Mental Health in Scotland

A Guide to delivering evidence-based Psychological Therapies in Scotland
“The Matrix - 2011”
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“The Matrix”

A Guide to delivering evidence-based Psychological Therapies in Scotland

March 2011

Introduction and Overview

The Scottish Government is committed to increasing the availability of evidence-based psychological interventions, and the Local Delivery Plan Guidance for 2011-12 introduces for the first time a new maximum waiting times access target for Psychological Therapies. Targets for Psychological Therapies, CAMHS and Alcohol Misuse will help tackle some of Scotland’s biggest economic and social problems.

The Reshaping Care and Mental Health Division is also committed to supporting NHS Boards to meet HEAT 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 plan and provide the most effective available psychological treatments for their particular patient population. The Matrix is a guide to planning and delivering evidence-based Psychological Therapies within NHS Boards in Scotland. 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.

The Matrix has been produced to help NHS Boards:

- Deliver the range, volume and quality of Psychological Therapy required to achieve the HEAT Psychological Therapies Access Target, and to meet ICP accreditation standards.
- Provide evidence-based psychological interventions in other key government priority areas;

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 Quality and Efficiency Support Team (MH QuEST); Health Improvement Scotland (HIS) and the Integrated Care Pathway (ICP) process; the Information Services Division (ISD); and NHS Education for Scotland (NES)

As such, it aligns with the ambitions of the NHSScotland Healthcare Quality Strategy, by promoting the delivery of efficient and effective treatments, and by seeking to minimise wasteful and harmful variations in practice through the clarification of training standards and supervision requirements. In addition it offers guidance on service structures and governance arrangements necessary to ensure patient safety.

**Expansion and Update of the Evidence Tables**

The summary evidence tables in the current document cover

• Key areas within Adult and Older People’s 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 range of conditions covered by *The Matrix* evidence tables has been expanded since the original 2008 version, however the tables do not yet encompass all diagnoses or mental health patient groups. We have continued to focus on common mental health problems and disorders, the conditions covered by the ICPs, and other key Scottish Government priority areas.

The current version includes new or revised tables on the evidence base for the application of Psychological Interventions

• with Older People
• with Children and Adolescents
• with people with Learning Disabilities
• with Forensic populations
• for Trauma and PTSD
• for Depression

The intention is to continue to extend the evidence tables over time to give more comprehensive coverage, and to update the recommendations as new evidence becomes available.
There is no suggestion that NHS Boards should provide all of the therapies and interventions listed in the tables. For any patient group choices over which evidence-based intervention to deliver will have to be made locally, based on costs of training and sustainable service delivery, available expertise and existing strategic plans.

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 Chapter 3).

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.
Summary Guidance  
on  
' Well-functioning Psychological Therapies Services'

Psychological Therapies (PTs) services should be structured, staffed and governed in such a way as to meet people’s expectations in terms of both waiting times and the quality of care they receive. This section, which replaces the more traditional ‘executive summary’, encapsulates the attributes essential to any service in achieving these standards. The content of this summary guidance is elaborated in the subsequent sections of the document.

Approach

Well-functioning Psychological Therapies services should be embedded in a ‘psychologically-informed’ system encompassing health, social care, the voluntary sector and service users and their families, within which staff from all disciplines deliver psychologically informed care. In addition, many staff will have the competences necessary to offer specific, evidence-based psychological interventions as a core aspect of their work.

There should be multi-disciplinary delivery of psychological interventions and therapies at a variety of levels in both mental and physical health settings. Training and accreditation in therapeutic approaches should be competence-based.

The system should
- deliver evidence-based care
- within a framework of values-based practice -as laid out in the 10 Essential Shared Capabilities (Scotland)
- have a recovery focus
- engage with service users and carers at all stages of the process

Recognising that access is not simply a function of availability, the well-functioning system should 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 population.

The system should be strategically managed at National and NHS Board level in a manner which creates confidence around effectiveness, efficiency and patient safety. Effective strategic management should involve oversight and planning at a level above that of the delivery of individual treatment, as outlined below.
Strategy

- There should be direct accountability for Psychological Therapies at NHS Board level, and an appropriate mechanism (for example a local multi-professional and multi-agency psychological therapies strategic planning and management group) to ensure coherent and comprehensive planning across an NHS Board area.
- Consideration should be given to equity of provision/availability of treatment across NHS Board areas and across specialist areas of service.
- The planning group should have the authority to dis-invest in therapies and services which are ineffective, inefficient or not cost-effective.
- Planning groups should oversee service audit and re-design, workforce planning, training and governance of psychological therapies. They should also promote service-based research to advance the evidence base.
- Links should be made between the work around the Psychological Therapies HEAT target, the ICP process, the Mental Health Quality and Efficiency Support Team and NHS Education for Scotland.
- The well-functioning system should involve staff in developing the processes around the monitoring and delivery of the various HEAT targets, in order to harness local expertise and maximise subsequent engagement.
- Boards should have IT systems which can collect information with minimal investment of time and effort, and will feed meaningful and clinically relevant information back to staff to inform both direct patient care and service audit and re-design.
**Implementation**

Well-functioning Psychological Therapies services should operate within the framework of a clearly articulated and well governed matched/stepped-care system. Each matched/stepped care service will be audited and managed pro-actively to manage demand and capacity, and to maximise effectiveness, efficiency, cost-effectiveness and patient safety, in the context of achieving the HEAT targets.

Processes within ‘Matched/Stepped-Care’

- There should be clarity around the thresholds for accessing the various tiers of service, based on complexity of presentation. GPs should have guidance to enable them to refer appropriately, and within the system staff should be clear about the criteria for assignment to the different levels of intervention.

- There should be clear pathways through the system, specifying how patients will be allocated to levels of intervention, and how they will be stepped up or down as necessary. The system should gather intelligence on activity levels within each tier, on the numbers of those who are not considered as suitable for psychological intervention and on what happens to those individuals.

