Mental Health in Scotland

A Guide to delivering evidence-based Psychological Therapies in Scotland

“The Matrix”
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December 2008

Overview

The Matrix is a guide to planning and delivering evidence-based Psychological Therapies within NHS Boards in Scotland.

It has been produced to help NHS Boards:

- Deliver the range, volume and quality of Psychological Therapy required for the effective treatment of common mental health problems, and the achievement of ICP accreditation;
- Provide evidence-based psychological interventions in other key government priority areas; and
- Work towards reducing waiting times for Psychological Therapies in anticipation of future ‘referral to treatment’ targets, by
  - Summarising the most up-to-date advice on evidence-based interventions;
  - Providing information and advice on strategic planning issues in the delivery of efficient and effective Psychological Therapies services;
  - Explaining the levels of training and supervision necessary for staff to deliver Psychological Therapies safely and effectively; and
  - Describing the additional support available from Government in terms of related Mental Health initiatives-the Mental Health Collaborative, QIS and the ICP process, and NHS Education for Scotland

The current document covers

- Key areas within Adult Mental Health services;
- Key areas within services for children, young people and families; and
- Some aspects of Long Term Conditions management and physical health care.

The Guidance is not intended to be prescriptive, but does offer guidance to local groups involved in the strategic planning and delivery of Psychological Therapies.

To remain current this document will be updated regularly to expand the scope of its coverage and to incorporate new evidence as this becomes available.
Introduction

The Scottish Government wants to support NHS Boards in meeting their Better Health Better Care targets in a way which best fits with local services and circumstances and will be sustainable in the long term.

The Matrix project grew out of requests from NHS Boards for advice on commissioning psychological therapies in local areas to enable them to provide the most effective available psychological treatments for their particular patient population, and to demonstrate the range and level of provision necessary to fulfil the aspirations of the Integrated Care Pathways (ICPs) and future waiting times targets.

It provides a summary of the information on the current evidence base for various therapeutic approaches, a template to aid in the identification of key gaps in service, and advice on important governance issues.

This version of the Matrix tables does not cover all conditions or mental health patient groups. We have focussed in the first instance on common mental health problems, the conditions covered by the ICPs, and other key Scottish Government priority areas.

We are particularly aware that we have not included any specific recommendations for the treatment of Older People or those with Learning Disabilities. The intention is to extend the evidence tables over time to give more comprehensive coverage, and to update the recommendations as new evidence becomes available. However, as indicated the document is not intended to be prescriptive, to replace local strategic planning processes or to stand alone. It is to be seen as guidance which will be adapted to local circumstances by local experts within the relevant strategic planning settings, such as multi-disciplinary Psychological Therapies strategic planning groups.

It is expected that Psychological Therapies will be delivered within a matched/stepped-care model of service delivery, and this document should be read in conjunction with the publications outlining the competences necessary to provide safe and effective psychological care at different tiers of the system. (See Section 3)
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**Background**

**Targets and Commitments**

The provision of effective psychological interventions at sufficient volume is essential to ensure that Boards achieve the ambitious targets the Scottish Government has set for improving mental health outcomes in Scotland.

**Targets and Commitments / HEAT**

**Target 1**  Reduce the annual rate of increase of defined daily dose per capita of anti-depressants to zero by 2009/10 and put in place the required support framework to achieve a 10% reduction in future years;

**Target 2**  Reduce suicide rate by 20% between 2002 and 2013 supported by 50% of key frontline staff in mental health and substance misuse services, primary care and accident and emergency being educated and trained in using suicide assessment tools/suicide prevention training programmes by 2010;

**Target 3**  Reduce the number of re-admissions within one year for those who have had a psychiatric hospital admission of over 7 days by 10% by the end of December 2009;

**Target 4**  Agreed improvements in the early diagnosis and management of patients with dementia by March 2011; and

**Target 5**  To deliver faster access to Child and Adolescent Mental Health services.

**Commitment 3** - We will work with GPs to ensure that new patients presenting with depression will have a formal assessment using a standardised tool, and a matched therapy appropriate to the level of need.

**Commitment 4** - We will increase the availability of evidence-based psychological therapies for all age groups in a range of settings and through a range of providers.

**Commitment 6** – NHS QIS will develop the standards for Integrated Care Pathways (ICPs) for schizophrenia, bi-polar disorder, depression, dementia and borderline personality disorder by the end of 2007. NHS Board areas will develop and implement ICPs and these will be accredited from 2008 onwards.
Child and Young People’s Mental Health Commitments

- We will implement the Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care by 2015;
- We will reduce the number of admissions of children and young people to adult beds by 50% by 2009;
- We will increase dedicated inpatient beds nationally from the current 44 to 56 beds by 2010;
- We will provide mental health training for all those working with, or caring for, looked after or accommodated children and young people by 2008;
- We will ensure that a named mental health link person is available to every school by 2008 to better inform all concerned and to help identify needs at the earliest point; and
- We will provide training for child psychotherapy through NHS Education for Scotland.

A significant increase in access to appropriate evidence-based therapies, delivered to the highest standards, within well governed and quality-assured local structures, will be essential if NHS Boards are to deliver the targets and commitments listed above.

Purpose

The purpose of this guidance is to support NHS Boards across Scotland to deliver an increase in access to effective psychological therapies by offering clear and easily accessible guidance on:

- the evidence base for the effectiveness of psychological interventions for specific patient groups; and
- how these interventions should be delivered in practice to ensure maximum impact on services.

NHS Boards will be able to assess the capacity of local services to deliver these therapies as part of their strategic planning for mental health and long term conditions.
Main Aims

- To summarise preferred options for commissioning psychological interventions for specific patient groups based on evidence of efficacy;
- Thereby guiding NHS Boards in determining which interventions they should consider providing in their area;
- To aid NHS Boards in identifying gaps in the provision of psychological therapies;
- To enable NHS Boards to develop a strategic plan for increasing local capacity to deliver Psychological Therapies;
- To provide an indication of the associated staff training requirements; and
- To provide advice on other important governance issues.

Psychological interventions will be embedded in specific models of service delivery. These may vary in the fine detail, but in general a matched/stepped care approach is assumed. It is important to bear in mind that the Standards for the delivery of Psychological Therapies within a stepped care system will be based around the competence framework developed by 'Skills for Health' (see Section 3).

Services will be expected to work towards complying with these standards.

Priority is given, in the first instance, to delivering psychological interventions to help NHS Boards move towards:

- Improving services for the common mental health problems-depression and anxiety;
- Meeting the QIS standards for ICPs and achieving accreditation of the Integrated Care Pathways; and
- Building capacity in other clinical priority areas.
In line with the strategic aims of the exercise, the document is divided into 5 sections:

**SECTION 1- Delivering Psychological Therapies -The Fundamentals**

**SECTION 2 – Service Structures and Processes**

**SECTION 3 - Training, Supervision and Governance Issues**

**SECTION 4 – Support for Change**

**SECTION 5- Key Developmental Questions for Services**

**SECTION 6 - ‘The Matrix’ - Summary of the Psychological Therapies Evidence Base**

**SECTION 1- The Delivery of Psychological Therapies -The Fundamentals**

**Values-based care and a Recovery focus**

The Scottish Government is strongly committed to ensuring values-based practice across all professions within the Mental Health services in Scotland.

Any psychotherapeutic intervention must be rooted in respect for the individual, ethical practice, service user-centred care and respecting diversity and promoting equality and must have a Recovery focus. Values-based training- developed by NHS Education for Scotland, and based on the ‘10 Essential Shared Capabilities for Mental Health Practice: Learning Materials (Scotland)’- is being rolled out for all Mental Health nursing staff as part of the programme of work arising from ‘Rights, Relationships and Recovery: A Review of Mental Health Nursing in Scotland’.

The dissemination format also creates the opportunity for team-based multi-disciplinary/agency and service user participation in the roll-out, and this approach has been highly successful in some areas.

There is an expectation that professional training for all mental health staff will demonstrate effective coverage of the learning outcomes in the 10 Essential Capabilities- Learning Materials (Scotland). This is now a requirement for pre-registration training in nursing.
The Learning Materials can be downloaded from

http://www.nes.scot.nhs.uk/mentalhealth/publications/default.asp

There has also been an increasing emphasis in Scotland on Recovery focused practice, led by the Scottish Recovery Network (SRN). The SRN, in partnership with NHS Education for Scotland, have published a framework for learning and training in Recovery focused practice, and a set of national learning materials which will help support all staff in operating from a recovery-based perspective.

These can be downloaded from

http://www.nes.scot.nhs.uk/mentalhealth/work/#recovery


Combined these materials offer all mental health workers opportunities to develop their knowledge, skills and values in ways that maximise the involvement of service users, embrace the belief that recovery is possible and facilitate new relationships between people who use services and the communities they live in.

Working with children and young people

Much of what has been said about values and a recovery focus will apply equally in work with young people. But as well as this, policy developed in this area over recent years has articulated a number of additional values and principles which are re-iterated here.

Mental health promotion for children and young people should be an underpinning principle for all who come into contact with children and young people, whether they are well or unwell.

Mental health promotion, illness prevention, treatment and care for children and young people should have the rights of children and young people as a core value. Services must recognise the right of children and young people to be heard, and their capacity to play a full part in thinking about mental health and in influencing the arrangements that we make to improve mental health.

Interventions must be designed and delivered in a way that recognises the developmental stage of the children’s lives and the social and relationship contexts in which they live. Particular attention has to be paid to the experience of, and the quality of, family and other care-giving relationships.
**What are ‘Psychological Therapies’?**

There is a recognition that the phrase ‘Psychological Therapies’ is used to describe a wide range of practices, and that there is a degree of confusion over the meaning of the term. At the higher tiers of the stepped-care system (see below), staff may be accredited to a specialist level in one of the major therapeutic approaches. Further down the pyramid they may simply be required to use circumscribed elements of any particular approach.

For the purposes of this paper, the term ‘Psychological Therapies’ refers to a range of interventions, based on psychological concepts and theory, which are designed to help people understand and make changes to their thinking, behaviour and relationships in order to relieve distress and to improve functioning. The skills and competencies required to deliver these interventions effectively are acquired through training, and maintained through clinical supervision and practice.

A range of different psychological models have been applied to mental health problems, and different ‘schools’ or modalities of therapy have grown up around these models. The modalities of therapy most commonly provided within the Health Service in Scotland are Cognitive Behavioural Therapy (CBT), Systemic and Family Therapy, Psychodynamic Psychotherapy, Inter-Personal Therapy (IPT) and Person-Centred Therapy.

There are a range of other therapies on offer, many of which are offshoots or developments from the main modalities, some of which offer an integrative approach.

Effective psychological interventions tend to share the following key characteristics:

- A clear underlying model/structure for the treatment being offered;
- A focus on current problems of relevance to the service user; and
- Recognition of the importance of a good therapeutic alliance between patient and therapist.

For any particular patient population it is possible to review the scientific evidence, based on published research trials, for the effectiveness of any particular therapy. The Matrix tables set out to summarise this evidence.

Different levels of skills and competences are required at the various tiers of patient care, and these need to be clearly articulated for each therapeutic modality to ensure that appropriate care is delivered at each stage of the patient journey. The description of these competences will inform the training agenda. (See Section 3)
Delivering Evidence-based Psychological Therapies

The concept of delivering ‘evidence-based’ interventions have a number of implications for any service. The evidence base is derived from the results of key therapeutic research trials, and to deliver an ‘evidence-based’ therapy we must be able to demonstrate that we are replicating the conditions operating within those trials as closely as possible.

In practice this means having therapists:

- trained to recognise standards, and having the competences necessary to deliver psychological interventions effectively to the tier of service within which they work;
- delivering well-articulated therapy, and adhering to the appropriate model; and
- operating within a well-governed system which offers regular high quality, model-specific clinical supervision, support and relevant CPD.

NHS Education for Scotland (NES) has been working in partnership with the UK-wide organization ‘Skills for Health’, and with NIMHE and CSIP from England, to articulate the competences necessary both to deliver Psychological Therapies, and to supervise others who are in training or delivering within the service (see Section 3).

It is important to bear in mind that the standards for the delivery and supervision of Psychological Therapies within a stepped-care system will be based around these competences, and services will be expected to work towards complying with these standards to demonstrate that they are providing evidence-base care. All NHS Boards are currently being encouraged to review their service provision, staff training and supervision arrangements in the light of these developments.

The Key Role of Clinical Supervision

It is important to distinguish between traditional work-related supervision, which may cover a range of managerial and related issues, and the term ‘Clinical Supervision’ as used in relation to Psychological Therapies.

Clinical supervision is essential to the delivery of Psychological Therapies services, both during training and to ensure the ongoing safety and quality of subsequent practice. It is a requirement of all professional bodies accrediting psychological therapists.

Clinical Supervision:

- Ensures that the supervisee practices in a manner which conforms to ethical and professional standards;
• Promotes fidelity to the evidence base (The therapeutic trials from which the evidence base is derived routinely insist on close supervision of individual cases and outcomes);
• Ensures adherence to the therapeutic model;
• Provides support and advice in dealing with individual cases where the therapy may be stuck, or where there are elements of risk; and
• Acts as a vehicle for training and skills development in practice.

In order to deliver safe and effective Psychological Therapies, NHS Boards will have to ensure that there are enough adequately trained psychological therapies supervisors within the system, and the capacity for regular supervision of both trainees and practising staff.

**Matched/Stepped-care models of service delivery**

Stepped care is a tiered approach to service provision, best described as pyramidal in structure, with high-volume low intensity interventions being provided at the base of the pyramid to service users with the least severe difficulties.

Subsequent ‘steps’ are usually defined by increasing levels of case complexity, and increasingly intensive forms of treatment. In ‘matched’ stepped-care models, there is a system for matching the appropriate level of treatment to the level of complexity of the service user’s problem, and the service user receives the minimum input compatible with effective treatment.

In providing treatment to any service user population presenting with problems spanning a spectrum of severity, evidence suggests that a matched/stepped care model is the best way to make use of limited resources.

The tiered approach to delivering mental health services in Scotland is laid out in the Framework for Mental Health Services (1997), and in the CAMH SNAP report (2003). Historically, however, a variety of stepped-care models have been developed to deliver Psychological Therapies, with different definitions of the steps and of the skills needed at each level. Some are described in terms of the severity of problem and it’s impact on functioning, some in terms of the level of expertise of professional involved, some in terms of the nature or of the service delivered in that tier, or the likely duration of input etc.

However, most service-level based PT models would have levels of service delivery corresponding to:

• Information

  This is generally accessed directly, does not involve one-to-one contact with mental health staff, and does not require GP referral. Would include information available on
mental health issues in general, on common mental health problems, and on different treatment approaches.

It would include information leaflets available through GPs surgeries or other health and social care agencies. It may also cover library/reading schemes, large-scale psycho-educational groups, and direction to high quality Psychological Therapy websites.

- ‘Low Intensity’ interventions

Most commonly accessed through GPs, would cover Doing Well Advisors/Self-Help Coaching, solution-focused problem solving, supported self-help, structured anxiety management groups etc.

Aimed at transient or mild mental health problems with limited effect on functioning, time-limited and normally lasting between 2-6 sessions.

- ‘High Intensity’ interventions

Secondary care based. Standardised psychological therapies-CBT, IPT etc, delivered to protocol.

Aimed at common mental health problems with significant effect on functioning, and normally lasting between 6 and 16 sessions.

- Specialist Interventions

Most commonly accessed through secondary care and specialist services. Standardised high intensity psychological therapies developed and modified for specific patient groups.

Aimed at moderate/severe mental health problems with significant effect on functioning e.g. substance misuse, eating disorders, bi-polar disorder and normally lasting between 10 and 20 sessions.

- Highly Specialist Interventions

Highly specialist, individually tailored interventions based on case formulations drawn from a range of psychological models.
Accessed through secondary, tertiary and specialist services. Aimed at service users with highly complex and/or enduring problems, and normally lasting 16 sessions and above.

It is expected that a range of evidence-based therapeutic approaches would be available within each ‘step’—particularly at the lower levels—as it is recognised that no one therapeutic modality produces significant change for all patients.

The outcomes from well-designed research trials would predict a response rate of around 60% for most evidence-based therapies, leaving 40% of patients who may well respond better to an alternative evidence-based approach. The aim would be to try to match patients with the treatment which is most likely to be effective, and considerations of patient preference are important here.

Users and carers should be informed of the available options, and fully engaged in the process of decision making around their care.

There are also significant numbers of service users experiencing more than one problem, often with very complex presentations, who do not fit neatly into traditional diagnostic categories. It is important that a range of therapeutic approaches are available for this group, and there is evidence that experienced and highly skilled therapists able to work flexibly using a range of models are more successful in engaging these patients in psychological therapy.

The full range of ‘steps’ are required within any Psychological Therapies service, although the proportions of care delivered within each step may vary according to the context. Careful thought need to be given to this aspect of service design in order to balance the availability of care at each level with the aspiration to maximise access to the service as a whole.

