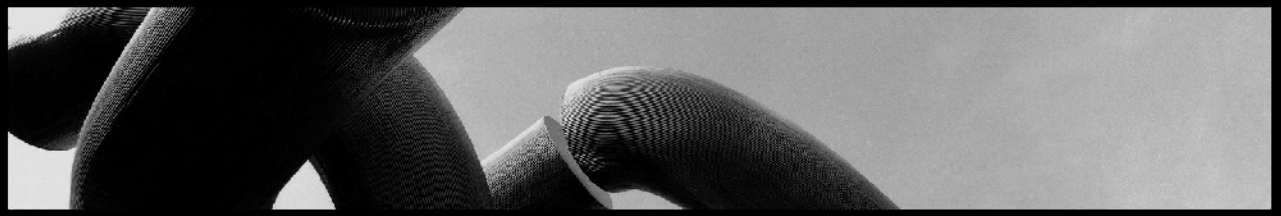

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

NICE guidelines:

Will NICE Guidelines help with the Management of people with Personality Disorder?

Dr Tim Kendall

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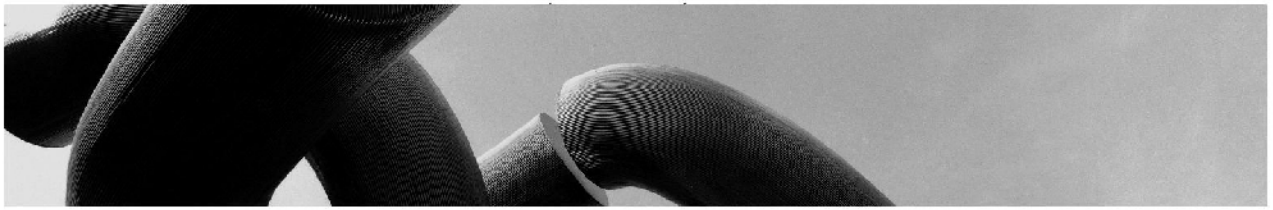

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Declaration of interests

- Joint director NCCMH
- Deputy Director CRU
- Medical Director, Sheffield Care Trust
- Consultant psychiatrist (general psychiatry)
- Trained in psychoanalytic psychotherapy

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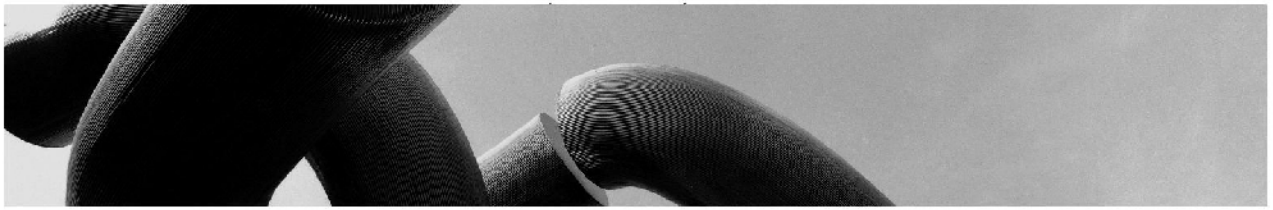

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The role of NICE in the NHS

- Clinical practice guidelines
- Technology Appraisals
- Interventional Procedures
- Public Health guidelines

- Implementation directorate

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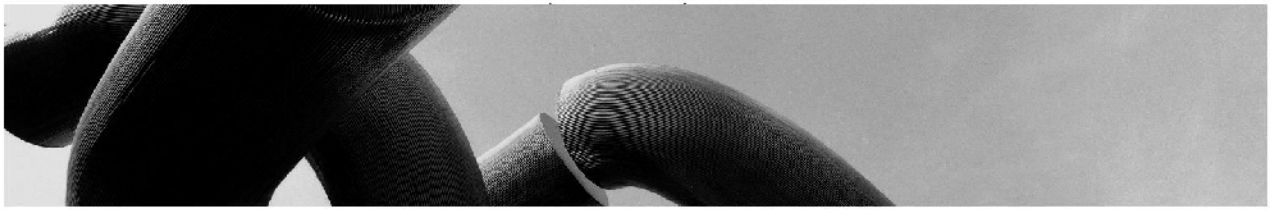

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

The National Collaborating Centres

- NICE has established seven Collaborating Centres to help develop clinical guidelines
  - Acute care
  - Cancer
  - Chronic conditions
  - Mental Health
  - Nursing and Supportive Care
  - Primary Care
  - Women and Children's Health

