant problems and limited or poor evidence about very important ones. Therefore a distinction must be drawn between absence of evidence, of poor evidence and evidence of ineffectiveness. The two former are not the same as the latter. It will need to be recognised that the links between scientific knowledge and policy and practice are not linear and that the	Thank you for your comment. NICE guidelines a evidence based and are developed systematica following rigorous NICE protocols. Systematic r narrative synthesis and qualitative reviews are c to inform the development of recommendation

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				scientific evidence base is generally imperfect in its own ethodological, theoretical and empirical terms. Consequently the connection between evidence and policy and practice inevitably involves matters of judgements (Kelly *et al*., 2004). Therefore the strength of evidence alone should not drive the strength of policy recommendation (Harbour & Miller, 2001). Linking evidence based to health policy will require the identification of appropriate and culturally sensitive mechanisms (Rawlins, 2005; Briss, 2005). This leads to a commitment to the principle that the application of research findings to non research settings requires an understanding of the local context and the tacit knowledge and the life worlds of practitioners and end users. It also means that evidence hierarchies must be used flexibly."	
SH	College of Occupational Therapists	1	3f	We welcome the acknowledgement that it is hard for people with BPD to function successfully in the home, educational settings and the workplace.	Thank you for your comment.
SH	College of Occupational Therapists	2	4.3d	It is important that occupational therapy is included in the psychosocial interventions bearing in mind the above comment relating to 3f. Occupational therapists are routinely involved in working with people with BPD. Although there is little evidence published in this area it would be useful to include this intervention in the list of further research recommended.	Thank you for your comment, where there is ins evidence, we will be drawing upon consensus e opinion.
SH	College of Occupational Therapists	3	4.3h	We would welcome the inclusion of treatment with management of comorbidities if the team has the necessary skills. Common comorbidities such as substance misuse are often used as a way of excluding people from treatment for BPD and this group often falls between services.	Thank you for your comment. Time does not pe run the evidence searches across populations w and a range of different comorbidities, but we w we can to include specific considerations for comorbidities, where they impact on the clinical management of BPD.
SH	College of Occupational Therapists	4	General	We have concerns that the environment and the service setting has not been included for this client group, as these are considered to be so important as a factor in the treatment of BPD and could be viewed as iatrogenic. We are very concerned that issues regarding environment are included, as in the settings in which OTs work a change to the environment can be considered as a clinical intervention in itself.	Thank you for your comment. These issues hav added to the scope (please see section 4.3h)
SH	College of Occupational Therapists	5	4.2c	We would welcome the inclusion of substance misuse services as it is not clear whether these are included in these services.	Thank you, this section does not seek to be a comprehensive list of all possible interfaces. Th will consider interfaces during the development guideline.

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SH	College of Occupational Therapists	6	General	We would welcome a comment about the importance of supervision/support for staff working with this group, as it is our experience that this issue is integral to and cannot be separated from treatment interventions.	Thank you for your comment. These issues hav added to the scope (please see section 4.3h)
SH	College of Occupational Therapists	7	4.3	We would like to include the role of occupational participation in the treatment and support of people with BPD, linking it to functioning in the home, educational settings and the workplace. Further, it is our experience that people with BPD often present as very competent in some areas yet function poorly in others and this can easily be missed if this is not specifically and fully assessed. Many people with BPD have severe difficulties with activities of daily living and avoid dealing with practical issues that have significant implications. It is our experience that they often tend to avoid talking about in psychotherapy and that addressing these areas specifically has to be central to their treatment.	Thank you for your comment. Whilst it is difficul precisely all the range of support and help that with BPD might need (home, education, workpl occupation) most of our guidelines to attempt to a holistic approach to assessment, treatment ar
SH	College of Occupational Therapists	8	General	Would welcome a comment/report on research that looks at impact on individuals receiving diagnosis of BPD and how this is viewed by primary care and many mental health settings.	Thank you for your comment. The evidence ass with the experience of diagnosis from the persp the service user will be included in the guideline
SH	College of Occupational Therapists	9	4.3k	We support the involvement of families in treatment.	Thank you for your comment.
SH	College of Occupational Therapists	10	General	The description of BPD seems very thorough but could service-users views be included in this? Many people diagnosed with BPD feel stigmatised by the diagnosis and we feel this needs to be acknowledged as it may have implications for how people with symptoms associated with BPD seek treatment. For this reason also we are concerned about the inclusion of under 18's as our experience suggests that it is difficult to make a distinction between adolescent behaviour and BPD symptoms and there is a risk of pathologising people too early.	Thank you for your comment. The perspective users will be included in the full guideline and w the development of recommendations. With regard to your second point on the difficult distinguishing BPD symptoms, it is important to guidance where confusion exists and the scope acknowledged the difficulties that you have high (Please see section 4.1.1b)
SH	College of Occupational Therapists	11	General	There is no mention of issues of ethnicity. The majority of people diagnosed with BPD are white. There is little research on why this is. Perhaps it could be recommended that there be further research in this area?	Thank you for your comment. The guideline will these and other associated issues (Please see 4.3l)
SH	College of Occupational Therapists	12	General	People with BPD often have very traumatic personal histories. Could this be acknowledged in more depth as it has implications for any treatment approach?	Thank you for your comment. We are happy wit current wording of the scope. The scope lays o will be included / excluded from the guideline ar cover a full discussion of the disorder.
SH	College of Occupational Therapists	13	General	Because of the complexity of this diagnosis we would welcome an emphasis on an integrative approach to treatment and a holistic	Thank you for your comment. This is the approa intend to take.

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				approach.	
SH	Cumbria Partnership NHS Trust		4.2b	In common with a number of others at the meeting, I felt there was some misunderstanding of the place of therapeutic communities within services. I would wish it to be recognised that in their various forms, ranging from day hospitals to inpatient units, many democratic analytic therapeutic communities are based within the NHS, are a recognised part of the care pathway and therefore their place needs to be commented on. Not to do so risks marginalising an important source of treatment for those service users with moderate to severe personality disorder but also an important training ground for the many professionals who take these vital skills out into the wider NHS.	Thank you, the text has been amended to reflec comment (please see section 4.3g)
SH	Cumbria Partnership NHS Trust	1	General	I attended the stakeholder meeting on Friday 1st December. Generally, the document seemed to encompass the wide range of issues relevant to clinical management of BPD. I expressed concerns about the tendency of commissioners to interpret NICE guidelines in a rigid way and how the guidelines therefore need to reflect the plurality and timing of a range of services and interventions required. Because of the particular anxieties raised by contact with these service users, and the difficult relationships and failures of communication that may ensue, many workers have been developing whole systems approaches to care, with treatment of the whole system seen as essential to good service delivery. This has certainly been the impetus in the development of the DH/NIMHE Pilots (one of which is hosted by this Trust and for which I am clinical lead). A suitable model may be 'hub and spoke' with Psychotherapy Services and Specialised Outreach at the centre. Such an approach involves support, supervision, consultation to and training of staff across the agencies and the provision of a range of psychological treatments and planned environments as and when service users can use them. The emphasis is on medium to long term treatment, increasing the ability of service users to self-regulate anxiety and make significant personality change. The benefits, to service users, carers, staff groups and agencies of a facilitated approach cannot be overemphasised, not least in managing risk, avoiding costly and wasteful duplication of effort and preventing inappropriate and	Thank you for your comment. Whilst it is not ou include staff training, we will be covering a wide treatment across various sectors, incorporating of service users and carers.