- There should be drivers which strongly encourage clinicians to match to the least intensive intervention which will provide significant health gain.

- There should be ‘direct access’ options to the service which will help to address issues of low uptake by ‘hard to reach’ groups.

- Patients and carers should be involved in decision making around care.

- Patient outcomes should be collected routinely, and services should be moving towards session-by-session outcome monitoring to maximise data completeness for purposes of service audit and continuous improvement, to drive ‘stepping-up,’ and to inform clinical supervision and improve patient outcomes.

- Staff should have the training and supervision necessary to deliver the functions required to operate the system effectively, as appropriate to their role.

- There should be continuous monitoring and feedback on the performance of the matched/stepped-care model and referral system, and outcome data should be used to drive improvement.

- Properly funded research trials to evaluate new and innovative therapeutic approaches should be facilitated.
Tiers of Care

Although there will be some variation among services, which should be configured to best meet local needs, the well-functioning service will have levels of service delivery corresponding to:

- **High Volume interventions.**

  Aimed at those experiencing stress or other forms of psychological distress, and may include provision of information, psycho-education, prescribed exercise, counselling or the use of psychological principles within another healthcare context.

  These do not fall within the scope of the target, but some measurement of the volume of activity within this tier should be made.

- **‘Low Intensity’ evidence-based treatments.**

  Protocol-driven interventions aimed at less complex mental illness and disorder and normally lasting between 2 and 6 sessions.

  Low Intensity treatments will be counted under the PTs HEAT Access target if they are delivered to people with a mental illness or disorder, face-to-face, in protected time, to protocol, by properly trained staff under appropriate supervision.

Both High Volume interventions and Low Intensity treatments should be highly valued as essential elements of the well-functioning system, recognising their potential to deliver effective care to a significant number of patients, thereby reducing the pressure on the higher tiers and enabling the delivery of the HEAT Access target.

- **Psychological Therapies—‘High Intensity’ and ‘Specialist’ interventions.**

  Traditional, standardised psychological therapies (Cognitive Behavioural Therapy (CBT), Interpersonal Psychotherapy (IPT), Short-term, focused Psychodynamic Psychotherapy etc) aimed at moderate to severe mental illness and disorder with significant complexity, sometimes within a specialist service, and normally lasting between 6 and 20 sessions.

- **Highly Specialist Psychological Therapies and interventions.**

  Individually tailored interventions based on case formulations drawn from a range of psychological models, aimed at service users with highly complex ad/or enduring mental illness and disorder, and normally lasting for 16 sessions and above.
Waiting times for ‘High Intensity’, ‘Specialist’ and ‘Highly Specialist’ psychological therapies and interventions will be measured under the Psychological Therapies HEAT Access target.
The provision of effective psychological interventions at sufficient volume is essential to ensure that NHS Boards achieve the ambitious targets the Scottish Government has set for improving mental health outcomes in Scotland.

Psychological Therapies HEAT Target

The target for Psychological Therapies is constituted as an Access target for mental health services

‘Deliver faster access to mental health services by delivering 18 weeks referral to treatment for Psychological Therapies from December 2014’

There are no exclusions from the target, which will be applied across the age range, and to all patient groups.

Related targets

In addition to the Psychological Therapies Access target, the timely provision of effective psychological interventions will be necessary to support Boards in meeting a number of the other current HEAT targets

**Suicide Target:** 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;

**Drug and Alcohol Target:** By March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery

**Children and Young People’s Mental Health: Targets and Commitments**

In addition to the Psychological Therapies HEAT target, Child and Adolescent Mental Health Services (CAMHS) services are also working to meet an Access target for specialist services-

‘Deliver faster access to mental health services by delivering 26 weeks referral to treatment for specialist CAMHS from March 2013’

and a number of other commitments
• To implement ‘The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care’ by 2015;

• To increase access to parenting training in line with the recommendations of the Early Years Framework

• To 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.
The Purpose and Structure of this Paper

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 support NHS Boards in developing strategic plans 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 Chapter 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:

- Meeting the Psychological Therapies HEAT Access target
- Improving services for the common mental health problems-depression and anxiety;
- Meeting the HIS standards for ICPs and achieving accreditation of the Integrated Care Pathways; and
- Building capacity in clinical priority areas.

In line with the strategic aims of the exercise, the document is divided into 6 chapters:

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

**CHAPTER 2 – Service Structures and Processes**

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

**CHAPTER 4 - Support for Changes**

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

**CHAPTER 6 - ‘The Matrix’ Evidence Tables - Summary of the Psychological Therapies Evidence Base**
CHAPTER 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 has been taken forward by NHS Education for Scotland (NES), based on the ‘10 Essential Shared Capabilities (ESC) for Mental Health Practice: Learning Materials (Scotland)’.

NES launched the first version of the Scottish materials in 2007 and also commissioned a “training for trainers” programme that prepared and supported individuals drawn from across mental health services in Scotland to further disseminate and cascade the 10 ESC training within their organisations. The 10 ESCs training and learning has been widely disseminated in Scotland, particularly among mental health nurses as a result of Rights, Relationships and Recovery – the 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. An independent evaluation of the learning materials and the dissemination of the ESC learning in Scotland was published in 2010.

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 mental health nursing. The principles have also been supported by AHPs in Scotland, and have been adopted by the College of Occupational Therapists and the Charted Society of Physiotherapists as their underpinning values.

For further information and to download the Learning Materials go to:


A second edition of the learning materials will be available from April 2011.

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/initiatives/mental-health/publications


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 matched/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 under appropriate supervision.

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), Behaviour Therapy (BT), Systemic and Family Therapy, Psychoanalytic/Psychodynamic Psychotherapy, Inter-Personal Therapy (IPT) and Humanistic 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 (Chapter 6) 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 Chapter 3)
Psychological Therapies and the HEAT Access target

The objective of the target is to:

‘Deliver faster access to mental health services by delivering 18 weeks referral to treatment for Psychological Therapies from December 2014’

The target is intended to improve access to evidence-base psychological therapies for people who have a mental illness or disorder.

