Grampian Specialist Psychotherapy Service

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NHS Grampian

In Confidence

Date 28/10/2019
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SIGN Executive
Gyle Square
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EDINBURGH
EH12 9EB

Dear Sir/Madam,

Please find enclosed a proposal for a SIGN Guideline on Complex and Multidiagnostic Psychological Presentations, which is submitted on behalf of the Faculty of Medical Psychotherapy of the Royal College of Psychiatrists in Scotland.

Yours faithfully,

Dr Marina McLoughlin
Consultant Psychiatrist in Psychotherapy

Chair, Faculty of Medical Psychotherapy
Royal College of Psychiatrists in Scotland

Dr Alasdair Forrest
ST7 in Forensic Psychiatry & Medical Psychotherapy

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Topic proposal

I understand that this proposal will be retained by the SIGN Programme Lead and be made available on the SIGN website for time period that the proposal is being considered. **Only proposals with a completed Declaration of Interests for the principal proposer will be considered**

1.	**What is the problem/need for a guideline/clinical scenario?**

There is a need for a guideline to assist realistic clinical practice in treating individuals with psychological disorders, because current guidelines uniformly focus on treatment of single diagnoses. However, multiple co-occurring problems are more usual in specialist mental health care. Guidelines recognising this reality of multidiagnostic presentations are needed. Additionally, the effects of Adverse Childhood Experiences, including childhood trauma and attachment difficulties in childhood, can have broad effects on adult mental wellbeing, including on the ability to make and form relationships. This has implications for the individual's engagement with treatment, and has implications for the therapeutic relationship, making these complex presentations. Because of this, the term Complex and Multidiagnostic Psychological Presentations is proposed.

Heterotypic Continuity and Co-Occurring Symptoms

Psychiatric epidemiological studies over the past two decades have disproven any previous idea that mental illness arises as discrete episodes circumscribed by periods of wellness. For example, Kim-Cohen et al. (2003), in their (n=1037) prospective longitudinal study, the Dunedin Multidisciplinary Health and Development Study, showed that of adults at 26 years of age with a mental disorder diagnosis, 73.9% met the criteria for a diagnosis at 18 as well, and 50.0% did at 15 years of age. This underlines the more recent interest in developmental psychopathology, or tending to view disorders not as discrete entities but as expressions of psychological problems throughout the lifespan. Importantly, while many showed persistence of the same diagnosis—homotypic continuity—a number showed heterotypic continuity, or persistence of mental disorder but with a different diagnostic expression.

This heterotypic continuity has been investigated in other longitudinal studies. The Avon Longitudinal Study of Parents and Children (ALSPAC) (n=4815) (Shevlin et al., 2017) and the US National Comorbidity Survey Replication Adolescent Supplement (NCS-A) (n=904) (Kessler et al., 2012) both show high degrees of heterotypic continuity. In the US National Epidemiologic Study of Alcohol and Related Conditions (n=28,958) (Lahey et al., 2014), heterotypic continuity was found to be nearly universal among adults with a mental disorder.

These findings underscore the need to offer psychological treatment that recognises the multidiagnostic and developmental aspects of psychological problems, rather than one that focuses on the treatment of isolated diagnostic categories.

Adverse Childhood Experiences and Attachment Problems

Alongside this interest in investigating a lifespan perspective on psychological disorders, there is renewed interest in the role of early childhood experience on multiple physical and mental health outcomes throughout adulthood. This is important because these difficulties affect the ability to make and form a relationship, which means that special attention is needed to the therapeutic relationship if treatment is to be experienced by the patient as psychologically-safe and effective.

High ACE scores are associated with insecure attachment patterns in adulthood (Murphy et al, 2014).

It is a well-replicated finding that increasing levels of childhood trauma predict drop-out from psychotherapy for bulimia nervosa, for example (Mahon et al., 2001), and that there is a more

general adverse effect on the therapeutic relationship from those with insecure adult attachment styles (Diener et al., 2011).

Given this, it is essential that therapists have sufficient skill, and work in a model that sufficiently takes account of, these relational problems and how they make treatment more complex.

Relationship with Personality Disorder

A number of the patients with Complex and Multidiagnostic Psychological Presentations are likely to have diagnoses of Personality Disorder as part of the formulation of their difficulties. Cattane et al (2017) report on a gene-environment interaction between Adverse Childhood Experience and the development of Borderline Personality Disorder, for example. It is established that childhood maltreatment is associated with the development of various personality disorder types (Yen, et al, 2002; Battle, et al, 2004).

