NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION SUMMARY REPORT

1 Quality standard title

Personality disorders: borderline and antisocial

Date of Quality Standards Advisory Committee post-consultation meeting:
21 January 2015

2 Introduction

The draft quality standard for Personality disorders (borderline and antisocial) was made available on the NICE website for a 4-week public consultation period between 21 November and 19 December 2014. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 21 registered stakeholders and 5 non-registered parties, which included service providers, national organisations, professional bodies and others.

This report provides the Quality Standards Advisory Committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the Committee as part of the final meeting where the Committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the Committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the Committee should read this summary alongside the full set of consultation comments, which are provided in appendices 1 and 2.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

3. For each quality statement what do you think could be done to support improvement and help overcome barriers?

Stakeholders were also invited to respond to the following statement specific questions:

1. For draft quality statement 2: Could you provide a list of psychological therapies that are relevant to borderline or antisocial personality disorder.

2. For draft quality statement 6: Is statement 6 aspirational or are all mental health professionals already routinely supervised?

3. For draft quality statement 6: Could you specify what level of intensity or what frequency of supervision would be required to achieve quality improvement?

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- The statements were felt to be areas for quality improvement.
- Issues on diagnosis for personality disorders were raised: its contentious nature, inaccuracy, lack of quality, under-diagnosis and misdiagnosis of people with autism and post-traumatic stress disorder.
- Funding to services is being cut and it needs to reflect the complexity of services.
- The following are not felt to be adequately represented in the quality standard: young people, the role of families and carers, the prison population, young offenders and secure hospitals.
- The role of the care plan and crisis planning need greater emphasis.
- Integrated working between specialist and general services is needed. This could be led by medical psychotherapists.
- Stakeholders questioned why borderline and antisocial personality disorders are in the same quality standard.
- Concerns were raised that there were no members of community and prison mental health teams, secure hospital settings or people who work with the most severe presentations of personality disorders on the committee.

Consultation comments on data collection

- There are difficulties in collecting data on this population due to drop-out, poor engagement and service users not being in specific Trust clusters.
- Resource issues were raised: constrains on IT and admin support due to financial pressures, time limits of clinicians and risk of diverting resources from clinical care.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

People have a structured assessment before they are given a diagnosis of borderline or antisocial personality disorder.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Specify at what point in the pathway this is most likely to take place e.g. when entering secondary care.
- The requirement to carry out an assessment could be a barrier to accessing support. Specify that failure to do the assessment is not an acceptable exclusion criterion to services.
- Service users should be involved in the assessment and asked about their needs.
- Information should be provided to patients on the diagnosis.
- Staff need to understand other influencing factors e.g. autism, hormonal disturbance, co-morbid conditions.
- The assessment should be done by specialist personality disorder services.
- The resource implications for this statement were raised: staff training and time, which could lead to waiting lists and delays in diagnosis.
- An assessment should only be done when there is diagnostic uncertainty.
- Concerns were raised about the assessment tools regarding quality and the classification of personality disorders. Stakeholders questioned which tools should be used, in particular for young people.

5.2 Draft statement 2

People with borderline or antisocial personality disorder are offered psychological therapies relevant to the disorder or individual symptoms of the disorder.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- Symptoms of personality disorders can only be properly addressed through therapy for the disorder rather than treating individual symptoms.
- A timeframe for treatment to commence should be included to avoid delays.
- Staff accessibility and the stability of the environment also need to be considered.
- Consider which therapies will be successful for people with autism.
- The statement needs to acknowledge that these disorders may have different service configurations.
- Specialist personality disorder services need to be involved in decisions about therapy.
- Young people are not mentioned.
- Patients with personality disorders within services should have reasons documented if they have not had psychological therapy.
- Include provision of patient information and patient involvement in decisions about treatment as measures.

Consultation question 4

Stakeholders made the following comments in relation to consultation question 4 on the types of psychological therapies that are relevant to borderline or antisocial personality disorder:

- Stakeholders suggested the following :
    - Group based psychodynamic therapies
    - Dialectical Behaviour Therapy
    - Mentalisation Based Therapy
    - Psychotherapy
    - Transference-Focused Psychotherapy
    - Psychoanalytic Psychotherapy

- Cognitive Analytic Psychotherapy
- Therapeutic Community
- Schema therapy
- Art therapy
- Music therapy
- Eye Movement Desensitisation and Reprocessing
- The STEPPS group treatment program
- Family work
- Compassionate Mind Therapy

5.3 Draft statement 3

People with borderline or antisocial personality disorder are not prescribed antipsychotic or sedative medication for medium or long term management unless there is a diagnosed psychotic disorder.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- A number of stakeholders disagreed with the statement. The statement needs to acknowledge that different practice might be needed in specialist groups e.g. in prisons/secure settings.
- Suggestion to include all psychiatric medication and short term drugs.
- Information about medication should be provided for patients.
- The effects of medication on young people should be mentioned.
- Do hallucinatory experiences, such as voices, warrant antipsychotics for people with borderline personality disorders or do they need to experience additional psychotic experiences or have a diagnosis of a psychotic disorder?
- Pharmacology should be targeted at specific symptoms.
- The definition of ‘medium term’ was queried.
- Suggestion to measure people prescribed more than one antipsychotic and/or sedative medication.

5.4 Draft statement 4

People with borderline or antisocial personality disorder have the risks associated with transitions and changes to services addressed in their care plan.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- Consult service users on managing endings and involve them in decision making early on.
- Ease of access in a crisis should be included.
- Include people who have been discharged from services as well.
- There are breaks in service and no joined up care due to commissioning arrangements.
- Issues relating to young people were raised.
- Service user involvement should be a measure.
- Feedback from service users should be used to measure whether services are easy to access.
- Link the data collected with crisis contacts accessed during the time of transition.

5.5 Draft statement 5

People with borderline or antisocial personality disorder have their social care, social support and occupational needs identified in their care plan.

Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

- The statement will be hard to implement.
- The statement covers identifying need but not addressing and dealing with those needs.
- Include patients treated in outpatient departments and inpatient settings as well as community settings.
- Support needs for the family should be included.
- Issues relating to young people were raised.
- Include prisons and probation services in the bracketed list of service providers.
- The practice of discharging people from services when they begin work will skew the data for outcome measure a.
- The measurability of outcome measure c was questioned.

5.6 Draft statement 6

Mental health professionals supporting people with borderline or antisocial personality disorder are routinely supervised.

Consultation comments

Stakeholders made the following comments in relation to draft statement 6:

- The statement does not address the quality of supervision.
- Rewording the rationale was suggested.
- Clarification is needed on the nature of supervision: is it supportive or for monitoring performance?
- Add the importance of group supervision/reflective practice.
- Supervision should be provided for all staff supporting people with personality disorders.
- Measuring the number of professionals being supervised who use evidence of what happens in sessions was suggested.
- The measures need to reflect the supportive, reflective component of what staff need in supervision.

Consultation question 5

Stakeholders made the following comments in relation to consultation question 5 on whether the statement is aspirational or all mental health professionals are already routinely supervised:

- Stakeholders varied in their responses. Some felt generic supervision is a basic requirement for mental health professionals and is examined by the CQC. However, some felt a statement on supervision specific to personality disorders would be aspirational as it is not widespread across services.
- The quality of supervision can be improved.

Consultation question 6

Stakeholders made the following comments in relation to consultation question 6 on the level of intensity or frequency of supervision is required to achieve quality improvement:

- The nature and frequency of supervision should be appropriate to the complexity of the work undertaken and tailored to individual roles and needs.
- The suggested frequencies for individual supervision were 1 hour per week/fortnight, monthly, every 4 to 6 weeks and every 8 weeks.
- The suggested frequencies for group supervision were monthly and every 4 to 6 weeks.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Continuity of care between primary and secondary care.
- Information for patients on their diagnosis.
- Organisation of services: mental health trusts agreeing a personality disorder strategy with commissioners.
- Management of co-morbid personality disorders and mental illness.
- The challenges of risk taking behaviours in people with personality disorders.
- Using acute psychiatric admissions for people with a diagnosis of borderline personality disorders.
- Assessing occupational functioning and provision of occupational therapy.

Appendix 1: Quality standard consultation comments table

ID	Stakeholder	Statement No	Comments
1	Association for Improvements in the Maternity Services	General	We wish to make a general comment about this quality standard. AIMS members have a number of concerns about the diagnosis of personality disorder and borderline personality disorder, and our experiences relate to maternity care, child safeguarding, and expert evidence in the family courts. Whilst we welcome this consultation our main concern is not treatment and management but DIAGNOSIS. For us and many families this is a crucial issue. We, and other consumer groups, know of many cases where the initial diagnosis is suggested by social workers who want to remove babies and cases are referred to professionals known to produce the required report. As we

ID	Stakeholder	Statement No	Comments
			have access to court documents as advocates we have had good reason to question both the diagnosis and the process by which it was made. Many clients whom we have come to know well who have had no previous problems with health care professionals and have long experience as valued employees have been so labelled. It is therefore, the standard of diagnosis which is, for us, the most crucial issue. In the context of child safeguarding issues all alleged domestic violence and MARAC conferences information is widely distributed to many agencies (including voluntary agencies in MARAC). In our extensive experience interpretation of medical terms by non-professionals and those in other professions e.g. social work can be a serious problem. The quality of the diagnosis is vital and we regard diagnostic standards as absolutely crucial because we have had so many cases where the methods and the standards used are highly suspect and are widely used in family courts. When we, or our clients, have tried to obtain the psychiatric or psychological interview notes or questionnaires used to make the diagnosis we have never been able to do so. There have, however, been a number of cases where we have seen the expert evidence presented in the secret family courts. Because we have had access to some of the case records we have seen how inaccurate, unacceptable, and poor the quality of diagnosis has been. These issues can have adverse effects far into the future for the whole family. Therefore for a diagnostic tag which can do so much harm accuracy is crucial. We know of cases where a personality disorder label has been written on the case notes simply because there was a disagreement or genuine complaint about the quality of care, and where the professionals, having problems of their own, were unable to deal with them. It should be noted, however, that many people develop personality disorders because they have been mistreated in childhood. One of our contacts, over time, revealed that she had been sexually abused by her mother and diagnosed as having a personality disorder; instead of being regarded with sympathy and support she was faced with antagonism and action to remove her children. There was no evidence at all that she was a risk to her children, something we have noted is too often assumed by social workers in particular. We had no problems at all in our long-term relationship with her. We note that the prison population and young offenders are likely to include a number of people with personality disorders from past treatment, their needs should be met and we would like them specifically to be mentioned in the quality standard. Finally, we very much welcome this policy of trying to improve care for people who have serious problems which impacts on their lives and the lives of others.