There are no exclusions from the target, which applies across the age range and in inpatient as well as community settings. It will also apply in physical health, learning disability and substance misuse settings where there is associated mental illness or disorder.

The target will be part of the HEAT performance management system and will require NHS Boards to make monthly data submissions to ISD. Progress against the delivery of the target will be monitored through the existing 6-monthly review visits which the Reshaping Care and Mental Health Division has with NHS Boards

Data to be collected nationally

In order to monitor progress towards the target the key information to be collected on every patient to enable monitoring of waiting times is:

- Date of receipt of the referral
- Date psychological therapy commences as planned

As a balancing measure the waiting time between assessment and commencement of therapy will also be recorded by collecting

- Date of start of initial assessment for suitability for psychological therapy

Waiting times should be measured and adjusted for patient unavailability in line with national waiting times guidance. In order to ensure that information is collected consistently ISD is working with key stakeholders to develop data standards and guidance on the application of national waiting times guidance to psychological therapies.

Data to be collected locally

Balancing Measures

The setting of a HEAT target for any part of the system can have repercussions for other areas of service. It is expected that NHS Boards will collect data locally on a
number of additional balancing measures. This will help to ensure that the existence of the target does not impact negatively on other parts of the system, or on the quality of patient care.

Patient outcomes are an important balancing measure. These need to be monitored closely to ensure that any changes made to achieve the target do not impact adversely on clinical effectiveness. The Reshaping Care and Mental Health Division is currently consulting on the possibility of standardising outcome measures across Scotland, and on what will be monitored nationally in this regard.

The monitoring of the target should also include a balancing measure capturing the percentage of people assessed as not suitable for psychological therapy.

Further information on key measurement points and other guidance can be found on ISD’s website http://www.isdscotland.org/Health-Topics/Mental-Health/Psychological-Therapies.asp

Measures around evidence-based practice

For the purposes of the HEAT target, ‘Psychological Therapies’ will be defined as evidence-based interventions (as recommended in the evidence tables in Section 6 of this document), delivered to patients experiencing a mental illness or disorder. In the vast majority of cases these interventions will be delivered to people with depression and anxiety.

However, during development of the target, representatives from NHS Boards made the case that there are circumstances where a psychological therapy is delivered that is not included in The Matrix in order to meet the needs of a particular patient. At the moment there is no clear picture of what therapies are delivered across Scotland, and what proportion of them are delivered in line with the evidence-base. For this reason, data will be collected nationally on all psychological therapies being delivered to people with a mental illness or disorder.

Collecting information locally about the level of variance – how often therapies are delivered outwith the evidence base – will provide an overview, both locally and nationally, of where there might be gaps in The Matrix, as well as where there might be barriers to delivering evidence-based therapies e.g. due to a lack of trained staff.

In order for a Board to be able to determine whether a psychological therapy is being delivered in line with the evidence base, it will need to know that the therapy being delivered is:

- a therapy which has an evidence base for that particular diagnosis

and that it is being delivered:
by appropriately trained staff
• to individuals or groups on a face-to-face basis.
• in dedicated/focused sessions within protected time
• with recommended levels of psychological therapies supervision.

‘Face-to-face’ will include interventions delivered by telephone or direct video link.

There are also situations in which psychological therapy is delivered through family members, carers and health or care staff, where they are being trained or supported to deliver a particular intervention. This may happen, for example, in Child, Learning Disabilities and Dementia services. In these circumstances the therapist will be involved in face-to-face sessions with third parties as described. Although the named patient may not be present, these interventions should be counted under the target.

It is expected that ISD will make recommendations on the key information requirements for the target, to enable Boards to develop their own local datasets for the collection of information on diagnosis, type of therapy delivered and clinical outcomes in addition to the information required around access. Ensuring the competence of therapists, the provision of adequate psychological therapies supervision and the availability of protected time for delivery is a local governance issue.

It is recognised that the current evidence tables do not cover all diagnostic groups, and it is assumed that Boards will take advice from local experts on the status of current evidence and best practice where national guidance is not available.

What should be counted?

The target is focused on mental health services, and on patients who would meet diagnostic criteria for mental illness and disorder, and consequently the waiting times measures will primarily focus on therapies delivered at higher tiers of service, and on those Low Intensity interventions which meet the criteria listed above.

This is not to suggest that other higher volume, low intensity interventions are unimportant. The evidence is that a substantial proportion of those with mild/moderate mental illness and disorder can be treated effectively at this level, reducing demand for service at higher tiers. Indeed it is envisaged that NHS Boards will only be able to meet the target if they provide a substantial volume of high quality ‘Low Intensity’ interventions as part of an integrated service. It is expected that NHS Boards will put in place some measure of volume of care delivered within the lower tiers.

Examples of what should and should not be counted under the target:

Everything listed below is desirable, and should happen in a well-functioning service, but not everything should be counted under the target.
(Note: The list does not attempt to cover every possible intervention, but to provide helpful exemplars)

- All staff should be delivering psychologically-informed care, which may involve formulating a patient’s difficulties in psychological terms. Although this is essential element of holistic care, it should **not** be counted under this particular target.

- Staff delivering open access, large scale psycho-educational groups should **not** count this under the target, although some measure of volume of care should be in place.

- Staff delivering counselling for psychological distress at lower tiers of the service should **not** count this under the target, although, again, some measure of volume of care delivered should be in place. Counselling should only be counted under the target where it is recommended in *The Matrix* as an evidence-based intervention for a specific condition.

- Staff delivering CBT-based guided self-help to protocol, or standardised small-scale anxiety management groups, **should** count this under the target.

- Staff delivering ‘High Intensity’ Therapy and ‘High Intensity Specialist’ Therapy for mental illness or disorders **should** count this under the target.

- Staff delivering ‘Highly Specialist’ Therapy **should** count this under the target.