However, the literature on Personality Disorder rarely makes a distinction between mild, moderate, and severe levels of disorder, which are proposed in the new ICD-11 classification of mental disorders. This means that evidence-based treatment decisions relating to Personality Disorder, such as with Mentalization-Based Treatment (Bateman & Fonagy, 2004) or Dialectical Behavioural Therapy (Linehan, 1993) typically do not make a dimensional assessment. This could lead to inappropriate recommendation of treatment to patients with mild to moderate levels of disturbance, based on study of the more clinically-distinct patients with severe levels of personality disturbance.

Bateman A, Fonagy P. Psychotherapy for Borderline Personality Disorder: Mentalization-based Treatment. 2004; Oxford: Oxford University Press.

Battle CL, Shea MT, Johnson DM, Yen S, Zlotnick C, Zanarini MC, Sanislow CA, Skodol AE, Gunderson JG, Grilo CM, McGlashan TH, Morey LC. Childhood maltreatment associated with adult personality disorders: findings from the Collaborative Longitudinal Personality Disorders Study. J Pers Disord. 2004 Apr;18(2):193-211.

Cattane N, Rossi R, Lanfredi M, Cattaneo A. Borderline personality disorder and childhood trauma: exploring the affected biological systems and mechanisms. BMC Psychiatry. 2017 Jun 15;17(1):221.

Diener MJ, Monroe JM. The relationship between adult attachment style and therapeutic alliance in individual psychotherapy: a meta-analytic review. Psychotherapy (Chic). 2011 Sep;48(3):237-48.

Kessler RC, Avenevoli S, McLaughlin KA, Green JG, Lakoma MD, Petukhova M, Pine DS, Sampson NA, Zaslavsky AM, Merikangas KR. Lifetime co-morbidity of DSM-IV disorders in the US National Comorbidity Survey Replication Adolescent Supplement(NCS-A). Psychol Med. 2012 Sep;42(9):1997-2010.

Kim-Cohen J, Caspi A, Moffitt TE, Harrington H, Milne BJ, Poulton R. Prior juvenile diagnoses in adults with mental disorder: developmental follow-back of a prospective-longitudinal cohort. Arch Gen Psychiatry. 2003 Jul;60(7):709-17.

Lahey BB, Zald DH, Hakes JK, Krueger RF, Rathouz PJ. Patterns of heterotypic continuity associated with the cross-sectional correlational structure of prevalent mental disorders in adults. JAMA Psychiatry. 2014 Sep;71(9):989-96.

Linehan M. Cognitive Behavioural Treatment of Borderline Personality Disorder. 1993; New York: Guilford.

Mahon J, Bradley SN, Harvey PK, Winston AP, Palmer RL. Childhood trauma has dose-effect relationship with dropping out from psychotherapeutic treatment for bulimia nervosa: a replication. Int J Eat Disord. 2001 Sep;30(2):138-48.

Murphy A, Steele M, Dube SR, Bate J, Bonuck K, Meissner P, Goldman H, Steele H. Adverse Childhood Experiences (ACEs) questionnaire and Adult Attachment Interview (AAI): implications for parent child relationships. Child Abuse Negl. 2014 Feb;38(2):224-33.

Shevlin M, McElroy E, Murphy J. Homotypic and heterotypic psychopathological continuity: a child cohort study. Soc Psychiatry Psychiatr Epidemiol. 2017 Sep;52(9):1135-1145.

Yen S, Shea MT, Battle CL, Johnson DM, Zlotnick C, Dolan-Sewell R, Skodol AE, Grilo CM, Gunderson JG, Sanislow CA, Zanarini MC, Bender DS, Rettew JB, McGlashan TH. Traumatic exposure and posttraumatic stress disorder in borderline, schizotypal, avoidant, and obsessive-compulsive personality disorders: findings from the collaborative longitudinal personality disorders study. J Nerv Ment Dis.2002 Aug;190(8):510-8.

2. Burden of the condition

Mortality

Kelly-Irving et al. (2013) found increased all-cause mortality below 50 years of age among those in a British birth cohort who have two or more ACEs. In a large population study in the US (n=17,337), after multivariable adjustment, adults with six or more ACEs were 1.7 (95% CI=1.06, 2.83) times more likely to die when aged at or under 75 years and 2.4 (95% CI=1.30, 4.39) times more likely to die when aged at or under 65 years (Brown et al, 2009).

Brown DW, Anda RF, Tiemeier H, Felitti VJ, Edwards VJ, Croft JB, Giles WH. Adverse childhood experiences and the risk of premature mortality. Am J Prev Med. 2009 Nov;37(5):389-96.

Kelly-Irving M, Lepage B, Dedieu D, Bartley M, Blane D, Grosclaude P, Lang T, Delpierre C. Adverse childhood experiences and premature all-cause mortality. Eur J Epidemiol. 2013 Sep;28(9):721-34.