ID	Stakeholder	Statement No	Comments
2	College of Occupational Therapists	General	The COT Specialist Section-Mental Health would seek clarification as to why BPD and ASPD have been put together in the standards.
3	College of Occupational Therapists	General	There is no explicit mention of the role of an occupational therapist. There is evidence of the impact of personality disorder on occupational functioning and the need for occupational therapy intervention. Jones, L. (2010) 'The Role of the Occupational Therapist in Treating People with Personality Disorder' in Murphy, N. and McVey, D. (eds) Treating Personality Disorder: Creating Robust Services for People with Complex Mental Health Needs - the skill required in "identifying the nature and extent of the occupational needs of people with personality disorder...occupational functioning in personality disordered clients is frequently characterised by an illusion of competence, whereby individuals can appear to achieve a higher level of occupational adaptation than actually exists...further investigation, however, can reveal deficits in other areas that result in the individual struggling to maintain a balanced routine of work, leisure, self-care and social occupations, indicating that occupational therapy intervention is required" (pg. 203 Kindle edition). - "occupational functioning of people with personality disorder can vary significantly according to the social and physical environment. Assessing individuals in a limited range of settings may mislead therapists into concluding that occupational therapy is not required." (pg. 203) - "individuals' functioning may also fluctuate greatly over time. Consequently, initial assessments of competence may require revisiting." (pg. 204) - "During times of crisis, personality disordered individuals' participation in occupation can become grossly disrupted and routines may disintegrate or an obsessive focus upon valued occupations may develop" (pg. 204) - "Occupational needs may not always be apparent. Superficial analysis may indicate that a client's engagement in occupation is adapative when it is actually pathologically driven" (pg. 204) - "People with personality disorder can possess a chronic mistrust of others that can lead them to attempt to conceal their areas of vulnerability from their therapists. Shame is also a powerful dynamic contributing to individuals hiding their difficulties.... These factors contribute to an illusion of competence that masks individuals' occupational needs" (pg. 204) - "Therapists need to be mindful of the fact that conducting a simple formulation of clients' problems is insufficient when working with people with personality disorders. Without thorough consideration of how issues develop and persist, treatment is unlikely to be successful" (pg. 206) - "Services need to have clearly defined referral criteria based around the tenet that clients need occupational therapy when they have occupational needs that impact on their health, wellbeing, personal development, life satisfaction and/or risk of harm to self or others. Screening assessments provide a useful aid" (pg. 211).
4	College of Occupational Therapists	General	All the standards have benefits to the service user, in assisting with adaptation, change and developing a stable identity. The implications for commissioners and services is to ensure they have appropriately qualified professionals available on a permanent or consultation basis and that the NICE recommended therapies are available in all areas.

ID	Stakeholder	Statement No	Comments
5	College of Occupational Therapists	General	Awareness training about BPD and ASPD should be provided for all healthcare professionals regardless of whether in a mental health or physical workplace. This should also include a multi agency perspective e.g. police, prison service, custody and probation. Suggestion that this training should be coproduced with service users to help with the understanding and tackling stigma.
6	College of Occupational Therapists	General	Support to family and carers particularly in relation to education of how to help and support those with personality disorder.
7	College of Occupational Therapists	General	Reference to the importance of employment (this is in the global quality indicators from NHS/ Public Health). It would be worth emphasising that this may not be appropriate for all and occupational therapy can ensure that patients have access to meaningful productive occupation that enables a patient to contribute without the pressure of employment.
8	Department of Health	General	I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.
9	Digital Assessment Service, NHS Choices	General	The Digital Assessment Service welcome the QS and have no comments on it as part of the consultation.
10	The National Forensic Psychotherapy Development Group	General	We were concerned about the absence of key clinical stakeholders on the Advisory Committee and Project Team (eg members from community and prison mental health teams). Quality Statements are less likely to be embraced if they are imposed on professionals who have not been fully involved as stakeholders in their development.
11	The National Forensic Psychotherapy Development Group	General	We were concerned about the absence of key clinical stakeholders on the Advisory Committee and Project Team (eg members secure hospital settings or those working with the most severe and complex presentations eg with people with personality disorders detained under the Mental Health Act). Quality Statements are less likely to be embraced if they are imposed on professionals who have not been fully involved as stakeholders in their development.
12	National Offender Management Service	General	How have these six quality statements been selected as the most important? There is mention within these statements of workforce development and training but it may be helpful to have a separate Quality Standard outlining the necessity of tailored staff training for those directly involved with service users, and wider awareness training for peripheral staff (such as receptionists).
13	NHS England	General	Thank you for the opportunity to comment on the above Quality Standard. I wish to confirm that NHS England has no substantive comments to make regarding this consultation.
14	Nottinghamshire Healthcare NHS Trust	General	The quality standard does not appear to say anything about positive risk taking. One of the key challenges of working with people with a diagnosis of Borderline Personality Disorder in a clinical setting is that they can often present with significant risk behaviours. There is no guidance on this within the document and yet it is potentially the most concerning thing to mental health professionals.

ID	Stakeholder	Statement No	Comments
15	Nottinghamshire Healthcare NHS Trust	General	Linked to the above comment the guidance says nothing about using acute psychiatric admissions for people with a diagnosis of BPD and the pros and cons of this, despite their being some guidance around these issues in the NICE guidance on BPD.
16	Nottinghamshire Healthcare NHS Trust	General	Whilst the document mentions PTSD there is not enough focus on how common significant abuse and trauma is in clients with a diagnosis of BPD.
17	Nottinghamshire Healthcare NHS Trust	General	There is nothing within the document on the contentious nature of the diagnosis of BPD itself.
18	Parents Protecting Children UK (in association with False Allegations Support Organisation and other groups and individuals)	General	It must be borne in mind that females on the autistic spectrum are not uncommonly misdiagnosed with BPD. When females with ASC encounter difficulties which necessitate involvement from support services, they do not meet widely used male centric diagnostic criteria for ASC, and can then be misdiagnosed with conditions such as personality disorders http://www.emergenceplus.org.uk/carers-useful-information/343-borderlinepersonality-disorder-a-correct-diagnosis.html and http://autismwomensnetwork.org/autistic-womenmisdiagnosis-and-the-importance-of-getting-it-right/ for instance. This could contribute to the discrepancy in presentation between males and females.
19	Parents Protecting Children UK (in association with False Allegations Support Organisation and other groups and individuals)	General	Case study: Parents Protecting Children UK and Parents Against Injustice Network were approached in 2010, by an Afro Caribbean woman with a mixed race son who was then in his final year of primary education. The boy had some previous and ongoing difficulties in school but had not been assessed by an educational psychologist. During school year 6 the mother suffered from severe gynaecological difficulties, which resulted in a radical hysterectomy. Whilst she was awaiting surgery, she became severely anaemic and wasn't coping well. A school ancillary worker who misinterpreted events made a child protection referral. The local authority followed up the child protection referral without recognising the mother's medical condition. They ignored the report of the Child & Adolescent Psychiatrist at a nearby family centre, which commended the mother's parenting skills and recommended a Statutory Assessment of the son's difficulties. They ignored the views of local youth and community services who knew the boy and his mother well, and had no concerns about him. They did not assess the boy but insisted on assessment of the mother by an eminent centre, known for its psychodynamic interpretation of human personality and interaction. This assessment was delayed until the mother underwent surgery and conducted whilst she was still medicated for pain during post-operative recovery and was suffering the inevitable emotional and hormonal consequences of sudden and premature menopause. Their report made no mention whatsoever of her medical condition, but noted her fluctuating mood and suggested that she had a Borderline Personality Disorder. This terrified a trainee social worker, assigned to the case by the Local Authority. The Local Authority deemed the mother's supposed BPD to be a potential risk to the boy and applied to the family courts for his removal. He has absconded frequently from the Care provided, which has been atrocious, inappropriate and at times dangerous to him. He has been assessed and found to have an autism spectrum condition, which explains his sometimes challenging behaviour. His education has been massively disrupted by several changes of residential placement

ID	Stakeholder	Statement No	Comments
			over a wide geographical area. Subsequent examination of the mother has found no evidence of psychiatric disturbance and has suggested that the BPD diagnosis reflected temporary hormonal and consequent emotional upheaval. Nevertheless she was denied legal aid to fight for her son's return. Only when the boy was 15 and could be declared Gillick competent, could a legally aided lawyer, acting for him, challenge the local authority and begin the process to return him home. The recent court action relating to the boy in the case study above, has coincided with another case, which came to Parents Protecting Children UK from False Allegations Support Organisation, in which it has been suggested that a young mother, requiring an urgent radical hysterectomy, is suffering from a personality disorder and recommending that her son be removed for assessment. This is a family known to have other medical and neurological difficulties, none of which necessarily affect parenting capacity. In another case, a mother with severe endometriosis was declared by child protective services to be mentally unstable. Her two children were taken into care and the Local Authority threatened to remove her unborn child at birth. Action on behalf of the baby, procured care and assessment in a mother and baby unit where the mother was found to be in good mental health and where the father and older children were eventually reunited with the family. In the few days whilst preparing these comments a fourth case has been brought to the attention of Parents Protecting Children UK in which the emotional and hormonal difficulties following removal of the ovaries of a health care professional, were misinterpreted as mental illness, resulting in inappropriate child protective intervention. We understand from colleagues at Parents Against Injustice Network that they have seen other similar cases.
20	Parents Protecting Children UK (in association with False Allegations Support Organisation and other groups and individuals)	General	Misdiagnosis of women with Autism Spectrum Conditions as having BPD, leads to individuals being wrongly labeled and mistreated in the mental health system. This is a very serious issue, even more so if they are mothers because autism is not a mental health condition, they would be seen as mentally ill and therefore potentially deemed an unfit parent. Of course, this could mean inappropriate child protection concerns and interventions. Already, there are many undiagnosed ASC mothers who are being falsely accused of MSBP/ FII. Misdiagnosis of mental health conditions and personality disorders will only make this worse. We understand from others that there are undiagnosed women with autism spectrum conditions imprisoned or in other ways caught up in the Criminal Justice system.
21	Parents Protecting Children UK (in association with False Allegations Support Organisation and other groups and individuals)	General	It becomes apparent that not only could an ASC female be misdiagnosed, but also prevented from receiving any support and potentially seen as untreatable. This could have devastating effects on such a female, who could suffer an impact on wellbeing, caused unnecessary distress and this may be erroneously investigated in relation to child protection. They may also find themselves wrongfully treated within the Criminal Justice system. Women who suffer PTSD as a result of abuse by their partners can also be misdiagnosed with BPD and that diagnosis can be used by the abuser to remove her children from her care. This can then leave the child in a volatile or potentially dangerous living arrangement with the abuser.