So, for example, a community psychiatric nurse using CBT-informed practice, (or a particular CBT technique outside of a standardised treatment package), while on a routine home visit to a patient would not count this under the target. Whereas, the same CPN delivering a specific CBT-based intervention (eg guided self-help) to a recognised protocol in the course of a series of home visits, would count this under the target.

Where a diabetic patient is receiving a cognitive behavioural intervention focused on improving control of diabetic symptoms, this would not be counted under the target. However, if the same patient were receiving a psychological therapy for depression, which may be related to the physical condition, this would be counted under the target.

A psychological therapist working with carers or support staff to establish and oversee the delivery of an evidence-based intervention for anxiety to a person with a learning disability would count this under the target, even though the therapist might not be working ‘face-to-face’ with the patient themselves.
Assessments

Where assessments are quite clearly for the purpose of establishing suitability for psychological therapy, and/or triage to appropriate levels of service, they will be captured as a ‘balancing’ measure for the HEAT target as outlined above.

However, there are more complex assessments which are not necessarily linked to the delivery of psychological therapies, but which may require a number of sessions to complete. These may include general diagnostic assessments, neuro-psychological assessments, assessments to establish the presence of a learning disability etc.

- If these assessments are purely investigative or diagnostic, or for the purpose of general care planning, and do not involve, or lead on to the delivery of psychological therapy (as defined for the purposes of the target), they should not be counted under the target.
- However, during the course of such an assessment it may be appropriate to deliver a formal psychological intervention. This psychological intervention should be counted under the target if it meets the criteria for an evidence-based psychological therapy as defined for the purposes of the target. The clock would stop at the point at which therapy commences, which may be during the assessment phase
- If, following the assessment, the patient is referred on for a psychological intervention or therapy for a mental illness or disorder, the waiting time should be measured in line with national waiting times guidance.

Further information on what is to be counted can be found in the ISD Frequently Asked Questions (FAQ) document at http://www.isdscotland.org/Health-Topics/Mental-Health/Psychological-Therapies-FAQ.asp This will be updated on an ongoing basis.

Phased approach to data collection

There is a recognition that it will be nearly impossible for NHS Boards to provide all of the required data to ISD from the outset, and that it will be some months before NHS Boards are in a position to collect good quality data on waiting times, evidence-based delivery and ICP variance across all services for which the target applies.

NHS Boards are being encouraged to take a phased approach to data collection as suggested below

Year 1 (April 2011 to March 2012)
• During year one focus will very much be on identifying the services and workforce delivering therapies, making changes to IT systems to enable data to be collected, and engaging with clinicians to begin to capture baseline waiting times information. It is understood that it may be some months before all services are able to supply data.

• By the end of year one it is hoped that data will be coming in from all services within NHS Boards which deliver psychological therapies. It is expected that by that stage data will be available locally on waiting times for specific therapies.

Year 2 (April 2012 to March 2013)

• During year two the focus will be on improving the quality of the data collected through the application of national waiting times guidance, so that in the early part of year two NHS Boards are able to submit adjusted waiting times.

• By the end of year two it is anticipated that NHS Boards will be submitting waiting times information which is complete for all services delivering therapies, and is in line with national waiting times guidance to enable national comparisons. It is hoped that information on waiting times for specific therapies will be routinely collected and available locally.

Year 3 (April 2013 to March 2014)

• During year three it is likely that there will be plans to include the data returned by NHS Boards in the HEAT dashboard system as ‘management in confidence’ (unpublished) information. During this year NHS Boards may also be requested to provide information for national use on waiting times for the delivery of specific therapies, and on the delivery of therapies which are outside the evidence base.

• By the end of year three, which is six months from the delivery of the target, there should be good quality, nationally comparable data.

(Issues around the delivery of evidence-based therapy, the role of clinical supervision, the definition of High and Low Intensity interventions and the specification of appropriate training levels are discussed further below)

**Delivering Evidence-based Psychological Therapies**

The commitment to deliver ‘evidence-based’ interventions has 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 recognised standards, and having the competences necessary to deliver psychological interventions effectively to the tier of service within which they work;
- delivering a therapy which has a strong evidence base with respect to the patient’s diagnosis;
- delivering well-articulated therapy, and adhering to the appropriate model; and
- operating within a well-governed system which offers regular high quality, model-specific psychological therapies supervision, support and relevant Continuing Professional Development (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 Chapter 3).

It is important to bear in mind that the standards for the delivery and supervision of Psychological Therapies within a matched/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 Psychological Therapies Supervision

As with all other Health Service treatments, Psychological Therapies must, in line with the ambitions of the Quality Strategy, be delivered in a way which is safe, effective and efficient.

However Psychological Therapies differ significantly from physical interventions in a number of respects. The vehicle for delivery is a complex interpersonal interaction, and treatment sessions often take place over extended periods of time, usually on a one-to-one basis with no direct observation.

The best available evidence suggests the regular Psychological Therapies supervision covering all active cases, and focusing on adherence to protocol, progress in treatment and elements of the therapeutic relationship, is the best mechanism for reducing potentially harmful variations in practice, and for ensuring the safe, effective and efficient delivery of therapy.
At the outset, it is important to distinguish between traditional clinical or work-related supervision - which may cover a range of clinical, managerial and related issues- and the term ‘Psychological Therapies supervision’.

Psychological Therapies supervision focuses on the delivery of a particular therapy in a specific context. It is essential to the provision of effective Psychological Therapies services, both during training and to ensure the safety and quality of subsequent practice. It is a requirement of all professional bodies accrediting psychological therapists.

Psychological Therapies 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)
- Promotes 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
- Acts as a vehicle for training and skills development in practice
- Can improve treatment effectiveness when it is outcome focussed.

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. (See Chapter 3)

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

Matched/stepped-care models were developed to enhance the capacity of Mental Health services and to increase access to evidence-based psychological interventions in the face of escalating demand and diminishing resources. They build on the development of a range of ‘Low Intensity’ psychological interventions which are less restrictive and resource intensive than traditional approaches. It is now accepted that many patients who present to the mental health services can achieve good outcomes from these less resource-intensive interventions, freeing up capacity at the higher tiers of service to provide effective treatments for those with more complex difficulties.