Incidence

The incidence of patients with Complex and Multidiagnostic Psychological Presentations has not been determined. Given the dimensional aspect of the concept—which is based on ideas of heterotypic continuity across the lifespan—prevalence figures are likely to be more instructive.

Prevalence

The prevalence of patients with Complex and Multidiagnostic Psychological Presentations has not been determined. However, the prevalence of Adverse Childhood Experiences is currently being studied in Scotland as part of the *Growing Up in Scotland* longitudinal study, which recruited its first birth cohort in 2004/5 and its second in 2010/11. From the earliest study on ACEs, the Kaiser Permanente study, a replicable association has been found between having four or more ACEs and having poor mental health and premature mortality (Felitti et al., 1998). In a representative household survey in England, 8.3% of adults had experienced four or more ACEs, and the adjusted odds ratio for poor mental wellbeing increased with the number of ACEs (Hughes et al., 2016). A similar prevalence of having experienced four or more ACEs was found in a Welsh population survey (Bellis et al, 2015).

Bellis MA, Ashton K, Hughes K, Ford K, Bishop J, Paranjothy S. Welsh Adverse Childhood Experiences Study. 2015, Cardiff: Public Health Wales. Available from: http://www2.nphs.wales.nhs.uk:8080/PRIDDocs.nsf/7c21215d6d0c613e80256f490030c05a/d488a3852491bc1d80257f370038919e/$FILE/ACE%20Report%20FINAL%20(E).pdf

Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. Am J Prev Med. 1998 May;14(4):245-58.

Hughes K, Lowey H, Quigg Z, Bellis MA. Relationships between adverse childhood experiences and adult mental well-being: results from an English national household survey. BMC Public Health. 2016

	Mar 3;16:222.
3.	**Variations**
	In practice in Scotland There is a substantial variation in practice in Scotland. Some patients with complex and multidiagnostic psychological presentations are treated in primary care or general psychiatric services, often using off-label prescriptions of psychotropic medication, given that the patients sometimes do not meet full diagnostic criteria for a single licensed indication. Instead, their symptoms are broader and more complex. Others are referred for psychological therapy, and there is a wide variation in practice there. Some receive short-term therapy, such as Cognitive-Behavioural Therapy. Others have longer-term therapy, such as Psychodynamic or Psychoanalytic Psychotherapy, or Group Analysis.
	In health outcomes in Scotland Because of the complexity of the presentation, this has not yet been studied.
4.	**Areas of uncertainty to be covered**
	Key question 1 **Primary Care Services** Which patients should be recognised as having Complex and Multidiagnostic Psychological Presentations, including those associated with Adverse Childhood Experience? How can they be recognised and offered appropriate treatment?
	Key question 2 **Secondary Care Psychiatric Services** Which patients should be seen in general psychiatric services, and which should be referred for specialist psychological therapy?
	Key question 3 **Specialist Psychological Therapy Services** Which forms of psychological therapy should be offered, over which duration, and with which arrangements for supervision and training?
5.	**Areas that will not be covered**
	The treatment of children.
6.	**Aspects of the proposed clinical topic that are key areas of concern for patients, carers and/or the organisations that represent them**
	The population studies show a high degree of longstanding psychological morbidity in the population. This clinical topic will be of concern to patients who seek longer-term psychological treatment to help with complex and longstanding difficulties that affect their functioning and wellbeing.
7.	**Population**
	Included Adults seeking treatment for complex and multidiagnostic psychological presentations, including those associated with Adverse Childhood Experiences.
	Not included Children and young people.

8.	**Healthcare setting**
	Included Primary care, secondary mental health care services, and specialist psychological therapies services.
	Not included Child and adolescent mental health services.
9.	**Potential**
	Potential to improve current practice This could improve current practice by helping clinicians to decide on appropriate treatments for patients presenting with these complex difficulties. They are often allocated to various or serial psychological or drug treatments currently.
	Potential impact on important health outcomes (name measureable indicators) The potential impact is on general psychological distress, which could be measured using the Clinical Outcomes in Routine Evaluation (CORE) questionnaires, or the Symptom Checklist-90 (SCL-90) measure.
	Potential impact on resources (name measureable indicators) The guideline may influence the development of specialist psychological therapy services in Scotland.
10.	**What evidence based guidance is currently available?**
	None
	Out-of-date (list) None
	Current (list) There are currently none. *The Matrix: A Guide to Delivering Evidence-Based Psychological Therapies in Scotland* only considers single diagnoses without adopting a lifespan perspective.
11.	**Relevance to current Scottish Government policies**
	Scottish Government Health Priority 3 is *A Scotland Where We Have Good Mental Wellbeing.* It is also relevant to the Scottish Government policies around trauma-informed care expressed in *Transforming Psychological Trauma* (https://www.nes.scot.nhs.uk/media/3971582/nationaltraumatrainingframework.pdf). The Scottish Government has recently proposed the development of a Managed Clinical Network for Personality Disorder as part of the 2019-20 *Programme for Government.*
12.	**Who is this guidance for?**
	NHS Scotland staff, particularly in specialist mental health services and primary care.
13.	**Implementation**
	Links with existing audit programmes Specialist treatments currently used for complex and multidiagnostic psychological presentations could be monitored using the NHS Scotland Psychological Therapies Access HEAT Target. For example, the date of referral to, date of commencement of, and date of termination of Psychodynamic Psychotherapy are each recorded as a key indicator gathered by NHS ISD Scotland.
	Existing educational initiatives There could be a link with the National Trauma Training Framework, as it is likely that the psychological treatments reviewed in the proposed guidelines represent some of the