ID	Stakeholder	Statement No	Comments
22	Rethink Mental Illness	General	Although there are recommendations about involving families and carers in both CG77 (rec 1.1.6) and CG78 (rec 1.1.5), there is very little mention of families or carers in any of the quality statements. Families and carers, where appropriate and with agreement from the person using the service, can play a vital role in collaborative care planning and shared decision making. We would therefore like to see references to this involvement embedded throughout the quality standard, particularly statements 2-5. This should also be part of how health and social care providers and practitioners deliver these quality statements, so we would recommend that this is reflected under what these statements mean for them.
23	Royal College of General Practitioners	General	I am generally in agreement with the standards and welcome them as this is a difficult area of mental health and many people receive poor quality services of no service at all. I think that the role of the care plan and crisis care planning needs greater emphasis. People with PD can use many health and social care resources (financially and time resources) particularly in crisis. Need to include a recovery based approach and creating opportunities for self management and peer involvement. The other area which is very important is continuity and stability in care. This isn't necessarily the same as integrated care and would involve much better liaison and communication between primary care and secondary care. Given the prevalence of PD, the numbers of people being diagnosed and managed in both primary and secondary care means PD is grossly underdiagnosed and poorly recognised.
24	Royal College of Nursing	General	The Royal college of Nursing welcome the development of the Personality disorders (borderline and antisocial) quality standards
25	Royal College of Paediatrics and Child Health	General	No substantive comments
26	The Royal College of Psychiatrists	General	The standard frequently refers to employment – in under 18s it needs to also refer to education throughout this document (too numerous to mention individually)
27	The Royal College of Psychiatrists	General	As can be seen from the above comments, this standard has not been developed with YP in mind, and the language that is used is entirely adult orientated. Since this topic is of great importance due to the high risks associated with BPD in adolescents, together with the burden on services, both community and inpatient, and the controversies re diagnosis, perhaps NICE could consider a separate guidance for YP?
28	The Royal College of Psychiatrists	General	Consideration needs to be given to funding for PD services as they require highly trained staff and the development of complex services. Funding needs to reflect this complexity.
29	The Royal College of Psychiatrists	General	Page 4, domain 1: Describes the proportion of adults living independently. This would also generally be a concern for those under 18.

ID	Stakeholder	Statement No	Comments
30	The Royal College of Psychiatrists	General	Page 4, domain 2: Needs to include looked after children.
31	The Royal College of Psychiatrists	General	Page 5, domain 4: Specifies safeguarding adults only; no mention of sexual abuse, often a major trauma with BPD.
32	The Royal College of Psychiatrists	General	Page 5, domain 4: Integrated care for YP with BPD usually requires health, social care and education multi-agency working.
33	The Royal College of Psychiatrists	General	Page 6, domain 1: High rates of suicidal behaviour are a particular risk issue for suicide in YP.
34	The Royal College of Psychiatrists	General	Page 7, domain 1: Indicator 1.06ii only refers to adults; 1.07 – how about Youth Offending Teams (YOTs) and the juvenile justice system?
35	Emergence Plus CiC	Question 1	These standards reflect important areas for development. What strikes me as missing is: Addressing need for information about the diagnosis at the time of being given a diagnosis. Too many people are told they have PD but given no explanation, sources of reliable info, and so have no idea what it means. This too needs to be addressed and requires very little investment. Service user involvement is largely absent from the quality standards but is crucial to working effectively with people with personality disorder, who are often very intelligent, capable individuals who struggle with being at the mercy of others (this has usually been the case in the past to devasting effect). So involvement, important within any area of health provision, is even more so with people with personality disorder. In my comments I have tried to interweave ideas about involvement, but also as the largest, national service user led organisation focussed on personality disorder we would be very keen to discuss this further.
36	The National Forensic Psychotherapy Development Group	Question 1	Yes. We find that there remain significant issues around the management of co-morbid personality disorder and mental illness and the presence of mental illness can lead to confusion or avoidance around treatment co-morbid mental illness, and is still leading to the exclusion of people with personality disorders from services. A statement addressing this would be helpful. We are aware that many areas do still not have established Tier 1-4 services and many mental health still trusts do not have personality disorder strategies agreed with commissioners. A quality statement addressing this level of organisation of services would support service developments that could be the foundation for future, more patient-focussed, quality statements.

ID	Stakeholder	Statement No	Comments
37	Royal College of Nursing	Question 1	Yes we feel it does, however, we also feel it is missing in terms of the need for more staff training about issues associated with working with people with personality disorder. For example, we do not think personality disorder is significantly addressed in undergraduate nurse training.
38	The Royal College of Psychiatrists	Question 1	Yes. However, I would add the relevance of promoting and improving the current knowledge and understanding of these two disorders, their impact on the person's life and the factors contributing to their development. There is a disparity between BPD (Borderline Personality Disorders) and ASPD (Anti-social Personality Disorders). While treatments, services and resources for BPD are reasonable, those for ASPD are still almost non-existent. Services need financial/staff investment. Those with PD (Personality Disorders) have an assessment for comorbid axis 1 disorders as over 90% will have at least one comorbid disorder and they are offered the evidenced based treatment for that co-morbid disorder as often PTSD (Post-traumatic Stress Disorder), OCD (Obsessive Compulsive Disorder) etc get missed. Patients with PD within services should have reasons documented if not had psychological therapy e.g. refused or assessed and deemed unsuitable due to active substance misuse, lack of motivation etc. Care plan addressing social, occupational needs etc should include those patients treated in Outpatient departments (OPD) and not just those on Care Programme Approach (CPA). Need more services for ASPD in the NHS e.g. community based forensic psychology services.
39	The Royal College of Psychiatrists	Question 1	The standard does not accurately reflect the needs of adolescents;
40	South West Yorkshire NHS Foundation Trust	Question 1	The quality standard does not address the provision of information to service users and their understanding of their diagnosis. This is often undertaken on an ad-hoc basis and it not uniform across services.
41	South West Yorkshire NHS Foundation Trust	Question 1	The quality standard does not address aspects of family and carers support, such as the undertaking of carers needs assessments.
42	The National Forensic Psychotherapy Development Group	Question 2	At present this would be very difficult and involve disproportionate use of resources that would be diverted from clinical care. If clinically relevant, and implementable, statements can be agreed with stakeholders then collection of data and comparison across services could support quality improvement but this would only be optimal if it could be linked to the development of regional and national personality disorder clinical networks and quality improvement programmes.
43	Royal College of Nursing	Question 2	Yes

ID	Stakeholder	Statement No	Comments
44	The Royal College of Psychiatrists	Question 2	Yes, with a willing and motivated workforce, it would be possible to collect the data for the proposed quality measures (systems and structures alone not sufficient, staff need to be supported and motivated). However there is difficulty in data collecting within such a complex clinical population, characterized by high drop-out rates, poor engagement and risk behaviour towards self and others.
45	The Royal College of Psychiatrists	Question 2	Data collection entirely depends on resources particularly adequate IT and admin support which has been under considerable constraint under current financial pressures – clinicians would struggle to also collect this data with the current case loads and pressures; data collection is important but would be challenging.
46	South West Yorkshire NHS Foundation Trust	Question 2	Different systems are used in the organisation, and so it would be difficult to collect the data as not all personality disorder service users are in a specific Trust cluster.
47	The National Forensic Psychotherapy Development Group	Question 3	See comment below for each Statement.
48	Royal College of Nursing	Question 3	More training and staff awareness needs to be provided to promote empathy and understanding, especially for adult nurses in A&E. More needs to be done to reduce the stigma of having a personality disorder. The diagnosis could do with being renamed as it immediately implies negativity and stigma. Specialist teams, of people who have an interest in working with people with personality disorder should be made, within inpatient and community mental health services. Provision of better links between acute inpatient/A&E liaison services to encourage and co-ordinate the use of joint crisis admission plans for people with borderline personality disorder. There must be investment in intensive psychological/mental health treatment for young people at risk of developing a personality disorder as it has already been proven that this improves prognosis and prevents recurring admissions into adult mental health services later down the line (as evidenced by the work done in CAMHS in Liverpool several years ago). More investment in training staff in DBT therapy and easier access to Schema therapy

ID	Stakeholder	Statement No	Comments
49	The Royal College of Psychiatrists	Question 3	There needs to be an encouragement of a deeper understanding of these two conditions, merging knowledge and theories from a wide range of theoretical perspectives. Further research and community services are needed for ASPD, so it can catch up with the resources for BPD. There is also a need for more specialist supervision and access to CPD courses for staff. Consideration could be given to using structured self-report clinical tools for all patients assessed within services such as the DSM 4 self-report checklist which includes sections on BPD and ASPD. This is used in the North-West London Community Mental Health Trust. As a general comment underpinning all statements, the quality standards are increasingly undermined by: Current cuts to services, driving cost-cutting reorganisation of services, especially CMHTs, so staff in CMHTs feel pressured and demoralised and feel less competent to work with PD, so more pressure to exclude such patients, (in favour of psychosis) increasing the following: inaccurate diagnosis not based on structured history/clinical exam; missing co-morbity with alcohol/drugs, increased medication, increased poor experience of care by patient (rejected, discharged without follow-up or care plan etc.,) Medical psychotherapists well-placed in terms of expertise and experience to lead innovation at these service interfaces, to lead specialist PD teams and take liaison with AMH services (and other agencies/pathways) and training/supervision of AMH staff, also to lead specialist PD services that can offer diagnosis, care-coordination & risk management, prescribing, etc.,
50	BABCP	Statement 1	Structured assessments for diagnosing personality disorder improve the accuracy of diagnosis. The downside is that these are time consuming and individuals undertaking these assessments require to be trained to be competent to carry out the assessments. It would be helpful to know how many people are trained to assess PD. Patients with ASPD and BPD will enter into the health and social care system at multiple points. (e.g. A&E, primary care, secondary care etc.) It may be helpful to state at what point in the pathway these assessments are most likely to take place. For example, at the point an individual enters secondary care. This appears to be the implication here but the accuracy of recording diagnosis may be improved if this is stated.
51	Emergence Plus CiC	Statement 1	The key issue faced by service users is access to support, the requirement for a structured assessment is good, but there is a real risk it could introduce a further barrier to accessing support – i.e. services may not provide the assessment but then use the fact it hasn't been carried out as a justification for not implementing QS 2. This could be addressed by stating that whilst it is recommended to carry out a structured assessment, failure to do so is not acceptable exclusion criteria to support/therapeutic services.
52	Emergence Plus CiC	Statement 1	Any assessment ought to be carried out collaboratively with service users (as opposed to carried out on service users), seeking our views and understanding of our own difficulties this is well embedded in some services but absent in others. It would be helpful if this was enshrined in the quality standard. Involvement in planning ones care and thinking about ones difficulties are central to individual empowerment and provision of good services.