SECTION 2 – Service Structures and Processes

It is recognised that there is a considerable gap in most areas between what is currently available and the level of service required to meet the aspirations of the Scottish Government.

Where there is such a discrepancy, up-skilling of staff alone will not be enough to produce the necessary increase in capacity. Organisational change and service re-design will be essential, and some re-configuration of resources may well be necessary.

One of the functions of the Mental Health Collaborative will be to facilitate such change. (See Section 4 below).
In relation to mental health services for children and young people, alongside training and re-design, the SGHD now recognises that, in many NHS Boards, CAMHS staffing levels will have to increase to bridge this discrepancy.

**Strategic**

At a strategic level it is expected that there will be direct accountability for Psychological Therapies at NHS Board level, which will ensure meaningful engagement with the local Psychological Therapies strategic planning mechanisms, facilitating negotiation around service re-design and the allocation of resource.

An appropriate mechanism—for example a local multi-professional and multi-agency psychological therapies management group—comprised of senior clinicians and managers—will exist for Psychological Therapies planning across a NHS Board area. This group should have formal links with local service users and carers to ensure meaningful engagement in the planning process.

The remit of this grouping should include:

- Planning the sustainable development of the Psychological Therapy services to meet published targets and commitments, and in line with Scottish Government priorities;
- Auditing availability of appropriately trained Psychological Therapy practitioners and supervisors;
- Prioritising and commissioning training based on service need, available evidence of effectiveness of treatment approaches for particular service user groups, cost-effectiveness and issues of equity and accessibility;
- Facilitating and contributing to local service re-design to support the implementation of the strategic plan;
- Putting in place appropriate governance to ensure safe service delivery, including ensuring necessary clinical supervision and CPD both for those in training and those practicing in the service;
- Promoting service-based research and audit to advance the evidence base and audit effectiveness of local delivery models, including appropriate activity and outcome measures. This includes acting to alter systems based on the result of audit exercises; and
- Facilitating the implementation of properly funded research trials to evaluate new and innovative therapeutic approaches.

**Service Delivery**

The expectation is that a matched/stepped-care model will be adopted as the most cost-effective way of delivering the service.
To ensure sustainability of this approach, and maximum service impact:

- Services will be designed based on consultation with all stakeholders, including service users and carers;
- There will be investment at system level to foster change. Engaging with the Mental Health Collaborative would be one way of achieving this;
- Appropriate training will be provided to enable staff to deliver psychological care and therapy at each tier of the service;
- There will be an educational infrastructure to support training and supervision;
- The service will be structured in such a way as to support and enable trained staff to deliver PTs safely and effectively;
- Staff will have protected time in which to make use of their skills; and
- There will be access to, and protected time for, regular supervision and CPD appropriate to level of service delivery.

Good access to the service depends on well-defined care pathways to psychological therapy, on the effective functioning of all tiers of the service, and on efficient communication between tiers.

To operate matched/stepped care systems effectively, to design appropriate training for staff, and to ensure sustainability in the long-term, it is essential to have:

- Clarity about the most effective way of describing the various ‘steps’ or tiers;
- Clearly defined inclusion criteria for each ‘step’, well-defined pathways from one step to the next, and good communication between different tiers of the service;
- Clear patient pathways based on explicit mechanisms for allocation to particular therapies or tiers of the service, taking into account issues of patient preference;
- Robust measures of complexity for allocating service users to levels of the system;
- Routine collection of valid and reliable outcome measures both to determine the appropriate pathway for individual service users and to monitor the effectiveness of the service;
- Clear understanding of the knowledge and competencies necessary for staff to operate safely and effectively at each tier of the system; and
- Well-defined career pathways for staff.

The aim is to match the level of intervention as far as possible to the level of service user need, taking into account such factors as problem severity, chronicity, history of previous treatments and service user’s preference.

Regular review of service user’s progress should be built into the system to compensate for any shortcomings in the assessment and allocation process, so that individuals requiring a higher level of intervention, are ‘stepped-up’ speedily and efficiently. To facilitate this process health and social outcomes should be routinely and regularly recorded.
Local matched/stepped-care models should be designed to maximize the capacity of the system, and to make best use of available expertise and resources. The Mental Health Collaborative will be offering NHS Boards support in systems change methodology to support any necessary re-design (see Section 4). The design of matched/stepped-care models in local areas should also be linked to the emerging ICPs.

To increase access we must look across all tiers, and focus training efforts and resources where they will have maximum impact on the service user experience.

**Services for children and young people**

In addition to the above, there are some additional considerations necessary when designing systems for delivering stepped care interventions for children and young people:

- Recognition of the relationship between contextual factors, such as family relationships, and the effectiveness of psychological therapies for children and young people;
- Clear arrangements to ensure that these contextual factors are identified during assessment; and
- Attention to the steps (such as concomitant family work, parent training, sibling group work) which are necessary to achieve and sustain a robust and supportive context for the young person engaging in psychological therapy.

Safe and effective service delivery also requires to be underpinned by appropriate governance and educational infrastructure in the service.

**SECTION 3 – Training, Supervision and Governance**

Training and skills development are key to the Psychological Therapies strategy outlined previously, which is based on increasing the capacity of the current workforce to deliver effective interventions at the required volume.

However, there are a number of training issues which need to be addressed before we can have confidence that we are operating within a safe and sustainable system.

Until recently we have not had any recognized national qualifications or training standards specifically for Psychological Therapies which map clearly onto the levels of psychological intervention required at different levels of matched/stepped care systems.

Nor have we had clarity around what skills are required by those providing the clinical supervision necessary to guarantee safe practice. This has made it difficult for service managers to plan training for staff within services and to ensure the educational and clinical governance of systems.
With this in mind, NHS Education for Scotland, which has a role in setting the standards for training within the NHS, has been working in partnership with ‘Skills for Health’ (the Sector Skills Council for the UK Health Sector) and partners in England to articulate the competences necessary to deliver Psychological Therapies safely and effectively.

Three Competence Frameworks have already been produced:

- Cognitive and Behavioural Therapy for Depression and Anxiety (which differentiates between the competences needed at the ‘Low Intensity’ and ‘High Intensity’ levels within stepped care);
- Psychoanalytic / Psychodynamic Competences; and
- Supervision Competences.

These can be accessed at

www.ucl.ac.uk/clinical-psychology/CORE/competence-frameworks.htm

Further competence frameworks covering Systemic and Family Therapy and Humanistic Therapy are on course for publication on the same website shortly.

**Matched/Stepped Care and Levels of Training**

In this section an attempt is made to describe the levels of training needed to operate effectively at different tiers of the stepped care system, and to illustrate this by highlighting some examples. It is in no way intended to be an exhaustive overview of the training available across the country.

**Values Base and Recovery Focus**

It is assumed throughout this section that all staff working in adult mental health services are operating from the values base as described in the 10 Essential Shared Capabilities, and have a strong Recovery focus. (See Section 1).

It is also assumed that all staff working in child and adolescent mental health services are operating from the values base set out in the national policy document *Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care* (2005).
Psychological Awareness/Basic Psychological Literacy

In addition to the training in values based care and Recovery, all mental health staff should have a basic level of psychological ‘awareness’ and ‘literacy’. This should include:

- training in a basic psychological model to run in tandem with the medical model, and within which they can construct a basic psychological formulation of service user’s problems;
- training in listening and communication skills;
- training in basic counseling skills; and
- training in self-awareness and the role of the therapeutic relationship.

For staff working in CAMHS this should also include:

- training in a developmental approach which equips them to understand the developmental stages of childhood, adolescence and the family life-cycle; and
- training in the key elements of systemic thinking, such that they can understand:
  - the importance of, and likely significance of, family relationships in relation to mental health problems;
  - the importance and potential impact of other contextual factors on the lives of children; and
  - the need to attend to these contextual factors when designing any psychological therapy intervention.

The aim is that this will now be covered in professional pre-registration training. (see Section 1), but some consideration needs to be given within NHS Boards as to whether there is a need for locally based CPD for current staff around knowledge and skills in this area.

Psychological Therapy

The category of interventions which would fall under the rubric of Psychological Therapy can be subdivided into:

- ‘Low Intensity’ therapy;
- ‘High Intensity’ therapy;
- ‘Specialist’ therapy; and
- ‘Highly Specialist’ therapy.

The mapping of competences and levels of training against the tiers of the stepped-care system is currently best articulated for the Cognitive-Behavioural Therapies in the context of common mental health problems, and the model described below focuses primarily on this area.
However, NES and the Scottish Government are supporting the development of stepped-care approaches for a range of conditions and incorporating a range of therapeutic modalities, and further guidance will be incorporated as it becomes available.

The principles of the stepped-care approach can be applied to different patient groups, and different therapeutic modalities. Within the Matrix evidence tables, evidence-based treatments are labeled as ‘Low’ or ‘High’ intensity.
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<th>Treatment delivered</th>
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<th>Examples in Scotland</th>
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<td>Low Intensity</td>
<td>Patient Group: Common Mental Health Problems – Stress/Anxiety/Depression Severity: Mild/moderate, with limited effect on functioning</td>
<td>Supported self-help, solution-focused problem solving, structured anxiety management groups, self-help coaching.</td>
<td>Minimum training required: generally 5-10 day training plus intensive, ongoing clinical supervision Level of competence: must meet the ‘Skills for Health’ ‘Low Intensity’ competences</td>
<td>-SPIRIT training as developed and delivered by Chris Williams and his team at Glasgow University -Dumfries and Galloway training for ‘Self-Help Coaches’; -Borders training for ‘Doing Well Advisors’; -‘Certificate’ level training on the Dundee and South of Scotland CBT courses (60 ‘scotcat’ points)</td>
</tr>
<tr>
<td>High Intensity</td>
<td>Patient Group: Common Mental Health Problems Severity: Moderate/severe with significant effect on functioning.</td>
<td>Standardised psychological therapies – delivered to protocol and normally lasting between 6 and 16 sessions</td>
<td>Training required: Diploma level Normally at least 24 days formal teaching, 24 days of CBT in the workplace, plus intensive supervision over at least 1 year of training. Level of competence: must meet the ‘Skills for Health’ ‘High Intensity’ competences</td>
<td>-South of Scotland CBT Course: Diploma Level Training -Dundee CBT course: Diploma Level Training (120 ‘scotcat’ points) -Clinical Associate in Applied Psychology MSc training -Doctoral level Clinical and Counselling Psychology training.</td>
</tr>
<tr>
<td>High Intensity - Specialist</td>
<td>Patient Group: Moderate/Severe mental</td>
<td>Standardised psychological therapy,</td>
<td>Training required: Diploma level CBT</td>
<td>Dundee CBT Course Masters level options</td>
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<td>Level of Therapy</td>
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<td></td>
<td>health problems with significant effect on functioning-Specialist areas E.g.: Schizophrenia, Personality Disorder, Bipolar Disorder, Eating Disorders, Substance Misuse etc Severity: Moderate/Severe with significant effect on functioning</td>
<td>developed and modified for specific patient groups. 16 to 20 sessions.</td>
<td>training, plus further training in application of CBT techniques to specialist area. Further knowledge and skills may be acquired through formal training or through specialist supervision. Level of competence: must meet the ‘Skills for Health’ ‘High Intensity’ competences</td>
<td>in Trauma, Chronic Anxiety/OCD etc South of Scotland CBT Course Masters level options in Personality Disorder, Eating Disorder etc Diploma level CBT training plus supervised placement in specialist service Clinical Associate in Applied Psychology MSc training plus supervised placement in specialist service</td>
</tr>
<tr>
<td>Highly Specialist</td>
<td>Patient Group: Complex, enduring mental health problems with a high likelihood of co-morbidity, and beyond the scope of standardized treatments. Severity: Highly Complex</td>
<td>High specialist, individually tailored, interventions, drawing creatively on the theoretical knowledge base of the discipline of psychology. Normally lasting 16 sessions and above.</td>
<td>Competences: Specialist knowledge of a range of theoretical and therapeutic models Ability to formulate complex problems using a range of psychological models, taking into account historical, developmental, systemic and neuropsychological processes.</td>
<td>Doctoral level Clinical Psychology or Counselling Psychology Training. Individual clinicians with a highly developed special interest, normally including involvement in research, and identified by colleagues as having the requisite knowledge and skills.</td>
</tr>
</tbody>
</table>
Notes:

1) Some training at the ‘Low Intensity’ level is available centrally (e.g. SPIRIT training and training provided by the CBT courses), but it is anticipated that much will be commissioned and delivered locally.

It is important that local training schemes are structured around the relevant Skills for Health competences, and that those delivering the training have the appropriate level of expertise.

In the light of the expected recommendations of the SGHD Applied Psychology Review, it is expected that NHS Boards will look to local Psychology Departments, working in partnership with Nurse Consultants and other local specialist services such as Psychotherapy Departments, to develop, deliver and quality assure such training in the first instance.

NES is developing a ‘toolkit’ to support NHS Boards in the commissioning of education and training locally:-

‘NES Planning for Education Learning and Development Toolkit; Testing for the Best in Educational Solutions’

Available December 2008.

2) It is recognised that the outline above does not adequately reflect the complexity of the delivery of Psychological Therapies within the service.

Staff may, for example, be involved in the delivery of a specific ‘low intensity’ intervention to patients with complex problems-for example an Occupational Therapist delivering a structured, time limited anxiety management group within an inpatient setting. Good governance would demand that all the relevant factors be taken into consideration.

3) As above, matched/stepped care approaches are not exclusive to Cognitive Behavioral Therapy or Adult Mental Health, and there are, for example, a number of levels of intervention based on Psychodynamic Psychotherapy which would fit well with this approach.

Consultant Psychotherapists would function both at ‘high intensity’ and ‘highly specialist’ tiers, and a number of local training initiatives seek to equip staff with knowledge and skills which would fit at a ‘low intensity’ level. NHS Education for Scotland is supporting the scoping of currently available psychodynamic training with a view to articulating a matched/stepped care approach within this modality, structured around the ‘Skills for Health’ Psychoanalytic/Psychodynamic competence framework.
Supervision

There is a particular knowledge and skills set necessary for the delivery of good quality supervision, and being a competent therapist does not in itself equip a practitioner to be a competent supervisor.

As stated earlier, Skills for Health have developed a set of supervision competences, and NES is leading work in Scotland to produce a training curriculum for the supervision of psychological therapies. It is intended that this will be rolled out using ‘training for trainers’ model, starting in 2009/10.

The aspiration is that anyone delivering clinical supervision within a Psychological Therapies service will:

- be a qualified psychological therapist with a working knowledge and experience of the interventions in which they are providing supervision;

and

- have training which equips them with the ‘Skills for Health’ supervision competences.

Staff delivering Psychological Therapies should receive regular supervision, in line with existing guidelines for the particular therapeutic modality. This supervision should address all ongoing clinical cases. If supervision takes place in a group format, the time devoted to it should be appropriately extended.

SECTION 4 – Support for Changes

There are a number of Scottish Government initiatives which have been put in place to support NHS Boards in the delivery of efficient and effective Mental Health services, and which include Psychological Therapies within their remit.

Every effort has been made to promote coherent strategic planning by ensuring that these initiatives are aligned at national level, and that the various elements dovetail to provide NHS Boards with complementary advice within a clear direction of travel.
NHS Education for Scotland

Current NES activity includes:

- As detailed in earlier sections, working with ‘Skills for Health’ to produce Competence Frameworks which will set standards for staff training and performance in both psychological therapies and clinical supervision;

- Working with current training providers (including CBT, Psychodynamic Psychotherapy, Mindfulness-based Cognitive Therapy etc) to re-structure Psychological Therapies training based on the competence frameworks and future service needs;

- Supporting the training of trainers and supervisors in a number of therapeutic approaches recommended in the Matrix-e.g. CBT, Behavioural Family Therapy (BFT), Mindfulness-based Cognitive Therapy and Mentalisation Based Therapy (MBT);

- Taking forward the actions from Rights, Relationships and Recovery—the report of the National Review of Mental Health nursing in Scotland. These include rolling out the 10 ESC and Recovery Training (as detailed in Section 1-Values-based Care), and progressing the role of the Mental Health Nurse in delivering psychosocial interventions and psychological therapies; and

- Supporting the development of the educational infrastructure necessary to support training and supervision in local areas by funding Psychological Therapies Training Co-ordinators (PTTC) posts in each NHS Board.

PTTC posts

The role of the Psychological Therapies Training Co-ordinator is to support the territorial NHS Boards in meeting their commitment to increase access to evidence-based Psychological Therapies by increasing the capacity within the current workforce to deliver Psychological Therapies and supporting service change to ensure that the available resource is used most effectively in practice.

Although detail varies according to local circumstances their functions may include:

- Working with Psychological Therapies strategic planning groups to support the increase in access to psychological therapies;
- Working with staff/services to redesign roles to enable additional capacity for the delivery of psychological therapies;
- Scoping the training currently available within the service and identifying future needs;
- Advising on and organising the appropriate evidence-based training taking into account quality, cost, timing, and reliability
- Ensuring that those selected for training have protected time to deliver Psychological Therapies within their service post; and
- Establishing clinical supervision structures to ensure safe and effective practice.