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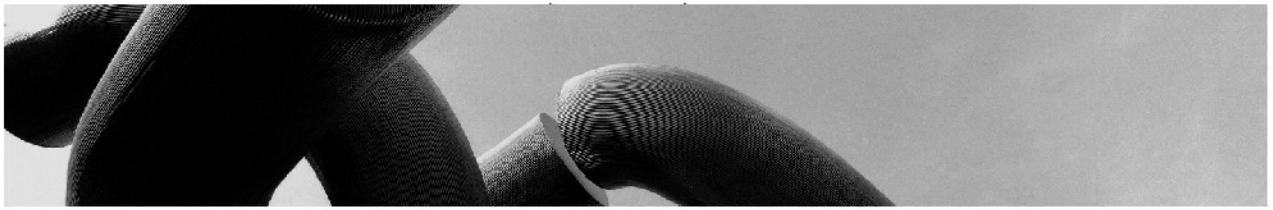

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The NCCMH

- Joint partnership between the Royal College of Psychiatrists and the British Psychological Society
- Commissioned by NICE to develop mental health clinical guidelines since 2001
- To produce integrated guidance for mental health including social care and education into guideline development
  - Dementia: The first NICE-SCIE guideline
  - ADHD: working with the Department for Children, Schools and Families

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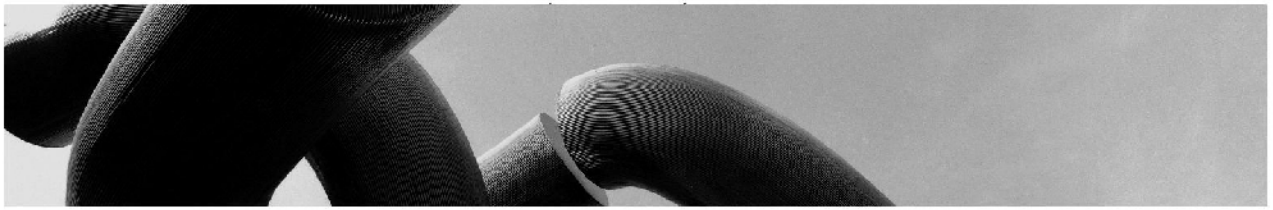

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Completed mental health guidelines

- Schizophrenia
- Eating Disorder
- Self-Harm
- Depression
- PTSD
- Childhood Depression
- OCD
- Bipolar Disorder
- Dementia
- APMH
- Drug Misuse: Psychosocial Interventions
- Drug Misuse: Opioid Detoxification

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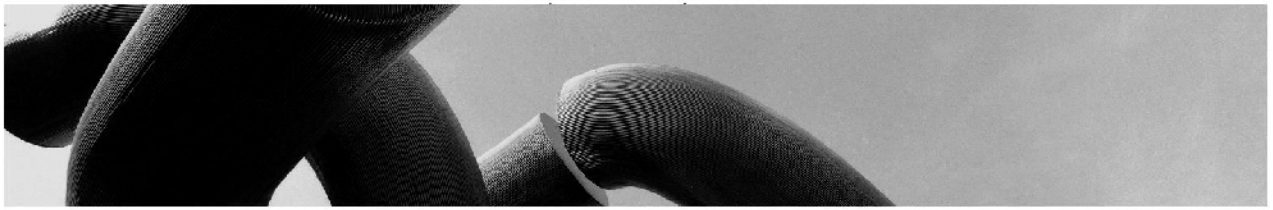

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Mental health guidelines currently under development

- Attention-Deficit Hyperactivity Disorder (Sept 2008)
- Borderline Personality Disorder (Dec 2008)
- Antisocial Personality Disorder (Dec 2008)
- Schizophrenia: Update (Jan 2009)
- Depression: Update (July 2009)
- Depression:
  - Chronic Physical Health Problems (July 2009)

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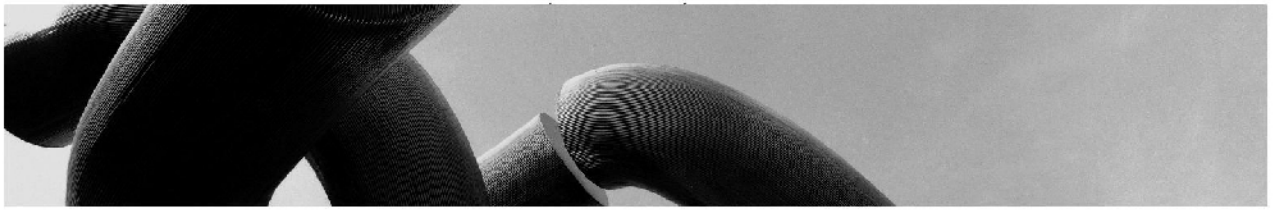

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How the guidelines are produced

- Scope
- GDG recruitment
- Clinical questions
- NCCMH review evidence and present to GDG for discussion
- Health economics
- Linking to other NICE guidelines
- Stakeholder comments
- Full guideline