ID	Stakeholder	Statement No	Comments
53	The National Forensic Psychotherapy Development Group	Statement 1	We had significant concerns about this statement, from a number of perspectives: 1) DSM5 has recently been introduced but its development has been highly problematic in relation to classifying personality disorder and there are significant concerns that it is no longer fit for purpose clinically. It is particularly problematic for those working with severe and complex personality disorder due to the high levels of multiple co-morbid personality disorders it produces and the high levels of co-morbid mental illness in this group. 2) ICD11 is now being introduced and represents a significant divergence from DSM5 in classifying personality disorder. It potentially has far greater clinical utility for people with personality disorders and professionals but structured instruments will need further development and testing to clarify their viability and usefulness in routine clinical practice. 3) We think that it is not clear that this quality statement is implementable at present due to the above factors and also significant resource implications associated with its implementation, both in terms of staff time and the training (associated with significant costs) that would be required to implement it. 4) We would be very concerned if NICE introduced further guidance that could not be realistically implemented as we think this distances NICE from clinicians, and increases the chance of NICE being ignored and/or not being considered relevant to clinical practice. 5) As a first step we support the use of structured assessments (once a consensus has been established on the ones most appropriate for routine clinical use and compatible with ICD11) in cases where: a. there is diagnostic uncertainty. b. full assessment by a specialist personality disorder service is indicated (ie where possible personality disorder is severe and/or complex and associated with significant risk to self or others) c. this is requested by the person with a possible personality disorder
54	The National Forensic Psychotherapy Development Group	Statement 1	Question 3: A structured assessment that can be used routinely by clinical services without the need for external training and which links to ICD11, and which is not too time consuming for everyday use.
55	National Offender Management Service	Statement 1	In addition to an assessment before being given a diagnosis of BPD or ASPD, the quality statement could usefully refer to the patient being given a full and clear explanation of what the diagnosis means and the treatment options available.
56	Nottinghamshire Healthcare NHS Trust	Statement 1	An assessment to provide a diagnosis of BPD should also provide people with information from different sources which question the concept of the diagnosis so service users are aware of the diagnosis being only one viewpoint of their difficulties.
57	Nottinghamshire Healthcare NHS Trust	Statement 1	A wider and more helpful assessment would include a formulation of the person's difficulties including their social and historical context in order to help understanding and plan care.

ID	Stakeholder	Statement No	Comments
58	Parents Protecting Children UK (in association with False Allegations Support Organisation and other groups and individuals)	Statement 1	Professionals involved with the diagnosis of possible Borderline or Antisocial Personality Disorder should be aware of other influencing factors that may temporarily affect a patient, but are not long term mental health conditions. One example of a physical condition which often leads to a misdiagnosis of BPD is in mothers with hormonal disturbance due to gynaecological illness and procedures, who are on occasion misdiagnosed as having personality disorders leading to the actual or potential removal of their children into care. There is a case study that highlights this situation at the end of this document.
59	Parents Protecting Children UK (in association with False Allegations Support Organisation and other groups and individuals)	Statement 1	If a clinician who assesses BPD is not also adequately trained in ASC identification, they could misdiagnose ASC traits as BPD. The NHS frequently does not check for co-morbid conditions, despite their obligation to do so. Parent's Protecting Children UK has significant anecdotal & survey evidence of failings to adequately investigate all presenting issues in patients with co-morbid conditions. Therefore the assessor must be experienced in other conditions that could be misdiagnosed as BPD. It is clear to us and our partner organisations, Parents Against Injustice Network & False Allegations Support Organisation, that much more care is needed to take physical and especially hormonal disturbance and gynaecological illness into account when assessing mothers for possible personality disorders
60	Partnerships in Care, Midlands	Statement 1	There are significant resource implications for this standard if all patients considered to have a PD are required to complete a structured assessment before diagnosis. These assessments take time and there are supervision and training implications (they are largely carried out by psychologists). What value is gained in all possible PD patients undergoing one of these assessments if the clinical picture clearly points towards a BPD/ASPD diagnosis? We foresee waiting lists and delays in diagnosis if this standard is applied to all patients particularly in community settings. Recommended use when there is diagnostic uncertainty would perhaps help overcome some of these potential problems.
61	The Royal College of Psychiatrists	Statement 1	See point about diagnosis above All too often diagnoses of Personality disorder are made with no recorded basis in clinical history, let alone structured interview. More training (one-off and regular PD teaching as part of CPD) and supervision required in diagnosis. Who provides this? Specialist PD services, ideally, but more emphasis needs to be placed on how specialist PD services link in with AMH services so clear roles and responsibilities re general v specialist. Outreach and defined pathways needed, including role of CMHT in diagnosis of PD. Medical psychotherapists well-placed in terms of expertise and experience to lead innovation at these service interfaces.
62	The Royal College of Psychiatrists	Statement 1	See points above. Which assessments would be recommended for YP? Training for structured assessments would be a big unmet need, together with professional resistance regarding making the diagnosis in YP. Therefore it would be important for NICE to clarify when this diagnosis should be made in YP.

ID	Stakeholder	Statement No	Comments
63	BABCP	Statement 2	1) Since the BPD NICE guidelines was published, structured clinical management has been found to be as helpful as some “brand named” psychological therapies. Structured clinical management should also be provided by mental health teams and recorded. 2) As a cautionary note, it may be important to follow up any emerging new evidence about psychological therapies for mixed PD. Those with ASPD and BPD are likely to have comorbid PD and therefore fall into this category.
64	Emergence Plus CiC	Statement 2	An absence of provision or significant waiting lists are the major difficulties which service users report to us – so we strongly support this standard. It would be helpful if it specified a maximum waiting time, we know of NHS Trusts where a waiting list are literally 2/3/4 yrs long – this leaves people without support for far too long and considerably increases risk, and depletes hope and motivation to engage.
65	Emergence Plus CiC	Statement 2	Psychological therapies relevant to personality disorder or individual symptoms are often at odds eg treatment for depression through CBT or short term IAPT, is often unhelpful to those with personality disorder, and fails to bring about change which induces a feeling of personal failure, hopelessness and then reduces the likelihood of someone engaging in something more appropriate. In suggesting treatment for PD or for individual symptoms, this needs a clearer working through. EG that many symptoms can only be properly addressed through therapy for personality disorder. It doesn’t make sense from a service user perspective to be dividing up areas of distress and say, this treatment is for your anxiety/depression and we can’t talk about or address your personality difficulties – the experience is one of being in distress and needing support, not compartmentalised feelings.
66	The National Forensic Psychotherapy Development Group	Statement 2	Question 3: Medication is being routinely used for the treatment of personality disorder in many different settings – from the community to prison settings to secure hospital settings. This can be appropriate when this is done in a rigorous way and carefully planned and monitored (see above). Our experience is that there remains significant confusion and variability in practice in consultant psychiatrists from all specialities in this area but an avoidance of considering this issue by the profession as a whole. We recommend that the Royal College of Psychiatrists is asked to review this issue to support the development of professional good practice guidelines. At present consultant psychiatrists are routinely ignoring NICE guidelines in this area and the divergence between NICE guidelines and professional practice needs to be reviewed.
67	National Offender Management Service	Statement 2	Development of therapeutic relationships between patients and practitioners and environmental factors has been missed and needs to be included (see further comments below)

ID	Stakeholder	Statement No	Comments
68	National Offender Management Service	Statement 2	Of equal importance to the actual therapy used and the theoretical framework from which it draws, is the relational environment within which the therapy is delivered: the competence of the staff, their accessibility and stability over time, and the stability of the environment. These issues cannot be separated out, as the relational elements of the environment provide both an opportunity for addressing and changing the symptoms of PD, and provide a psychologically safe place to do so regardless of the actual therapy delivered. We feel this is not adequately explored or expressed in this standard.
69	Parents Protecting Children UK (in association with False Allegations Support Organisation and other groups and individuals)	Statement 2	Inappropriate psychological therapies can be very harmful to someone on the autistic spectrum. The brain is wired differently in ASC, the person senses the world differently to neurotypical people. They therefore cannot be “treated” to think neurotypically. Therapy with this intention will not be successful and may disrupt previously viable coping strategies, possibly irrevocably.
70	Rethink Mental Illness	Statement 2	This quality statement should explicitly mention health practitioners providing accessible information about relevant psychological therapies. This would help people affected by borderline or antisocial personality disorder make informed choices about their treatment. To embed this, the provision of accessible information and the involvement of people in decisions about treatment should be included as separate quality measures under this quality statement. Although personal preference is currently mentioned under the ‘definitions’ for the statement, this needs to be more strongly emphasised in this quality statement and a quality measure could help support this.
71	The Royal College of Psychiatrists	Statement 2	Often referred without diagnosis (see above) or discussion with specialist PD/Psychotherapy services. Need more outreach, consultation, liaison and supervision from specialist service to general CMHT services so patients are identified more accurately in terms of diagnosis and readiness to engage in psychological treatment. Engagement work is key-need to be clear re who does this,usually best achieved by integration and crossover working on care-plan/care pathway with specialist input to CMHT. Medical psychotherapists well-placed in terms of expertise and experience to lead innovation at these service interfaces.
72	The Royal College of Psychiatrists	Statement 2	No mention of YP and evidence for DBT.
73	South West Yorkshire NHS Foundation Trust	Statement 2	There is a broader approach to therapy for antisocial and borderline personality disorder. See answers to question 4 above. Also, the quality standard needs to recognise that these are different disorders and so may have different service configurations around them.

ID	Stakeholder	Statement No	Comments
74	South London and Maudsley NHS Foundation Trust	Statement 2	Comment about Recommendation 1.3.4.1 'When considering a psychological treatment for a person with a borderline personality disorder, take into account' I think this should include: Evidence base for the psychological treatment. Current evidence supports DBT, MBT, TFP A colleague sent through some references about TFP. Here are some references to support MBT's evidence: Bateman A, Fonagy P. The effectiveness of partial hospitalization in the treatment of borderline personality disorder - a randomised controlled trial. Am J Psychiatry. 1999;156:1563-1569. Bateman A, Fonagy P. Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalisation: an 18-month followup. Am J Psychiatry. 2001;158:36-42. Bateman A, Fonagy P. 8-year follow-up of patients treated for borderline personality disorder: mentalization-based treatment versus treatment as usual. Am J Psychiatry. 2008;165:631-638. Bateman A, Fonagy P. Randomized controlled trial of outpatient mentalization-based treatment versus structured clinical management for borderline personality disorder. Am J Psychiatry. 2009;166:1355-1364. Rossouw TI, Fonagy P. Mentalization-based treatment for self-harm in adolescents: a randomized controlled trial. J Am Acad Child Adolesc Psychiatry. 2012;51(12):1304-1313

ID	Stakeholder	Statement No	Comments
75	West London Mental Health NHS Trust	Statement 2	Individuals with antisocial and borderline personality disorder often present in primary care with anxiety or depression, and may be considered for treatment in secondary mental health services. For people with antisocial personality disorders, the statement only mentions group based cognitive and behavioural interventions to address problems such as impulsivity, interpersonal difficulties, and antisocial behaviour. There is clinical and evidence based practice to suggest that group based psychodynamic therapies including mentalization in forensic settings to address interpersonal difficulties and antisocial behaviour has been beneficial. For people with borderline personality disorder the statement only specifically mentions comprehensive dialectical behaviour therapy for women with borderline personality disorder for whom reducing recurrent self harm is a priority In fact for people with borderline personality disorder, group based psychodynamic therapy, including mentalization for women and men in forensic setting has been shown to be beneficial McGauley, G., Yakeley, J., Williams, A., & Bateman, A. (2011) Attachment, Mentalization and Antisocial Personality Disorder; the possible contribution of Mentalization-Based Treatment. European Journal of Psychotherapy and Counselling 13(4): 1-22. Meloy, R. & Yakeley, J. (2013) Antisocial personality disorder, in: Gabbard's Treatments of Psychiatric Disorders, edited by Gabbard, G.O., Gunderson, J. American Psychiatric Publishing. Yakeley, J. & Williams A. (2014) Antisocial personality disorder: New directions. Advances in Psychiatric Treatment, 20: 132-143.