*What NES will be doing to ensure that the broader range of evidence-based interventions outlined in the Matrix are available within the service:*

- Working in partnership with Scottish Government and NHS Boards to help build equitable and accessible Psychological Therapies services across Scotland;
- Supporting sustainable training in the evidence-based interventions required to allow NHS Boards to accredit the ICPs and deliver Psychological Therapies in other key Scottish Government priority areas, within the available resources; and
- Producing an Educational and Development ‘Toolkit’ to aid NHS Boards in commissioning education and training locally (see section 3).

**QIS and the ICP Process**

The integrated care pathway (ICP) standards for mental health developed by Quality Improvement Scotland (QIS) represent an ongoing commitment to improve the quality of treatment and outcomes for service users and their informal carers.

An ICP is a way of comparing planned care with the actual care a patient receives. The ICPs determine locally agreed, multi-disciplinary practice based on guidelines and evidence, where available, for the treatment of a specific patient group. This might include advice on appropriate pathways through which patients can access the care they need at the time they need it, and the kind of care that should be available.

ICPs focus on achieving agreed outcomes for individual users of the service, working towards their recovery. They document the care given, and record any variations from best practice, thereby identifying gaps in the care of the individual, and in the service as a whole. Analysis of these variations from best practice is the most important part of using ICPs and helps to develop a culture of continuous quality improvement.

As directed by the Scottish Government NHS QIS has developed national standards for ICPs for:

- Schizophrenia;
- Bi-polar disorder;
- Dementia;
- Depression; and
- Personality Disorder.
NHS Boards are currently developing local ICPs based on the national standards for these conditions.

Development and implementation of the local ICPs to meet the standards will be accredited by NHS QIS, who are committed to an accreditation model which is proportionate, that recognises good work completed ‘on the road to full accreditation’, and that compliments other national initiatives and priorities to support Boards in achievement of the HEAT targets.

To support NHS Boards in taking this work forward, NHS QIS have put in place national ICP co-ordinators and link co-ordinators at regional level. An online ICP toolkit is also available, and continues to be updated, with the aim of sharing good practice and providing additional useful links and resources.

The ICPs themselves have four main elements:

- Process standards, which describe the key tasks which affect how well ICPs are developed in a local area;
- Generic care standards, which describe the interactions and interventions that must be offered to all people who access mental health services;
- Condition-specific care standards, which will build on the generic care standards and describe the interactions and interventions that must be offered by mental health services to people with a specific condition; and
- Service improvement standards which measure how the ICPs are implemented and how variations from planned care are recorded and acted upon.

Of particular relevance in the context of Psychological Therapies is Standard 15 of the Generic Care Standards:

‘The need for structured psychological and/or psychosocial intervention for the service user is assessed’

The Standard sets a number of criteria, which echo many of the recommendations in the Matrix:

- That Psychological Therapies are delivered by appropriately trained and accredited staff under practice supervision;
- that assessed need for psychological and/or psychosocial interventions is recorded;
Where needs have been identified, that there is a record that the service user has been offered a range of therapies, including educational, social and lifestyle advice as well as psychological and/or psychosocial therapies; and

- That there are systems for the provision of psychological and/or psychosocial therapies including;
  - delivery within 3 months of referral;
  - review of individual service user progress; and
  - recording of outcome.

In addition to Generic Standard 15 there is more prescriptive guidance within the condition-specific care Standards around the availability of particular psychological interventions for specific patient groups.

The Matrix evidence tables supplement this guidance by summarising the evidence base and recommended therapeutic approaches for the ICP diagnostic categories, and providing information and advice on strategic planning issues and training and supervision considerations in the delivery of efficient and effective Psychological Therapies services.

The Mental Health Collaborative

The overall aim of the Mental Health Collaborative is to support NHS Boards to deliver against identified mental health HEAT targets and commitments. Clearly in this context the focus is on the potential contribution of the Collaborative to increasing access to Psychological Therapies.

Increasing access is not only about training increased numbers of staff to deliver high quality care, it is also about delivering this care in the most efficient way possible in order to produce the maximum impact within the resource available.

The processes and systems employed in the delivery of care are key determinants of the capacity of any service, and it is recognised that many of the capacity problems in healthcare are systems-related. Thorough and methodical study of the processes of care, and careful and sensitive re-design, have the potential to increase that capacity. Further, how services are designed impacts on the levels of actual demand. The Mental Health Collaborative will equip services to better understand their local demand and generate alternative ways of handling it.

Whereas the Matrix presents the evidence base for the effectiveness of treatments, the Mental Health Collaborative can be seen as supporting Boards in applying a different evidence base - the evidence base in relation to systems improvement methodology. This will aid NHS Boards in designing efficient and effective processes and systems.
With reference to Psychological Therapies the objectives of the Collaborative are:

- To identify where the use of improvement methodologies and techniques would lead to improved performance, and to then work with NHS Boards and key partners to ensure effective application;
- To enable NHS Boards to use information effectively to support improvement;
- To develop a culture of NHS Boards sharing information and knowledge about what works and what doesn’t for improving Psychological Therapies services; and
- To support the development of a culture of continuous improvement across Psychological Therapies services in Scotland.

The Collaborative has allocated programme funding to every NHS Board in Scotland over three years to provide them with dedicated time and expertise to set up their local ‘systems improvement’ teams.

The aim is to create a culture of continuous improvement across Scotland’s Mental Health services. It is providing training in evidence-based improvement methodology to staff at a number of levels. This training, together with hands on support from the National Team, will promote widespread understanding of the approach and techniques involved, and equip staff to participate in local service re-design initiatives.

Where services are not currently delivering the volume of therapy necessary to meet the demand, it is important that the systems and processes are examined and improved where possible. It is only once efficient processes are in place that maximum benefit will be gained from increased investment in either staff training or additional posts.

It is anticipated that any examination of systems and processes will also suggest potential changes in roles or functions which will in turn highlight a range of staff development needs, so it is important that the work of the Collaborative is linked in to the local planning structures for delivering training in psychological interventions and therapies.

The Mental Health Collaborative has commissioned a specific piece of work to develop guidelines on how to maximise the use of current psychological therapies capacity – drawing on both service improvement theory around causes of waiting lists but also practical examples of work already undertaken across a number of NHS Boards to reduce waiting times in psychological therapies. It anticipates this will be completed by Spring 2009.
SECTION 5 - Key Developmental Questions for Services

The Matrix tables, taken together with the advice on service structure and governance set out in the earlier sections of this document, form a template against which service planners in Boards can map their current services.

The key questions for any service would fall into two main categories:

- Process questions; and
- Service availability questions.

Process Questions

- Is there a mechanism whereby information on the progress in increasing access to psychological therapies can be fed back at NHS Board level?

- Is there a multi-disciplinary, multi-agency Psychological Therapies strategic planning group with the authority and remit as described in Section 2?

- In order to ensure the sustainability of a matched/stepped-care approach, and maximum service impact:
  - Is there a mechanism for involving service users, carers and other key stakeholders in service re-design?
  - Will there be investment at system level to foster change? Have links been made with the Mental Health Collaborative to engage them in the process?
  - Is there a process for determining what training will be necessary to enable staff to deliver psychological care and therapy at each tier of the service?
  - Is there an educational infrastructure to support training?
  - Will the re-designed services be structured in such a way as to support and enable trained staff to deliver PTs safely and effectively?
  - Do staff have protected time in which to make use of their skills?
  - Is there access to, and protected time for, regular supervision and CPD appropriate to level of service delivery?
  - Is there routine monitoring of outcomes using reliable and validated outcome measures?
Service Availability Questions

For any patient group/ diagnostic category

- What is the potential patient population in the locality?
- What percentage of potential patients is accessing service?
- What services are currently available?
  - Location
  - Organisational structure
  - Therapeutic Modality
  - Treatment Outcomes.
  - Capacity – How much therapy being delivered?
  - Throughput
  - Waiting Times
  - Cost effectiveness.
- How many staff are trained at different levels?
  - Low Intensity
  - High Intensity
  - High Intensity-specialist
  - Highly Specialist.
- What are supervision and governance arrangements?
  - How many trained supervisors
  - Amount of supervision delivered.

For the overall service

- What are the gaps in service?

- What are the priorities for development?

- How will increased access be demonstrated?

When thinking about access to psychological therapies it is important to bear in mind that access is not simply a function of availability or service capacity. We know that there are groups within the community who do not access services in proportion to the level of mental health problems and distress they experience.

There are issues around social deprivation, life circumstances, ethnicity, gender and age which influence people’s decision as to whether or not to make contact with the services available.

It is not acceptable simply to set up services and expect that they will be equally acceptable to and accessible by all. The onus is on NHS Boards to identify groups which are having difficulty engaging with services as currently configured, and support innovative approaches to deliver care which are acceptable and accessible by the target groups.
SECTION 6- ‘The Matrix’ Summary of the Psychological Therapies Evidence Base:

The development of ‘The Matrix’

The Matrix is intended to provide a summary of the information on the evidence base for the effectiveness of particular Psychological Therapies for particular service user groups.

Given that the evidence base for many common mental health problems has already been interrogated using a transparent and rigorous process in the production of the various SIGN and NICE guidelines, it was decided that these published documents would form the basis of the Matrix tables.

Within each diagnostic classification the evidence from the various guidelines was collated by specialists in that area, and further input was sought from individuals with identified expertise, and from the members of the Scottish Government Psychological Therapies Group.

Psychological therapies play a particularly important role in mental health services for children and young people. Although this remains an under-researched area compared to mental health overall, much of the evidence of “what works for whom” in relation to children and young people comes from the psychological therapies literature.

It is also the case that various forms of psychological therapy contribute to “generic” CAMHS clinical practice, given the need for clinicians to develop skills in communicating effectively, for example, with small children or with families.

How to use ‘The Matrix’

Effectiveness and Cost-Effectiveness

The evidence base for any intervention, as currently defined in SIGN and NICE guidelines, will generally tell us one of three things:

1) That there is evidence in the literature for the effectiveness of that intervention; and

   If this is the case the intervention will then be ranked on the quality of the available evidence.

2) That there is no evidence in the literature for the effectiveness of that intervention;

   It is recognised that the absence of robust evidence for any particular approach does not prove that the approach is ineffective—it may simply be that the evidence
has not yet been collected. However, in an environment where resources are limited it is prudent to focus on where we can have the greatest confidence in the maximum return for our investment.

3) That there is evidence in the literature that the particular intervention is ineffective, or indeed harmful

In the first and last cases the implications are clear:

- NHS Boards should provide interventions for which there is good evidence of effectiveness; and.

- Clearly, where an intervention has been proven ineffective or harmful, it should not be provided within the NHS.

Where little or no evidence has been collected, however, then there needs to be some flexibility of approach. In a number of areas, for example, there are longstanding services which are recognized as being of benefit to patients in spite of the lack of a tradition of collecting evidence in a way which would be recognized by SIGN or NICE.

There is no suggestion that these services should be dismantled, but it is crucial that NHS Boards begin to collect their own good quality evidence around the effectiveness of such services. Not only is this essential for good governance, but it will contribute to the wider evidence base, and help ensure that what we invest in is effective in the longer term.

When using the tables as an aid to strategic planning, it is important to start off by scoping local expertise, and building on the experience already available. However, services need to be able to demonstrate that they are working towards providing evidence-based services in a developmental way.

Where two or more treatment options are comparable in terms of effectiveness, then issues of cost-effectiveness should be considered. Factors which need to be taken into account include:

- the cost of treatment in terms of therapist time and other resources, taking account models of service delivery and service user turnover;
- the investment required in training staff to deliver the intervention, taking into account levels of skills/knowledge already available within the system;
- the sustainability of training to maintain service in the long term;
- the efficiency of training-i.e. what percentage of time the trained staff are able to deliver the intervention within the service;
- the capacity of the system; and
- issues of patient choice.
Which Therapies?  The Evidence Base and the ICPs

At Scottish Government level the strategic focus has been on CBT in the first instance because it is the therapeutic modality which currently has the widest evidence base and is most cited in the literature.

A strong CBT foundation will put NHS Boards in a good position both to provide many of the ‘high intensity’ interventions necessary to accredit the ICPs, and to deliver psychological interventions at the ‘low intensity’ level appropriate for mild/moderate mental health problems and with maximum likely impact on the anti-depressant target. Most of the evidence-based ‘low intensity’ options, including self-help, problem-solving and computerised or online packages, are CBT based.

Beyond this it is expected that the requirement to accredit the ICPs will drive the choice and provision of a wider range of evidence-based therapeutic approaches, and the information presented in this document focuses on the diagnostic categories covered by the ICPs in addition to the common mental health problems.

It is not expected that NHS Boards will provide all of the therapeutic approaches recommended in the tables for any particular patient group. The Psychological Therapies they choose to provide will be guided by:

- the services they already have;
- the expertise available locally; and
- the advice of the local Psychological Therapies planning group.

It is important that service users and careers are engaged meaningfully in this decision making process, and that issues of patient preference are given due consideration.

It is also crucial that the field of Psychological Therapy continues to evolve, and we want to avoid the situation where either therapeutic advances or innovative service developments are stifled by the rigid application of current guidelines. Trials of new therapies, or of new applications of existing therapies, will generally be organized by national research networks, and local Psychological Therapies planning groups can contribute to this process by facilitating access to patients.

Local groups can also encourage service innovation, based on the evidence as it currently stands, and support the robust evaluation of new projects. However the interests of service users must remain paramount, and appropriate research protocols must be adopted wherever innovative approaches are being trialed.
Definitions used in the tables

**Level of severity.** A description of the level of severity of illness and an indicator of potential level of functioning.

**Level of service.** Where service users are most likely to be treated most effectively.

**Intensity of intervention.** Low intensity interventions are standardised interventions aimed at transient or mild mental health problems with limited effect on functioning. High Intensity / specialist interventions denotes a formal psychological therapy delivered by a relatively specialist psychological therapist and are aimed at common mental health problems with more significant effect on functioning.

**What intervention?** The interventions are those that are recommended by guideline development groups such as NICE and SIGN.

**Level of evidence** This is the level of evidence of efficacy that is reported in published national guidelines.
Recommendations for psychological therapies
Grading the evidence.
Where available, SIGN or NICE guidelines are used to complete the tables for each disorder. We are aware that different guidelines use different systems for grading evidence. We have therefore used a unified system for grading evidence and making recommendations. See Table X Grading of Evidence and Recommendations.

Table X. Grading of Evidence (a) and Recommendations (b).