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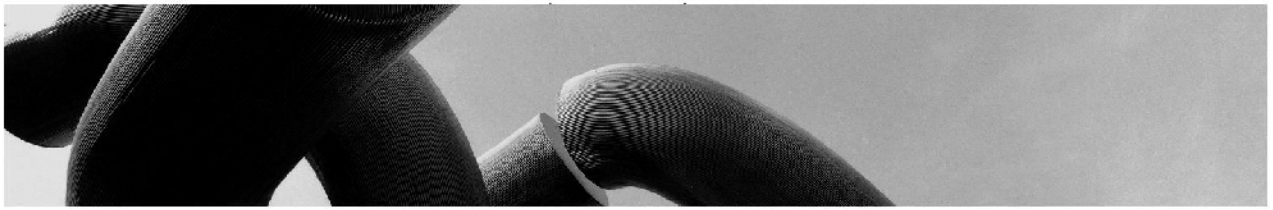

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Guideline products

- Full guideline (evidence, recommendations and guideline summary, references, tables etc)
- Quick Reference Guide (QRG)
- Understanding NICE Guidance (UNG)
- Key recommendations
- Audit tool
- Implementation tools

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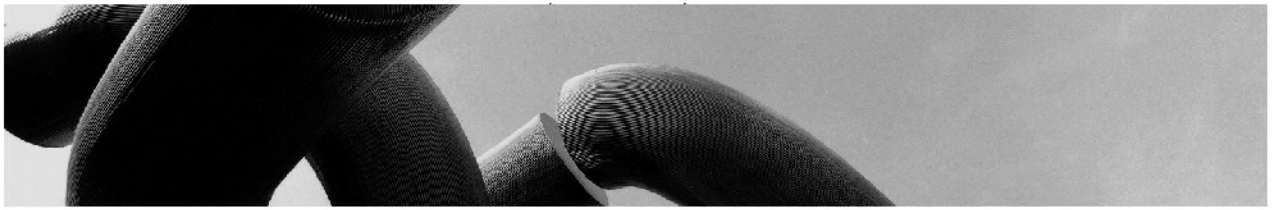

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Problems from previous guidelines I

- Populations (adverts, special clinics, children who agree to be randomised etc)
- RCT studies in mental health 95% of drug RCTs funded by drug industry
- Most head to heads favour companies own drug (100%in CAMHS)
- Selective publishing of trials (eg SSRIs)
- Systematic reviews done by drug companies often dodgy (eg Venlafaxine)

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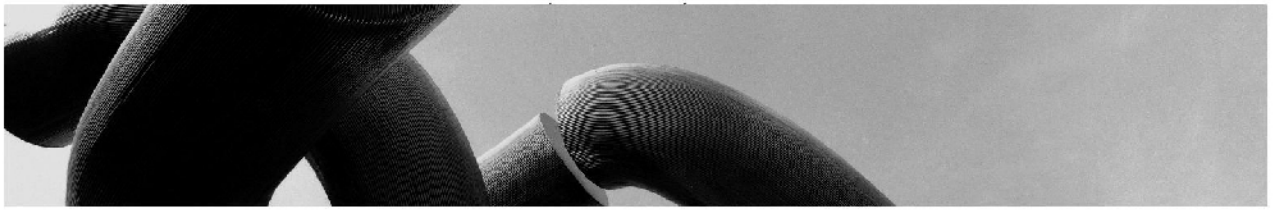

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Problems II

- Very little evidence in some areas (eg Early Intervention services for psychosis)
- Too much evidence in others (methylphenidate, TCAs, SSRIs, antipsychotics)
- Outcomes
  - Too many
  - Not shared (no meta-analysis)
  - Irrelevant

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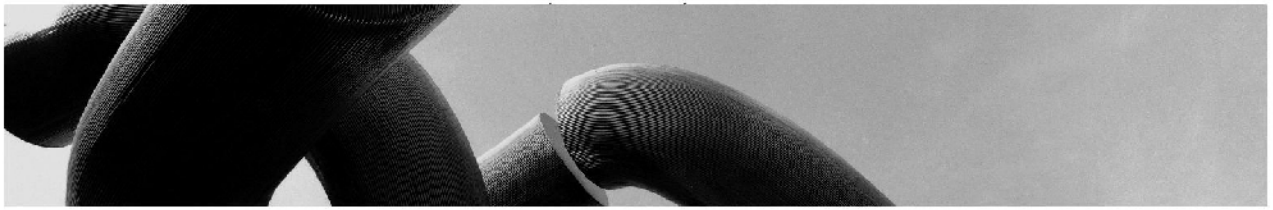

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Problems III

- Significance:
  - Statistical
  - Clinical
- Relevance
  - Outcomes (what works for whom, and how/who judges this)
  - Populations (effectiveness vs efficacy)