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				unhelpful interventions such as repeated hospital admission.	
SH	Department of Health	1	General	The focus on 'clinical ' management, whilst understandable congruent with the intention to develop an NHS guideline and of the role of NICE. We consider there should be some reference to the crucial importance of social perspectives – e.g. fundamental requirements in relation to housing, finance etc. without which stable lifestyles are not possible; nor are recovery concepts as they relate to desired outcomes.	Thank you for your comment. The Social Care I Excellence (SCIE) will be asked to participate in guideline development process and these issue considered during the development of the guide
SH	Department of Health	2	General	Experience from the National Personality Disorder Programme pilot services suggests that services which are capable of deploying both direct therapeutic interventions to individuals and which also work indirectly to address the psychosocial contexts of individuals' lives can be beneficial. The scope of the indirect work being undertaken within the pilot services has only recently begun to emerge. This embraces activities which might, more traditionally, be called case management, interventions which address the social and economic determinants of symptoms, addressing negative and exclusionary attitudes and practices within local health and care systems and the provision of effective forms of support for practitioners and teams. In our view, the guideline should focus not only on 'clinical ' management, narrowly defined but address the evidence in relation to best practice in working with individuals with BPD, more broadly.	Thank you for your comment. The Guideline De Group will consider evidence from the national programme.
SH	Department of Health	3	General	Linked to this point the Scope does not include primary prevention of BPD but addresses secondary prevention, treatment and management. Whilst the rationale for this is accepted, there is a case to be made for a further guideline which addresses PD more generally as a public health issue and which identifies the evidence for broad, multi factorial interventions aimed at the preventable root causes, which are briefly referred to in the draft scope.	Thank you for your comment. Primary preventio important but not possible to cover in depth at t time as primary and secondary treatment in the and prisons. You might like to consider referring of Primary Prevention to NICE as a separate pu topic if you feel it needs special attention.
SH	Department of Health	4	General	Population In our opinion the scope should include the evidence for working therapeutically with the families of young people with borderline symptoms or a BPD diagnosis	Thank you for your comment, issues associated treatment of young people will be included in th (please see section 4.3i)
SH	Department of Health	5	General	Healthcare Setting While primary and secondary care, prison care etc are mentioned, there is no reference to voluntary sector care. Some people with BPD will avoid NHS care and for some groups such as young people, women or ethnic minority groups, services may be specifically commissioned through the voluntary sector to improve	Thank you for your comment. The scope alread the provision of care by the voluntary sector and associations with the NHS (please see section 4

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				accessibility and take-up. We feel that there should at least be a reference to the NHS role in partnership/supporting such service provision to ensure effective care and interventions.	
SH	Department of Health	6	General	**Clinical Management** In our view, the guideline should also consider the evidence for early identification and early intervention with people younger than 18 years with 'emergent' BPD We would be grateful if the guideline could include a consideration of what constitutes effective case management across complex treatment pathways To enable the NHS to develop and improve services for people with BPD in the future we feel the scope must be broader than the 'routine ' availability of care within the NHS. It should also address the evidence emerging from novel services and approaches such as those being piloted in England through the National Personality Disorder Development Programme –and the international evidence of effectiveness of novel approaches Would you please consider including therapeutic communities as a psychological intervention – of great interest and relevance with this group. We feel that 'Common co-morbidities' needs further definition. We would welcome the Guideline Development Group to include complementary and alternative interventions to approaches to care relevant to BPD. In particular we would urge the Group to address the evidence for the importance of the therapeutic alliance as it relates to this group and of the therapeutic benefits of promoting the self-determination of service users, self help, mutual help, and of service user participation and involvement overall In our opinion, the current wording regarding racial and cultural issues is not strong enough; we know that patterns of diagnosis across racial groups suggests misdiagnosis and therefore inequitable treatments and access. We feel that the guideline should refer to those issues even if the current state of knowledge does not	Thank you for your comments. The scope of the guideline has already been ex (from the original DoH remit) to include people y than 18 years (please see section 4.1.1b) where a potential impact on the level of impairment, ris progression to adult personality disorder (please section 4.3i). To extend the scope further would increase the associated workload as it would be guideline that covers the clinical management o adults and young people. The Guideline Development Group will conside from the National Personality Disorder Develop Programme and will include evidence from inter sources. Evidence will not be routinely sought fr foreign language journals although where local exist to translate papers, this it will be undertake A comprehensive approach will be taken to the contribution of therapeutic communities in this g (please see section 4.3g). The term 'common comorbidities' is chosen with order not to pre-judge the findings of the guideli

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				allow definitive advice and practice guidance. Similar issues arise in relation to gender. Gender is highly implicated in aetiology, symptomatology, diagnosis, treatment and support. The scope also needs broadening to include gender aspects of BPD	
SH	East London and The City Mental Health Trust	1	3g	The evidence for this statement needs to be clearly cited. Could lend itself to misunderstanding of the impact of BPD on lives of clients & their families, friends, carers, over prolonged periods of time, well into middle & older age. This could impact on availability of treatment/access to treatment to older age group with BPD (who clearly exist & consult services) It could also distort the interpretation & planning of research into effective treatments across the adult age span, including for older adults.	Thank you, we have amended the text to reflect comment, (please see section 3g)
SH	East London and The City Mental Health Trust	2	3e	Role & incidence of trauma in BPD needs further clarification if not to mislead?	Thank you for your comment. We feel that these have been covered in sufficient depth for a scop document.
SH	East London and The City Mental Health Trust	3	4.2b	"Therapeutic community" refers to a mode of treatment rather than a separate service area/setting, e.g. like prison. Therapeutic community treatments (day hospital & inpatient) are also available within NHS settings (e.g. refer to Royal College of Psychiatrists "Community of Communities" audit/evaluation group)	Thank you, the text has been amended to reflec comment (please see section 4.3g)
SH	East London and The City Mental Health Trust	4	4.2c	Treatment settings include day hospital settings as well as outpatient & inpatient settings, including secure settings. Typically day hospital settings are in NHS secondary care settings, either community or hospital-based.	Thank you, the text has been amended to reflec comment, (please see section 4.2a).
SH	East London and The City Mental Health Trust	5	4.3m & general	The interface between psychological treatment services & general/other mental health service areas needs to be clarified where possible, including the role of CPA. Increasingly, NHS Trusts are seeing their core business as managing psychosis & patients with PD are excluded from e.g. locality team follow-up where this needs to be an integral part of care planning & implementation. The notion of stages & levels of treatment needs to be incorporated, depending on the patient's needs/readiness to engage etc., Hence need to consider consultation, ongoing levels of treatment, crisis management etc., Questions could be addressed around best practice in crisis management within CPA including professional roles & responsibilities, service user responsibilities etc.,	Thank you for your comments. We will look at s issues you have highlighted, although clinical gu by definition cover clinical interventions rather th roles of different professional groups and servic guidance. Nevertheless, thank you for raising th important issues.
SH	Henderson Hospital	1	3b	Prevalence figures for BPD in women given appear to underestimate absolute prevalence (and that relative to men) compared to figures	Thank you, we have amended the text to reflect comment, (please see section 3b). We acknowl