(a) Grading of Evidence

<table>
<thead>
<tr>
<th>SIGN</th>
<th>NICE</th>
<th>Matrix</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>At least one meta-analysis, systematic review, or RCT rated as 1+++, and directly applicable to the target population; or A body of evidence consisting principally of studies rated as 1++, directly applicable to the target population, and demonstrating overall consistency of results</td>
<td>At least one high quality meta-analysis or systematic review, or RCT of high quality aimed at target population</td>
</tr>
<tr>
<td>B</td>
<td>A body of evidence including studies rated as 2+++ (i.e. High quality systematic reviews of case control or cohort studies, directly applicable to the target population, and demonstrating overall consistency of results; or…</td>
<td>Well-conducted clinical studies but no randomised clinical trials on the topic of recommendation</td>
</tr>
<tr>
<td>C</td>
<td>A body of evidence including studies rated as 2++ (i.e. well conducted case control or cohort studies with a low risk of confounding or bias, directly applicable to the target population and demonstrating overall consistency of results</td>
<td>Expert committee reports or opinions and/or clinical experiences of respected authorities (evidence level IV). This grading indicates that directly applicable clinical studies of good quality are absent or not readily available</td>
</tr>
</tbody>
</table>

(b) Recommendation

<table>
<thead>
<tr>
<th></th>
<th>Highly recommended</th>
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<tbody>
<tr>
<td>A</td>
<td>Recommended</td>
</tr>
<tr>
<td>C</td>
<td>No evidence to date but opinion suggests that this therapy might be helpful</td>
</tr>
<tr>
<td><strong>Matrix: Level of evidence</strong></td>
<td><strong>Recommendation</strong></td>
</tr>
<tr>
<td>----------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>A</td>
<td>Highly recommended</td>
</tr>
<tr>
<td>At least one meta-analysis, systematic review, or RCT of high quality and consistency aimed at target Population</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Recommended</td>
</tr>
<tr>
<td>Well-conducted clinical studies but no randomised clinical trials on the topic of recommendation directly applicable to the target population, and demonstrating overall consistency of results</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>No evidence to date but opinion suggests that this therapy might be helpful</td>
</tr>
<tr>
<td>Widely held expert opinion but no available or directly applicable studies of good quality.</td>
<td></td>
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## The Matrix
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<td>Cardiac Health</td>
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</table>
# PANIC DISORDER WITH/WITHOUT AGORAPHOBIA

| Subclinical (Prevention of PD among those presenting with panic attacks but not meeting PD diagnostic criteria) | Primary Care | Low | Online Self-Help CBT Programme for Prevention of Panic Disorder  
Brief Exposure Instruction (Therapist-Delivered)  
Stepped-care programme comprising educational booklet; detailed self-help manual; five x 2-hour group CBT |  
B \textsuperscript{7}  
B \textsuperscript{19}  
A \textsuperscript{1} |
|---|---|---|---|
| Mild | Primary Care | Low | Minimal Therapy Contact CBT (4-6 hrs) with  
(a) Bibliotherapy  
(b) Internet-delivery |  
A \textsuperscript{5, 13}  
A \textsuperscript{3, 4, 9, 10, 18} |
## PANIC DISORDER WITH/WITHOUT AGORAPHOBIA

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Level of Service</th>
<th>Intensity of Intervention</th>
<th>What Intervention?</th>
<th>Recommendation</th>
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<tbody>
<tr>
<td>Moderate</td>
<td>Primary Care</td>
<td>Low</td>
<td>Therapist – Supported CBT (6-12hrs) augmented by CBT Self-Help</td>
<td>A&lt;sup&gt;5&lt;/sup&gt;, A&lt;sup&gt;11&lt;/sup&gt;, A&lt;sup&gt;16&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>a) Bibliotherapy</td>
<td></td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>b) Computer Assisted (e.g. FearFighter)</td>
<td>A&lt;sup&gt;8&lt;/sup&gt;, A&lt;sup&gt;14&lt;/sup&gt;</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>c) Internet-Delivered CBT with Therapist Contact (up to 6 hrs)</td>
<td>A&lt;sup&gt;4&lt;/sup&gt;, A&lt;sup&gt;9&lt;/sup&gt;, A&lt;sup&gt;10&lt;/sup&gt;, A&lt;sup&gt;18&lt;/sup&gt;</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>d) Group CBT (8-18hrs)</td>
<td>A&lt;sup&gt;11&lt;/sup&gt;, A&lt;sup&gt;17&lt;/sup&gt;, A&lt;sup&gt;20&lt;/sup&gt;</td>
</tr>
<tr>
<td>Severe</td>
<td>Primary Care/ Secondary Care</td>
<td>High</td>
<td>Individual Therapist- Directed CBT (16-20 sessions) with supplementary written material</td>
<td>A&lt;sup&gt;2&lt;/sup&gt;, A&lt;sup&gt;6&lt;/sup&gt;, A&lt;sup&gt;12&lt;/sup&gt;, A&lt;sup&gt;13&lt;/sup&gt;, A&lt;sup&gt;15&lt;/sup&gt;</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>CBT with medication more effective than medication alone. Some evidence of trend for CBT plus antidepressants to have slightly greater effect in acute phase compared to CBT alone, but difference not maintained at 6-24 months follow-up</td>
<td></td>
</tr>
</tbody>
</table>
## PANIC DISORDER WITH/WITHOUT AGORAPHOBIA CONTINUED...

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Level of Service</th>
<th>Intensity of Intervention</th>
<th>What Intervention?</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chronic or Treatment Resistant</strong></td>
<td>Secondary Care/ Specialist Service; In-Patient Care</td>
<td>High</td>
<td>Individual Therapist-Directed CBT (up to 20 sessions)</td>
<td>C</td>
</tr>
</tbody>
</table>
# SOCIAL ANXIETY/SOCIAL PHOBIA

<table>
<thead>
<tr>
<th>Level of severity</th>
<th>Level of service</th>
<th>Intensity of intervention</th>
<th>What intervention?</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>Primary Care, Voluntary settings</td>
<td>Low</td>
<td>Guided Self-help (bibliotherapy or internet-based)</td>
<td>A¹, ²</td>
</tr>
</tbody>
</table>
| Moderate          | Primary Care, Voluntary settings | High | Behaviour therapy: Exposure  
CBT: Exposure + Cognitive restructuring  
Social Skills Training  
Interpersonal Therapy  
Psychodynamic, Humanistic-Person-Centred-Experiential | A³, ⁴, ⁵  
A³, ⁶  
B³, ⁴, ⁵  
B⁷  
C |
| Severe: Generalised Social Phobia | Primary Care/Secondary Care | High | Same as moderate | A⁸ |
| Avoidant PD       | Primary Care/Secondary Care | High | CBT (20 sessions) | A⁸ |
## GENERALISED ANXIETY DISORDER

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Level of Service</th>
<th>Intensity of Intervention</th>
<th>What Intervention?</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>Primary Care</td>
<td>Low</td>
<td>Guided self-help&lt;br&gt;Large group psychoeducation&lt;br&gt;Brief counselling</td>
<td>B², 6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>B⁷</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>C</td>
</tr>
<tr>
<td>Moderate to severe</td>
<td>Primary Care/Secondary Care</td>
<td>High</td>
<td>CBT (8-16 sessions over 3-6 months)</td>
<td>A¹, ⁵</td>
</tr>
<tr>
<td>Severe &amp; Chronic</td>
<td>Secondary Care</td>
<td>High</td>
<td>CBT (20 sessions over 6 months) delivered to a specialist treatment protocol for GAD</td>
<td>B³, 4</td>
</tr>
</tbody>
</table>
# OBSESSIVE COMPULSIVE DISORDER

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Level of service</th>
<th>Intensity of Intervention</th>
<th>What intervention?</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>Primary Care</td>
<td>Low</td>
<td>CBT including Exposure and Response Prevention (ERP)* with less than 10 therapist hours which should consist of: Individual contact supported by self help materials. Brief individual telephone contact. Group sessions but with more than 10 hours of therapy</td>
<td>B&lt;sup&gt;1&lt;/sup&gt;, &lt;sup&gt;2&lt;/sup&gt;, &lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td>Moderate</td>
<td>Secondary care</td>
<td>High</td>
<td>CBT/ERP*. More than 10 hours of therapist guided sessions</td>
<td>A&lt;sup&gt;1&lt;/sup&gt;, &lt;sup&gt;3&lt;/sup&gt;, &lt;sup&gt;4&lt;/sup&gt;, &lt;sup&gt;5&lt;/sup&gt;</td>
</tr>
<tr>
<td>Severe</td>
<td>Secondary care</td>
<td>High</td>
<td>CBT/ERP*. More than 20 hours of therapist guided sessions augmented with anti-obsessional medication</td>
<td>A&lt;sup&gt;1&lt;/sup&gt;, &lt;sup&gt;3&lt;/sup&gt;, &lt;sup&gt;4&lt;/sup&gt;, &lt;sup&gt;5&lt;/sup&gt;</td>
</tr>
<tr>
<td>Chronic</td>
<td>Specialist Services</td>
<td>High</td>
<td>CBT/ERP*. More than 20 hours of therapist guided sessions augmented with anti-obsessional medication plus anti-psychotic</td>
<td>B&lt;sup&gt;1&lt;/sup&gt;, &lt;sup&gt;6&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

* ERP should be carried out in the person’s environment
# SCHIZOPHRENIA

<table>
<thead>
<tr>
<th>Level of severity</th>
<th>Level of service</th>
<th>Intensity of intervention</th>
<th>What intervention?</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe/ enduring</td>
<td>Secondary care</td>
<td>High</td>
<td>Cognitive Behavioural Therapy* (&gt;10 sessions or &gt; 6 months)</td>
<td>A&lt;sup&gt;1-14&lt;/sup&gt;</td>
</tr>
<tr>
<td>Severe/ enduring</td>
<td>Secondary care</td>
<td>High</td>
<td>Family Interventions</td>
<td></td>
</tr>
</tbody>
</table>

For those at **ultra high risk** for developing psychosis

<table>
<thead>
<tr>
<th>Level of severity</th>
<th>Level of service</th>
<th>Intensity of intervention</th>
<th>What intervention?</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate</td>
<td>Primary Care / Specialist Service</td>
<td>High</td>
<td>Cognitive Behavioural Therapy</td>
<td>B&lt;sup&gt;21-23&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

For **early detection** and **intervention for relapse**

<table>
<thead>
<tr>
<th>Level of severity</th>
<th>Level of service</th>
<th>Intensity of intervention</th>
<th>What intervention?</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe/ enduring</td>
<td>Secondary care</td>
<td>High</td>
<td>Detection of Relapse</td>
<td>A&lt;sup&gt;24-31&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cognitive Behavioural Therapy for Relapse</td>
<td>B&lt;sup&gt;32&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

* Strongest evidence indicates effectiveness of CBT for those with persistent and distressing psychotic experiences, rather than those in the acute phase of psychosis<sup>3</sup>

**Insufficient Evidence:**

a. There is currently insufficient evidence to recommend use of Cognitive Remediation as a Routine Therapy for Schizophrenia<sup>14, 33, 34</sup>
# BIPOLAR DISORDER

<table>
<thead>
<tr>
<th>Level of severity</th>
<th>Level of service</th>
<th>Intensity of intervention</th>
<th>What intervention?</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>All the interventions below are limited to the maintenance of patients in recovery from bipolar affective disorder in addition to medication (i.e. euthymic patients).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe and enduring</td>
<td>Secondary Care</td>
<td>High</td>
<td>CBT in relapse prevention in stable individuals. Group Psychoeducation</td>
<td>A&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>All the interventions below are limited to patients who are in an acute episode of bipolar affective disorder and are in addition receiving medication.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe and enduring</td>
<td>Secondary Care</td>
<td>High</td>
<td>CBT for those who have past history of less than 12 episodes. Interpersonal and Social Rhythm Therapy (IPSRT)</td>
<td>A&lt;sup&gt;2, 3&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>High</td>
<td></td>
<td></td>
<td>A&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

Family therapy is no more or less effective than individual psychosocial therapy or crisis management. It may be that family therapy has some benefit on relapse but further studies are warranted (Beynon et al., 2008). There is no evidence that care management or integrated group therapy is effective in the prevention of relapse (Beynon et al., 2008).
## DEMENTIA

<table>
<thead>
<tr>
<th>Level of severity</th>
<th>Level of service</th>
<th>Intensity of Intervention</th>
<th>What intervention?</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild/Moderate</td>
<td>Secondary Care/Day Hospital</td>
<td>Low (formal caregivers)</td>
<td>Reminiscence, Validation Therapy</td>
<td>B (1, 8)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Behaviour that Challenges.</td>
<td>C (1, 9)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cognitive Stimulation Therapy</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Cognitive Rehabilitation/Cognitive Training</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cognitive Behaviour Therapy for depression in Dementia</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Caregiver Interventions</td>
<td></td>
</tr>
<tr>
<td>Moderate/Severe</td>
<td>Secondary Care/Specialised</td>
<td>High (specialist)</td>
<td></td>
<td>B (1, 3, 4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>A (1, 2, 3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>C (1, 6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>B (1, 3, 5, 6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>A (1, 3, 5, 6, 7)</td>
</tr>
</tbody>
</table>

**NOTES:**
- There is no evidence that Validation therapy, cognitive stimulation therapy, and reminiscence reduce behaviour that challenges in people with dementia (NICE Guidelines 42)
# DEPRESSION

<table>
<thead>
<tr>
<th>Level of severity</th>
<th>Level of service</th>
<th>Intensity of intervention</th>
<th>What intervention?</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild/moderate</td>
<td>Primary Care/ Voluntary settings</td>
<td>Low</td>
<td>Self help guided by therapist input.*&lt;br&gt;Self help in the form of computerised CBT (CCBT)&lt;br&gt;Structured exercise.&lt;br&gt;Behavioural activation.&lt;br&gt;CBT.&lt;br&gt;IPT.</td>
<td>A&lt;sup&gt;1,2&lt;/sup&gt;&lt;br&gt;A&lt;sup&gt;3,4&lt;/sup&gt;&lt;br&gt;A&lt;sup&gt;6&lt;/sup&gt;&lt;br&gt;A&lt;sup&gt;5&lt;/sup&gt;&lt;br&gt;A&lt;sup&gt;7&lt;/sup&gt;&lt;br&gt;A&lt;sup&gt;8&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relapsing</td>
<td>Primary Care/ Secondary Care</td>
<td>High</td>
<td>Mindfulness based cognitive therapy to reduce relapse in patients with depression who have had three or more episodes.</td>
<td>A&lt;sup&gt;11&lt;/sup&gt;</td>
</tr>
<tr>
<td>Severe</td>
<td>Secondary Care</td>
<td>High</td>
<td>CBT</td>
<td>B&lt;sup&gt;12&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

*Guided self help (modelled around the principles of CBT) - greatest effectiveness is associated with input from a therapist to guide progress.
### BORDERLINE PERSONALITY DISORDER

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Level of service</th>
<th>Intensity of intervention</th>
<th>What intervention</th>
<th>Recommendation</th>
</tr>
</thead>
</table>
| Severe            | Secondary/ Specialist Outpatient  | High                      | CBT for personality disorders  
Individual therapy (30 sessions over 1 year)  
Schema Focused CBT  
Twice weekly over 3 years  
STEPPS -Systems Training for Emotional Predictability and Problem Solving (CBT approach) 20 group sessions group + usual treatment  
Transference-focused psychotherapy  
(twice weekly sessions plus weekly supportive treatment over one year)  
Dialectical Behaviour Therapy (DBT)  
Involves group + individual therapy + telephone support (Several times per week over one year) | A²  
A³  
A⁶  
A⁴  
A¹ |
| Severe            | Secondary/ Specialist Partial Day Hospital | High Multi-modal          | Mentalization based Day Hospital  
(Several times per week over 3 years) | A⁵ |

Lessons learned from the evaluation of pilot services in England suggests that due to the complexity of personality disorder most services should offer more than one type of intervention (Crawford et al, 2007).
# ALCOHOL PROBLEMS

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Level of Service</th>
<th>Intensity of Intervention</th>
<th>What intervention?</th>
<th>Recommendation</th>
</tr>
</thead>
</table>
| Mild to Moderate (hazardous and Harmful Drinker) | Primary Care/ Non-Specialist Health Setting including, for example, Antenatal Care | Low | Structured CBT orientated programme  
Provide a brief intervention*:  
Simple brief interventions – one session lasting 5-10 minutes/Extended brief interventions – one/several 20-45 minute session/s  
Two 15 minute feedback, advice and drink diary | B ¹, ², ³ |
| | | | | A ¹, ², ³ |
| | | | | B ¹, ², ³ |
| Moderate to Severe (Alcohol Dependence) | Secondary Care/ Specialist including residential settings.  
Mutual Help | High | Behavioural Self Control Training/ Motivational Enhancement Therapy/ Family Therapy/Community/  
Reinforcement Approach: Coping/Communication Skills Training/  
Social Behaviour Network Therapy/ 12 Step Facilitation | A ¹, ², ³ |
| | | | | A ¹, ², ³ |
| | | | | B ¹, ², ³ |
| | | Variable | Alcoholic Anonymous Attendance | B ¹, ², ³ |
# SUBSTANCE USE

<table>
<thead>
<tr>
<th>Level of severity</th>
<th>Level of service</th>
<th>Intensity of Intervention</th>
<th>What intervention?</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>Opportunistic contact</td>
<td>Low</td>
<td>Opportunistic Brief Intervention (Motivationally Based)</td>
<td>A¹, ²</td>
</tr>
<tr>
<td>Mild to Moderate Cannabis with co-morbid anxiety and/or depression Stimulants with Co-morbid anxiety and/ Benzodiazepines with Panic Disorder</td>
<td>Primary Care/Secondary Care</td>
<td>High</td>
<td>Cognitive Behavioural Therapy Group Cognitive behaviour Therapy + Gradual Tapering (10 Weeks)*</td>
<td>A¹, ²</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>A¹, ²</td>
</tr>
<tr>
<td><strong>Level of severity</strong></td>
<td><strong>Level of service</strong></td>
<td><strong>Intensity of Intervention</strong></td>
<td><strong>What intervention?</strong></td>
<td><strong>Recommendation</strong></td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>-------------------------------</td>
<td>-------------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Moderate to Severe Stimulants</td>
<td>Community/Inpatient/Residential/Criminal Justice</td>
<td>High</td>
<td>Contingency Management</td>
<td>A (^1, 2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Behavioural Couples Therapy</td>
<td>A (^1, 2)</td>
</tr>
<tr>
<td>Moderate to Severe Stimulants with Co-morbid anxiety and/or depression</td>
<td>Primary Care/Community</td>
<td>High</td>
<td>Cognitive Behavioural Therapy</td>
<td>A (^1, 2)</td>
</tr>
</tbody>
</table>
## EATING DISORDERS – ANOREXIA NERVOSA

<table>
<thead>
<tr>
<th>Level of severity</th>
<th>Level of service</th>
<th>Intensity of Intervention</th>
<th>What intervention?</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>GP/ Primary Care</td>
<td>Low</td>
<td>Advice about the help and support available such as self-help groups and internet resources. Medication should not be used as the sole or primary treatment for anorexia nervosa</td>
<td>C(^{18}) \n  C(^{17})</td>
</tr>
<tr>
<td>Moderate to Severe</td>
<td>Secondary Care/ Specialist</td>
<td>High</td>
<td>Family interventions A choice of psychological treatments for anorexia nervosa should be available as part of mental health services in all areas. CBT, Interpersonal Psychotherapy (IPT), Psychodynamic Therapy, Cognitive Analytic Therapy (CAT), Motivational Enhancement Therapy.</td>
<td>C(^{18}) \n  C(^{18})</td>
</tr>
</tbody>
</table>
## EATING DISORDERS – BULIMIA NERVOSA