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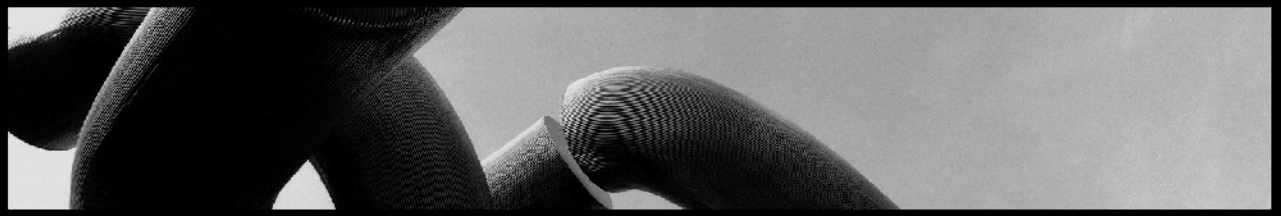

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"NICE" Personality disorder guidelines

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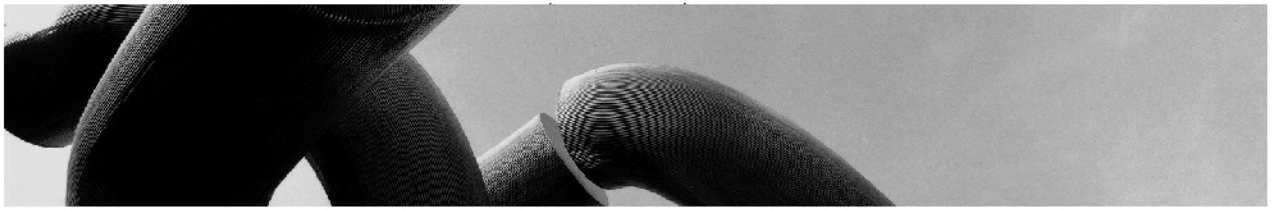

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

NICE personality guidelines

- The NCCMH is developing 2 guidelines on personality disorders which will be launched in December 2008
- **1. Borderline Personality Disorder**
- **2. Antisocial Personality Disorder**
- The centre is developing two separate personality disorder guidelines as there are marked differences between the two populations in terms of their interactions with services

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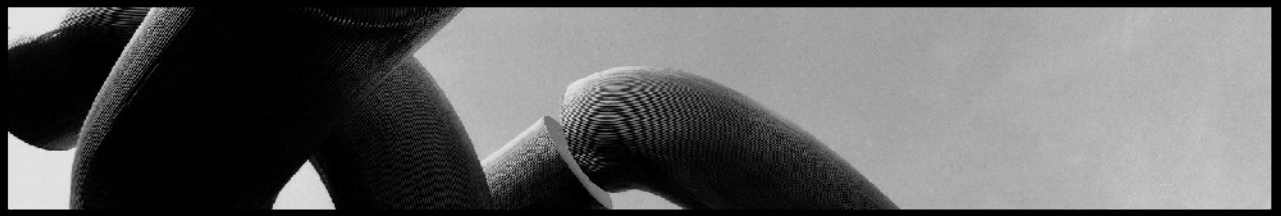

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The clinical need for personality disorder guidelines

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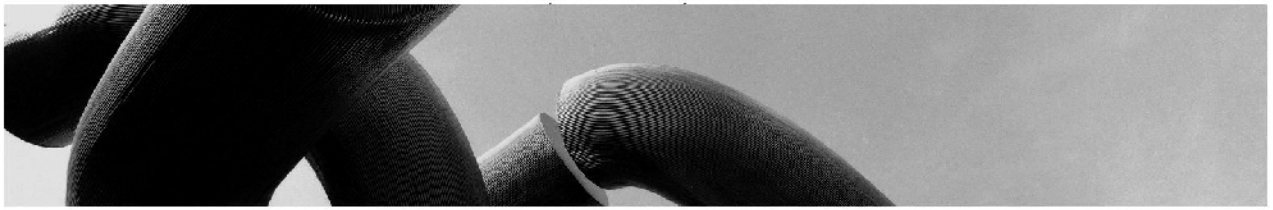

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The clinical need for BPD

- Between 0.7% and 2% in the general population; 20% of in-patients; 10 – 30% of out-patients and highly prevalent in prisons
- Seriously disabling and 1 in 10 people with BPD commit suicide
- People with BPD have frequent contact with mental health services, social services, A&E, GPs and the criminal justice system

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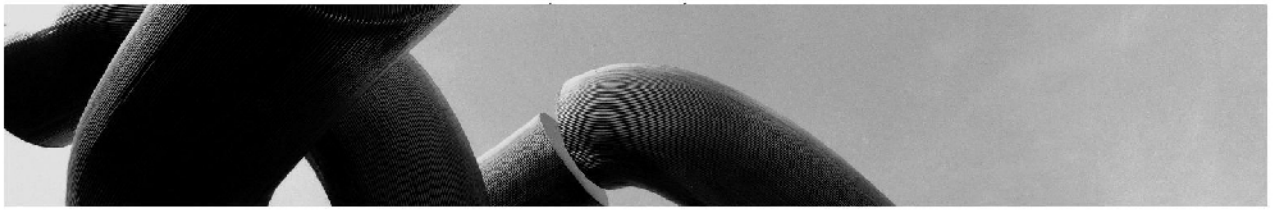