Matched/stepped –care services adopt 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 complex difficulties. Subsequent ‘steps’ are usually defined by increasing levels of case complexity, and increasingly intensive forms of treatment. An allocation process seeks to predict how
patients will respond to the different levels of therapy available, and to match them with the least resource-intensive treatment likely to be effective.

There are a number of features common to effective matched/stepped care systems:-

- Matched/stepped care requires a range of treatments of differing intensity to be available
- The least intrusive treatment available that will provide significant health gain should be offered first, and services should have ‘drivers’ that strongly encourage clinicians to match to the least intensive interventions
- The system should be ‘self-correcting’, ie provide feedback and allow for the intensity of the interventions to be adjusted.
- A range of systematic mechanisms must be in place to aid clinical decision making eg referral criteria, rank ordering or consensus on hierarchies of interventions, allocation guidelines, and subjective and objective measures of patient outcome.

A more detailed review of the issues around the provision of effective matched/stepped care services can be found at

http://www.nes.scot.nhs.uk/disciplines/psychology/psychological-interventions-team/review-of-literature-

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 matched/stepped-care models have been developed to deliver Psychological Therapies, based on a number of different conceptual frameworks. This has given rise to a range of definitions of the tiers of service and of the skills needed at each level. Some models are described in terms of the severity of problem and its impact on functioning, some in terms of the level of expertise of the professional involved, some in terms of the nature 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:
• **High Volume Interventions**

*Information*

Use of information and evidence-based ‘health technologies’ is the least resource intensive level of intervention. It is generally initiated by the individual and accessed directly, does not involve one-to-one contact with mental health staff, and does not require GP referral. It would include information available on mental health issues in general, on common mental health problems, and on different treatment approaches.

The dissemination mechanisms would include information leaflets available through GPs surgeries or other health and social care agencies, library/reading schemes, relevant television programming, large-scale psycho-educational groups, and direction to high quality Psychological Therapy websites.

*Structured Exercise*

This can be initiated by the patient and accessed directly, or ‘prescribed’ by healthcare staff, who can refer motivated individuals for appropriate exercise advice and activities in local communities.

*Counselling*

It is recognized that counselling is one of a range of interventions which NHS Boards may choose to make available at lower tiers of the service. These will meet the need of a significant number of people experiencing psychological distress, thereby contributing to a well-functioning system overall.

• **‘Low Intensity’ evidence-based treatments**

These are most commonly accessed through GPs, and would cover Doing Well Advisors/Self-Help Coaching, problem solving therapy, guided self-help, behavioural activation, some computerized CBT packages, structured anxiety management groups etc.

The interventions are aimed at mild/moderate mental health problems with little complexity, are time-limited and normally last between 2-6 sessions.
• ‘High Intensity’ interventions-Psychological Therapies

These are normally based in Secondary care, and comprise traditional, standardised psychological therapies (CBT, IPT, etc), delivered to protocol.

The therapies are aimed at moderate/severe common mental health problems with significant complexity and effect on functioning, and normally last between 6 and 16 sessions.

• Specialist Psychological Therapies

These are most commonly accessed through secondary care and specialist services. Essentially they are standardised high intensity psychological therapies developed and modified for specific patient groups. They are delivered at the same level as ‘High Intensity’ therapies, but in a specialist context.

Specialist therapies are aimed at moderate/severe mental health problems with significant complexity and effect on functioning e.g. substance misuse, eating disorders, bi-polar disorder and normally last between 10 and 20 sessions.

• Highly Specialist Psychological Therapies and Interventions

Highly specialist, individually tailored interventions based on case formulations drawn from a range of psychological models.

Normally 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. In IAPT services in England, which currently cover mild/moderate populations, a ratio of 60% High Intensity Psychological Therapists to 40% Low Intensity workers is emerging as the optimum staffing configuration. Services focusing on more complex patients would require a higher proportion of High Intensity and Highly Specialist Therapists. Careful thought needs 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.

**Psychological Therapies-a role for all disciplines**

All clinical staff working in the NHS in Scotland should have the basic level of knowledge and understanding necessary to communicate effectively with patients and deliver holistic care which takes account of the patients psychological and emotional presentation and needs.

Beyond that, staff from all disciplines have a role in the identification of psychological problems, and many will be involved in the delivery of specific evidence-based psychological interventions and therapies at different tiers of the service. Within primary care and mental health services in particular, it will be necessary to maximise the contribution of the various disciplines to the delivery of Psychological Therapies in order to meet the HEAT access target.

The educational framework for the delivery of psychological therapies, and for the provision of psychological therapies supervision, is competence-based. Staff from any discipline who can demonstrate the relevant competences may be involved in delivery and supervision of care, and of related teaching and training.

**Applied Psychology**

The bulk of psychological interventions delivered within the NHS were traditionally carried out by Clinical Psychologists from within psychology services and departments. However in recent years the emphasis has been on expanding capacity through skill
Skill mix has happened within psychology services themselves with the addition of Assistant Psychologists, Clinical Associates in Applied Psychology, Counselling Psychologists, Cognitive Behaviour Therapists and Self-help Workers to many departments. In addition there has been an increase in the number of staff from other disciplines trained in particular psychotherapeutic approaches. This expansion of the skill mix, and the demand for greater access to psychological interventions, has led to an increase in the requests for Applied Psychologists to provide training and supervision.

The 2011 document ‘Applied Psychology and Psychologists in NHS Scotland’ recommends that Applied Psychologists maintain and develop extended roles aimed at increasing the availability of psychological interventions whilst retaining a role in ensuring the quality of interventions offered. It is also recommended  that Applied Psychologists concentrate their direct clinical work on those with the most complex presentations.

**Nursing**

As the largest profession in the NHS, the input of nurses will be critical in enabling NHS Boards to deliver good psychologically-based care, and to meet the HEAT access target.