	modalities used in Trauma Specialist Practice. These have not yet been defined by the National Trauma Training Framework. These guidelines could inform the development of educational initiatives in the proposed Managed Clinical Network for Personality Disorder.
	Strategies for monitoring implementation The recently-proposed Managed Clinical Network for Personality Disorder could form part of the monitoring of implementation, where it relates to Personality Disorder.
14.	**Primary contact for topic proposal**
	Dr Alasdair Forrest Specialty Registrar in Forensic Psychiatry & Medical Psychotherapy Royal Cornhill Hospital, Cornhill Road, Aberdeen. AB25 2ZH
15.	**Group(s) or institution(s) supporting the proposal**
	Faculty of Medical Psychotherapy, Royal College of Psychiatrists in Scotland 12 Queen Street, Edinburgh. EH2 1JE

Declaration of Interests

Please complete all sections and if you have nothing to declare please put 'N/A

Having read the SIGN Policy on Declaration of Competing Interests I declare the following competing interests for the previous year, and the following year. I understand that this declaration will be retained by the SIGN Programme Lead and be made available on the SIGN website for time period that the proposal is being considered.

Signature:	(M. McLoughlin)
Name:	Dr Marina McLoughlin
Relationship to SIGN:	Topic proposal primary contact
Date:	28/10/2019
Date received at SIGN:	

Personal Interests

Remuneration from employment

	Name of Employer and Post held	Nature of Business	Self or partner/ relative	Specific?
Details of employment held which may be significant to, or relevant to, or bear upon the work of SIGN	NHS Grampian Consultant Psychiatrist in Medical Psychotherapy	Medical	Self	

Remuneration from self employment

	Name of Business	Nature of Business	Self or partner/ relative	Specific?
Details of self employment held which may be significant to, or relevant to, or bear upon the work of SIGN	N/A			

Remuneration as holder of paid office

	Nature of Office held	Organisation	Self or partner/ relative	Specific?
Details of office held which may be significant to, or relevant to, or bear upon the work of SIGN	N/A			

Remuneration as a director of an undertaking

	Name of Undertaking	Nature of Business	Self or partner/ relative	Specific?
Details of directorship held which may be significant to, or relevant to, or bear upon the work of SIGN	N/A			

Remuneration as a partner in a firm

	Name of Partnership	Nature of Business	Self or partner/ relative	Specific?
Details of Partnership held which may be significant to, or relevant to, or bear upon the work of SIGN	N/A			

Shares and securities

	Description of organisation	Description of nature of holding (value need not be disclosed)	Self or partner/ relative	Specific?
Details of interests in shares and securities in commercial healthcare companies, organisations and undertakings	N/A			

Remuneration from consultancy or other fee paid work commissioned by, or gifts from, commercial healthcare companies, organisations and undertakings

	Nature of work	For whom undertaken and frequency	Self or partner/ relative	Specific?
Details of consultancy or other fee paid work which may be significant of to, or relevant to, or bear upon the work of SIGN	N/A			

Details of gifts which may be significant to, or relevant to, or bear upon the work of SIGN				

Non-financial interests

	Description of interest	Self or partner/ relative	Specific?
Details of non-financial interests which may be significant to, or relevant to, or bear upon the work of SIGN	Chair, Faculty of Medical Psychotherapy, Royal College of Psychiatrists in Scotland	Self	

Non-personal interests

	Name of company, organisation or undertaking	Nature of interest
Details of non-personal support from commercial healthcare companies, organisations or undertakings	N/A	

Signature M. McLaughlin *Date:* 28/10/2019

Thank you for completing this form.

Please return to
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Data Protection

Your details will be stored on a database for the purposes of managing this guideline topic proposal. We may retain your details so that we can contact you about future Healthcare Improvement Scotland activities. We will not pass these details on to any third parties. Please indicate if you do not want your details to be stored after the proposal is published.