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				from other epidemiological studies. Basis or reference for this estimate not given, nor mention of proportion of psychiatric in- or outpatients with BPD (about 20% and 30% respectively) thereby underestimating likely clinical relevance and varying presentation especially when co morbid.	range of estimates regarding the prevalence of disorder and that this can vary widely.
SH	Henderson Hospital	2	4.2a & 4.2c	The guideline will cover care for primary, secondary and community settings but omits more severe BPD (+/- traits of other Cluster B PD's) which often requires (but is often not alone contained by) care in these settings +/or needs more specialised tertiary care options. There is no mention of the nature/scope of services needed where primary/secondary care does not suffice other than c) where the guideline mentions hospital out- and inpatient care but without specifying which is better of these from the evidence base.	a. Thank you, the text has been amended to ref comment (please see section 4.2a)
SH	Henderson Hospital	3	General & 4.4.1	Lack of continuity/consistency/cross reference for different BPD presentations/severities between different NICE guidelines eg in the CGI6 Self Harm NICE guidelines (July 2004) for people who 'repeatedly self harm' (often with BPD), the guidelines extend to hospital admission but without reference to the evidence base for this eg therapeutic community admission leads to greater improvement than general psychiatric ward admissions. In the 'Quick Reference' Guide to the self harm guideline(omitted in the other NICE guideline) under 'Admissions' – for those at risk of repetition 'intensive therapeutic intervention with outreach'… 'for at least 3 months' is suggested but not specified. Therapeutic community intervention fits this requirement but is not specified.DBT for BPD is suggested as well as other unnamed 'psychological treatments for people with this diagnosis' which is 'outside the scope of this guideline'. Why? Without specifying the evidence based range of short and longer term treatments for the full spectrum/severity of BPD presentations (even if limited to primary and secondary care settings where most are seen and treated) the guidelines are unnecessarily limited and don't join up as they may to more fully guide the recognition and treatment of many people with BPD in the different arenas or stages of problems and help-seeking in which they may be found.	Thank you for your comment. In so far as we ur the points that you are making, we shall incorpo into the scope (for example looking at the evide therapeutic communities) and in the final guidel cross reference the self harm guideline.
SH	Leicestershire Partnership NHS Trust & Managed Clinical Network for PD	1	4.1	Population - We are pleased that the needs of the younger age group will be covered, but would discourage labelling a person with BPD during adolescence.	Thank you for your comment. This and other as issues will be considered during the developme guideline, including the perspective of the servi

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					themselves.
SH	Leicestershire Partnership NHS Trust & Managed Clinical Network for PD	2	4.2	Health Care Settings a) A number of patients with a primary diagnosis of BPD end up in tertiary NHS services. It is important that this is covered in the Scope because at the present time commissioning for this is random and inequitable. b) There are a number of therapeutic communities for this client group within the NHS with an evidence base. Within our Leicestershire network for example, we have two - a residential (Monday to Friday) TC which will hopefully become a Regional resource, and a two day per week women only day TC.	a. Thank you, the text has been amended to ref comment (please see section 4.2a) b. Thank you, the text has been amended to ref comment, (please see section 4.2a)
SH	Leicestershire Partnership NHS Trust & Managed Clinical Network for PD	3	4.3	Whilst this section has deliberately been kept general, we are concerned that group therapy, creative therapies and therapeutic communities are not mentioned. It should be kept in mind that by definition personality disorder is an interpersonal problem and as an Axis II diagnosis, involves the 'whole' person. It is therefore particularly amenable to group based therapies. We also feel strongly that the clinical management section needs to include the positive impact of specialist PD Services indirectly managing and co-ordinating care e.g. through clinical networks, working with teams, providing support groups for staff, attending CPA meetings etc. Although this may seem to be broadening the scope too widely, to miss it out would be to miss the point in a very fundamental way, i.e. this client group, almost by definition cause chaos on contact with caring agencies and unless this is understood by the wider system, have a tendency to regress and get worse. However good a specific intervention, it will be undermined if there is not some understanding and attempt to manage the wider system. More specifically: a) It is our experience that a significant subgroup of people with BPD present at an older age and get misdiagnosed. This older age group have slightly different needs (often having children for example) and can be particularly difficult to treat. We feel strongly that interventions aimed at improving parenting skills where parents of young children have a diagnosis of BPD, should be included in this section.	Thank you for your comment. Both individual and group therapy will be consid during course of the guideline development pro Allied Health Professions will also be included (see section 4.3c) The text has been amended to reflect your com therapeutic communities (please see section 4. With regard to specialist PD services the text ha amended to reflect your comment, (please see 4.2a) Thank you for your comment. Where applicable guideline will address the needs of particular su in this population. Thank you for your comment. This issue is curr considered as part of another NICE / SCIE guid currently under development. Thank you for your comment on BME issues.

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				j) We are keen that the Scope includes the assessment of the BME clients and an understanding of both why BME clients are under-represented in PD services and an understanding of diverse, culturally dependent pathways into care.	
SH	North Staffordshire Combined Healthcare NHS Trust	1	3	In mentioning the enormous toll on individuals of BPD, mention should also be made of the burden on families and in particular children, who may suffer from a repeated cycle of deprivation and trauma because of their parent's difficulties	Thank you for your comment. The experience o users, their carers and family will be included in guideline, (please see section 4.3m). The joint N SCIE guideline on Parental Mental Health and C Welfare will also cover this type of issue.
SH	North Staffordshire Combined Healthcare NHS Trust	2	4.2b	Interface issues – should consider how non-NHS services should be involved in over-all care planning eg through CPA. (People with BPD often access services in a chaotic and inappropriate way, making delivery of an appropriate care plan very difficult unless all organisations offering significant involvement can meet with the individual to care plan). Clinical question: is there evidence of existing models of effective delivery across interfaces? (eg from established Personality Disorder Services such as Thames Valley)	Thank you for your comment. We will consider y suggestions during development of the guidelin
SH	North Staffordshire Combined Healthcare NHS Trust	3	4.2c	Re care in secondary mental health services – most out-patient care is delivered appropriately through multi-disciplinary teams, eg CMHT's, functional teams, not through the medical model of out-patients.	Thank you for your comment.
SH	North Staffordshire Combined Healthcare NHS Trust	4	4.2c	Re in-patient care – evidence for what therapies can be effectively delivered in different in-patient settings Clinical question: what if any therapy for BPD can be delivered on an acute in-patient ward?	Thank you for your comment. . We will consider suggestions during development.
SH	North Staffordshire Combined Healthcare NHS Trust	5	4.3 general	Clinical management should include evidence re best practice for organising and managing services ie Best practice guidelines for: How components of a care package can be delivered ie through CPA/Care Coordination using a team approach building into services **supervision and consultation** services to support those delivering care Collaborative assessment, planning and delivery of care with the service user including risk management planning and positive risk-	Thank you for your comment.

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				taking Clinical question: What structural elements of service delivery support successful delivery of interventions to people with B.P.D. through multi-disciplinary teams	
SH	North Staffordshire Combined Healthcare NHS Trust	6	4.3d	Evidence for Cognitive Analytic Therapy should be sought	Thank you for your comment. Evidence associa Cognitive Analytic Therapy will considered durin development of the guideline.
SH	North Staffordshire Combined Healthcare NHS Trust	7	4.3d	Attention needs to be paid to generalisability of psychological interventions to different settings ie What works for whom, where?	Thank you for your comment. Settings will be co part of this guideline, as this is mentioned in the from the DoH.
SH	Nottinghamshire Acute Trust	1	3	BPD is usually comorbid with other PDs, especially when of any severity.	Thank you for your comment. The issue of com personality disorders will be considered during t development of the guideline.
SH	Nottinghamshire Acute Trust	2	3	The core "experience" of being borderline – a chaotic life of which one rarely feels in any sort of control, and a very insecure sense of self or identity – are easily recognisable clinically by those with suitable experience.	Thank you for your comment.
SH	Nottinghamshire Acute Trust	3	3f	Many aspects of individuals' BPD trajectory could be better described by chaos theory	Thank you for your comment.
SH	Nottinghamshire Acute Trust	4	3g	Although people may "gain close to normal function" over time, their subjective experience	Thank you for your comment. The experience o users will be incorporated.
SH	Nottinghamshire Acute Trust	5	4a	The choice of those leading and most closely involved in the guideline development will introduce bias in an area as controversial as this. The process of appointing these people happened without most people in the field knowing how it was done: it was not open or transparent.	The process that has been followed conforms to current process that has been set out by NICE, been subjected to public consultation. Not all m have been recruited so your comments will be c in recruiting the remaining members and expert
SH	Nottinghamshire Acute Trust	6	4.2	Healthcare setting: some of the work most likely to be effective (as is emerging from the pilot PD projects) is done in close partnership between health, voluntary and service user organisations. If the guideline only considers those only delivered as "pure" treatments by health services, or just the "interface" with other sectors, it will exclude much current effort, much promising development, and opportunity for genuine innovation.	Thank you for your comment. The GDG will con evidence from the pilot PD projects as part of th guideline development process.
SH	Nottinghamshire Acute Trust	7	4.3	"Whole system" interventions should not be excluded	Thank you for your comment.
SH	Oxfordshire & Buckinghamshire Mental Health Trust	1	General	The scope should include prevention, as it does for ASPD.	Thank you for your comment. The remit receive Department of Health has a different emphasis ASPD remit. A considerable expansion of both would be required to ensure that the guidelines