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The clinical need for ASPD

- Prevalence estimated at 0.6% in general population of Great Britain
- 64% of male sentenced prisoners and 50% of female sentenced prisoners
- Significant burden to the individual, those around them and society as a whole
- Families can endure episodes of anger, rage, depression, self-harm and ASPD is often associated with significant drug and alcohol misuse
- And, similar to BPD, people with ASPD tend to make heavy demands on many services

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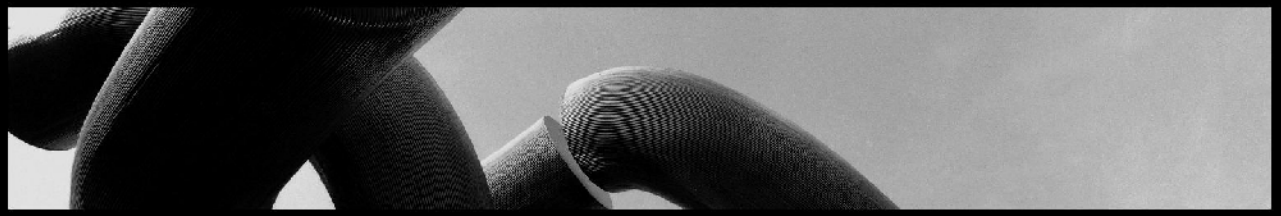

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Borderline Personality Disorder Guideline

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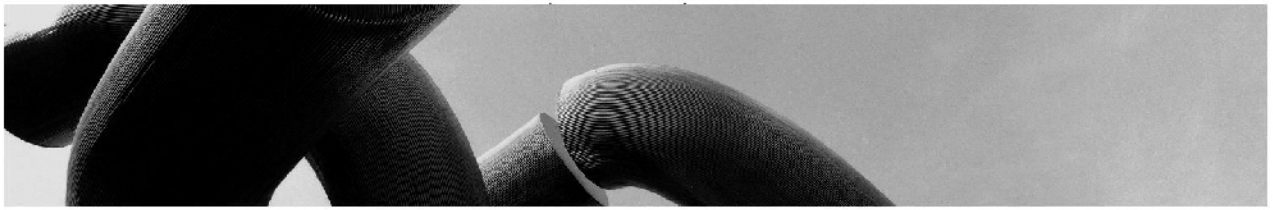

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BPD Scope

- Treatment pathways
- Psychological interventions
- Pharmacological interventions
- Complex interventions
- Therapeutic environment
- Treatment of people younger than 18 (Early interventions)
- Common co-morbidities
- People with BPD and learning disabilities
- Family and carer
- Race and culture issues

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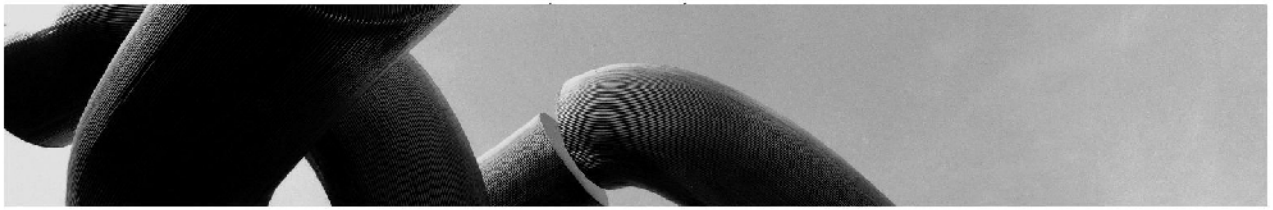

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BPD psychological interventions

Interventions	Studies
• Cognitive Analytic Therapy (CAT)	N=1
• Cognitive Behavioural Therapy (CBT)	N=1
• Dialectal Behaviour Therapy (DBT)	N=10
• Psychodynamic therapy	N=3
• Complex interventions	N=1
• Arts Therapy	N=0

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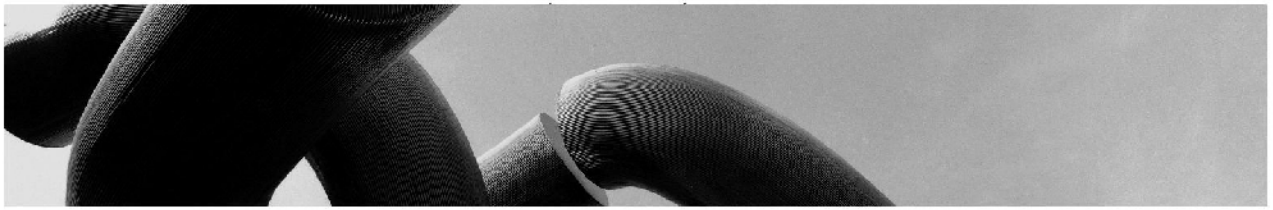