Action 6 from the refreshed Rights, Relationships and Recovery action plan published in June 2010 (which was re-iterated in ‘Keeping Going’, the RRR annual report in 2011) states that:

'Mental health nurses’ role in delivering Psychological Therapies must be progressed using a stepped approach to competence development'

It’s achievement requires the provision of accredited training, ongoing psychological therapies supervision for nurses practising Psychological Therapies, and pro-active management activity to ensure nurses have protected time to deliver psychological interventions and therapies in practice.

**Allied Health Professionals (AHPs)**

AHPs have contact with patients in a range of settings, and are in a good position both to identify psychological distress and mental illness, and to offer appropriate interventions.
Recommendation 7 from ‘Realising Potential: an action plan for allied health professionals in mental health. 2010’ states that:

‘NHS Boards should ensure the delivery of evidence-based psychological interventions by appropriately trained AHPs to support rehabilitation, self-management and recovery approaches as part of local delivery strategies.’

The challenge for services is to utilise the AHP staffing resources at their disposal to deliver a range of evidence-based psychological interventions and maximise AHPs potential to promote better outcomes for service users and carers. The challenge for AHPs is to clearly articulate their contribution to delivering psychological interventions and actively engage in local psychological forums and strategy groups, working in partnership with NES Psychological Therapies Training Co-ordinators

AHPs can integrate recognised psychological approaches into their core practice, and contribute significantly to the national Psychological Therapies agenda by enabling service users and carers to have a choice of evidence-based non-pharmacological therapies. Appropriately trained AHPs can deliver a range of the evidence-based interventions as described in the psychological therapies Matrix while continuing to provide specialist AHP rehabilitation interventions.

‘Realising Potential: an action plan for allied health professionals in mental health’ can be found at http://www.scotland.gov.uk/Publications/2010/06/15133341/0

* AHPs working in Mental Health include occupational therapists, arts therapists, dieticians, podiatrists, physiotherapists and speech and language therapists.

Psychiatry

The Royal College of psychiatrists has recommended that psychological therapy services are expanded nationally so that they are available in all areas.

All psychiatrists working in the NHS have some basic training in the different forms of psychological therapy, and may deliver low intensity psychological therapies – as well as more supportive psychological interventions for people with long-term problems as part of their role within the general psychiatric services. Psychiatrists from a range of specialities may have additional training in psychological interventions and therapies which are relevant to their areas of work.

A smaller number of psychiatrists will have completed a higher specialist training in psychotherapy, which included intensive training in one psychotherapeutic modality (CBT, Psychodynamic or systemic therapy), and training in the other two approaches. They are then designated ‘Consultant Psychiatrists in Psychotherapy’. As such they are able to train speciality registrars in psychotherapy, and staff from other disciplines.
In their role as psychological therapies trainers and supervisors, and Consultant Psychiatrists in Psychotherapy, psychiatrists have an important role in the governance of the psychological treatment services within NHSScotland.

Primary Care Staff

The majority of psychological distress and mental health problems are dealt with in the Primary care setting. With reference to psychological interventions, GPs and other Primary care staff who are working closely with patients and families in the general health context have a key role in identifying psychological problems, offering advice and low level interventions as appropriate, and referring on to mental health services where this is indicated. Within some GP practices staff may be trained to deliver psychoeducational packages and guided self-help interventions.
CHAPTER 2
Service Structures and Processes

Introduction

It is recognised that there is a considerable gap in many 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 required. One of the functions of the Mental Health Quality and Efficiency Support Team will be to facilitate such change. (See Chapter 4).

In relation to mental health services for children and young people, alongside training and re-design, the SGHD recognises that, in many NHS Boards, CAMHS staffing levels will have to increase to bridge this discrepancy. In recent years there has been significant investment to support and accelerate development of specialist CAMHS services. There are additional psychologists and Child and Adolescent Psychotherapists in training, and there has been an overall increase of 33% in the size of the specialist CAMHS workforce since 2008. This increase, together with the training in evidence-based Psychological Therapies and parenting interventions commissioned through NHS Education for Scotland, will help provide the increase in capacity required to deliver the Psychological Therapies target.

Strategic Planning

At a strategic level it is expected that there will be an identified NHS Board lead for the Psychological Therapies HEAT target at executive director level. Direct accountability for Psychological Therapies at NHS Board level, will ensure meaningful engagement with the local Psychological Therapies strategic planning mechanisms, facilitating negotiation around service re-design and the allocation of resource.

There will be an identified project lead/team for the implementation of the target.

An appropriate mechanism-for example a local multi-professional and multi-agency Psychological Therapies strategic planning and management group- comprised of senior clinicians and managers- will exist to ensure comprehensive 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;
- Ensure linking across to work on the implementation of the ICPs, work of the Mental Health Quality and Efficiency Support Team, work of the NES Psychological Therapies training Co-ordinators in local areas, and work of the local CAMHS waits reporting leads;
- 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 should be designed based on consultation with all stakeholders, including service users and carers;
- There should be investment at system level to foster change.;
- Appropriate training should be provided to enable staff to deliver psychological care and therapy at each tier of the service;
- There should be an educational infrastructure to support training and supervision;
- The service should be structured in such a way as to support and enable trained staff to deliver Psychological Therapies safely and effectively;
- Staff should have protected time in which to make use of their skills; and
There should be access to, and protected time for, regular Psychological Therapies 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 around thresholds for accessing the Psychological Therapies service.
- 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;
- 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 risk, problem severity, chronicity, comorbidity, social complexity, history of previous treatments and service user’s preference.

http://www.nes.scot.nhs.uk/disciplines/psychology/psychological-interventions-team/review-of-literature-

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. There is emerging evidence from the ongoing evaluation of the IAPT services in England that regular psychological therapies supervision informed by routine outcome measures, collected on a session-by-session basis, provides the level of information necessary to ensure timely step-up, and can improve the effectiveness of therapy.