<table>
<thead>
<tr>
<th>Level of severity</th>
<th>Level of service</th>
<th>Intensity of Intervention</th>
<th>What intervention?</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subclinical/ Mild</td>
<td>Primary Care</td>
<td>Low</td>
<td>Evidence-based self-help programme</td>
<td>B, B&lt;sup&gt;6&lt;/sup&gt;, B&lt;sup&gt;13&lt;/sup&gt;, B&lt;sup&gt;17&lt;/sup&gt;, B&lt;sup&gt;20*&lt;/sup&gt;, B&lt;sup&gt;22&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Guided CBT self-help</td>
<td>B&lt;sup&gt;6&lt;/sup&gt;, B&lt;sup&gt;17&lt;/sup&gt;, B&lt;sup&gt;20*&lt;/sup&gt;, B&lt;sup&gt;22&lt;/sup&gt;</td>
</tr>
<tr>
<td>Moderate</td>
<td>Secondary Care</td>
<td>Low</td>
<td>Evidence-based self-help programme</td>
<td>B, B&lt;sup&gt;6&lt;/sup&gt;, B&lt;sup&gt;4&lt;/sup&gt;, B&lt;sup&gt;17&lt;/sup&gt;, B&lt;sup&gt;20*&lt;/sup&gt;, B&lt;sup&gt;23&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>Evidence-based self-help programme</td>
<td>B&lt;sup&gt;6&lt;/sup&gt;, B&lt;sup&gt;4&lt;/sup&gt;, B&lt;sup&gt;17&lt;/sup&gt;, B&lt;sup&gt;20*&lt;/sup&gt;, B&lt;sup&gt;23&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Guided CBT self-help</td>
<td>B&lt;sup&gt;13&lt;/sup&gt;, B&lt;sup&gt;17&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CBT for bulimia nervosa (CBT-BN). 16 to 20 sessions over 4 to 5 months.</td>
<td>B&lt;sup&gt;1&lt;/sup&gt;, B&lt;sup&gt;7&lt;/sup&gt;, B&lt;sup&gt;9*&lt;/sup&gt;, B&lt;sup&gt;14*&lt;/sup&gt;, B&lt;sup&gt;15&lt;/sup&gt;, B&lt;sup&gt;17&lt;/sup&gt;, B&lt;sup&gt;21&lt;/sup&gt;, B&lt;sup&gt;23&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Interpersonal Psychotherapy (IPT). 8 to 12 months to achieve same results as CBT&gt;</td>
<td>B&lt;sup&gt;13&lt;/sup&gt;, B&lt;sup&gt;7&lt;/sup&gt;, B&lt;sup&gt;17&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

* Evidence from adolescent studies and adolescent recommendations.
# Insomnia

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Level of Service</th>
<th>Intensity of Intervention</th>
<th>What Intervention?</th>
<th>Recommendation</th>
</tr>
</thead>
</table>
| **Chronic primary insomnia**              | Primary/ Specialist Health Settings | *****High (4-10 sessions) | CBT (individual or small group)  
Best validated/ most efficacy data for  
- Sleep Restriction  
- Stimulus Control  
- Progressive Relaxation  
- Paradoxical Intention components | *A$_{1-13}$ |
<p>| <strong>Chronic insomnia associated with medical or psychiatric illness</strong> | Specialist Health Settings | *****High (4-10 sessions) | CBT                                                                                 | **A$<em>{12,13}$ |
| <strong>Insomnia in older adults</strong>              | Primary/ Specialist Health Settings | *****High (4-10 sessions) | CBT                                                                                 | ***A$</em>{2,3,10,17,18}$ |
|                                           |                                   |                           |                                                                                    | ****A$_{2,3,7,11,14,15}$ |</p>
<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Level of Service</th>
<th>Intensity of Intervention</th>
<th>What Intervention?</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic insomnia</td>
<td>Primary care</td>
<td>*****High (4-10 sessions)</td>
<td>CBT (delivered by trained nurses)</td>
<td>A&lt;sup&gt;16,19,20&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Primary/ Specialist Health Settings</td>
<td>*****High (4-10 sessions)</td>
<td>These are therapeutic components with as yet unproven efficacy (from high quality RCTs)</td>
<td>B/C&lt;sup&gt;2-3&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Intensive Sleep-Retraining</td>
<td>C&lt;sup&gt;21&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Multicomponent Cognitive Therapy</td>
<td>B&lt;sup&gt;22&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Imagery Training</td>
<td>C&lt;sup&gt;24&lt;/sup&gt;</td>
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<td></td>
<td></td>
<td>Mindfulness Training</td>
<td>B&lt;sup&gt;23,26&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Self-Help</td>
<td>B&lt;sup&gt;25&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

* Meta-analytic studies and systematic reviews  
** As concluded in practice parameter statements although strongest evidence indicates effectiveness of CBT rather than any singular interventions  
*** Most encouraging in the context of insomnia associated with cancer care, pain and depression  
**** Treatment is equally efficacious in older adults  
*****4 biweekly individual sessions is the least ‘dose’ so far found to be effective<sup>27</sup>  

Other Evidence:  
  a. There is currently sufficient evidence against using Sleep Hygiene as a singular intervention  
  b. There is currently sufficient evidence against using Psychoeducation as a singular intervention  
  c. There is currently no evidence of the effectiveness of any psychological or behavioural intervention for acute insomnia
## OBESITY/ WEIGHT LOSS INTERVENTIONS

<table>
<thead>
<tr>
<th>Level of severity</th>
<th>Level of service</th>
<th>Intensity of Intervention</th>
<th>What intervention?</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overweight (BMI &gt; 28)</td>
<td>Primary/ Specialist Health Settings</td>
<td>Low</td>
<td>CBT based weight loss programme (including dietary and activity interventions)</td>
<td>A 1–4</td>
</tr>
<tr>
<td>Obesity (BMI &gt; 30)</td>
<td></td>
<td></td>
<td>Provided in either a group or individual basis – equally effective.</td>
<td></td>
</tr>
</tbody>
</table>
## CHRONIC PAIN

<table>
<thead>
<tr>
<th>Level of severity</th>
<th>Level of service</th>
<th>Intensity of Intervention</th>
<th>What Intervention?</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic pain. Constant pain of 3 months duration or more. Associated distress and disability</td>
<td>Tertiary level</td>
<td>High</td>
<td>CBT based pain management programme (approximately 12 weeks either inpatient or outpatient).</td>
<td>A (^{1-4})</td>
</tr>
</tbody>
</table>
# CARDIAC HEALTH

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Level of Service</th>
<th>Intensity of Intervention</th>
<th>What Intervention?</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Arrhythmias including cardiac arrest, sudden cardiac death syndrome and insertion of implantable cardioverter defibrillators (ICD)</td>
<td>Acute care</td>
<td>Low</td>
<td>Cardiac rehabilitation (10-12 week) programmes incorporating CBT reduce anxiety and improve quality of life for patients with ICDs and cardiac arrhythmias</td>
<td>A1, 7</td>
</tr>
<tr>
<td>Myocardial infarction</td>
<td>Acute Care</td>
<td>Low</td>
<td>CBT as part of a 10 – 12 week educational rehabilitation programme delivered by nurses and physiotherapists addressed cardiac misconceptions and attributions and used goal behaviour change to improve mood. setting and pacing principles to shape desired lifestyle changes</td>
<td>A5</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Level of service</td>
<td>Intensity of Intervention</td>
<td>What intervention?</td>
<td>Recommendation</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>---------------------------------------</td>
<td>---------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Angina</td>
<td>Acute Care/Primary care</td>
<td>Low</td>
<td>CBT.</td>
<td>B 7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The Angina Plan is a cognitive behavioural self-management programme for people with chronic stable angina.</td>
<td></td>
</tr>
<tr>
<td>Myocardial Infarction (M.I)</td>
<td>Acute Care/Primary care</td>
<td>Low</td>
<td>The Heart Manual is a 6 week CBT tool.</td>
<td>A 2, 3, 5</td>
</tr>
<tr>
<td>Coronary bypass (CABG)</td>
<td></td>
<td>Low</td>
<td>The Heart Manual is a 6 week CBT tool.</td>
<td>B 4</td>
</tr>
<tr>
<td>Prevention of coronary heart disease</td>
<td>Primary Care</td>
<td>Low</td>
<td>CBT should be considered for increasing physical function and improving mood.</td>
<td>A 6</td>
</tr>
</tbody>
</table>

*CARDIAC HEALTH CONTINUED...*
REFERENCE SECTION

PANIC DISORDER WITH/WITHOUT AGORAPHOBIA


SOCIAL ANXIETY/SOCIAL PHOBLA


GENERALIZED ANXIETY DISORDER


**OBSESSIVE COMPULSIVE DISORDER**


SCHIZOPHRENIA


14. NICE Schizophrenia: Core interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care. Available at: http:\www.nice.org.uk. (Accessed 30.06.08.)


**BIPOLAR**


**DEMENTIA**

Recommendations are based on SIGN guideline criteria for evaluating the efficacy of interventions.


Behaviour management may be used to reduce depression in people with dementia. Multilevel behavioural management interventions may be more effective than individual interventions at improving behaviour and well-being in people with dementia.


5. Selwood, A, Johnston, K., Katona, C., Lyketsos, C., & Livingston, G. (2007) Systematic review of the effect of psychological interventions on family caregivers of people with dementia. *Journal of Affective Disorders, 101*, 75-89. A large number of studies were identified of which ten were considered high quality (level one). The authors of this high quality review report that there is 'consistent, excellent evidence' that individual behavioural management techniques produce positive outcomes for reducing depression in caregivers. Good evidence also exists for individual and group coping strategies for reducing depression symptoms in caregivers. Education alone and supportive therapy appears ineffective.

6. Gallagher-Thompson, D & Coon, D. (2007) Evidence-based psychological treatments for distress in family caregivers of older adults. *Psychology and Aging, 22*, 37-51. Three categories of evidence-based treatments for caregiver distress were found to be efficacious; multicomponent programmes, psychotherapy and symptom focused skills-enhancing psychoeducation interventions. Individualised CBT caregiver interventions are most efficacious for caregivers with significant levels of depression and group based CBT interventions are most efficacious for caregivers exhibiting high levels of stress but without overt symptoms of depression.


8. Woods, B., Spector, A., Jones, C. Orrell, M., Davies, S. (2005) Reminiscence therapy for dementia. *Cochrane Database of Systematic Review, Issue 2*. Art. No. CD001120 Although the data is relatively small beneficial impact of reminiscence in cognition and mood were reported. In addition beneficial outcomes for caregivers were also reported.

DEPRESSION


BORDERLINE PERSONALITY DISORDER


ALCOHOL


**SUBSTANCE USE**


**EATING DISORDERS**


**INSOMNIA**


**OBESITY/WEIGHT LOSS INTERVENTIONS**


CHRONIC PAIN


CARDIAC HEALTH


<table>
<thead>
<tr>
<th>Area</th>
<th>Contributors</th>
</tr>
</thead>
</table>
| Panic Disorder With/Without Agrophobia       | **Dr. Mike Dow**  
Chartered Clinical Psychologist.                                                |
| Social Anxiety/Social Phobia                 | **Prof. Robert Elliot**  
PhD, Professor of Counselling, University of Strathclyde.                    |
| Generalised Anxiety Disorder                 | **Dr. Rob Durham**  
Senior Lecturer in Clinical Psychology, University of Dundee.               |
| Obsessive Compulsive Disorder                | **Mr. John Swan**  
Clinical Lecturer, Section of Psychiatry and Behavioural Sciences, University of Dundee.  
**Mr. Bob MacVicar**  
Clinical Nurse Specialist in Advanced Interventions Service, Honorary Lecturer, University of Dundee. |
| Schizophrenia                                | **Prof. Andrew Gumley**  
Chair of Psychological Therapies, University of Glasgow.                    |
| Bipolar Disorder                             | **Prof. Kate Davidson**  
Director of Glasgow Institute of Psychosocial Interventions, NHS Greater Glasgow and Clyde.  
**Dr. Anne Nightingale**  
Consultant Psychiatrist in Psychotherapy.                                      |
<table>
<thead>
<tr>
<th>Condition</th>
<th>Name</th>
</tr>
</thead>
</table>
| Dementia                        | **Dr. Ken Laidlaw**  
Senior Lecturer in Clinical Psychology, University of Edinburgh/Consultant Clinical Psychologist and Professional Lead for Older Adults Psychology Services, NHS Lothian.  
**Ms Susan Cross**  
Consultant Clinical Psychologist. Head of Service, Older Adults Psychology Service, NHS Greater Glasgow and Clyde. |
| Depression                      | **Dr. Mike Henderson**  
Consultant Clinical Psychologist, NHS Borders  
**Prof. Kevin Power**  
Area Head of Psychological Therapies, NHS Tayside |
| Borderline Personality Disorder | **Prof. Kate Davidson**  
Director of Glasgow Institute of Psychosocial Interventions, NHS Greater Glasgow and Clyde.  
**Dr. Linda Treliving**  
FRCPsych., Consultant Psychiatrist in Psychotherapy, NHS Grampian. |
| Alcohol Problems                | **Dr. Peter Rice**  
Consultant Psychiatrist, NHS Tayside, Alcohol Problems Service. |
| Substance Use                   | **Dr. Catherine Keogh**  
Lead Consultant Clinical Psychologist, Glasgow Addiction Service. |
| Eating Disorders                | **Patricia Graham** |
| Insomnia                        | **Dr Jason Ellis**  
Associate Director of University of Glasgow Sleep Centre, Sackler Institute of Psychobiological Research/Section Of Psychological Medicine  
**Prof. Colin Espie**  
Professor of Clinical Psychology, Psychological Medicine, University of Glasgow and Director of the University of Glasgow Sleep Centre, Sackler Institute of Psychobiological Research |
| Obesity/Weight Loss Interventions | **Dr. Susan Boyle**  
Consultant Clinical Psychologist, Glasgow and Clyde Weight Management Service, Glasgow Royal Infirmary. |
| Chronic Pain Interventions      | **Dr. David Craig**  
Consultant Clinical Psychologist, Dept of Anaesthetics, Southern General Hospital, Glasgow. |
| Cardiac Health                  | **Dr. Morag Osborne**  
Consultant Clinical Psychologist, Southern General Hospital, NHS Greater Glasgow and Clyde. |
# Evidence-Based Psychological Interventions for Children and Young People

<table>
<thead>
<tr>
<th>Matrix: Level of Evidence</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>A Highly Recommended</td>
</tr>
<tr>
<td><strong>At least one meta-analysis, systematic review, or RCT of high quality and consistency aimed at target population</strong></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>B Recommended</td>
</tr>
<tr>
<td><strong>Well-conducted clinical studies but no RCTs on the topic of recommendation directly applicable to the target population, and demonstrating overall consistency of results</strong></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>C No evidence to date but opinion suggests that this therapy might be helpful</td>
</tr>
<tr>
<td><strong>Widely held expert opinion but no available or directly applicable studies of good quality</strong></td>
<td></td>
</tr>
</tbody>
</table>
Evidence – Based Psychological Interventions for Children and Young People

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1. Infant Mental Health (p.82-83) – Christine Puckering

2. Disruptive Behaviour Disorders (Disorders of Conduct) (p.84-86) – Brenda Renz

3. Attention-Deficit Hyperactivity Disorder (ADHD) (p.87-90) – Cathy Richards, Natasha Prescott, Fiona Forbes, Helen Stirling

4. Autism Spectrum Disorders (p.91-93) – Gill Kidd, Anne Gilchrist, Jacqui Howison

5. Anxiety
   5.1 Anxiety Disorders (p.94-96) – Anna Stallard
   5.2 Obsessive Compulsive Disorder (p.97) – Louise Duffy
   5.3 Specific Phobia (p.98) – Cathy Richards, Natasha Prescott

6. Post Traumatic Stress Disorder (PTSD) (p.99-100) – Gillian Affleck
   6.2 The Impact of CSA (p.101-103) – Gillian Affleck

7. Depression (p.104-106) – Cathy Richards and Gillian Fraser

8. Eating Disorders (p.107-110) – Cathy Richards, Natasha Prescott, Jane Morris, Vicki Robinson
   8.1 Anorexia Nervosa
   8.2 Bulimia Nervosa

9. Psychotic Disorders (p.111-114) – Matthias Schwannauer
   9.1 Schizophrenia / Psychosis
   9.2 Bipolar Disorder

10. References (p.115-142)

11. Appendix 1 (p.143-146)

12. Appendix 2 (p.147)

Co-ordinating Editor Cathy Richards
Notes:

The information in this document has been informed by:


Reference has been made to NICE and SIGN guidelines where they exist.
1. Infant Mental Health Risks and Disorders
(Data taken from Infant Mental Health: A Guide for Practitioners, 2007)

Infant Mental Health is by definition an area of early intervention both in the life of the individual child and in the possible development of difficulties. The evidence of the long-term effects of very early experience and the cost effectiveness of early intervention is growing and early intervention is a priority in Scottish Government targets.