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BPD combined (pharmacological and psychological) interventions

Intervention	Studies
• Fluoxetine plus IPT	N=1
• Fluoxetine plus DBT	N=1
• Olanzapine plus DBT	N=1

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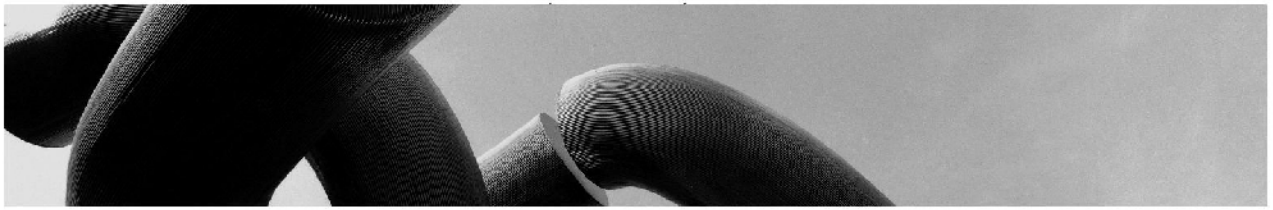

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BPD pharmacological interventions

Intervention	Studies
• Anticonvulsants and lithium	N=8
• Antipsychotics	N=7
• Antidepressants	N=3
• Omega – 3 fatty acids	N=1

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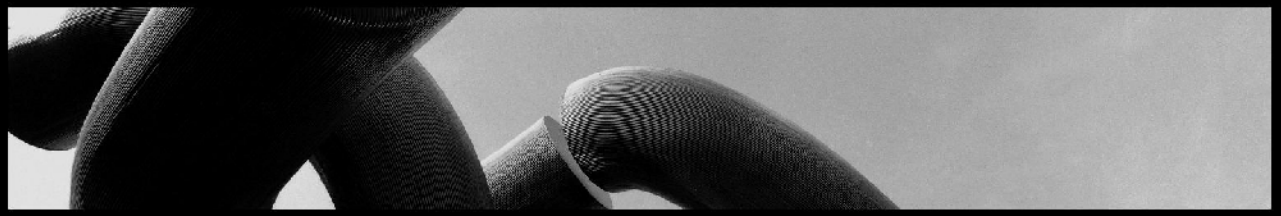

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Antisocial Personality Disorder Guideline

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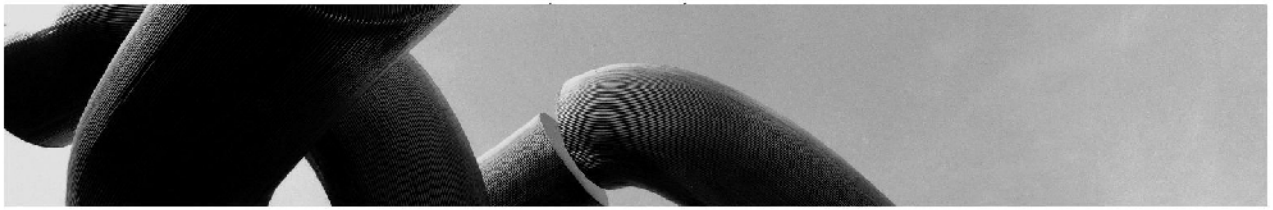

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Scope

- Threshold for intervention
- Risk factors
- Psychological and psychosocial interventions
- Pharmacological interventions
- Therapeutic environment
- Supervision of service delivery
- Race, culture and social exclusion issues
- Family and carers
- Transition from child to adult services

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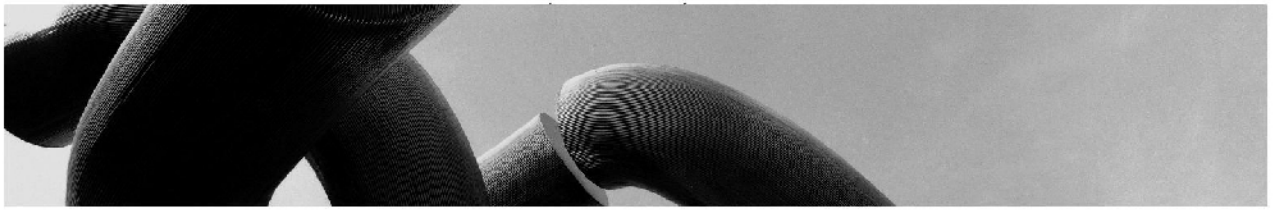

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ASPD psychological/psychosocial interventions

Interventions	Studies
• CBT	N=1
• Cognitive skills training	N=10
• Social skills training	N=1
• Practical skills training	N=4