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. Tools developed previously by the Mental Health Collaborative, and resources emerging from the MH QuEST early implementer sites can be accessed to support re-design work around
demand and capacity (see Chapter 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 further 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.

**Issues around Access to Services**

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. Issues of differential utilisation are central here. 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.

Emerging evidence from the Increasing Access to Psychological Therapies (IAPT) initiative in England suggests that having a ‘direct access’ option within the service-ie one where referrals are not filtered through the GP-increases uptake by disadvantaged groups. The English Department of Health has been so convinced by the evidence accumulating through the ongoing evaluation, that all IAPT services have now been directed to create ‘direct access’ options.

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 populations.

CHAPTER 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 recognised 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.

A number of evidence-based Competence Frameworks have already been produced, including:

- 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
- Systemic Competences
- Humanistic Competences
- Supervision Competences.

These, and others, can be accessed at

http://www.ucl.ac.uk/clinical-psychology/CORE/competence_frameworks.htm
Further competence frameworks are in the pipeline, including a CAMHS framework, commissioned by NES, which will include the competences needed to deliver psychological interventions with children and young people.

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 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 Chapter 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 Interventions and Therapy**

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

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

The mapping of competences and levels of training against the tiers of the matched/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.
<table>
<thead>
<tr>
<th>Level of Therapy</th>
<th>Patient Group / Severity</th>
<th>Treatment delivered</th>
<th>Training required / competencies</th>
<th>Examples in Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Intensity</td>
<td>Patient Group: Common Mental Health Problems – Stress/Anxiety/Depression Severity: Mild/moderate, with little complexity and 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 complexity and 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>
</tr>
<tr>
<td>Level of Therapy</td>
<td>Patient Group / Severity</td>
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<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>

- Developed and modified for specific patient groups. 16 to 20 sessions.

- Level of competence: must meet the ‘Skills for Health’ ‘High Intensity’ competences

- 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.
Notes:

1) Some training at the ‘Low Intensity’ level is available centrally (e.g. SPIRIT training and training provided at post-graduate certificate level 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 recommendations of the SGHD Applied Psychology Review, it is expected that NHS Boards will look to local Psychology Departments, working in partnership with Nurse and AHP Consultants and other local specialist services such as Psychotherapy Departments, to develop, deliver and quality assure such training in the first instance.

NHS Education for Scotland has developed a ‘toolkit’ to support NHS Boards in the commissioning of education and training locally:-

'http://www.test4best.scot.nhs.uk/

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.
**Psychological Therapies Supervision**

As outlined in Section 1, the function of Psychological Therapies Supervision is to reduce potentially harmful variations in practice and to ensure the safe, effective and efficient delivery of therapy, in line with the ambitions of the Healthcare Quality Strategy.

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

As stated earlier, NHS Education for Scotland have worked in partnership with Skills for Health to develop a competence framework for Psychological Therapies supervision.

The aspiration is that anyone delivering psychological therapies supervision will:

- be a qualified psychological therapist with a working knowledge and experience of the interventions in which they are providing supervision
  (A qualified high-intensity CBT therapist, for example, would normally be expected to have two or three years of experience of delivering the therapy under supervision before putting themselves forward for supervisor training)

and

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

To support NHS Boards to realise the psychological therapies supervision capacity necessary to deliver on the HEAT target, NES has developed a training curriculum and course materials which cover the essential Skills for Health competences-The NES Generic Psychological Therapies Supervision Course. This is currently being rolled out using a ‘Training for Trainers’ model which will enable Boards to deliver high quality training in line with local need.

Further modality-specific supervision modules, which cover the content specific to supervision within the main psychotherapeutic approaches, are in development.

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, and be informed by the patient’s routine outcome measures. If supervision takes place in a group format, the time devoted to it should be appropriately extended.
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**

NES is working in partnership with Scottish Government and NHS Boards to help build effective, equitable and accessible Psychological Therapies services across Scotland through education, training and workforce development. NES develops and supports sustainable training in the evidence-based interventions required to allow NHS Boards to meet the HEAT target and accredit the ICPs.

In collaboration with the Reshaping Care and Mental Health Division, and other key stakeholders, NES has supported quality improvement in psychological therapies services by producing this document - *The Matrix* - which offers guidance on the safe and efficient delivery of effective, evidence based care.

**Improving quality by establishing training standards**

- As detailed in earlier sections, NES has been 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, IPT etc) to re-structure Psychological Therapies training based on the competence frameworks and future service needs;

- Developing innovative ways of assessing competence in CBT

- Producing a competence-based curriculum for Psychological Therapies supervision training, and rolling this out using a ‘training for trainers’ model.

**Training and Workforce Development**

*The Psychological Interventions Team (PIT)*

The Psychological Interventions Team is supported by the Reshaping Care and Mental Health Division and hosted within NES. The team has contributed to the development of the HEAT target, and will now focus on organising the training required to improve general access to psychological interventions and therapies in SGHD priority areas – Older People’s Services, Forensic Services, Alcohol and Substance Misuse, PTSD and Trauma, and Low Intensity Treatments.

Further details of the work of the Psychological Interventions Team, including details of forthcoming training events, can be found on the NES website.

In addition to the work of the PIT, NES:

• Is supporting the training of frontline staff and ‘cascade’ trainers in a range of therapeutic approaches recommended in *The Matrix*.

• Is training psychologists at Doctoral and Masters level in support of the psychological therapies agenda, and is aligning training plans and building capacity in key Government priority areas such as CAMHS and Older People’s services.

• Is developing, through the Psychology of Parenting initiative within NES, a workforce capacity-building plan to support early intervention and improved outcomes for 3 and 4 year old children with early-onset behaviour problems. The dissemination plan outlines the educational infrastructure required to ensure that these parenting programmes are delivered with fidelity, in sustainable ways.

• Is working with AHPs to develop and deliver psychological training opportunities for all AHPs to consolidate and develop their current skills and respond to the training needs identified in *Realising Potential*.