ID	Stakeholder	Statement No	Comments
			In addition there are these by Fonagy and Bateman for ASPD and BPD Bateman A, Fonagy P (2008) Co-morbid antisocial and borderline personality disorders: mentalisation-based treatment. Journal of Clinical Psychology: In Session 64: 181-94. Bateman AW, Fonagy P (2011) Antisocial personality disorder. In Handbook of Mentalizing in Mental Health Practice. (eds AW Bateman, Fonagy P): 289-308. American Psychiatric Publishing. Bateman, A. and P. Fonagy, Randomized Controlled Trial of Outpatient Mentalization-Based Treatment Versus Structured Clinical Management for Borderline Personality Disorder. American Journal of Psychiatry, 2009. 166(12): p. 1355-1364. Bateman A, Fonagy P. Impact of clinical severity on outcomes of mentalisation-based treatment for borderline personality disorder. Br J Psychiatry 2013; 203: 221-7 Other reviews for ASPD: Vollm, B., et al., Cochrane Reviews of Pharmacological and Psychological Interventions for Antisocial Personality Disorder (Aspd). European Psychiatry, 2010. 25. Warren, F., et al., Review of treatments for severe personality disorder, H. Office, Editor. 2003, Research Development and Statistics Directorate, Home Office. Gibbon, S., et al., Psychological interventions for antisocial personality disorder. Cochrane Database of Systematic Reviews, 2010(6). Khalifa, N., et al., Pharmacological interventions for antisocial personality disorder. Cochrane Database of Systematic Reviews, 2010(8).
76	Emergence Plus CiC	Question 4	Relevant therapies: DBT, MBT, Psychotherapy, Therapeutic Community, Schema therapy, art therapy. If the standards are going to suggest group based cognitive and behavioural interventions – the value of peer led or co-facilitated (one expert through lived experience and one professionally trained expert) interventions ought to be stressed. These provide hope, a sense of 'realism' and ability to relate and role model which is not found in interventions drawing solely on professional facilitators.

ID	Stakeholder	Statement No	Comments
77	National Hospital for Neurology and Neurosurgery	Question 4	For psychological therapies there should be some inclusion of EMDR as a suitable therapy as high proportion of patients will have some level of psychological trauma that can be helped with EMDR
78	Royal College of Nursing	Question 4	Dialectical therapy and Schema therapy are proven effective treatments for borderline personality disorder and Schema therapy also help people with anti-social personality disorder. There are also several offender treatment psychological programs available to assist people with anti-social traits It is unfortunate that access to these therapies is very limited, unless you are admitted to a secure mental health hospital, where psychological programs seem to be very good. The STEPPS group treatment program could be set up in inpatient and outpatient settings to provide local treatment for people with Borderline personality disorder.

ID	Stakeholder	Statement No	Comments
79	The Royal College of Psychiatrists	Question 4	For statement 2, could you provide a list of psychological therapies that are relevant to borderline or antisocial personality disorder. For BPD: Structured clinical management (clear, structured, crisis and contingency plans, especially around transitions). Consistent and reliable clinicians, risk management, plan understood by treating team and patients, clear goals and outcomes both clinical and social/occupational Mentalisation-based therapy (MBT) Dialectical behaviour therapy (DBT) Schema-focussed Cog therapy (and other specialist therapies including Therapeutic communities, CAT). Need long enough treatments, tapered, individualised and integrated. 4. Transference-focused therapy. These treatments should be specified in the quality standard with the evidence base for the therapies as follows: Transference-focused therapy: • Clarkin, J.F., Levy, K.N., Lenzenweger, M.F., & Kernberg, O.F.. Evaluating three treatments for borderline Personality Disorder: a multiwave study. American Journal of Psychiatry, (2007), 164, 922-928 • Doering, S., S. Hörz, M. Rentrop, M. Fischer-Kern, P. Schuster, C. Benecke, A. Buchheim, P. Martius, & P. Buchheim. (2010), Transference-focused psychotherapy v. treatment by community psychotherapists for borderline personality disorder: Randomised controlled trial. Brit. J. Psych., 196(5):389–395 Mentalisation-based therapy: • Bateman & Fonagy (1999) Am J Psych, 156; 1563-1569 • Bateman & Fonagy (2001) Am J Psych; 158:36-42 • Bateman & Fonagy (2003) Am J Psych; 160: • Bateman & Fonagy(2008). Am J Psych 165, 631-638 • Bateman & Fonagy(2009). Am J Psych 166:1355–1364) For ASPD: We are aware of the suggestion that any therapy is implemented in structured environments, such as residential settings. Anger management interventions are recommended. Currently, MBT is being delivered to patients with ASPD. However, the clinical outcomes have still not been presented. Other therapies that are recommended are; MBT, DBT, Schema Focused Therapy and Cognitive Analytical Therapy.
80	The Royal College of Psychiatrists	Question 4	The evidence for treatment in adolescents is limited but DBT is a particularly promising approach, and there is some recent data on mentalising. Family work is usually essential together with the management of parental mental health problems.

ID	Stakeholder	Statement No	Comments
81	South London and Maudsley NHS Foundation Trust	Question 4	There is evidence of the effectiveness of both Transference-Focused Psychotherapy and Mentalisation Based Therapy in the treatment of borderline and antisocial PDs and that the quality standards should reflect this. Some of the evidence is in the Full Nice guidelines, some post-dates it but will almost certainly appear in the next revision as evidence has been mounting in the interim. A comprehensive article on TFP citing some of the evidence is: • Yeomans F (2013) Transference-focused psychotherapy. Psychotherapy: theory, research and practice:50 pg:449 And a couple of individual RCTs: • Clarkin, J.F., Levy, K.N., Lenzenweger, M.F., & Kernberg, O.F.. Evaluating three treatments for borderline Personality Disorder: a multiwave study. American Journal of Psychiatry, (2007), 164, 922-928.] • Doering, S., S. Hörz, M. Rentrop, M. Fischer-Kern, P. Schuster, C. Benecke, A. Buchheim, P. Martius, & P. Buchheim. (2010), Transference-focused psychotherapy v. treatment by community psychotherapists for borderline personality disorder: Randomised controlled trial. Brit. J. Psych., 196(5):389–395. There are numerous other papers developing aspects of TFP in e.g comorbid BPD and narcissistic PD. Kernberg has also written clearly about the levels of anti-social PD and which may or may not be amenable to TPF. I am less familiar with the literature on MBT but colleagues will be submitting this separately.
82	South London and Maudsley NHS Foundation Trust	Question 4	Schema Therapy has been shown to be effective for people with personality disorders. Farrell, Joan M; Shaw, Ida A; Webber, Michael A (June 2009). "A schema-focused approach to group psychotherapy for outpatients with borderline personality disorder: a randomized controlled trial". *Journal of Behavior Therapy and Experimental Psychiatry* **40** (2): 317–328. doi:10.1016/j.jbtep.2009.01.002. PMID 19176222. Nadort, Marjon; Arntz, Arnoud; Smit, Johannes H; Giesen-Bloo, Josephine; Eikelenboom, Merijn; Spinhoven, Philip; van Asselt, Thea; Wensing, Michel; van Dyck, Richard (November 2009). "Implementation of outpatient schema therapy for borderline personality disorder with versus without crisis support by the therapist outside office hours: a randomized trial". *Behaviour Research and Therapy* **47** (11): 961–973. doi:10.1016/j.brat.2009.07.013. PMID 19698939.

ID	Stakeholder	Statement No	Comments
83	South West Yorkshire NHS Foundation Trust	Question 4	There is compelling evidence (e.g. Bateman and Fonagy (1999)) that a multicomponent programme of interventions is necessary for the treatment of Borderline Personality Disorders and its critical feature are the way in which its components are brought together. The essential features for an effective programme for treating borderline personality disorder are the following: A theoretically coherent treatment approach, A relational focus Consistent application over a period of time. A variety of psychological approaches have a good evidence base for effectiveness delivered within the three principles above, these include: Schema focused Cognitive Behavioural Psychotherapy Psychoanalytic Psychotherapy Cognitive Analytic Psychotherapy Dialectic Behaviour Therapy And other integrated approaches such as Compassionate Mind Therapy There is evidence that these can be delivered in both individual and group modalities and that they can often be complemented by engagement in other creative therapies such as Art therapy and Music therapy. The provision of a range of psychological approaches is necessary in order to build an individualised multicomponent treatment programme attending appropriately to the different stages of change necessary for successful clinical outcomes e.g. skills based interventions which increase distress tolerance prior to relationally focused interventions.
84	BABCP	Statement 3	Those with BPD are likely to receive a number of psychotropic medications. The data collected could helpfully reflect this. We suggest that the following is assessed in addition: Numerator- the number of people with BPD prescribed more than one antipsychotic and/or sedative medications in the medium term Denominator – number of people with BPD prescribed medication.
85	Emergence Plus CiC	Statement 3	Good to see this included – still happening widely, so needs this attention.
86	The National Forensic Psychotherapy Development Group	Statement 3	In severe and complex personality disorder, such as that managed in secure settings, diagnostic uncertainty can be a significant feature of people with personality disorders' presentation and trials of medication can play an essential part in clarifying this and can also demonstrate a need for ongoing treatment with medication in particular people with personality disorders.

ID	Stakeholder	Statement No	Comments
			In such settings medication can also be important is stabilising people with personality disorders in order to support them engaging in psychological therapies, which is often not possible without this. We strongly recommend that such practice is not excluded by this Quality Statement, and that it is amended to support this practice, as long as it is undertaken in a way that is consistent with established good practice around consent to treatment, and demonstration of individual patient benefit.
87	Nottinghamshire Healthcare NHS Trust	Statement 3	If drugs should not be used for treating the “symptoms of personality disorder”, then why does the quality statement only deal with antipsychotic or sedative medication? Why does it not include all psychiatric medication?
88	Nottinghamshire Healthcare NHS Trust	Statement 3	In the definitions section medium term is defined as both between 2-4 weeks and 3-6 months. Is “medium term” different for different classes of drugs?
89	Parents Protecting Children UK (in association with False Allegations Support Organisation and other groups and individuals)	Statement 3	Parents Protecting Children UK agrees that long term pharmacological intervention is not suitable in patients diagnosed with Borderline Personality disorders. Furthermore, even short term psychoactive drugs should be avoided in those with BPD as the evidence does not currently support effectiveness for overall severity of BPD (Lieb et al. 2010 http://bjp.rcpsych.org/content/196/1/4.full) and little is known of their impact on those with ASC and other co-morbidities (Murray et al 2013 http://link.springer.com/article/10.1007/s00213-013-3140-7/fulltext.html) The organisation A.P.R.I.L. and other individuals / agencies have evidence that use of psychoactive medication on people with autism spectrum conditions can cause permanent regression as they can disrupt carefully built alternative neural pathways.