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					each other exactly.
SH	Oxfordshire & Buckinghamshire Mental Health Trust	2	General	The scope should include the place of compulsory treatment, ie treatment under the mental health act.	Thank you for your comment. As you know the being revised and cannot therefore be dealt wit guideline at the current time.
SH	Oxfordshire & Buckinghamshire Mental Health Trust	3	General	Given the way Trusts tend to interpret NICE guidelines, ie rigidly, we would ask for due consideration to be given to the early stage of development of the evidence base in this area to avoid the premature restriction of treatment options for this patient group.	Thank you for your comment - we will pass you to the GDG, We will only be recommending trea that are supported by research evidence and/or consensus expert opinion.
SH	Oxfordshire & Buckinghamshire Mental Health Trust	4	General	Also we are concerned at the lack of Clinical experts (as opposed to academic experts) on the Guideline development group.	At the time of the stakeholder meeting, the Guid Development Group was incomplete; a mix of b and academic experts will be brought together i produce the final guideline, either as full GDG m or Special Advisors. In addition, there will be thr user and carer representatives.
SH	Rethink Severe Mental Illness	1	3h	Rethink is concerned that a diagnosis of PD is given to facilitate discharge of patients or to deny someone access to services, especially if they have assaulted a nurse. Sudden discharge with no where to go can lead directly to crisis.	Thank you for your comment. The guideline will help to address this type of problem.
SH	Rethink Severe Mental Illness	2	4.2c	Rethink recommends some sort of guidance be produced on diagnosis of PD for mental health professionals. There is variation in the interpretation of diagnostic criteria – for example, some psychiatrists deem hallucinations to be 'pseudo-hallucinations' if the person has insight into their symptoms, and change a diagnosis of schizophrenia to one of PD. It is possible for a person with schizophrenia to have insight, and it is not good practice for a diagnosis to be changed due to misinterpretation of diagnostic criteria.	Thank you for your comment. The GDG will end make as clear as possible precisely what trigge of this guideline and thereby which people the g will consider.
SH	Rethink Severe Mental Illness	3	General	Rethink is anxious that problems with diagnosis be addressed in the guideline. People with diagnosis of PD will often have had their diagnosis changed. This may partly be due to the lack of consistency in support professionals.	Thank you for your comment. The GDG will end make as clear as possible precisely what trigge of this guideline and thereby which people the g will consider.
SH	Rethink Severe Mental Illness	4	General	Rethink is concerned that not all psychiatrists are aware that a person may have both PD and a mental illness. Also, some people receive a PD diagnosis when in fact they have a psychotic illness which has not yet responded to any treatments.	Thank you for your comment. We plan to comm diagnostic factors that should trigger the use of guideline. This clarification should assist with m accurate diagnosis.
SH	Rethink Severe Mental Illness	5	General	People with a diagnosis of PD, and their carers, must be provided with information so that they understand what it means, and also why diagnosis can change. Rethink has produced information on this but health professionals should also be providing information.	Thank you for your comment. The role of inform provided to service users and their carers will b considered as part of the guideline.

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SH	Royal College of Nursing	1	General	With a membership of over 395,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. The RCN promotes patient and nursing interests on a wide range of issues by working closely with Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations. Mental health nursing is represented in all its diverse forms. This embraces clients across the life span and in settings as diverse as high security hospitals, statutory care settings and the community. Mental health nurses are engaged in these diverse areas engaging with service users, carers and families in promoting well being and recovery.	Thank you.
SH	Royal College of Nursing	2	General Guideline title	The assessment, diagnosis and clinical management of borderline personality disorder (BPD). BPD is being used as a catch all "diagnosis" for people who are considered to be "unpopular" or "difficult to treat". For many BPD is a stigmatising label that leads to victim blaming and accusations of attention seeking/ manipulative behaviour. There needs to be a greater emphasis on ensuring accurate diagnosis and consideration given to alternative diagnosis such as complex post traumatic stress disorder (PTSD) or attachment disorder.	Thank you for your comment. The GDG will end make as clear as possible precisely what trigge of this guideline and thereby which people the g will consider.
SH	Royal College of Nursing	3	3a & 3e	We would highlight the self-harm/self-injurious behaviours. The statement that "specific cause of BPD has not been identified" does not adequately highlight that it is the presence of severe, repetitive abuse, involving multiple trauma that is so important in the development of BPD. There needs to be acknowledgement that both BPD and complex PTSD can be at least partly understood through failure to develop secure attachments during childhood. In regards to the neuropsychological impairments the physiological studies in PTSD brain function needs to be acknowledged particularly in relation to the individual's attempts to self-medicate through re-traumatisation i.e. Self-harm, self-medication etc as a means of altering the production of endogenous, or natural opiates.	Thank you for your comment. We feel we have acknowledged this issue in the scope. The scop to reflect issues that will be included / excluded guideline, rather than being a full discussion of disorder. Thank you for your comment. Clearly, the envir and psychosocial factors that may contribute to development of Borderline Personality Disorder be considered in developing both general and s aspects of any treatment programme; in so far a research evidence to support this.
SH	Royal College of Nursing	4	4.1	Population - It is imperative that "high risk" groups are identified with	Thank you for your comment. The clinical mana

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				recommendations in relation to pro-active planning for these groups i.e.: children who have spent long periods in particularly if they have been cared for by several different carers. Those who have been subjected to repetitive abuse/trauma.	sub groups of patients e.g. "high risk" will be co where appropriate during the development of th guideline. Risk factors associated with the deve BPD will not be considered.
SH	Royal College of Nursing	5	4.3	It would be preferable to change the "early identification" to the "accurate identification" – the label BPD has never been the most helpful diagnosis when people are trying to access mental health services. Earlier diagnosis may lead to earlier exclusion. In regards to pharmacological interventions it may be important to consider the use of Clozapine which may not fall within licensed indications.	Thank you for your comment. We are happy wit current wording. Thank you for your comment. The text has beer amended to reflect these concerns (please see 4.3e)
SH	Royal College of Nursing	6	General comment	It is imperative that the care/management of people with BPD as they move through the services of mental health be seen as a priority. This should focus on the psychosocial nursing skills required and identify an appropriate nursing model that can be used as a theoretical framework to support consistent practice for all clinicians. Women with BPD continue to be transferred to secure independent care settings or excluded from mainstream mental health services - this needs to be addressed as a matter of urgency.	Thank you for your comment. Clinical guideline normally make recommendations on the role of professional groups, but concentrate on identify recommending interventions that are found to b effective, for which people, and at which stages pathway or illness.
SH	Royal College of Nursing	7	4.4.2	The Royal College of Nursing has a wealth of expert and experienced mental health nurses within its membership and we are in a position to nominate suitable candidates to be considered as members of the guideline development group. The RCN looks forward to actively participating in the development of this guideline.	Thank you for your comment.
SH	Royal College of Paediatrics and Child Health	1	General	The scope is about treatment of adults with a diagnosis of BPD and young people with emerging features of BPD. This could perhaps be widened to include the prevention of events known to predispose to BPD, such as childhood sexual abuse.	Thank you for your comment. The scope of the has been extended as far as possible within the remit. Therefore it will not be possible to cover p
SH	Royal College of Paediatrics and Child Health	2	General	The scope appropriately focuses on the treatment and prevention of BPD, but should also specifically mention the need to safeguard the children of such adults from the effects these conditions can have on parenting and family life. This comment was made by several members.	Thank you for your comment. The joint NICE / guideline on Parental Mental Health and Child W will cover this type of issue.
SH	Royal College of Psychiatrists	1	General	We welcome the development of this report, as people with Borderline Personality Disorder create considerable challenges to	Thank you.

