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
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 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.


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).


Incidence
The incidence of patients with Complex and Multidagnostic 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 Multidagnostic 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).


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](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 NI-S 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:**

![Signature]

**Name:**

Dr Marina McLoughlin

**Relationship to SIGN:**

Topic proposal primary contact

**Date:**

28/10/2019

**Date received at SIGN:**


### Personal Interests

**Remuneration from employment**

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**Remuneration from self employment**

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**Remuneration as holder of paid office**

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### Remuneration as a director of an undertaking

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

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

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Details of interests in shares and securities in commercial healthcare companies, organisations and undertakings

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

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

Non-financial interests

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Non-personal interests

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<td>Details of non-personal support from commercial healthcare companies, organisations or undertakings</td>
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Signature: [Signature]

Date: 28/10/2015

Thank you for completing this form.

Please return to
Roberta James
SIGN Programme Lead
SIGN Executive, Healthcare Improvement Scotland,
Gyle Square | 1 South Gyle Crescent | Edinburgh | EH12 9EB

t: 0131 623 4735
e: roberta.james@nhs.net

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.