ID	Stakeholder	Statement No	Comments
90	Partnerships in Care, Midlands	Statement 3	As a group of psychiatrists working in forensic/secure settings we continue to have concerns about this standard. There are a significant number of patients in secure and prison settings with BPD/ASPD diagnoses who present at the 'severe' end of the personality disorder spectrum. Due to their high levels of disturbance, these patients are frequently unable to engage in meaningful psychological therapy without stabilisation in the form of medication. Time and again, we encounter patients who report positive effects from antipsychotic and other medication and who would not be able to even contemplate commencing psychological therapy without the help from medication. These patients are likely to be longer term patients and whilst we support the concept that medication use should be reviewed regularly always with an aim for reduction/cessation, for some patients, longer term pharmacological therapy may be required. This group of patients are never going to be represented in RCT or other evidence based studies due to the nature of the patient but are unlikely to be represented by a community based population sample. We believe that use of antipsychotic and other medication is widely considered beneficial by psychiatrists working in this specialist field. There are papers to support use of medication with BPD, for example the Cochrane review by Lieb et al (2010) We appreciate that NICE issues guidance and clinical discretion can be used where practice deviates but such a strongly worded quality standard may leave little room for discretion especially if outcome measures are used to rate performance against this. A way around this for those in our position would be to revise diagnoses to include psychosis but surely this should not be the intended outcome of any such standard? We suggest that there should be some acknowledgement for the need to accommodate different practice in specialist groups or that the wording should be more related to 'should not be prescribed but in specialist settings where use has been advantageous, should be subject to regular review with a view to minimisation/cessation' especially if there are implications for commissioning of services.
91	Rethink Mental Illness	Statement 3	Given the side effects associated with antipsychotic medication, Rethink Mental Illness supports a quality statement advocating that they are used only where appropriate. However, where antipsychotic medication is prescribed, it is also important that people are offered accessible information about the benefits and side effects. We therefore recommend including the provision of information where medication is being used for short-term management of crisis of where there is a comorbid psychosis as quality measure under this statement. This would support recommendation 1.3.5.5 in NICE guideline CG78 (borderline personality disorder) and could drive up the quality of prescribing.
92	The Royal College of Psychiatrists	Statement 3	Antipsychotics have particularly significant adverse effects in YP, this needs to be addressed here; how are voices within the context of BPD diagnosed here? Does this require an additional diagnosis of psychosis although hallucinatory experiences are common in BPD? Again, meds seriously overprescribed because of general point above-clinicians feeling incompetent and pressured so write prescription. Need more training and integrated outreach models of working between specialist and general services. Medical psychotherapists well-placed in terms of expertise and experience to lead innovation at these

ID	Stakeholder	Statement No	Comments
			service interfaces.
93	The Royal College of Psychiatrists	Statement 3	No mention of adverse effects of meds in YP
94	The Royal College of Psychiatrists	Statement 3	Clarification needed whether voices within the context of BPD also require an additional diagnosis when fluctuating hallucinatory experiences are a symptom of BPD – or is the standard stating that these types of hallucinatory experiences do not warrant antipsychotics and additional psychotic experiences are required?
95	South London and Maudsley NHS Foundation Trust	Statement 3	Although it is true that there are no licenced pharmacological interventions for borderline or antisocial PD there is uncertainty in this area and insufficient scientific evidence for NICE to make such an unequivocal statement. There is some evidence that pharmacological treatments may be effective in the short to medium term in relieving a number of symptoms of borderline personality disorder (For reviews see: see Vita et al Antipsychotics, Antidepressants, Anticonvulsants, and Placebo on the Symptom Dimensions of Borderline Personality Disorder A Meta-Analysis of Randomized Controlled and Open-Label Trials J Clin Psychopharmacol 2011;31: 613-624; Ripol et al Evidence-based pharmacotherapy for personality disorders International Journal of Neuropsychopharmacology (2011), 14, 1257–1288; and the Cochrane Review. Specifically for antipsychotics see Black et al Comparison of Low and Moderate Dosages of Extended-Release Quetiapine in Borderline Personality Disorder: A Randomized, Double-Blind, Placebo-Controlled Trial The American Journal of Psychiatry 171, 11: 1174) Furthermore, given that prescribing for personality disorder is common practice (for example see Crawford MJ, Kakad S, Rendell C, Mansour NA, Crugel M, Liu KW, et al. Medication prescribed to people with personality disorder: the influence of patient factors and treatment setting. Acta Psychiatr Scand 2011;124:396-402.) it would be helpful if NICE acknowledged uncertainties, including the limited evidence, and thus contributed to the debate on rational prescribing.

ID	Stakeholder	Statement No	Comments
96	West London Mental Health NHS Trust	Statement 3	The current evidence from randomised control trials suggest that drug treatment especially with mood stabilizers and second generation antipsychotic may be effective for treating a number of core symptoms and associated psychopathology, but the evidence does not currently support the effectiveness of overall severity of borderline personality disorder. Pharmacology should therefore, be targeted at specific symptoms. K. Lieb, B. Vollm, G. Rucker, A Timmer, and J. Stoffers (2010). Pharmacotherapy for Borderline PD Cochrane systemic review of Randomised trials. The British Journal of Psychiatry 196, 4-12
97	BABCP	Statement 4	Will the data collected be linked to crisis contacts accessed during time of transition? Such information is not always collected routinely (during transition points and outwith transition points). It may be useful to collect this data routinely and systematically across time to explore the nature if these links more fully. Crisis contact are often high cost contacts and important to monitor.
98	College of Occupational Therapists	Statement 4	The standard refers to the difficulties at time of transition and change – key role for occupational therapy to facilitate adaptation to new environments. The transitional guidance refers to risk assessment – we suggest that recognising strengths and protective factors and enabling patient to perform these is equally important in managing change. It is acknowledged that as part of transition this includes endings – of therapy, contacts , interventions and input. It is recommended that the service user is consulted in how they would like the endings to happen.
99	Emergence Plus CiC	Statement 4	Good management of transitions needs to also include involvement of service users in decision making processes, whether at individual, local, regional or national level. If people feel they have had a say in the changes they are easier to come to terms with. This would help this QS be in line with other NHS policy documentation re service user involvement (e.g. NHS Constitution).
100	Emergence Plus CiC	Statement 4	Ease of access in a crisis is crucial and is becoming more problematic as services make cuts, so important that this is included.
101	Emergence Plus CiC	Statement 4	Evidence of local arrangements to provide easy access is very different to services actually being easy to access – this QS can only genuinely be measured via feedback directly from service users. Care plans often include crisis plans but these are not always implemented or fail to be followed (e.g. it is easy to say, call your care co-ordinator in times of crisis, but the reality is often people are unable to get through, staff often do not have capacity to respond to messages and so on). We would like to see service user led evaluation of this quality standard as evidence suggest service users talk more honestly and openly with service user researchers than clinicians.
102	Emergence Plus CiC	Statement 4	Checking care plans re ease of access will not yield reliable results – only people already in services have a care plan, for them it is reasonably easy to access the service during a crisis – its impossible to everyone that has been discharged because they have been deemed to have 'recovered' but then hit a crisis- this quality standard needs to cover both populations. se are the people this standard needs to focus on.

ID	Stakeholder	Statement No	Comments
103	National Offender Management Service	Statement 4	Needs to strengthen the need for the availability of properly sequenced interventions, and pathways to support people into and out of services, and evidence that pathways are routinely discussed with the service user. A systemic issue is that of different commissioning landscapes leading to breaks in service and 'cliff edges' which prevent a seamless care pathway for patients. For example, specialised commissioners commission secure services for people with PD, but CCGs will commission local community mental health services. Very often these are not comparable across geographies, and are not joined up within a coherent pathway.
104	National Offender Management Service	Statement 4	Pathway planning and managing transitions is a critical part of managing the relational environment. Statements in this standard could be strengthened by insisting on the provision of clear pathway descriptions, that have been discussed with service users, and evidence of early discussion and engagement with service users regarding pathway options.
105	Rethink Mental Illness	Quality statements 4 & 5	Rethink Mental Illness supports these quality statements around effective care planning, however we would like to see involvement of people in developing their care plans set out as a quality measure for both standards. A collaborative approach to care planning is outlined in the 'definitions' section of both standards, but including it as a quality measure under each standard would strengthen this. This would support recommendation 1.3.2.1 in NICE CG78 (borderline personality disorder)
106	Rethink Mental Illness	Quality statements 4 & 5	The fact that care plans should be collaborative needs to be stated more explicitly here to set expectations among people using mental health services that they will be involved in care planning.
107	The Royal College of Psychiatrists	Statement 4	Poorly done in general services because of general statement made above. Need more training and integrated outreach models of working between specialist and general services. Medical psychotherapists well-placed in terms of expertise and experience to lead innovation at these service interfaces.
108	The Royal College of Psychiatrists	Statement 4	Transition to AMH is a very difficult issue for YP, particularly if the threshold to AMH is not met. Also professionals in AMH may not have training in managing older adolescents/younger adults.
109	The Royal College of Psychiatrists	Statement 4	Out of hours crisis care for YP is very variable throughout the country; often young adolescents will be repeatedly admitted to paediatric wards; the provision for older adolescents is even more difficult and they may end up on adult wards. A major issue which is not addressed adequately in guidelines is the often detrimental effect of admission to tier 4 units on these YP. Units are often regarded as the default plan for every crisis, however, YP often become adversely affected by other YP in these units and learn new unhelpful behaviours; discharge is often difficult due to lack of community resources and length of stay is often prolonged. Cycles of repeat admissions often occur due to insufficient community support.