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				mainstream secondary care services.	
SH	Royal College of Psychiatrists	2	General	The document appears to be limited to primary and secondary health services. As is acknowledged, much of the morbidity from this conditions is found in the offending population. Where there is significant risk to others, they may be managed by forensic in-patient or community services – tertiary level services. We consider that guidelines should be extended to this group where possible	Thank you, we shall amend the guideline to refl comment, (please see section 4.2a)
SH	Royal College of Psychiatrists	3	General	We note that comments about guidance on pharmacological treatment only being given in "off-licence" situations in exceptional circumstances – this will limit the value of guidelines in this conditions unless exceptional is broadened as there is extensive and diverse prescribing at present for these conditions, and clinicians are in great need of guidance even if the evidence base is less sound than for mental illness	Thank you for your comment. This will be consi during guideline development.
SH	Royal College of Psychiatrists	4	General	We feel that meeting plans should involve patient and carer input, and be consistent across community/ IP domains.	Thank you for your comment. This will be consi during guideline development.
SH	Royal College of Psychiatrists	5	3a	Agreed. Add here that it is associated with high levels of self-destructive behaviour. It is the most frequent Personality Disorder in Accident and Emergency Departments and psychiatric clinical settings.	Thank you for your comment.
SH	Royal College of Psychiatrists	6	3b	The figures of prevalence of BPD in the UK must be taken with great caution, as this contradicts literature available, mostly from the USA, where consistently BPD is found to be more prevalent in females. It is possible that referrals to NHS psychiatrists from Primary Care settings for this condition in isolation are rare, that UK psychiatrists are not identifying BPD in their clinical populations, and that most of the identified BPD patients are diagnosed in prison or forensic services, which could explain the preponderance of males in those diagnosed. Figures available in the USA indicate that BPD is present in 10% of psychiatric outpatients and 15-20% of psychiatric in-patients. Figures are not available when BPD complicates an Axis I or II disorder and/or Drug and Alcohol misuse. This makes the management of all of these conditions difficult. These associations are certainly not rare, and when BPD is identified in clinical settings in the NHS, it is more likely to present itself in association with these disorders rather than as a discrete entity.	Thank you, the text has been amended to reflec variation in prevalence (please see section 3b). Other common comorbid conditions will be cons part of the guideline, as far as these conditions treatment of BPD (please see section 4.3j)

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				The guideline should therefore tackle the management of BPD when it presents not only as a discrete diagnosis but in association with other disorders. Among the most common co-morbid Axis I disorders are mood disorders (where there can be substantial overlap of symptomatology), substance-related disorders, eating disorders (especially bulimia), PTSD (a history of trauma is characteristic of BPD and often does not require additional diagnosis of PTSD), panic disorder and ADHD. Axis II disorders commonly occurring are other personality disorders, such as antisocial, avoidant, histrionic, narcissistic and schizo-typal.	
SH	Royal College of Psychiatrists	7	3c	It might be worthwhile stating here that Personality Disorder services in the UK appear to be adopting DSM-IV criteria because of its broader description and the clarity offered by the cluster classification of Personality Disorders	Thank you for your comment; we shall address of which diagnostic criteria should be applied in guideline.
SH	Royal College of Psychiatrists	8	3d	Clinical experience suggests that a continuum model should be adopted, as conduct disorders in childhood and adolescence are early indicators of eventual development of BPD in adulthood. Many patients over 18 diagnosed with BPD have already been in contact with CAMHS or Educational Psychology because of their disruptive behaviour at home or at school.	Thank you for your comment. We will be outlini diagnostic features which trigger the use of this and will be including early identification.
SH	Royal College of Psychiatrists	9	3e	Agreed.	Thank you.
SH	Royal College of Psychiatrists	10	3f	BPD seriously affects others, either the family, the workplace and those involved in their care. Patients with BPD evoke very negative responses from those around them, as well as rejection from services, which compounds their own feelings of abandonment.	Thank you for your comment. The guideline will carer and family issues (please see section 4.3 issues around the response of clinical staff (plea section 4.3h)
SH	Royal College of Psychiatrists	11	3g	There is conflicting evidence about the degree of improvement in BPD populations. Some long-term studies of BPD indicate that only 50% of women and 25% of men diagnosed with the condition gain stability and satisfactory relationships characterised by intimacy. Most long term studies have focused on patients from middle or upper-middle class families, and there are indications that those from poor backgrounds fare less well in areas of relationships and work.	Thank you, we have amended the text to reflect comment, (please see section 3g)
SH	Royal College of Psychiatrists	12	3h	Agreed. This matter could be improved with appropriate training of professional staff in the management of acute crisis that characterise patients who suffer from BPD, especially effective use of in-patient admissions when this is required, good networking, and specific input from dedicated PD services into secondary care services, such as inpatient and community mental health teams.	Thank you for your comment. Although we will n specifically cover staff training, we will cover wh interventions are thought to be the most effectiv interface between different services.

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SH	Royal College of Psychiatrists	13	4.1.1	Add here d) Management of BPD and co-morbid conditions.	Thank you, we feel that this has already been c section 4.3j.
SH	Royal College of Psychiatrists	14	4.2a	Agreed	Thank you.
SH	Royal College of Psychiatrists	15	4.2b	Add interface with dedicated Personality Disorder Services, Medium Secure facilities and other Forensic Services, Substance Misuse Services.	Thank you for your comment, the services men used as examples, the GDG will consider which interfaces to address in more detail.
SH	Royal College of Psychiatrists	16	4.2c	Add Care in Specialist Personality Disorder Services and transition to and from secondary mental health services Care in the Accident and Emergency Department and transition to secondary mental health services.	Thank you, this is not intended to be a compreh of all the possible interfaces; the GDG will ident interfaces that it is important to address during development of the guideline.
SH	Royal College of Psychiatrists	17	4.3a	In this area explore transition with CAMHS	Thank you for your comment.
SH	Royal College of Psychiatrists	18	4.3b	Explore here the specific, if limited role of inpatient facilities in the management of crises presented by patients with BPD, the effective use of CPA, the important role of the care-co-ordinator, the requirement for effective networking and supervision, and the specific input from Personality Disorder Services (where they exist) into inpatient and community mental health teams.	Thank you for your comment. We will consider issues during development.
SH	Royal College of Psychiatrists	19	4.3c	We would recommend here that NICE not only covers care that is *routinely* available in the NHS, but also care that should be developed where it is lacking, in particular, treatment approaches and services that have proved to be effective in the management of patients with BPD.	Thank you for your comment. If there is suppor evidence for a particular treatment, an appropri recommendation will be made.
SH	Royal College of Psychiatrists	20	4.3d	Agreed	Thank you.
SH	Royal College of Psychiatrists	21	4.3e	Important to state here that medication has a very limited role in the management of BPD, and that one strategy adopted would be to clarify whether it is being used specifically for mood stabilisation (SSRIs, MAOIs or Mood stabilisers), for Impulsivity-Self-destructiveness (SSRIs, anticonvulsants), or for perceptual-cognitive symptoms (low-dose antipsychotics)	Thank you for your comment. However, we are with the current wording, as it is not possible to aspects of the disorder and its clinical manage the scoping document.
SH	Royal College of Psychiatrists	22	4.3f	Agreed	Thank you
SH	Royal College of Psychiatrists	23	4.3g	Agreed	Thank you
SH	Royal College of Psychiatrists	24	4.3h	Agreed	Thank you
SH	Royal College of Psychiatrists	25	4.3i	Agreed	Thank you
SH	Royal College of Psychiatrists	26	4.3j	Agreed	Thank you.
SH	Royal College of Psychiatrists	27	4.3k	Agreed	Thank you
SH	Royal College of Psychiatrists	28	4.3l	Agreed	Thank you
SH	Royal College of Psychiatrists	29	4.3m	Agreed	Thank you.
SH	Royal College of Psychiatrists	30	4.3n	Add specific support and training required for staff managing patients	Thank you, the text has been amended to reflec