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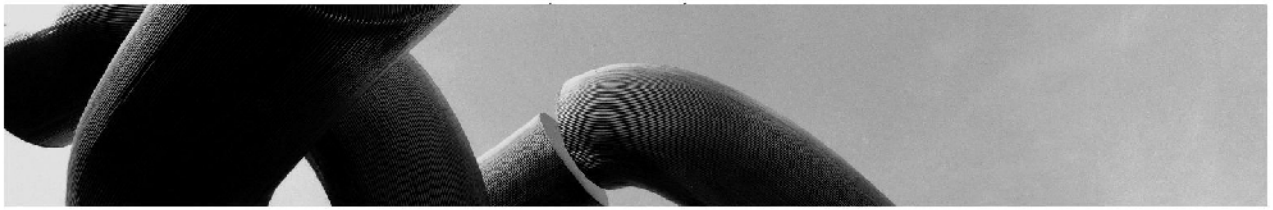

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ASPD psychological/psychosocial interventions continued

Interventions	Studies
• Criminal justice support	N=11
• Therapeutic communities	N=3
• 'Care' / organisations of care	N=8
• Other	N=2

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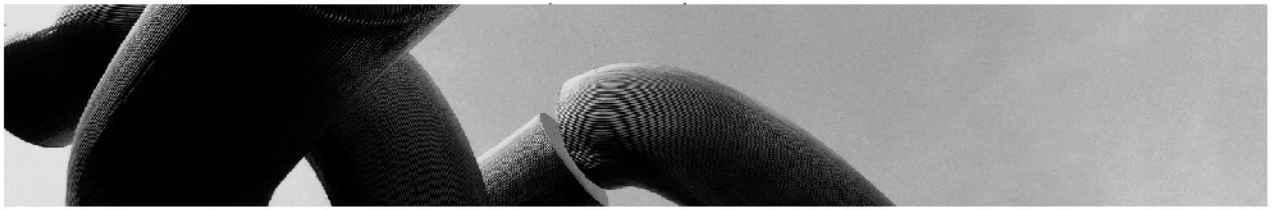

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ASPD physical interventions

Interventions	Studies
• Benzodiazepines	N=1
• Tryptophan	N=1
• Dietary	N=2

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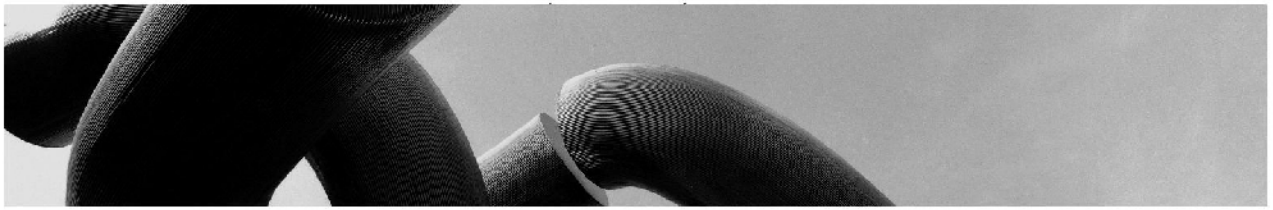

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Will NICE guidelines help people with Personality Disorders?

- Service user and carer perspective (GPPs) – care across all aspects of treatment
- Specific interventions ("should be" recommendations)
- Options ("may be considered" recommendations)
- Care pathway (realistic-optimal, not ideal)
- Service configuration (primary care mental health teams, secondary care teams, 'clinics', tertiary services)
- Case management/care programming

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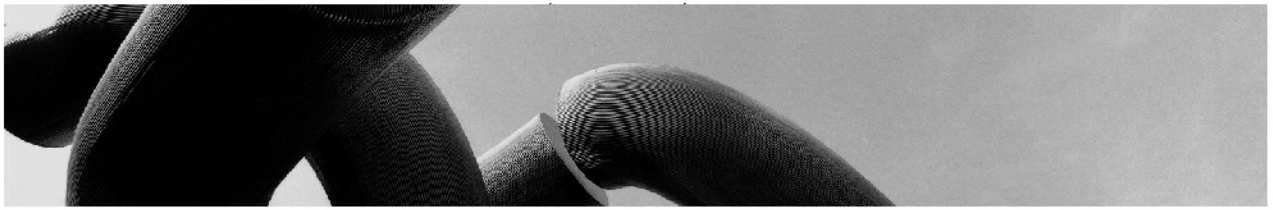

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

What are we aiming for?

- Aim for NICE to become standard treatment
- Newer treatments can then be compared to (good) standard care
- Build on standard care step wise
- Need for PD to be a routine standard part of mental health
- PD in payment by results?
- PD in the QoF?