The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care (FPPC), published by the Scottish Executive in October 2005, made the promotion of resilience and emotional well-being central to mental health policy and indicated a strategic commitment to achieving the earliest possible effective intervention for those in difficulty. The emerging field of infant mental health is clearly relevant to both of these dimensions and has the potential to become a key element of our activities in Scotland in the future.

The Significance of infancy for mental health

“Good parenting is fundamental for the development of a child’s mental health and wellbeing. As children’s primary carers, all parents need to be supported and helped, but especially when they are parenting in difficult circumstances or facing uncertainty about the way they are bringing up their children. Interventions focussed during pregnancy and at the time around the birth are likely to be the most effective in preventing mental health problems of a child. These include interventions which improve and enhance the wellbeing of the mother and of the baby and promote the mother-infant bond, and which take into consideration the psychosocial aspects of pregnancy, promote good early parent-child interactions, attachment, support problem-solving skills of the parents, and underline the roles of fathers.”

Infant mental health risks and disorders include: regulatory disorders, failure to thrive and feeding disorders, sleep disorders, psychosomatic and physical illnesses including low birth weight infants, attachment difficulties, children affected by parental ill health (eg post natal depression) and environmental factors (eg abuse, parental drug use, teenage pregnancy, poverty etc). The research on effective interventions and training to deliver is at an early stage; however, the practice guide, Infant Mental Health: A Guide for Practitioners summarises a variety of interventions and practices in current use and examines the evidence base for their effectiveness.
### 1. Infant Mental Health Risks and Disorders

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Level of Service</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>Tier 1-2</td>
<td></td>
<td>Brazelton Neonatal Assessment Scale</td>
<td>A^10</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Baby massage</td>
<td>A^2, 5</td>
</tr>
<tr>
<td>Moderate/Severe</td>
<td>Tier 2-4</td>
<td></td>
<td><strong>Individual interventions:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Video interaction guidance</td>
<td>A^9</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Attachment and Bio-behavioural Catch up</td>
<td>A^1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nurse-Family partnership</td>
<td>A^4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Group interventions:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mellow Babies</td>
<td>A^7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Circle of Security</td>
<td>A^3</td>
</tr>
</tbody>
</table>
2. Disruptive Behaviour Disorders (Disorders of Conduct)

Disruptive behaviour disorders describe children showing high rates of non-compliant, hostile and defiant behaviours, usually including aggression. Diagnostically, these behaviours are subsumed under three broad categories: Attention Deficit Hyperactivity Disorders (ADHD), Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD). The term ‘conduct disorders’ refers to Conduct Disorder (CD) and Oppositional Defiant Disorder (ODD). Both of these vary widely in their presentation with high levels of co-morbidity. It is therefore vital that interventions target a broad population of individuals. This needs to include those who fall within the clinical range of diagnosis, as well as those who do not, but whose behaviours place them at serious risk for later maladjustment.

Oppositional problems occur in 5­10% of non-clinical samples (Fonagy et al., 2000)\(^{12}\). The NICE Technology Appraisal 102 (www.nice.org.uk/TA102)\(^{20}\) estimated that in the UK, the prevalence of conduct disorders in children between the ages of 5 and 10 years is 6.9% for boys and 2.8% for girls, of which ODD represents 4.5% and 2.4%, respectively. In older children (11–16 years of age), the prevalence of diagnosed conduct disorders is slightly higher, at 8.1% for boys and 5.1% for girls, although ODD is less prevalent, at 3.5% and 1.7%, respectively.

Early onset conduct disorders represent the main reason for referral to CAMHS (Reid, 1993)\(^{22}\). Untreated, prognosis is poor, reinforcing the importance of early effective treatment and preventive approaches. This is especially so as the most powerful early interventions alter the maladaptive developmental trajectory of ODD/CD which so readily escalates into academic problems, school exclusion, substance abuse, delinquency and violence, and ultimately into a range of high cost psychiatric disturbances including antisocial personality disorders in adulthood (Loeber, 1998\(^{18}\); Webster-Stratton, 1998\(^{30}\)). Early intervention is also important as the literature suggests that early starter aggressive tendencies in children may crystallize around age eight and thereby become less amenable to change (Bernazzini & Tremblay, 2001)\(^{3}\).

Conduct disorders have a significant and detrimental impact on the quality of life of both the child and their family or carer(s). Caught early enough, they are however very treatable (Patterson et al., 2002)\(^{21}\), with significant gains benefiting not only individual children, but also improving maternal mental health and representing significant cost savings for the taxpayer (Hutchings, 1996\(^{14}\); Scott et al., 2001\(^{24}\); Webster-Stratton & Hammond, 1997\(^{31}\)).
Social learning theory-based group-based parenting is the treatment of choice for young children (NICE technology appraisal 102\textsuperscript{20}, Wolpert et al., 2006\textsuperscript{33}). With increasing age, multi-modal approaches, especially those incorporating cognitive problem-solving and social skills training become progressively required. By adolescence complex, multi-faceted and far more expensive interventions are required (Sexton & Alexander, 1999\textsuperscript{26}, Borduin & Schaeffer, 2001\textsuperscript{4}).
## 2. Disruptive Behaviour Disorders (Disorders of Conduct)

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Level of Service</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>3-6 years</th>
<th>7-12 years</th>
<th>13-17 years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mild</strong></td>
<td>Tier 1-2</td>
<td>Low</td>
<td>Social- Learning Theory- based Parent Management Training</td>
<td>A (5, 9, 11, 15, 19, 27, 28)</td>
<td>A (13, 21, 23, 25, 29, 32)</td>
<td></td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
<td>Tier 2-3</td>
<td>High</td>
<td>Social- Learning Theory- based Parent Management Training</td>
<td>A (5, 9, 11, 15, 19, 27, 28)</td>
<td>A (13, 21, 23, 25, 29, 32)</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>High</td>
<td>Psychodynamic Psychotherapy</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>Tier 2-3</td>
<td>High</td>
<td>Problem Solving Skills Treatment (PSST) (more effective when integrated with Parent Training Programme.)</td>
<td>A (31)</td>
<td>A (16)</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>Tier 2-3</td>
<td>High</td>
<td>Anger Coping Therapy</td>
<td>A (17)</td>
<td>A (17)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>High</td>
<td>Functional-Family Therapy</td>
<td>B (2)</td>
<td>B (2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3-4</td>
<td>High</td>
<td>Multi Systemic Therapy</td>
<td>B (1, 4)</td>
<td>B (1, 4)</td>
<td></td>
</tr>
<tr>
<td><strong>Severe</strong></td>
<td>Tier 3-4</td>
<td>High</td>
<td>Social- Learning Theory- based Parent Management Training</td>
<td>A (5, 9, 11, 15, 19, 27, 28)</td>
<td>A (13, 21, 23, 25, 29, 32)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>High</td>
<td>Functional-Family Therapy</td>
<td>A (2)</td>
<td>A (2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>High</td>
<td>Multi Systemic Therapy</td>
<td>B (1)</td>
<td>B (1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3-4</td>
<td>High</td>
<td>Therapeutic Foster Care</td>
<td>C (6, 7, 8, 10)</td>
<td>C (6, 7, 8, 10)</td>
<td></td>
</tr>
</tbody>
</table>
3. Attention Deficit Hyperactivity Disorder (ADHD)
(taken from SIGN guideline 52, 2001⁶; NHS.QiS Services Over Scotland, 2008⁵; NICE CG72, 2008⁴)

ADHD and hyperkinetic disorder (HKD) are commonly diagnosed behavioural disorders in children and young people. Core symptoms include developmentally inappropriate levels of activity and impulsivity and an impaired ability to sustain attention. Affected children and young people have difficulty regulating their activities to conform to expected norms and as a result are frequently unpopular with adults and peers. They often fail to achieve their potential and many have co-morbid difficulties such as developmental delays, specific learning problems and other emotional and behavioural disorders (Hill, 1998²).

For a diagnosis of ADHD, symptoms of hyperactivity/impulsivity and/or inattention should:
- meet the diagnostic criteria in DSM-IV or ICD-10 (hyperkinetic disorder),⁵ and
- be associated with at least moderate psychological, social and/or educational or occupational impairment based on interview and/or direct observation in multiple settings, and
- be pervasive, occurring in two or more important settings including social, familial, educational and/or occupational settings (NICE, 2008).

Children with ADHD are at increased risk of a wide range of adverse sequelae including low self-esteem, academic underachievement, poor peer relationships, disrupted family relationships, accidents and anti-social behaviour. They may also be at increased risk of later substance misuse.

ADHD is also associated with an increased rate of other disorders, including depression, anxiety, other behavioural disorders, tic disorders, specific learning difficulties and developmental co-ordination disorder. Sleep problems are common.

ADHD is a chronic disorder. At least two thirds of children continue to have ADHD symptoms through adolescence and, for some of them, symptoms persist into adulthood. Early diagnosis and intervention with the implementation of a long-term management plan is therefore crucial.

Prevalence rates for ADHD vary across epidemiological studies and in different countries. Much of this variation is attributable to differences in diagnostic criteria (DSM-IVⁱ or ICD-10³) and not necessarily to geographical differences. The point prevalence of the more severe form HKD is widely accepted as approximately 1.5 %** within the UK’s school-aged population (4–16) with attention deficit hyperactivity disorder having an estimated prevalence rate of at least 5%** for the same population group. This equates to an expected prevalence of approximately 39,000* school-aged children with ADHD, and 11,700 with HKD across Scotland.

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SIGN 52 recommends psychostimulants as first-line drug treatment for the core symptoms of ADHD whereas the recent NICE guideline (NICE CG72, 2008) states that drug treatment should be only offered as first-line treatment in school-age children and young people with severe ADHD and that parents or carers of the child or young person with moderate ADHD should be offered a parent-training/educational programme, possibly in combination with a group treatment programme (CBT and/or social skills training) for the child or young person.

It is beyond the scope of this matrix to resolve apparent differences between the two guidelines so we have listed all psychological interventions identified as effective in either guideline. There is a selective update of SIGN 52 underway (on treatment of ADHD) due to be published early 2009 and this section of the matrix will then need to be updated.

3. Attention Deficit Hyperactivity Disorder (ADHD)
(taken from SIGN guideline 52, 2001 & NICE CG72, 2008)

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Level of Service</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>Tier 1</td>
<td>Low</td>
<td>A period of watchful waiting up to 10 weeks</td>
<td>Pre-diagnosis**</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low</td>
<td>Parent-training/education programmes</td>
<td>Pre-diagnosis**</td>
</tr>
<tr>
<td>NICE CG72 (2008)</td>
<td></td>
<td></td>
<td></td>
<td>Pre-diagnosis**</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Pre-diagnosis**</td>
</tr>
<tr>
<td>Moderate/Severe</td>
<td>Tier 2-4</td>
<td>Low</td>
<td>Self-help approaches (e.g. ADHD self-instruction manuals, and other materials based on positive parenting and behavioural techniques).</td>
<td>Post-diagnostic advice</td>
</tr>
<tr>
<td>NICE CG72 (2008)</td>
<td></td>
<td>High</td>
<td>Family-based psychosocial interventions: group or individual based parent-training/education programmes, alone or together with a group treatment programme (CBT and/or social skills training) for the child or young person.</td>
<td>Post-diagnostic advice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>Individual psychological interventions (such as CBT and/or social skills)</td>
<td>First-line treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>Medication should be reserved for those with severe ADHD/HKD* or for moderate ADHD if refusal of non-drug treatment or if symptoms have not responded to psychosocial interventions.</td>
<td>First-line for older adolescents</td>
</tr>
<tr>
<td>Moderate/Severe</td>
<td>Tier 2-4</td>
<td></td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>SIGN 52 (2001)</td>
<td></td>
<td>High</td>
<td>Individualised school intervention programme including behavioural and academic interventions.</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>Family-based psychosocial interventions of a behavioural type are recommended for the treatment of co-morbid behavioural problems.</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>Psychostimulants should be considered as the first line of drug treatment for the core symptoms of ADHD/HKD*.</td>
<td>A</td>
</tr>
</tbody>
</table>

* Refer to NICE GC72 and SIGN 52 for guidance for specific pharmacological interventions.

** A diagnosis of ADHD should only be made by a specialist psychiatrist, paediatrician or other appropriately qualified healthcare professional with training and expertise in the diagnosis of ADHD⁴,⁶.
4. Autism spectrum disorders
(adapted from SIGN guideline, 2008)

The term autism spectrum disorders is used to cover conditions termed autism, atypical autism and Asperger’s syndrome. These are complex developmental disorders, behaviourally defined, that include a range of possible developmental impairments in reciprocal social interaction and communication, and also a stereotyped, repetitive or limited, behavioural repertoire. ASD may occur in association with any level of general intellectual/learning ability and manifestations range from subtle problems of understanding and impaired social function to severe disabilities.

Current diagnostic classification systems (the International Classification of Diseases, version 10 (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders 4th edition (DSM-IV), have similar symptom criteria for diagnosis, based on a triad of impairments, with the behaviours being discrepant from the individual’s mental age:

- social – impaired, deviant and delayed or atypical social development, especially interpersonal development
- language and communication – impaired and deviant language and communication, verbal and non-verbal. Impairment in pragmatic aspects of language
- thought and behaviour – rigidity of thought and behaviour and impoverished social imagination. Ritualistic behaviour, reliance on routines, impairment of imaginative play.

The diagnostic criteria for ASD continue to develop, and they are likely to change with future revisions. Currently, for a diagnosis of Asperger’s syndrome, there has to be no clinically significant general delay in language (speech of words and phrases by specified times) and no clinically significant general delay in cognitive development. There is not consistent evidence that the separation of autism and Asperger syndrome is meaningful in terms of the outlook, and it should be noted that clinical usage may not always reflect the definitions in classification systems. For example, the name Asperger’s syndrome may be used as a clinical diagnosis for some individuals who speak well later, but did in fact have early language delay.

Previously published figures suggested an ASD prevalence rate of 70.3 per 10,000 in pre-school children (PHIS, 2001, MRC, 2001). Recent UK prevalence figures indicate the overall ASD prevalence rate is 116.1/10,000 in 9-10 year olds with the majority being in the normal range of intelligence (Baird et al, 2006).
The SIGN guideline focused on clinical interventions for children and young people with ASD, but emphasised their entitlement also to additional support if needed to benefit from their education, and to have positive wider life experiences. The evidence base was insufficient to allow recommendations to be made for all areas. Additional suggestions for good practice were based on clinical experience of the multidisciplinary guideline development group. It was recognised that parents, educationalists, health professionals, social workers and the voluntary sector may use individualised interventions to optimise a child’s functioning, either by promoting development of skills, or by adapting the environment to compensate when skills are not present.

SIGN recommends that other common difficulties including mental health problems (particularly anxiety, depression, attention deficit disorders), sleep disorders and other neurodevelopmental problems such as tics, should not be assumed to be part of ASD but should be appropriately assessed and managed with reference to other clinical guidelines as relevant.

Information relevant to psychological approaches in ASD is included below. Recommendations in other sections of this document may also be relevant if children or young people have additional difficulties eg anxiety disorders. Other detailed recommendations and references about management of autism spectrum disorders in children and adolescents are available in the SIGN guideline.
### 4. Autism spectrum disorders

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Level of Service</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild, moderate and severe</td>
<td>Tier 1-3</td>
<td></td>
<td>Behavioural interventions For specific behaviours e.g. self injury, sleep to reduce symptom frequency and severity and to increase development of adaptive skills e.g. social skills, daily living skills</td>
<td>B 5, 18</td>
</tr>
<tr>
<td></td>
<td>Tier 1-3</td>
<td></td>
<td>Parent mediated intervention</td>
<td>C 3, 6, 10, 12, 14, 17</td>
</tr>
<tr>
<td></td>
<td>Tier 1-3</td>
<td></td>
<td>Social communication and interaction</td>
<td>C 11,15, 16, 19, 21</td>
</tr>
<tr>
<td></td>
<td>Tier 1-3</td>
<td></td>
<td>Communication supports</td>
<td>C 4, 13, 23</td>
</tr>
<tr>
<td></td>
<td>Tier 1-3</td>
<td></td>
<td>Parent education (pre school children)</td>
<td>B 17</td>
</tr>
<tr>
<td></td>
<td>Tier 1-3</td>
<td></td>
<td>Parent education (children and young people)</td>
<td></td>
</tr>
</tbody>
</table>

Other relevant recommendations:

- The Lovaas programme should not be presented as an intervention which will lead to normal functioning
- Auditory Integration Training is not recommended.
- Facilitated communication should not be used as a means to communicate with young people with ASD.
- CBT is feasible if verbal IQ of at least 69 but studies are unable to conclude about its effectiveness or potential harm in this client group.
- Insufficient evidence to support evidence based recommendations for Occupational Therapy, including sensory integration. Occupational therapists may provide advice and support in adapting environments, activities and routine in daily life
- Due to a limited number of studies and lack of clinically relevant outcomes, there is insufficient evidence for a recommendation about the use of music therapy in ASD.