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				with BPD	comment and those of other stakeholders, (plea section 4.3h)
SH	Royal College of Psychiatrists	31	4.4.1	There is also relevant information available in the Practice Guidelines for the Treatment of Psychiatric Disorders from the American Psychiatric Association, National Institute of Mental Health in England (2003) Personality Disorder: No longer a diagnosis of exclusion and recent papers in Advances in Psychiatric Treatment by Bateman, Tyrer and Fagin	Thank you.
SH	Social Care Institute for Excellence (SCIE)	1	4.2a	"The guideline will cover the care provided by primary, community and secondary healthcare professionals who have direct contact with , and make decisions concerning , the care of adults with BPD …" Community mental health services include mental health social workers who are not health care professionals but are seconded to work under Mental Health Trust management. How will the guidelines address their work as Care Co-ordinators and Approved Social Workers as the definition-"health care professional" does not include their role?	Thank you for your comment. SCIE will be aske participate in the guideline development proces
SH	Social Care Institute for Excellence (SCIE)	2	4.2b	"This is an NHS guideline" Interface with other services including voluntary sector, social services and education." This should also crucially include interface issues with the police, CAMHS, housing and residential care.	Thank you, this section does not seek to be a comprehensive list of all possible interfaces. Th will consider interfaces during the development guideline.
SH	Social Care Institute for Excellence (SCIE)	3	4.1.1c 4.3i	People with BPD and a learning disability: why is LD included in the BPD guidelines but not the ASPD guidelines?	The NCCMH receives the remit for each guideli the DoH and it not privy to the detailed thinking remit; however the remit does reflect current pri identified by the DoH. The ASPD guideline will the issue of intellectual functioning including its importance, treatment and management.
SH	Social Care Institute for Excellence (SCIE)	4	General	Given the range of social problems that people with PD present could a joint guideline or close collaboration with Social Care Institute for Excellence be considered?	Thank you for your comment. SCIE will be aske participate in the guideline development proces
SH	Social Care Institute for Excellence (SCIE)	5	4.3	Why not include under Clinical management: assessment and risk assessment as for ASPD	Thank you for your comment. In the remit from the BPD guideline was asked to focus on differe However, assessment and risk assessment will included in the guideline as part of the treatmen pathways section.
SH	Social Care Institute for Excellence (SCIE)	6	4.3j & 4.3k	Issues of diversity and social inclusion and working with carers are all areas where a social perspective needs to be included.	Thank you for your comment.
SH	Social Care Institute for Excellence (SCIE)	7	4.3c	" The full range of care made available by the NHS" : in community mental health services this includes social care delivered by social	Thank you for your comment. These issues will during the development of the guideline and SC

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				workers and health care staff. People with borderline PD present many social problems , including : working with carers and in some cases the police around threats or acts of self harm ; working with housing departments and Homeless Persons Unit regarding issues to do with eviction and homelessness; working with Children and Families services where children are involved. Any guideline addressing the management of a diagnosis with this range of presenting social problems has to address how community mental health staff work in this area, as the guideline will not be comprehensive otherwise.	asked to participate in the process.
SH	Sussex Partnership NHS Trust	1	3c	Consideration of the controversial nature of this diagnosis and of alternatives, such as complex PTSD, Emotional Intensity Disorder	Thank you for your comment. Thank you for you comment. The GDG will endeavour to make as possible precisely what triggers the use of this g and thereby which people the guideline will con
SH	Sussex Partnership NHS Trust	2	3e	Include factors which have helped resiliency or may have been reparative to potential early damage. (This may help widen focus of treatment /therapy)	Thank you for your comment. This section of th addresses the clinical need for the guideline rat this type of issue.
SH	Sussex Partnership NHS Trust	3	4.3	Collaborative treatment planning and full involvement of service users in their own treatment.	Thank you for your comment. Service user issu considered during the development of the guide inform the synthesis of recommendations.
SH	Sussex Partnership NHS Trust	4	4.3c	'Full range of care routinely available on NHS' has been (and in some cases still is) inadequate. There needs to be consideration of new ways of working, which might involve systemic change. This section should include the need for service development, not necessarily requiring new investment, but better use of existing resources.	Thank you for your comment. This is a clinical g resource related issues are beyond its remit.
SH	Sussex Partnership NHS Trust	5	4.3d	Allow for possibility that new therapies may be developed or introduced	Thank you for your comment.
SH	Sussex Partnership NHS Trust	6	4.3	Working with staff teams to provide support, supervision and prevent burnout. Development of teamwork and collaboration. Bringing about necessary attitude change.	Thank you, the scope has been amended to ref comment (please see section 4.3h)
SH	Sussex Partnership NHS Trust	7	4.3	Suggest include issue of appropriate staff selection and training. Not all people are able to work with this client group.	Thank you, the scope has been amended to ref comment (please see section 4.3h)
SH	Sussex Partnership NHS Trust	8	4.1.1	Refer to Breaking the Cycles of Rejection (2003)	Thank you for your comment. The scope does n population we shall be addressing in the guideli
SH	Sussex Partnership NHS Trust	9	General	Emphasis on recovery and the Recovery Model. Stronger inclusion of psychological/psychosocial model and emphasis on collaborative nature of the work. Less focus on illness/disease model	Thank you for your comment. This will be consi during guideline development.

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SH	Tavistock and Portman Foundation Trust	1	General	1) The description of this disorder include little about the **actual inner experience** of these patients - for instance pervasive feelings of emptiness, disturbance of identity, tendency to splitting that is idealisation and denigration of significant people (and instability of these perceptions)	Thank you for your comment. The scope is a br outline of the disorder. Full consideration will be the experiences of service users during the dev of the guideline.
SH	Tavistock and Portman Foundation Trust	2	General	2) There is no mention of **tertiary services** – I think this is an important omission and should be referred to in any document on Personality Disorder	Thank you, we have amended the text to reflect comment, (please see section 4.2a)
SH	Tavistock and Portman Foundation Trust	3	General	3) The document is very geared to treatment and I think more scope could be given to what I would prefer to call 'good management'. The document mentions that the patients create a great deal of anxiety in those around them, including staff. Effective management would mean that structures were in place to contain these anxieties so that they are not acted upon to the detriment of the patient and to the staff. The structure would mean regular skilled supervision. This is also necessary for maintaining staff morale, a vital ingredient in the therapeutic team.	Thank you for your comment. Issues around "go management" will be considered during the dev of the guideline (please see section 4.3h)
SH	Tavistock and Portman Foundation Trust	4	General	4) Linked to above as relates to good management. Rapid turnover of personnel is very damaging to the care of these patients and so good management would mean that patients are looked after by staff of sufficient seniority that they re likely to be able to provide this care for a reasonable period of time (e.g. at least 2 years)- that is effective management would avoid key support being provided by less skilled/ more junior individuals who are not likely to have the necessary maturity to manage the intense anxiety evoked and further would be likely to move on. **i.e. Borderline patients require enduring stable structures.** These issues relate not only to treatment but to **damage limitation** which is an important aspect of the therapeutic milieu and which, I think, requires more emphasis**.**	Thank you for your comment. The therapeutic environment and associated iss be considered during the development of the gu (please see section 4.3h)
SH	The Cassel Hospital	1	General	1) The description of this disorder include little about the actual inner experience of these patients - for instance pervasive feelings of emptiness, disturbance of identity, tendency to splitting that is idealisation and denigration of significant people (and instability of these perceptions)	Thank you for your comment. The scope is a br outline of the disorder. Full consideration will be the experiences of service users during the dev of the guideline.
SH	The Cassel Hospital	2	General	2) There is no mention of tertiary services – I think this is an important omission and should be referred to in any document on Personality Disorder	Thank you, we have amended the text to reflect comment, (please see section 4.2a)