ID	Stakeholder	Statement No	Comments
110	BABCP	Statement 5	This is also an important standard. However, it may be hard to implement. Identifying social care, social support and occupational needs is one thing: actually doing something about these is another. It is stated that the care plan should: identify long-term goals, including those relating to employment and occupation, that the person would like to achieve, which should underpin the overall long-term treatment strategy; these goals should be realistic, and linked to the short-term treatment aims. • What is the responsibility of the health and social care practitioner to meet these needs? What does realistic mean is this context? Does it mean available? Presumably if the service or another service or opportunity is not available, does that mean the need cannot be met? • What steps would the local service take to provide for these needs? Although a laudable aim, there may be considerable degree of interpretation in what this means. To state the needs without a plan as to how to meet these needs may be problematic raising expectations that are not likely to be met in the short term for that individual. To only state those needs that are likely to be met might miss many other needs that cannot be met (realistically). It may add to level of frustration people with PD experience to have social care, social support and occupational needs identified but not met.
111	College of Occupational Therapists	Statement 5	The COT Specialist Section-Mental Health is pleased to see the importance of Occupational needs recognised. It would also be worth emphasising: • The importance of appropriately trained / qualified staff to assess occupational needs – as is required for making diagnosis and providing psychological therapies. • Recognition that meeting occupational needs is applicable to both inpatients and community settings (standard refers to community only).
112	Emergence Plus CiC	Statement 5	Identifying needs which are not then met, is a painful and frustrating process – this area does need consideration, but it needs a corollary for working alongside social care and voluntary sector to identify how someone will then get those needs met. The life histories of people with personality disorder is usually rife with needs which have not been met (eg basic need for safety, food, attachment etc in childhood) there is a danger her of repeating a pattern for people which will just reinforce existing coping strategies as means of dealing with needs not being met.
113	Emergence Plus CiC	Statement 5	It is routine in many areas for people who have started work to be discharged from services as a marker of recovery – what they need to be supported to stay in work and maintain their wellbeing is not addressed. This practice will skew the data on how many people in secondary care are in employment.
114	National Offender Management Service	Statement 5	Include prisons and probation services within the bracketed list of service providers.

ID	Stakeholder	Statement No	Comments
115	Parents Protecting Children UK (in association with False Allegations Support Organisation and other groups and individuals)	Statement 5	It is vital that the correct plan be put in place in order to support the patient and/or their family, rather than discriminate against or persecute those with a condition, whether it is ASC, a physical condition, or a mental health condition such as borderline or antisocial personality disorder. Each requires specific and different support. Parents in particular are often discriminated against after a mental health diagnosis (whether it is a correct diagnosis or not), to the extent that they can lose contact with their children. In many of these cases the child's wellbeing would actually be best served by supporting birth parents to care for the child at home rather than placing them with an alternative family or in state care. Providing the correct diagnosis and support is essential. As ASCs are heritable and familial it is likely that, if a parent is on the spectrum, some children born into the family will also be on the spectrum, although symptoms can manifest differently. Parents Protecting Children UK have heard stories of women on the autism spectrum, misdiagnosed as having mental illness, losing their children to fostering or adoption. The fostering or adoptive placements then break down quickly because the child has behavioural difficulties driven by an undiagnosed autism spectrum condition with which the new parents aren't equipped to cope. The child can then either be passed around the care system with sequential placement breakdowns, or the child can receive proper diagnosis and a level of support is then put in place for the adoptive family, which if given to the birth family would have allowed the child to grow up with his or her own siblings, cousins, grandparents etc. and avoided the emotional damage to the child caused by removing them.
116	The Royal College of Psychiatrists	Statement 5	The transition to adult mental health is a huge national issue particularly with regards to YP who may have 'features' of BPD and even the diagnosis; often adult mental health services will not accept these cases despite the high level of need and risk. There is a need for more liaison links between specialist services and agencies that facilitate recovery in relation to education and occupation. Without attention to resource issue and staff training as described above, won't achieve the sophisticated and fit for purpose care plans needed.
117	South West Yorkshire NHS Foundation Trust	Statement 5	How is this measurable? What is the impact/outcome?

ID	Stakeholder	Statement No	Comments
118	BABCP	Statement 6	Staff supervision This is a useful standard. The measure suggested will give information on the numbers of mental health professionals supporting people with BPD and ASPD but not quality of supervision. This seems to go beyond routine supervision and suggest a specific form of supervision more akin to what would be expected in high level CBT training for example. Why not assess what happens in supervision? Routine supervision is often interpreted rather broadly and it seems to be different from the definition of what is included here. It may be the quality of supervision that may be important in influencing outcome. The quality statement does suggest that routine supervision includes some very specific features of supervision e.g. use of direct observation, supporting adherence to the specific intervention etc. Could this also be monitored as this is known to have an effect on the outcome of the therapy? Suggest for those receiving therapy: Nominator - Number of people who offer therapy to those with BPD and ASPD and who are being supervised using evidence of what happens in sessions e.g. through audio recordings etc. Denominator – number of people being supervised offering therapy to those with BPD or ASPD
119	Emergence Plus CiC	Statement 6	Wording could be more sensitive, quite stigmatising as it currently reads: “Working with these people can be very demanding, stressful and can sometimes result in negative staff attitudes.” Instead could say, “working with people with personality disorder who have often experienced considerable trauma, often communicate via actions and whose difficulties come to the fore in how they relate to others, can be complicated and stressful, sometimes giving rise to negative staff attitudes”. In addition, many staff we work with fear using supervision openly, as it is a mechanism to check their performance rather than support them so this needs to be captured in the rationale, I’d suggest: “The support and supervision need to be part of the routine service, and should be properly resourced and monitored”. Change to: “The support and supervision need to include protected time for reflective space included as part of the routine service, and should be properly resourced and monitored”
120	Emergence Plus CiC	Statement 6	Although the standard talks about support and supervision, the measures are of supervision, my experience is that there is considerable variation in what people mean when they talk about supervision – for many staff this is not a supportive thinking space but a performance check and run through of practical matters. It is vital that what you mean by supervision is articulated and that the measures reflect the supportive, reflective component of what staff need.

ID	Stakeholder	Statement No	Comments
121	Emergence Plus CiC	Statement 6	Feedback needs to be sought directly from staff as to whether or not this is in place, lots of services we work with have nominal structures in place which might look good on paper but don't actually happen in reality. This could be measured via a staff survey.
122	The National Forensic Psychotherapy Development Group	Statement 6	This statement was firmly supported. We thought it would be helpful to add that the nature and frequency of supervision should be appropriate to the nature and complexity of the work being undertaken. We also thought that it would be helpful, as part of this statement, to emphasise the importance of group supervision for teams and/or reflective practice, in this work, and would strongly endorse this being added to the quality statement.
123	The National Forensic Psychotherapy Development Group	Statement 6	Question 3: There is still an absence of research on the best models of supervision. The development of clinical networks could support the development and sharing of good practice.
124	National Offender Management Service	Statement 6	Clarify what is meant by supervision – i.e. clinical and/or management. Clinical Supervision is not only required for mental health professionals, but any professional regularly supporting people with personality disorder, e.g. prison and probation officers working within commissioned personality disorder services in criminal justice settings.
125	Parents Protecting Children UK (in association with False Allegations Support Organisation and other groups and individuals)	Statement 6	Someone on the autistic spectrum may be seen as resistant to treatment for supposed psychiatric illness. This resistance might seemingly confirm the BPD diagnosis. Someone with an autism spectrum condition may end up medicated for supposed mental illness through lack of understanding of their correct condition. Psychoactive medication may cause permanent regression and loss of social functioning skills for people on the autism spectrum because of disruption of learned alternative neural pathways. The concern is that if ASC is misdiagnosed then the patient will not react to treatment in the way professionals may be expecting. Individuals with ASC may also miscommunicate to professionals, affecting their handling by mental health services.
126	The Royal College of Psychiatrists	Statement 6	I agree wholeheartedly but this does not happen in general services enough (it does in specialist services for PD.) Again, for reasons in my general comments. Medical psychotherapists well-placed in terms of expertise and experience to lead innovation at these service interfaces.
127	Emergence Plus CiC	Question 5	This is a crucial QS – the feedback we get suggests many staff do not get routine support or supervision ie yes, it is aspirational, if supervision is explained as supportive space to stop and think about the work.

ID	Stakeholder	Statement No	Comments
128	The National Forensic Psychotherapy Development Group	Question 5	It depends what you mean by supervision. CQC now routinely looks at generic supervision in its inspections but this is more of a quantitative exercise and does not address the issue of appropriate supervision being in place for staff working with people with personality disorder ie the question is whether specialist supervision around personality disorder is routinely available and in place. The answer, in our view, is that there is very little evidence that this is the case on a widespread basis across all services, but that pockets of good practice in this area exist.
129	Royal College of Nursing	Question 5	This statement is aspirational. For nurses to get regular supervision there needs to be allocation of funds for protected time.
130	The Royal College of Psychiatrists	Question 5	Improving supervision of clinicians in terms of their reflective practice and self-awareness is important in order to manage the emotional impact of the work with this clinical population and also to ensure that therapy is delivered according to the established therapeutic goals. The quality standard is still aspirational, especially in relation to ASPD. Staff development groups for purely PD Services should be recommended and reflective practice sessions for other teams. Also, recommendations should be made the minimal frequency of those and a remark that there should be a separate provision for those in the budget. Yes, all are supervised but we need to specify what the supervision would be for working with patients with PD outside a specialist PD service.
131	The Royal College of Psychiatrists	Question 5	Supervision structures should be in place but these are likely to vary across the country.
132	South West Yorkshire NHS Foundation Trust	Question 5	The question is incorrect as it should be against statement 6
133	South West Yorkshire NHS Foundation Trust	Question 5	This is a basic requirement for all mental health professionals
134	The National Forensic Psychotherapy Development Group	Question 6	On a general basis a least monthly individual and team supervision would be a reasonable standard.
135	Partnerships in Care, Midlands	Question 6	We fully support the need for regular supervision for staff working with personality disorder and that this should be an achievable goal especially if different supervision formats are considered e.g. individual and group or reflective practice. A reasonable frequency might be considered 4-6weekly.
136	Royal College of Nursing	Question 6	We feel that every 8 weeks for individual supervision and group reflective practice on a monthly basis.

ID	Stakeholder	Statement No	Comments
137	The Royal College of Psychiatrists	Question 6	There is a range of views on the level of supervision with no clear evidence base. Frequencies of one hour weekly or fortnightly individual supervision with someone from your own professional background and monthly team supervision. In specialist PD services it is an integral and regular (at least weekly) part of treatment model to mitigate staff acting out and burn-out.
138	The Royal College of Psychiatrists	Question 6	It is essential that high quality supervision does exist particularly for high risk adolescents especially around risk and crisis management, safeguarding and boundaries. Often these YP need multiagency approaches rather than supervision of one individual.
139	South West Yorkshire NHS Foundation Trust	Question 6	The question is incorrect as it should be against statement 6
140	South West Yorkshire NHS Foundation Trust	Question 6	Different professionals require different levels and frequency of supervision, therefore it should be tailored to the role and individual needs. Professionals dealing with personality disorder service uses may require over and above the minimum levels to ensure support is provided to deal with these service users.