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5. Anxiety

Anxiety disorders have been shown to represent the most highly prevalent form of psychopathology in children and adolescents. The point prevalence for anxiety disorders is estimated to range from 3 to 6% in children and young people aged 5-15 years (ONS, 2004\(^{13}\)). Over the course of childhood between 5-18% of all children and young people experience anxiety disorders (Costello, 1995\(^3\)).

High levels of anxiety can have a number of immediate and longer-term consequences for young people. Henker et al. (2002)\(^6\) found that adolescents identified as having high levels of anxiety expressed higher levels of stress, anger, sadness and fatigue and lower levels of happiness and well-being than those with low anxiety levels.

Anxiety disorders also have a high rate of co-morbidity with other disorders such as depression, alcohol abuse and drug dependence (Hughes, 2002\(^7\); Woodward & Fergusson, 2001\(^15\)).

Anxiety in adolescence can precede the emergence of depressive disorders and when this occurs may lead to a longer depressive episode (Henker et al., 2002)\(^6\). Kovacs and Devlin (1998)\(^11\) found evidence to suggest that childhood anxiety can be become a chronic disorder, reporting that children with an anxiety disorder were likely to fulfil diagnostic criteria up to 8 years after the onset of the disorder. Adults with anxiety problems often report elements of childhood anxiety (Kendall, 1994)\(^9\).
## 5.1 Anxiety Disorder

This table contains evidence relating to anxiety taken from studies of heterogeneous anxiety disorders including generalised anxiety disorder, panic disorder with or without agoraphobia, separation anxiety and social anxiety.

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Level of Service</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Subclinical/Mild</strong></td>
<td>Tier 1-2</td>
<td>High</td>
<td>Cognitive Behavioural Therapy</td>
<td>B⁸</td>
</tr>
<tr>
<td></td>
<td>Tier 1-2</td>
<td>Low</td>
<td>Computerised CBT (e.g. FearFighter)</td>
<td>B⁸ C¹, 1²</td>
</tr>
<tr>
<td></td>
<td>Tier 1-2</td>
<td>High</td>
<td>Group CBT: FRIENDS programme</td>
<td>C⁵, 1⁴</td>
</tr>
<tr>
<td></td>
<td>Tier 1-2</td>
<td>Low</td>
<td>Bibliography/Book prescribing</td>
<td>C C</td>
</tr>
<tr>
<td></td>
<td>Tier 1-2</td>
<td>Low</td>
<td>Guided self-help</td>
<td>C C</td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
<td>Tier 2-3</td>
<td>High</td>
<td>CBT (group or individual)</td>
<td>B⁴, 8</td>
</tr>
<tr>
<td></td>
<td>Tier 2-3</td>
<td>High</td>
<td>Manualised CBT: Coping Cat/Coping Koala</td>
<td>B², 9, 1⁰</td>
</tr>
<tr>
<td></td>
<td>Tier 2-3</td>
<td>High</td>
<td>Family Anxiety Management</td>
<td>B⁴ B⁴</td>
</tr>
<tr>
<td></td>
<td>Tier 2-3</td>
<td>High</td>
<td>Behavioural: Modelling</td>
<td>B⁴ B⁴</td>
</tr>
<tr>
<td></td>
<td>Tier 2-3</td>
<td>High</td>
<td>Behavioural: In-Vivo Exposure</td>
<td>B⁴ B⁴</td>
</tr>
<tr>
<td></td>
<td>Tier 1-3</td>
<td>Low</td>
<td>Relaxation Training</td>
<td>B⁴ B⁴</td>
</tr>
<tr>
<td></td>
<td>Tier 1-3</td>
<td>High</td>
<td>Behavioural: Reinforced Practice</td>
<td>B⁴ B⁴</td>
</tr>
<tr>
<td></td>
<td>Tier 1-3</td>
<td>High</td>
<td>Psychodynamic Psychotherapy</td>
<td>C⁴ C⁴</td>
</tr>
<tr>
<td>Severe</td>
<td>Tier 3-4</td>
<td>High</td>
<td>CBT</td>
<td>B²,₉</td>
</tr>
<tr>
<td>--------</td>
<td>----------</td>
<td>------</td>
<td>-----</td>
<td>-------</td>
</tr>
<tr>
<td>Tier 3-4</td>
<td>High</td>
<td>CBT with family anxiety management treatment</td>
<td>B²</td>
<td></td>
</tr>
</tbody>
</table>

* Extrapolated from adult populations. A reading age of 11 is a prerequisite for FearFighter.
5.2 Obsessive Compulsive Disorder

Estimates of prevalence vary from 0.51% to 4% (Douglass 1995\(^3\), Flament 1988\(^4\), Rapoport 2000\(^9\)) with clear clinical evidence that it is often associated with significant disruption and impairment in family, social and academic life and can have adverse impacts on psychosocial development (Piacentini 2003\(^8\)).

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Level of Service</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>Tier 3</td>
<td>Moderate</td>
<td>Therapist guided BT or CBT</td>
<td>C</td>
</tr>
</tbody>
</table>
| Moderate-Severe (CYBOCS > 16\(^10\)) | Tier 3-4        | High                      | BT or CBT can lead to better outcomes when combined with medication compared with medication alone  
Between 12 & 20 sessions of therapist guided CBT which should consist of: Exposure and Response Prevention (ERP) augmented with: Psychoeducation  
Anxiety Management  
Cognitive Therapy  
Family sessions | A 1\(^*,\) 2, 5, 6, 7  
A 1, 2, 5, 6, 7  
A 1, 5  
A 1, 2, 5  
A 1, 2, 5 | A 2, 5, 6, 7  
A 2, 5, 6, 7  
A 5  
A 2, 5  
A 2, 5 |

*\(^1\): Only included under child as age range was 10-13
5.3 Specific Phobia

Treatment for phobias in children and young people is more likely to be successful in children under 11 years of age (Hampe, Noble, Miller & Barrett, 1973; Miller, Barrett, Hampe & Noble, 1972) and for an intervention to be successful it is important to have parental involvement (Ollendick & King, 1998).

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Level of Service</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate/Severe</td>
<td>Tier 2-3</td>
<td>High</td>
<td>Behavioural: Participant Modelling</td>
<td>A 1, 3, 11, 15, 17, 19</td>
</tr>
<tr>
<td></td>
<td>Tier 2-3</td>
<td>High</td>
<td>Behavioural: Contingency Management</td>
<td>A 3, 10, 13, 16, 17</td>
</tr>
<tr>
<td></td>
<td>Tier 2-3</td>
<td>High</td>
<td>Systematic Desensitisation (imaginal desensitisation is more effective than no treatment but not as effective as in vivo desensitisation for phobic children)</td>
<td>B 3, 8, 12, 14, 17, 21, 22</td>
</tr>
<tr>
<td></td>
<td>Tier 2-3</td>
<td>High</td>
<td>CBT</td>
<td>B 3, 4, 6, 17, 18, 20</td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>High</td>
<td>Psychodynamic Psychotherapy (not adequately evaluated)</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>Tier 2-3</td>
<td>High</td>
<td>The Family Anxiety Management Model (not adequately evaluated)</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Emotive Imagery (pairing frightening situations with an exciting story involving a hero-figure)</td>
<td>C 2, 7, 9</td>
</tr>
</tbody>
</table>

A 1, 3, 11, 15, 17, 19  A 3, 10, 13, 16, 17  B 3, 8, 12, 14, 17, 21, 22  B 3, 17, 18, 20  C 2, 7, 9
6. Post Traumatic Stress Disorder (PTSD)

Post Traumatic Stress Disorder (PTSD) refers to the development of specific features following exposure to a particularly severe (extreme) stressor. The disorder is characterised by a number of features across 3 areas: re-experiencing (for example re-enacting experiences, distressing dreams of the experience, or intense distress at a symbol of the experience), avoidance (for example, avoiding any event that might bring back memories of the trauma) and increased arousal (for example, irritability, sleep disturbance and hyper-vigilance) (American Psychiatric Association, 2000). The cause is likely to be multi-factorial, and the outcome mediated by family and other supports (AACAP, 1998).

Studies of at-risk child populations have demonstrated prevalence rates of around 3% (Garrison et al., 1995) to 36% (Fletcher, 2003). PTSD occurs across ethnic and cultural groups, but may be manifested in different ways (Ahmad & Mohamad, 1996; Diehl et al., 1994; DiNocola, 1996; Manson et al., 1996). It is important to note that certain cultural influences on living and working environments may resist recognising that trauma can have psychological consequences (NICE guidelines CG026, 2005).

The age of onset may be any age, but the manifestation of the disorder is likely to be developmentally mediated (AACAP, 1998; Carr, 2004) and will vary in accordance with other associated factors including the type of traumatic event, the frequency and severity of exposure to trauma and time that has lapsed since exposure to the trauma (Gillies et al., 2007). Due to the developmental implications, there is no clear consensus about the typical presentation of PTSD in children (Gillies, 2007) and children may display symptoms not seen in the adult population such as, behaviour problems, developmental regression and physical symptoms (Yule, 2001).

There is a large overlap between depressive disorders and PTSD (AACAP, 1998). There is evidence of the co-existence of substance-use disorder (Brent et al., 1995; Clark et al., 1995). There is also evidence of the coexistence of anxiety disorders (Brent et al., 1995; Clark et al., 1995). It has been suggested that there is also a link between PTSD and some experiences of ADHD (Cuffe et al., 1994; Glod & Teicher, 1996). There is evidence to suggest that there may be a co-morbidity or development over time between PTSD and Borderline Personality Disorder (BPD), particularly in people who have experienced sexual abuse (Stone, 1990).
6.1 Post Traumatic Stress Disorder (PTSD)
(Data taken from The Dunnachie Werry Centre Report, 2007\textsuperscript{18} & Drawing on the Evidence, 2006\textsuperscript{38})

* It has been suggested that a multi-modal approach is important with the involvement, where appropriate, of family and communities in the treatment.

** The evidence does not support the use of single-session debriefing for children of any age. Drug treatments should not be routinely prescribed for children and young people with PTSD. There is insufficient evidence of appropriate psychological interventions for children under 7 years of age (16).

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Level of Service</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate</td>
<td>Tier 2-3</td>
<td>High</td>
<td>Anxiety Management Training e.g. muscle relaxation, thought stopping, positive imagery and deep breathing</td>
<td>C \textsuperscript{18, 19}</td>
</tr>
<tr>
<td></td>
<td>Tier 2-3</td>
<td>High</td>
<td>Exposure &amp; parent training</td>
<td>C \textsuperscript{19}</td>
</tr>
<tr>
<td></td>
<td>Tier 2-3</td>
<td>High</td>
<td>Trauma-focused Individual CBT \textsuperscript{*for children aged over 7 years}</td>
<td>B*/C \textsuperscript{31, 38}</td>
</tr>
<tr>
<td></td>
<td>Tier 2-3</td>
<td>High</td>
<td>Eye Movement Desensitisation &amp; Reprocessing (EMDR)</td>
<td>C \textsuperscript{19, 31, 38}</td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>High</td>
<td>Group based grief/trauma-focused psychotherapy</td>
<td>C \textsuperscript{18, 19}</td>
</tr>
<tr>
<td>Severe</td>
<td>Tier 3</td>
<td>High</td>
<td>Child-parent parallel treatment</td>
<td>C \textsuperscript{11}</td>
</tr>
<tr>
<td></td>
<td>Tier 3-4</td>
<td>High</td>
<td>Psychodynamic psychotherapy</td>
<td>B \textsuperscript{37}</td>
</tr>
<tr>
<td></td>
<td>Tier 3-4</td>
<td>High</td>
<td>Psychodynamic group therapy</td>
<td>C \textsuperscript{37}</td>
</tr>
</tbody>
</table>
6.2 The impact of sexual abuse

The experience of sexual abuse can result in disturbances in behaviour, emotional regulation and social functioning. Sexual abuse varies in frequency, duration and severity and often co-occurs with other abusive experiences e.g. emotional abuse and neglect (Noll, 2008). These experiences constitute not only a series of traumatic incidents but are also characterised by the violation of a trusted relationship/s. There is no syndrome of, or uniform response to, sexual abuse (Finkelhor & Berliner, 1995). A wide range of possible effects are documented and these can be evident in the short and long-term (Beitchman et al., 1991; Beitchman et al., 1992). Responses to trauma of this kind include fear, anxiety, depression, self-harm, difficulties with emotional regulation, dissociation, PTSD, substance misuse, sexualised behaviour and risk-taking behaviour, including promiscuity. Children who have experienced sexual abuse can also appear asymptomatic (Saywitz et al., 2000). Sexual abuse PTSD may present a different constellation of symptoms than children who have experienced single incident traumas (Feeny et al., 2004).

Estimates of prevalence and incidence of sexual abuse vary widely due to methodological problems including how sexual abuse is defined (Macdonald et al., 2006). Not all young people who experience sexual abuse will develop mental health difficulties. However, the impact, in terms of mental health outcomes for a child or young person, is likely to be developmentally mediated (e.g. age when abused, child’s cognitive ability) and associated with features of the abuse itself i.e. nature and severity of abuse, relationship of the abusive figure to the victim (Beitchman et al., 1991), familial and professional responses to the abuse. Exposure to childhood sexual abuse is consistently related to increased risks for mental health problems in adulthood (Fergusson et al., 2008). Without intervention, children and young people who have experienced sexual abuse are likely to continue to show psychological disturbance in the longer-term and may experience an increase in the range of problems (Calam et al., 1999). Given the heterogeneous nature of this group, there is a need for diverse treatments to be available to meet the individual, specific needs of a young person who has been sexually abused (Hetzel-Riggin et al., 2007).
6.2 The impact of sexual abuse

Identification and management of risk and ensuring children’s safety is central to any treatment response. It has been suggested a multi-modal approach to treatment is core to this area, including use of specific treatment approaches where indicated (e.g. anxiety management, social skills, anger, problem solving skills based work). The involvement, where appropriate, of family and communities in treatment is also important. It is noted ‘level of severity’ is not taken to refer to sexual abuse, but symptomatology with which child or adolescent presents.

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Level of Service</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>Tier 1</td>
<td>Low</td>
<td>Psychoeducation – leaflets and recommended texts for families and professionals at Tier 1 or consultation to support these, e.g. to teaching staff.</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>Tier 2</td>
<td>High</td>
<td>CBT/Trauma-focused CBT</td>
<td>B 11, 12, 15, 29, 31, 33, 34</td>
</tr>
<tr>
<td></td>
<td>Tier 2</td>
<td>High</td>
<td>Eye Movement Desensitization and Reprocessing</td>
<td>C 4, 13, 15, 23, 27, 28, 33</td>
</tr>
<tr>
<td></td>
<td>Tier 2</td>
<td>High</td>
<td>Early intervention parent/carer abuse specific therapy (where not perpetrator of abuse)</td>
<td>B 4, 13, 15, 23, 27, 28, 33</td>
</tr>
<tr>
<td></td>
<td>Tier 2</td>
<td>High</td>
<td>Supportive Counselling</td>
<td>C</td>
</tr>
<tr>
<td>Severe</td>
<td>Tier 3</td>
<td>Specialist</td>
<td>CBT/Trauma-focused CBT</td>
<td>B 11, 12, 15, 29, 31, 33, 34</td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>High</td>
<td>Eye Movement Desensitization and Reprocessing</td>
<td>C 4, 13, 15, 23, 27, 28, 33</td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>High</td>
<td>Early intervention parent/carer abuse specific therapy (where not perpetrator of abuse)</td>
<td>B 4, 13, 15, 23, 27, 28, 33</td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>High</td>
<td>Longer term child-parent parallel treatment</td>
<td>C 27</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 3</td>
<td>High</td>
<td>Systemic Family Therapy</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Tier 3</td>
<td>High</td>
<td>Psychodynamic individual therapy</td>
<td>C</td>
<td>C 37</td>
</tr>
<tr>
<td>Tier 3</td>
<td>High</td>
<td>Attachment based therapy</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Tier 3</td>
<td>High</td>
<td>Play therapy</td>
<td>C</td>
<td>C 27</td>
</tr>
<tr>
<td>Tier 3</td>
<td>High</td>
<td>Group therapy</td>
<td>C</td>
<td>C 27</td>
</tr>
<tr>
<td>Tier 3</td>
<td>High</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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7. Depression

At any point in time about 1 in 100 children and 1 in 33 adolescents are likely to be suffering from depression (Angold & Costello, 2001).