Type	Stakeholder	No	Section number	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	The Cassel Hospital	3	General	3) The document is very geared to treatment and I think more scope could be given to what I would prefer to call 'good management'. The document mentions that the patients create a great deal of anxiety in those around them, including staff. Effective management would mean that structures were in place to contain these anxieties so that they are not acted upon to the detriment of the patient and to the staff. The structure would mean regular skilled supervision. This is also necessary for maintaining staff morale, a vital ingredient in the therapeutic team.	Thank you for your comment. Issues around "go management" such as staff supervision will be c during the development of the guideline (please section 4.3h)
SH	The Cassel Hospital	4	General	4) Linked to above as relates to good management. Rapid turnover of personnel is very damaging to the care of these patients and so good management would mean that patients are looked after by staff of sufficient seniority that they re likely to be able to provide this care for a reasonable period of time (e.g. at least 2 years)- that is effective management would avoid key support being provided by less skilled/ more junior individuals who are not likely to have the necessary maturity to manage the intense anxiety evoked and further would be likely to move on. i.e. Borderline patients require enduring stable structures. These issues relate not only to treatment but to damage limitation which is an important aspect of the therapeutic milieu and which, I think, requires more emphasis.	Thank you for your comment. The therapeutic environment and staffing issues will be conside the development of the guideline (please see se 4.3h)
SH	Victim Support	1	General	Borderline Personality Disorder and Domestic Violence - On pages 3 and 4 of the scoping document under point f) it says that 'BPD can be a seriously disabling condition…' and that people with BPD 'may experience difficulties such as considerable changes in mood, lack of confidence, impulsive and self-injurious behaviour, substance misuse, excessive sensitivity and fears of rejection and criticism'. It is also noted that 'suicide is a particular risk in BPD, with up to one in ten committing suicide' (p.4). We know from other research that victims of domestic violence can go on to experience a range of mental health problems including depression, Post Traumatic Stress Disorder (PTSD), phobias, anxiety, panic disorders, substance misuse, self-harm and suicide. Victims of domestic violence are on average 4 times more likely to be depressed than women in general and 4 times more likely to be suicidal. Studies also indicate significantly increased rates of self-harm among young Asian UK women in which domestic violence	Thank you for your comment. The potential imp Borderline Personality Disorder upon the perso affected, will be included.

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				linked to forced marriages is a factor. Victims of domestic violence are also 6 times more likely to abuse alcohol than women in general and a quarter use alcohol or drugs to self-medicate.	
SH	Victim Support	2	General	Given the apparent similarity between the 'symptoms' of BPD and the effects of domestic violence it is important that the scope of the guideline takes account of the research and evidence in the area of domestic violence and mental health. For example, Humphreys and Thiara (2003) describe a number of discourses within the medical model of mental health that appear to perpetuate inadequate health responses to victims of domestic violence and serve to exacerbate rather than alleviate problems, one of these is victim blaming. They suggest that the woman's 'mental illness' becomes the focus of treatment unconnected to the abuse context and go on to show how victims are blamed for the violence and abuse they experience. In this way '…after several admissions the woman becomes labelled as suffering from mental health problems, often depression, 'personality disorder' or 'borderline personality disorder'. The control exerted by the perpetrator over the woman, which is 'evident in her continued living with him, becomes seen as a symptom and indicator of the woman's mental health problems rather than the source of her problems'. The labelling of domestic violence victims as 'personality disorder' often closes down or restricts access to services that may be best placed to help them. In contrast openly acknowledging the link between violence and abuse and the emotional distress can open up the possibilities for appropriate referral and effective help and support such as advocacy, counselling, group work and support. Thus, Humphreys and Thiara (2003) argue that '…women's experiences of depression, post-traumatic stress, and self-harm can be understood as 'symptoms' or the effects of living with violence and abuse. Domestic violence is not just one of many problems, but an issue that requires addressing as a primary concern'. It is therefore essential that the research related to this issue is fully explored and considered by NICE in the development and drafting of	Thank you for your comment. Clearly, the envir and psychosocial factors that may contribute to development of Borderline Personality Disorder be considered in developing both general and s aspects of any treatment programme; in so far a research evidence to support this.

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				the Guideline for Personality Disorder if misdiagnosis and ineffective and inappropriate treatments are to be avoided.	
SH	Walsall PCT	1	4.3	I am concerned that the document will deal with the range of treatments currently offered by the NHS. The fact is that, by and large, the range of interventions offered are pathetic. It should also be noted that the emphasis of the guidelines MUST be on Psychological interventions (including newer treatments such as Mode Therapy (based on Young's Schema Therapy) and should not be NICE's usual over-emphasis on medical approaches (which to date have offered little or nothing in the successful treatment of BPD). In this regard, Psychotherapy (of the psychoanalytic sort) has little to offer… The research evidence does NOT support inpatient treatment centres such as the Henderson and NICE must be honest in not wasting valuable resources in these areas any more than absolutely necessary.	Thank you for your comments. Recommendatio in NICE guidance are arrived at after a rigorous of evidence synthesis has been completed. Unf there will usually be a greater depth of evidence particular areas. The existence of NICE guidanc not preclude new approaches being developed, and published. If shown to be successful, new r will be included in future updates. Thank you for your comment. These comments considered during the development of the guide
SH	Walsall PCT	2	4.3	A key area that seems to have been missed out is the liaison between adult and child services when children become the subject of care proceedings because of parents with BPD who fail to cope. Services should include family orientated approaches that meet the needs of both adults and children in these circumstances.	Thank you for your comment. These issues will addressed at least in part during the developme guideline.
SH	Walsall PCT	3	4.3	The guidelines should also provide explicit information about the training required by staff as well as, if possible, indications regarding an adequate level of training/expertise that should be guaranteed by Trusts.	Thank you for your comment. The scope has be amended to include staffing issues (please see 4.3h)
SH	Walsall PCT	4	General	It should be remembered that we are starting from a very low baseline. Very few Trusts offer anything like an adequate service for people with PD. As usual, Trusts will do the bare minimum to comply with the guidelines because of the intolerable financial pressures that our incompetent government is placing on the NHS. Thus, the clearer and tighter the guidelines are, the better.	Thank you for your comment. This will be consi during guideline development.