Stakeholders who submitted comments at consultation

- Association for Improvements in the Maternity Services
- British Association for Behavioural and Cognitive Psychotherapies (BABCP)
- College of Occupational Therapists
- Department of Health
- Digital Assessment Service, NHS Choices
- Emergence Plus CiC
- The National Forensic Psychotherapy Development Group
- National Hospital for Neurology and Neurosurgery
- National Offender Management Service
- NHS England

- Nottinghamshire Healthcare NHS Trust
- Parents Protecting Children UK (in association with False Allegations Support Organisation and other groups and individuals)
- Partnerships in Care, Midlands
- Rethink Mental Illness
- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Paediatrics and Child Health
- The Royal College of Psychiatrists
- South London and Maudsley NHS Foundation Trust
- South West Yorkshire NHS Foundation Trust
- West London Mental Health NHS Trust

Appendix 2: Quality standard consultation comments table (non-registered stakeholders)

ID	Stakeholder	Statement No	Comments
146	Individual 1	General	I wish to express my concerns regarding the number of parents of children on the autism spectrum, who are likely to be autistic themselves, being notionally diagnosed with BPD, APD and MSbP/FII or Attachment Disorder, due to their behaviour in advocating for their children or themselves when dealing with services such as Education and Social Services. The lack of knowledge of Autism and Erhler's Danlos Syndrome in the services – health, education and social care leaves us fighting battles on a daily basis. We often find ourselves the subject of Child Protection and allegations of FII, which are totally unfounded because the services, set up to support us, are more interested in blaming the parents and refusing support. We perseverate and this is seen as attention seeking. Much more in-depth and ongoing training needs to be done in these services to ensure that gross errors are not made, which can lead to tragic consequences for the whole family. Our mental health is affected, children stolen and all because someone, who in many cases is not medically trained, sees fit to label us with conditions seen to place our children at risk. The evidence that MSbP is an unsafe diagnosis in many case but there is little to suggest that the professionals are aware of this and subject people to what can only be described as a witch hunt.
147	Individual 2	General	Not ONCE in this document did I see the word Autism mentioned. Many, many people who have unrecognised and undiagnosed AUTISM get labelled with personality disorders. When are the 'professionals' going to wake up and recognise that, especially in women, mental health issues are VERY OFTEN the outcome of years of 'trying to fit in' but failing and not knowing or understanding why, when the real issue is Autism. If you addressed this, you have a hell of a lot less 'personality disorders'.
148	Emergence Carers Group	General	p2 'the care provided to people with personality disorders is often fragmentary'. I think this should also say scarce, patchy in terms of locality, long waiting lists, inadequate eg in terms of covering social and occupational needs. I do not feel fragmentary covers the sense of despair about the general inadequacy and insufficiency of services, frequently resulting in people turning to expensive private options if they can afford it (and the majority cannot).

ID	Stakeholder	Statement No	Comments
149	Emergence Carers Group	General	p9. I welcome the reference to including carers in decision making about assessment, treatment and care. This is vital. However, in the experience of members of the Emergence carers group, and from my experience of attending a carers programme at the Anna Freud centre led by Anthony Bateman, there is a largely unmet need for education about BPD for carers, and for skilled training especially where the person with BPD is living with family members, in the treatment techniques being taught to the person with BPD for example, validation, mentalization. Even after treatment, many BPD sufferers remain very dependent on their families for long term support, so there is also a need for ongoing support for fami8liers playing the carers role. At present funding for such programmes, which require skilled professional support, appears to be dependent on fund raising of grant applications rather than being systemic. I would suggest an additional Quality Standard relating to carers is needed. There is good evidence that families make a difference to outcomes for sufferers but also that caring is an extremely stressful role which frequently adversely affects the health and wellbeing of carers. Altogether, the statement here in the introduction , while recognising carers and families, is totally inadequate and misses an opportunity to support much better outcomes for sufferers by training and supporting families. At the same time, given that family and relationship conflicts are frequent triggers for people with BPD, more skilled carers can effect direct improvement in sufferers' everyday lives by learning to respond in more helpful ways to BPD type behaviours and patterns of thought. In addition, it seems clear that family and carer support makes a significant difference to keeping patients out of hospital and reduces the use of emergency services.
150	Emergence Carers Group	General	p1 I welcome the focus on BPD and the revision of quality standards. However, I am concerned that for the person with BPD and for their carers who may be reading these quality standards, the bringing together of BPD and anti-social personality may be deeply unhelpful. This pairing may serve to reinforce stigma about BPD and in addition serves to produce a very long document. If they are to be grouped together in this way, then it is important that some explanation for this pairing is given in the Introduction.
151	Emergence Carers Group	General	As already emphasised, there should be a separate statement re families and carers which goes far beyond including them in planning and refers to specialist provision of information, training and support for their role.
152	IAPT	Question 1	Yes the quality standard does address some of the key areas but does not address an attempt to create a change in attitudes within the system. Leadership is key in promoting organisational change hence the importance of competent PD aware practitioners.
153	IAPT	Question 2	Outcome measures can be collected we are trialling a data set looking at patient reported outcome measures in the IAPT demonstration sites
154	IAPT	Question 3	We need to think about primary and secondary care services for this client group to overcome barriers. Exclusion from secondary care services is evident however we need to build alternatives which may be more appropriate. Emphasis on the standards is relating it to secondary care mental health. More people sit outside secondary care than within it i.e. primary care IAPT services

ID	Stakeholder	Statement No	Comments
155	Emergence Carers Group	Statement 1	Agree
156	IAPT	Statement 1	The rationale focusses on symptoms and diagnosis not needs. PD is a behavioural presentation therefore symptoms not always likely to respond. Evidence suggests that work to reduce self-harming behaviours creates better outcomes therefore the clients needs will need to be taken into account which may well be more behavioural outcomes. It is hard to check the quality of these assessments
157	Emergence Carers Group	Statement 2	Agree re offer, but statement should include a time frame for treatment to be both offered and commenced. In my daughter's case she was offered treatment but had a long delay before substantive treatment began (more than a year after her first presentation). Having received a very stigmatising and frightening diagnosis and then having to wait so long to access treatment resulted in a worsening of her condition.
158	Emergence Carers Group	Statement 2	P 17 reference for BPD to the need to 'take into account the availability of personal and professional support' seems a very unclear and potentially unhelpful statement. What does this mean? How does it relate to the choice and preference of the user . Given the patchiness of available provision and the variety of treatments available, to what extent is patient choice a reality or an aspiration? For example, in my daughter's case she would perhaps have chosen a more intensive residential or full time day treatment programmes, and was in fact initially offered this. However, this offer became unavailable during the long waiting period m, and she was eventually offered only a two session per week programme which left many of her needs unmet and has resulted, perhaps, in her journey towards recovery being much slower than might otherwise have been the case. I think the statement should include patients being offered alternatives , including access to those outside their home mental health partnership
159	IAPT	Statement 2	Appropriate psychological therapies will need to be made available according to the severity of the individuals presentation
160	IAPT	Question 4	Dialectical Behaviour therapy, Mentalisation, Cognitive Behavioural Therapy for PD, Cognitive analytic therapy, Structured clinical management, STEPPES. Evidence suggests it is not so important what the model is more that the characteristics of the model respond to the specific presentations of the people which underpin a consistent approach to treatment.
161	Emergence Carers Group	Statement 3	This statement is appropriate at present but should not preclude research as to possible drug treatments becoming relevant in future.

ID	Stakeholder	Statement No	Comments
162	Individual 3	Statement 3	Thank you for inviting comments. I disagree that antipsychotics and sedatives should not be prescribed. I believe that some individuals with borderline or antisocial personality disorder benefit from antipsychotics and sedatives in the medium to long term. From Draft Quality Standard: “Rationale No drugs are licensed for treating or managing borderline and antisocial personality disorder” - I don’t see this as a compelling rationale. Many drugs are used off licence. E.g. NICE itself recommends sertraline for Generalised Anxiety Disorder [GAD] although sertraline does not have a licence for GAD. The American Psychiatric Association certainly sees a role for antipsychotics in Borderline PD –see APA Practice Guideline: “For severe behavioral dyscontrol, consider adding low-dose antipsychotics”. Add [to SSRI]: Low-Dose Antipsychotic (for symptoms of anger), Clozapine may be warranted after other treatments have failed. 3. Pharmacotherapy and Other Somatic Treatments (continued) Symptoms to be targeted (continued) Cognitive-perceptual symptoms (see Figure 3, p. 271) • Low-dose antipsychotics are the treatment of choice for psychotic-like symptoms. • Antipsychotics may also improve depressed mood, impulsivity, and anger-hostility. • Antipsychotics are most effective when cognitive-perceptual symptoms are primary. • If response is suboptimal in 4 to 6 weeks, increase dose to the range used for axis I disorders. • Clozapine may be useful for patients with severe, refractory psychotic-like symptoms. This comes over as an unhelpfully inflexible standard, which doesn’t support clinical flexibility. I appreciate this is a draft Quality Standard, not a comprehensive account of treatment, but I think it would be helpful to say something about antidepressants and mood stabilisers [these are covered in detail in the APA Practice

ID	Stakeholder	Statement No	Comments
			Guideline].
163	Emergence Carers Group	Statement 4	Support strongly. Transitions are difficult. However, the statement assumes the availability of appropriate services for people transitioning out of specialist treatment programmes. It also assumes people leaving specialist services will have a care plan and there will be resources available to meet their needs. Of course this would be ideal, but this quality statement refers only to the existence of appropriate care plans, not access to the services required.
164	IAPT	Statement 4	Would it be useful to suggest that 1 person remains responsible whilst undergoing a transition as often this is where it falls down and people get lost. No responsibility ends until after a 6 week period post transfer
165	Emergence Carers Group	Statement 5	I am very pleased to see these areas referred to in the quality standards as in the experience of ourselves and other carers we have met, there is a huge gap at present. However, I think attention to social, occupational and vocational areas needs to be tackled more systematically during main psychological treatment programmes (which may therefore require longer hours) almost from the outset, rather than being placed as after 'transition' matters.
166	IAPT	Statement 5	Could we validate against people in services outside of secondary mental health as large numbers do not get into secondary care and remain at the primary care level

ID	Stakeholder	Statement No	Comments
167	Emergence Carers Group	Statement 6	Strongly support. I would also suggest there is a reference to supporting staff in obtaining, managing and responding to feedback from users and carers about the services being provided in structured and planned ways. I think there should also be a reference to the importance of very high quality supervision and support for students/trainees involved in face to face provision of services so that they are not asked to undertake duties for which they have insufficient experience. This has happened in the setting where my daughter received treatment and was damaging.
168	Emergence Carers Group	Statement 6	In terms of language, I find the expression 'working with these people' (p 29) very unhelpful as it 'lumps' all categories of patients together and tends to 'blame' the sufferer. I am sure that none of us would like to be referred to as 'these people' and for sufferers of BPD reading such a phrase could be very distressing. Better perhaps, while recognising special difficulties with BPD, to also recognise that many patients will have experienced a great deal of pain and distress in their lives prior to treatment. Dealing with this is in itself stressful for professionals. In general this paragraph could be reworded to be more mindful that staff and patients can lack skills at times.
169	IAPT	Statement 6	Need to emphasise that supervision needs to be provided by PD competent practitioner not enough in routine practice (See University college London personality Disorder competency framework for PD)
170	IAPT	Question 5	Need to ensure that routine supervision is conducted by PD competent staff. We do not have enough people in the current workforce to undertake the treatment and the supervision of psychological interventions. The IAPT PD pilots are looking at the training needs of the workforce
171	IAPT	Question 6	Supervision needs to be at least weekly with access to PD competent supervisors