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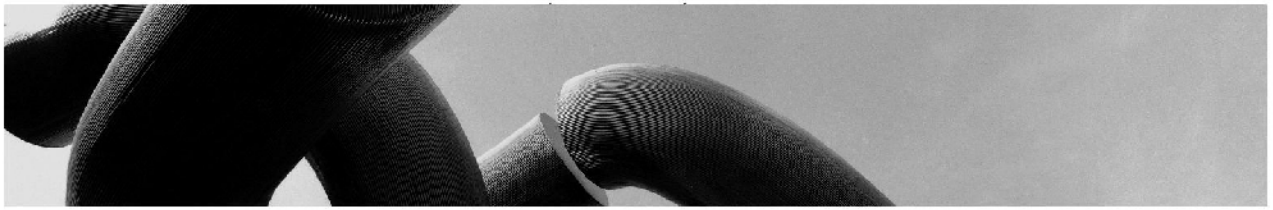

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The research base in PD research

- Rapidly rising research base for PD (especially for Borderline PD)
- Development of outcome measures has grown in parallel
- Cant easily meta-analyse or compare outcomes of different treatments
- Need to STANDARDISE outcomes

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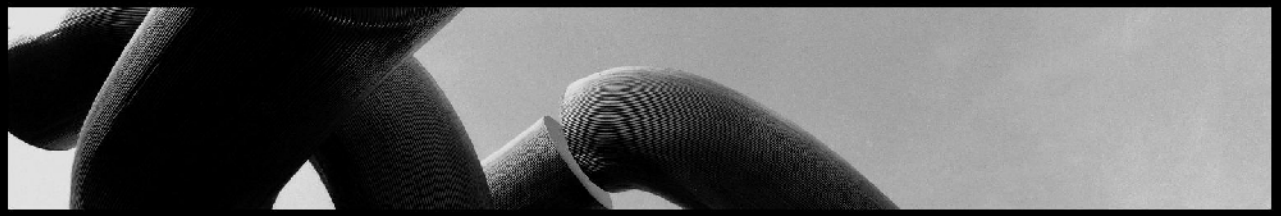

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Community of communities: questions and possible answers

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COMMUNITY OF COMMUNITIES

Meet the Man from NICE

Questions emailed to Dr Tim Kendall,

National Collaborating Centre for Mental Health,

NICE

For Community of Communities Annual Forum,

London, 28 March 2008

Questions From:

Jan Birtle

Chris Holman

David Kennard

Stephanie DuFresne

Michael Brookes

Gary Winship

Stephen Blunden

John Gale

Robin Johnson

COMMUNITY OF COMMUNITIES

Who gets appointed to Guideline Development Groups?

1 NICE process

- How do you make sure you have proper representation from all stakeholders? *(for example, senior women)*
- How can others with a particular interest get involved?
- Does it make a difference being an organisation or an individual?
- At the consultation stage, does it help to be a well-funded drug company, to have your voice heard?
- How do you prevent bias from powerful lobby groups?

COMMUNITY OF COMMUNITIES

How does NICE deal with ‘unstable diagnoses’ and ‘complex interventions’?

2 Methodological issues: complexity & uncertainty

- For example, where diagnosis is uncertain, where clinicians disagree about it, or where it changes over time? Or with comorbidity?
- How can distorting influences such as ***volition, will, intention, motivation*** and ***hope*** be controlled for in experimental studies?
- How does NICE take account of 'non-specific factors' in psychological therapies, which have been shown to be at least as important as specific methods?
- How does NICE evaluate complex systems of care? *(such as TCs, but also inpatient wards, community teams and many others)*
- Would TCs be better evaluated as a 'Health Technology?'

COMMUNITY OF COMMUNITIES

- Is it inevitable that TCs must be subject to a randomised trial to be considered evidence-based?

3 Methodological issues: experimental design

- Despite a history of unhelpful attempts at RCTs?
- And although qualitative work is preferred by many practitioners and service users? And some researchers claim that ‘the seriousness of science is compromised by RCTs’?
- Why does good qualitative research receive such low priority in NICE processes?
- How does NICE manage treatments that are adapting and changing so fast that published studies do not reflect current practice?

Is NICE too certain, and too powerful?

4 The Power and The Evidence

- Because so many people and organisations hang on to NICE's every word and phrase, does this make the guidelines an 'ultimate authority' which they were not intended to be?
- Does this 'amplification' contribute to the problem where, for example, commissioners tend judge a treatment with *no evidence* as being of *no use*?
- How can the inevitable uncertainties and imprecisions be best communicated?
- Is its systematic review process only suitable for drugs, where conditions such as dose and length of treatment are precisely controllable?

Why is it appropriate to use the technology of biological science to a social setting?

5 Social discourse

- Where social meaning is an important and seriously confounding variable?
- Where ‘subjects’ are necessarily co-authors of their own experience – and using positivistic science is ‘like using a microscope to look for ships on the horizon’?
- Is this paradigm problem not as undermining to individualistic theory as the observer effect of the uncertainty principle is in quantum mathematics?
- Is scientific truth the most important truth? What matters, and why?
- Does the quest for ‘evidence’ replace holistic forms of evidence, such as collective wisdom and memory, with atomised fragments of data - which create a permanent revolution and conditions of instability which damages children?