SH	Adults Strategy and Commissioning Unit			This organisation was invited to comment, but did not respond	
SH	Afiya Trust, The			This organisation was invited to comment, but did not respond	
SH	Association for Improvements in the Maternity Services				
SH	Association of Dance Movement Therapy UK			This organisation was invited to comment, but did not respond	
SH	Avon and Wiltshire Mental Health Partnership NHS Trust			This organisation was invited to comment, but did not respond	
SH	Barnsley PCT			This organisation was invited to comment, but did not respond	
SH	Bedfordshire & Hertfordshire NHS Strategic Health Authority			This organisation was invited to comment, but did not respond	
SH	Berkshire Healthcare NHS Trust			This organisation was invited to comment, but did not respond	
SH	Borderline UK			This organisation was invited to comment, but did not respond	
SH	British Association for Counselling and Psychotherapy (BACP)			This organisation was invited to comment, but did not respond	
SH	British Association of Drama Therapists			This organisation was invited to comment, but did not respond	
SH	British National Formulary (BNF)			This organisation was invited to comment, but did not respond	
SH	British Psychological Society, The			This organisation was invited to comment, but did not respond	
SH	Broadmoor Hospital			This organisation was invited to comment, but did not respond	
SH	Cambridgeshire & Peterborough Mental Health Trust			This organisation was invited to comment, but did not respond	
SH	CASPE			No comments	
SH	CIS'ters			This organisation was invited to comment, but did not respond	
SH	Commission for Social Care Inspection			This organisation was invited to comment, but did not respond	
SH	Connecting for Health			This organisation was invited to comment, but did not respond	
SH	Conwy & Denbighshire Acute Trust			This organisation was invited to comment, but did not respond	
SH	Cornwall Partnership Trust			This organisation was invited to comment, but did not respond	
SH	Counsellors and Psychotherapists in Primary Care			This organisation was invited to comment, but did not respond	
SH	Counsellors and Psychotherapists in Primary Care			This organisation was invited to comment, but did not respond	
SH	County Durham & Darlington Priority Services NHS Trust			This organisation was invited to comment, but did not respond	
SH	Critical Psychiatry Network			This organisation was invited to comment, but did not respond	
SH	Department for Education and Skills			This organisation was invited to comment, but did not respond	
SH	Derbyshire Mental Health Trust			This organisation was invited to comment, but did not respond	
SH	Eastern Specialised Mental Health			This organisation was invited to comment, but did not respond	

	Commissioning Group				
SH	Ex-Services Mental Welfare Society			This organisation was invited to comment, but did not respond	
SH	First Steps to Freedom			This organisation was invited to comment, but did not respond	
SH	Forensic Arts Therapies Advisory Group			This organisation was invited to comment, but did not respond	
SH	Foundation for the Study of Infant Deaths			This organisation was invited to comment, but did not respond	
SH	General Chiropractic Council			This organisation was invited to comment, but did not respond	
SH	Gloucestershire Partnership NHS Trust			This organisation was invited to comment, but did not respond	
SH	Hampshire Partnership NHS Trust			This organisation was invited to comment, but did not respond	
SH	Health and Safety Executive			This organisation was invited to comment, but did not respond	
SH	Health Commission Wales			This organisation was invited to comment, but did not respond	
SH	Healthcare Commission			This organisation was invited to comment, but did not respond	
SH	Heart of England NHS Foundation Trust			This organisation was invited to comment, but did not respond	
SH	Hertfordshire Partnership NHS Trust			This organisation was invited to comment, but did not respond	
SH	Home Office			This organisation was invited to comment, but did not respond	
SH	Humber Mental Health NHS Trust			This organisation was invited to comment, but did not respond	
SH	King's College Acute Trust			This organisation was invited to comment, but did not respond	
SH	Liverpool PCT			This organisation was invited to comment, but did not respond	
SH	London Development Centre for Mental Health			This organisation was invited to comment, but did not respond	
SH	Lundbeck Ltd			This organisation was invited to comment, but did not respond	
SH	Medicines and Healthcare Products Regulatory Agency (MHRA)			This organisation was invited to comment, but did not respond	
SH	Mental Health Act Commission			This organisation was invited to comment, but did not respond	
SH	Mental Health Nurses Association			This organisation was invited to comment, but did not respond	
SH	Mersey Care NHS Trust			This organisation was invited to comment, but did not respond	
SH	Merton CAMHS			This organisation was invited to comment, but did not respond	
SH	National Institute for Mental Health in England (NIMHE)			This organisation was invited to comment, but did not respond	
SH	National Patient Safety Agency			This organisation was invited to comment, but did not respond	
SH	National Public Health Service - Wales			This organisation was invited to comment, but did not respond	
SH	National Treatment Agency for Substance Misuse			This organisation was invited to comment, but did not respond	
SH	NCCHTA			This organisation was invited to comment, but did not respond	
SH	NHS Health and Social Care Information Centre			This organisation was invited to comment, but did not respond	
SH	NHS Plus			This organisation was invited to comment, but did not respond	

SH	NHS Quality Improvement Scotland			This organisation was invited to comment, but did not respond	
SH	North East London Mental Health Trust			This organisation was invited to comment, but did not respond	
SH	Northwest London Hospitals NHS Trust			This organisation was invited to comment, but did not respond	
SH	Nutrition Society			This organisation was invited to comment, but did not respond	
SH	Oxleas NHS FoundationTrust			This organisation was invited to comment, but did not respond	
SH	Peninsula Primary Care Psychology & Counselling Services			This organisation was invited to comment, but did not respond	
SH	PERIGON (formerly The NHS Modernisation Agency)			This organisation was invited to comment, but did not respond	
SH	Pottergate Centre for Dissociation & Trauma			This organisation was invited to comment, but did not respond	
SH	Regional Public Health Group - London			This organisation was invited to comment, but did not respond	
SH	Royal College of General Practitioners			This organisation was invited to comment, but did not respond	
SH	Royal College of Pathologists			No comment	
SH	Scottish Intercollegiate Guidelines Network (SIGN)			This organisation was invited to comment, but did not respond	
SH	Service for People with Personality Difficulties			This organisation was invited to comment, but did not respond	
SH	Sheffield PCT			This organisation was invited to comment, but did not respond	
SH	Sheffield Teaching Acute Trust			This organisation was invited to comment, but did not respond	
SH	Somerset Partnership NHS and Social Care Trust			This organisation was invited to comment, but did not respond	
SH	South London & Maudsley Acute Trust			This organisation was invited to comment, but did not respond	
SH	South West London & St George's Mental Health Trust			This organisation was invited to comment, but did not respond	
SH	Staffordshire Moorlands PCT			This organisation was invited to comment, but did not respond	
SH	Stockport PCT			This organisation was invited to comment, but did not respond	
SH	Surrey and Border Partnership Trust			This organisation was invited to comment, but did not respond	
SH	Surrey PCT			This organisation was invited to comment, but did not respond	
SH	Sustain: The alliance for better food and farming			This organisation was invited to comment, but did not respond	
SH	Tees, Esk & Wear Valleys NHS Trust			This organisation was invited to comment, but did not respond	
SH	The Association for Cognitive Analytic (ACAT) Therapy			This organisation was invited to comment, but did not respond	
SH	The College of Mental Health			This organisation was invited to comment, but did not respond	

	Pharmacists				
SH	The David Lewis Centre			This organisation was invited to comment, but did not respond	
SH	The Howard League for Penal Reform			This organisation was invited to comment, but did not respond	
SH	The National Self Harm Network			This organisation was invited to comment, but did not respond	
SH	The Royal Society of Medicine			This organisation was invited to comment, but did not respond	
SH	The Survivors Trust			This organisation was invited to comment, but did not respond	
SH	UK Council for Psychotherapy			This organisation was invited to comment, but did not respond	
SH	UK Psychiatric Pharmacy Group			This organisation was invited to comment, but did not respond	
SH	UK Specialised Services Public Health Network			This organisation was invited to comment, but did not respond	
SH	Welsh Assembly Government			No comment	
SH	Welsh Scientific Advisory Committee (WSAC)			This organisation was invited to comment, but did not respond	
SH	West London Mental Health NHS Trust			This organisation was invited to comment, but did not respond	
SH	Adults Strategy and Commissioning Unit			This organisation was invited to comment, but did not respond	