Published research indicates that the cumulative prevalence of rate for depression up to age 18 is 28%, 35% for girls and 19% for boys (Lewinsohn et al., 1993; Lewinsohn, et al., 1999). Depressive disorders are equally frequent in boys and girls until puberty (Angold et al. 1998), after which there is a predominance of girls (approximately 2:1) (AACAP, 1998; Cohen et al., 1993; Kessler et al., 1994; Lewinsohn, Clarke & Rohde, 1994; Werry, McClellan & Chard, 1991).

The course and causes of depression in children and adolescents is varied but for many young people will be severe with several episodes of depression and associated self-harm and or suicide. Without treatment about 10% recover spontaneously within three months but at 12 months around 50% remain clinically depressed (NICE, 2005).

For children and adolescents depression impacts significantly on their ability to meet key developmental tasks such as forming close peer relationships and first romantic relationships, achieving academic and vocational goals and successfully leaving home. Those young people who have an episode of depression before age 15 and a second episode before 20 are likely to have more severe, chronic, suicidal depressions, greater anxiety comorbidity, worse social functioning at 15, and poorer psychosocial outcomes at 20 (Hammen et al., 2008).

In community studies of depression, comorbidity with other mental health problems is common. The most frequently occurring co-morbid disorders are dysthymia and anxiety disorders, followed by disruptive disorders. Depressive disorders often develop after the other disorders are established (Biederman, Faraone & Lelon, 1995; Goodyer, et al., 1997; Lewinsohn et al., 1997). However most treatment outcome research excludes young people with co-morbid disorders and so are unlikely to represent the complex difficulties seen by specialist services.
### 7. Depression

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Level of Service</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sub-clinical/Mild</strong></td>
<td>Tier 1-2</td>
<td>High</td>
<td>Group CBT</td>
<td><strong>B</strong> 32, 33, 43</td>
</tr>
<tr>
<td></td>
<td>Tier 2</td>
<td>High</td>
<td>CBT (Brief – 8 sessions)</td>
<td><strong>B</strong> 41</td>
</tr>
<tr>
<td></td>
<td>Tier 1-2</td>
<td>Low</td>
<td>Cognitive Bibliotherapy</td>
<td><strong>C</strong> 33</td>
</tr>
<tr>
<td></td>
<td>Tier 1-2</td>
<td>Low</td>
<td>Relaxation</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>Tier 1</td>
<td>High</td>
<td>Watchful Waiting (further assessment within 2 weeks)</td>
<td><strong>C</strong> 33</td>
</tr>
<tr>
<td><strong>Moderate/Severe</strong></td>
<td>Tier 2-4</td>
<td>High</td>
<td>Interpersonal Psychotherapy for Adolescents (IPT-A)</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>Tier 2-4</td>
<td>High</td>
<td>CBT</td>
<td><strong>A</strong> 14, 29, 30, 31, 33, 37</td>
</tr>
<tr>
<td></td>
<td>Tier 2-4</td>
<td>High</td>
<td>Systemic Family Therapy/Other Family Therapies</td>
<td><strong>A</strong> 7, 8, 9, 11, 14, 17, 22, 27, 33, 34, 35, 36, 37, 43, 44, 45</td>
</tr>
<tr>
<td></td>
<td>Tier 2-4</td>
<td>High</td>
<td>Social Skills Training</td>
<td><strong>B</strong> 5, 7, 33, 39</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>C</strong> 21</td>
</tr>
<tr>
<td>Moderate/Severe (cont.)</td>
<td>Tier 3</td>
<td>High</td>
<td>Psychodynamic Psychotherapy &amp; Psychoanalysis should be used when a psychological intervention alone is not effective.</td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td>--------</td>
<td>------</td>
<td>---------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Tier 3-4</td>
<td>High</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 3-4</td>
<td>High</td>
<td></td>
<td>Antidepressant medication should not be used for the treatment of children and young people with moderate to severe depression without concurrent treatment with a psychological therapy.</td>
<td></td>
</tr>
</tbody>
</table>

References:
B 18, 39, 40
C 33
B 13, 33
B 12, 38, 39
B 33
B 13, 19, 28, 33
8. Eating Disorders

A central diagnostic feature for an eating disorder is whether the abnormal behaviour is based on over-evaluation of thinness or morbid fear of fatness but these may be difficult to elicit in younger patients. In anorexia nervosa and bulimia nervosa weight control is often achieved through overactivity including concealed exercise. Bulimia nervosa commonly develops in adolescents and may have a better prognosis if treated early (Lock & Le Grange, 2005).34

Prevalence estimates in Scotland are difficult to calculate given the likely numbers who do not seek medical help. Bulimia Nervosa has a prevalence rate of 1-2% with another 2-3% of teenagers experiencing clinically significant symptoms but not meeting full criteria for diagnosis (Fairburn & Beglin, 1990; Kotler & Walsh, 2000). Older adolescents’ prevalence rates for Anorexia Nervosa range between 0.2–0.8%, with an average reported rate of around 0.3% (Hoek & van Hoeken, 2003).

Both clinic and survey data show rates for eating disorders that are consistently higher for late adolescent girls. In adolescents and young adults around 5–10% of cases occur in males (Barry & Lippman, 1990). In children between 19–30% of cases have been in boys (Bryant-Waugh, 1993; Fosson et al., 1987; Hawley, 1985; Higgs et al., 1989; Jacobs & Isaacs, 1986).

Mortality in anorexia nervosa, with an age of onset before 18 years, is 2.72% (Signorini et al., 2007). Herpertz-Dahlmann and Remschmidt (1993) found anxiety disorders (41%) and affective disorders (18%) to be the most prevalent co-morbid mental health diagnoses, with a highly positive correlation between eating disorders and depressive psychopathology compared with healthy age-matched controls.

Very little research has been undertaken on the treatment of adolescent eating disorders. The NICE (2004) Guidelines identify this as a priority for future research.
8.1 Eating Disorders – Anorexia Nervosa

**Anorexia Nervosa (AN):** is characterised by a deliberate refusal to maintain body weight above a level that is 15% below that expected for the individual’s age and height (Fonagy et al., 2006)\(^1\).

NHS QIS guidelines\(^2\) recommend individualised care and treatment based on individual needs and not on arbitrary targets for weight gain or number of sessions of therapy.

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Level of Service</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>GP/Primary Care Team</td>
<td>Low</td>
<td>Advise of help and support available such as self-help groups and internet resources</td>
<td>C(^ {37, 41})</td>
</tr>
<tr>
<td>Moderate/Severe</td>
<td>Tier 2-4</td>
<td>High</td>
<td>Behavioural interventions (Brief Reward Programmes effective for short term weight gain only limited to 4-5kg – seen as less punitive)</td>
<td>B(^2, 7)</td>
</tr>
<tr>
<td></td>
<td>Tier 2-4</td>
<td>High</td>
<td>Family interventions that directly address the eating disorder should be offered to children and adolescents with AN*</td>
<td>B(^ {36, 38})</td>
</tr>
<tr>
<td></td>
<td>Tier 2-4</td>
<td>High</td>
<td>A ‘separated’ model of FT is recommended for families where there is high expressed emotion, or where they cannot tolerate conjoint work, and for adolescents and young adults.</td>
<td>B(^ {12})</td>
</tr>
<tr>
<td></td>
<td>Tier 2-4</td>
<td>High</td>
<td>CBT, Interpersonal Psychotherapy (IPT), Psychodynamic Therapy, Cognitive Analytic Therapy (CAT), Motivational Enhancement Therapy</td>
<td>C(^)</td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>High</td>
<td>A choice of psychological treatments for anorexia nervosa should be available as part of mental</td>
<td>C(^ {37})</td>
</tr>
<tr>
<td>Moderate/Severe (cont.)</td>
<td>Tier 3</td>
<td>High</td>
<td>health services in all areas.</td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td>--------</td>
<td>------</td>
<td>-------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td></td>
<td>Medication should not be used as the sole primary treatment and the side effects (in particular, cardiac side effects) should be taken into careful consideration.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td></td>
<td>Medication for co-morbid conditions (for example depressive or obsessive-compulsive features) should be used with caution as they may result with weight gain alone.</td>
<td></td>
</tr>
<tr>
<td>Severe</td>
<td>Tier 4</td>
<td>High</td>
<td>Regular physical monitoring is recommended for people with anorexia nervosa during both inpatient and outpatient weight restoration.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Specialist inpatient care that can provide the skilled implementation of refeeding with careful physical monitoring (particularly in the first few days of refeeding) in combination with psychosocial interventions. No evidence that it is superior to out-patient treatment21.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Services should be as close to home as possible to allow families to maintain links</td>
<td></td>
</tr>
</tbody>
</table>

* There is evidence of benefit for Manualised Family Therapy (for example, the Maudsley model)13,33.
8.2 Eating Disorders – Bulimia Nervosa

Bulimia Nervosa (BN): is characterised by recurrent episodes of binge eating with a feeling of lack of control over eating behaviour during binges, and excessive dieting and exercise, with the use of large doses of appetite suppressants, laxatives and/or diuretics in order to reduce weight, and self-induced vomiting (Fonagy et al., 2006). 

Most patients with bulimia nervosa can be managed on an outpatient basis (Hsu, 1990; Mitchell et al., 1990; QIS, 2006), with less than 5% requiring inpatient care (Fairburn, Marcus & Wilson, 1993). Care should be tailored to individuals rather than a rigid pattern or treatment (QIS, 2006).

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Level of Service</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subclinical/ Mild</td>
<td>Tier 1</td>
<td>Low</td>
<td>Evidence-based self-help programme</td>
<td>B 9*, 36, 41, 44*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Guided CBT self-help</td>
<td>B 29</td>
</tr>
<tr>
<td>Moderate/ Severe</td>
<td>Tier 2-3</td>
<td>High</td>
<td>Cognitive behaviour therapy for bulimia nervosa (CBT-BN).</td>
<td>A 1*, 16*, 18*, 30, 31*, 36*, 42*, 45*</td>
</tr>
<tr>
<td></td>
<td>Tier 2-3</td>
<td>High</td>
<td>Interpersonal Psychotherapy (IPT) should be considered as an alternative to CBT, but patients should be informed it takes 8-12 months to achieve results.</td>
<td>B 1*, 16*, 36*</td>
</tr>
<tr>
<td></td>
<td>Tier 2-3</td>
<td>High</td>
<td>Family Therapy</td>
<td>A 29, 41</td>
</tr>
<tr>
<td></td>
<td>Tier 2-3</td>
<td>Low</td>
<td>Evidence-based self-help programme</td>
<td>B 4*, 9*, 36, 41, 44*</td>
</tr>
<tr>
<td></td>
<td>Tier 2-3</td>
<td>Low</td>
<td>Guided CBT self-help</td>
<td>B 29</td>
</tr>
</tbody>
</table>

* Evidence from adult studies and adult recommendations.
9.1 Schizophrenia / Psychosis

The range of psychoses and schizophrenia are characterised by distortions of thinking and perception and a distorted affect. The symptoms associated with these difficulties are known as positive symptoms. Negative symptoms such as apathy, social withdrawal, poverty of speech and incongruent emotional responses may also be present. Scholastic ability and self-care may also be affected (Fonagy et al., 2000)\(^8\).

There are very few studies determining the incidence of schizophrenia in childhood and adolescence. One study identified the ages at first hospitalisation being 15-25 for males and 25-35 for females, although some females were identified before 25 years (Zigler & Levine, 1981)\(^{16}\). The peak ages for onset are 13-30 years (American Academy of Child & Adolescent Psychiatry: AACAP: 2001)\(^3\). In another study, the prevalence in children was identified as much lower than adolescents, being 2 per 10,000 children under 12 years (Eaton et al., 1992)\(^5, 6\).

The onset of Schizophrenia is therefore rare before 13 years of age (AACAP, 2001)\(^3\). The earlier the onset the more severe the disorder (Eaton et al., 1992)\(^5, 6\). Early detection and treatment are important in reducing the effects of the disorder (Falloon et al, 1998)\(^7\).

There are no empirical studies looking at the effectiveness of psychological intervention for this group in childhood and adolescence per se due to the very small incidence in children and younger adolescents. There has been however a surge in research investigating the benefits of psychological interventions for patients with an early onset or adolescent onset psychosis. Most of these studies span client groups between teenage years and early twenties. The clinical needs profile of those individuals who present with an early onset psychosis to CAMH services is seen to be comparable to the clinical populations presented in these studies.
9.1 Schizophrenia / Psychosis

There are few studies that have evaluated the use of psychological treatments in children or young people with schizophrenia. Psychological treatments have been chosen in line with the findings from appropriate adult studies.

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Level of Service</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate</td>
<td></td>
<td>High</td>
<td>Cognitive Behavioural Therapy for:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3-4</td>
<td>High</td>
<td>Prodromal symptoms</td>
<td>A 11*, 15*</td>
</tr>
<tr>
<td></td>
<td>Tier 3-4</td>
<td>High</td>
<td>Transition</td>
<td>B 9*, 11*, 15*</td>
</tr>
<tr>
<td></td>
<td>Tier 3-4</td>
<td>High</td>
<td>Functioning</td>
<td>B 14, 15*</td>
</tr>
<tr>
<td>Severe</td>
<td>Tier 3-4</td>
<td>High</td>
<td>CBT for acute symptoms</td>
<td>A 4*, 12*, 14</td>
</tr>
<tr>
<td></td>
<td>Tier 3-4</td>
<td>High</td>
<td>CBT for functioning</td>
<td>A 4*, 14</td>
</tr>
<tr>
<td></td>
<td>Tier 3-4</td>
<td>High</td>
<td>CBT for mood related to first episodes</td>
<td>B 4*, 13</td>
</tr>
<tr>
<td></td>
<td>Tier 3-4</td>
<td>High</td>
<td>Family Interventions</td>
<td>A 1*, 7*</td>
</tr>
</tbody>
</table>

* Participants were recruited from adolescent and adult populations.
9.2 Bipolar Disorder

DSM-IV recognises 2 types of bipolar disorder, types I and II. Bipolar I is characterised by the occurrence of 1 or more manic episodes or mixed episodes. Bipolar II disorder is characterised by the occurrence of one or more major depressive episodes accompanied by at least one hypomanic episode (APA, 1994)\(^2\).

There are very few studies of psychotic disorder in children and adolescence. Two studies identified the incidence as being 0.2 and 0.3% (Costello et al, 1988\(^7\); Lewinsohn, Hops, Roberts, Seeley & Andrews, 1993\(^{13}\)). The onset may occur following the initiation of antidepressant medication for a depressive illness (Bowring & Kovacs, 1992\(^4\)). The age of onset can be between 8 to 19 years with a mean onset age of 15.9 years (Carlson et al, 1977\(^6\)), with 20% having their first episode during adolescence (AACAP, 2001\(^1\)). Both sexes are affected equally (AACAP, 2001\(^1\)).

There are no published studies that have focused on comorbid disorders with bipolar disorder; however these are not uncommon (Fonagy et al., 2000\(^9\)). ADHD and Conduct Disorder are frequently seen in young people with Bipolar Disorder (Carlson, 1990\(^5\)). Substance abuse has also been noted (Borchardt & Bernstein, 1995\(^3\); Carlson, 1990\(^5\)).

As for the psychosis group there are few empirical studies investigating the effectiveness of psychological therapies for children and adolescents with bipolar disorder specifically. With the exception of family-focused treatments most findings are therefore extrapolated from relevant studies investigating adult or young adult samples.
### 9.2 Bipolar Disorder

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Level of Service</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate</td>
<td>Tier 3-4</td>
<td>High</td>
<td>Psychoeducation &amp; relapse prevention</td>
<td>B(^8^)*</td>
</tr>
<tr>
<td></td>
<td>Tier 3-4</td>
<td>High</td>
<td>CBT</td>
<td>B(^8^)*</td>
</tr>
<tr>
<td></td>
<td>Tier 3-4</td>
<td>High</td>
<td>Interpersonal and Social Rhythm Therapy (IPSRT)</td>
<td>B(^10^)*</td>
</tr>
<tr>
<td></td>
<td>Tier 3-4</td>
<td>High</td>
<td>Family intervention</td>
<td>A(^8^), 12, 14</td>
</tr>
</tbody>
</table>

* Participants were recruited from adolescent and adult populations.
1. Infant Mental Health Risks and Disorders


2. Disruptive Behaviour Disorders (Disorders of Conduct)


*Social Learning Theory based Parent Management Training – (Starred entries indicate UK research)

3. Attention Deficit Hyperactivity Disorder (ADHD)


4. Autism spectrum disorders


5. Anxiety


5.2 Obsessive Compulsive Disorder


5.3 Specific Phobia


6. Post Traumatic Stress Disorder (PTSD)


7. Depression


8. Eating Disorders


**9.1 Schizophrenia**


### 9.2 Bipolar Disorder


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Cathy Richards Oct 2008
Appendix 2

Sections to be developed/added in the future:

Self-harming Disorders
Substance Misuse
Atypical eating disorders including binge eating disorder
Body Dysmorphic Disorder
Panic Disorder With/Without Agoraphobia
Social Phobia
Separation Anxiety
Sleep problems
Children with physical illness
Chronic Fatigue
Chronic Pain
Neuropsychology