• Has produced a Knowledge and Skills framework in support of the *National Dementia Strategy*, and a *Dementia Workforce Development Plan* based on that framework, and will be undertaking a range of activities to support implementation of the workforce development plan.
• 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 Chapter 1—Values-based Care), and progressing the role of the Mental Health Nurse in delivering psychosocial interventions and psychological therapies.

**Developing innovative educational infrastructure**

NES is developing 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 Coordinator is to support the territorial NHS Boards in meeting the HEAT Access target 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 include:

• Working with Psychological Therapies strategic planning groups to support the increase in access to psychological therapies by identifying service gaps and workforce training needs.
• Advising on and organising the appropriate evidence-based training taking into account quality, cost, timing, and reliability
• Providing the educational infrastructure needed to ensure that training is sustainable, and establishing clinical supervision structures to ensure safe and effective practice.

**HIS and the ICP Process**

The integrated care pathway (ICP) standards for mental health, developed by Quality Improvement Scotland (QIS) and taken forward by Health Improvement Scotland (HIS), 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 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.

Work has begun on the development of a Healthcare Scrutiny Model (HSM) for HIS, which will be risk based, proportionate and cover all aspects of healthcare. In order to align the mental health work programme with our emerging HSM we have reviewed the approach we are taking for ICPs and rather than continue with a formal accreditation system, we will take the opportunity to identify key data points within the ICPs and test the usability of these data points within the HSM as it develops. This 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
Improvement Support for Psychological Therapies HEAT Target Delivery

Redesigning systems to make best use of current resources
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.

Whereas the Matrix presents the evidence base for the effectiveness of treatments, there is also a need for services to apply 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.

Identifying opportunities for designing more efficient and effective processes and systems.
Work has already been completed to summarise the key parts of the mental health system that need to be improved to deliver the Psychological Therapies HEAT Target and then, for each part of the system, identifying the specific changes that can be made to improve that aspect of the system. This is referred to as a Driver Diagram. Effectively, it is a cause and effect diagram that shows how actual changes at a service level feed into the delivery of a wider organisational aim. This driver diagram can be accessed at http://www.improvingnhsscotland.scot.nhs.uk/programmes/mental-health/Documents/PT_Driver_Diagram/Psychological_Therapies_Driver_Diagram_Working_Draft_V6.pdf

NHS Boards can self assess against this driver diagram to identify opportunities for improving their local systems.

Support for implementing changes to systems and processes.
There is now considerable experience within NHS Boards on using systems improvement methodology and most NHS Boards have centralised improvement teams who can work with specific services on organisational priorities. Further, through the previous work of the Mental Health Collaborative, there are now a range of individuals working in mental health services with the knowledge and experience of using service improvement methodologies.

In addition, during 2011/12, the Quality and Efficiency Team at the Scottish Government (QuEST), is working in partnership with two NHS Boards to demonstrate how these approaches can be used to improve access to psychological therapies within current resources, whilst delivering the same or better clinical outcomes. It will use these ‘early implementer’ sites to generate guidance, resources and tools that support the application of systems improvement methodologies to deliver improved access to Psychological Therapies. It will also use the learning from these early implementer sites to inform an assessment around what, if any, national improvement support is needed from April 2012.
**Information Services Division (ISD)**

NHS National Services Scotland’s Information Services (ISD) is Scotland’s national organisation for health information, statistics and IT services.

NHS NES, ISD (NSS), NHS QIS, the Mental Health Collaborative and NHS Board clinical leads worked together in 2010 as ‘The Information Systems, Referral Criteria and Patient Pathways Group’ and ‘Stakeholder Reference Group’ to take forward the various strands of work to develop the Psychological Therapies HEAT target. ISD’s Mental Health Programme worked with NHS Boards to gather information to help set and measure the target. An information review was carried out with territorial NHS Boards in May and July 2010 to capture key information on the current structure, management, monitoring and waiting times for psychological therapies. This information enabled the Scottish Government to set a sensible informed target.

ISD and NHS NES ran a series of workshops in across a number of NHS Boards in October 2010 to define and agree key measurement points for the target. Based on the feedback from these workshops it was decided that the waiting time will be measured between the **date referral received** and the **date psychological therapy commences** as planned.

ISD have worked with key stakeholders to develop and refine a reporting template (an excel document) to monitor progress against the HEAT target. NHS Boards will be required to submit an NHS Board level return of aggregated data to ISD on a monthly basis from May 2011. It is important that the information collected by NHS Boards is consistent to enable it to be used at national level. ISD is working with key stakeholders to develop data standards and definitions in order to support NHS Boards in this challenge.

In 2011/12 ISD will work with NHS Boards to:

1. Develop and embed national waiting times guidance and scenarios to ensure information collected is comparable across NHS Boards and in line with the key waiting time measurement stages. This will include work on the development of scenarios and delivery of new ways training (if required);
2. capture information on the delivery, and variance from integrated Care Pathway 15 – ‘The need for structured psychological and/or psychosocial intervention for the service user is assessed’ (this will involve close working with NHS QIS);
3. develop and consult on a list of psychological therapies with definitions;
4. explore the management information requirements for both NHS Boards and the Implementation Board;
5. undertake analysis to enable aggregated comparable data to be shared in order to improve data quality and assist the NHS Boards in meeting their target;
ISD have issued regular email newsletters during the scoping phase of the target on behalf of the 'The Information Systems, Referral Criteria and Patient Pathways and are working with the Scottish Government Mental Health Division on a focused engagement strategy to support the implementation of the target.

Further information on the HEAT target can be found in the FAQs section on the ISD website http://www.isdscotland.org/Health-Topics/Mental-Health/Psychological-Therapies-FAQ.asp
CHAPTER 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 NHS Boards can map their current services.

In this section the template is presented as a series of key questions which cover the monitoring and delivery of the HEAT target, and broader issues of improved access to psychological interventions and therapy.

*The Reshaping Care and Mental Health Division will use these questions to shape discussion at the implementation visits from Autumn 2011 onwards.*

Monitoring and Delivery of the HEAT target questions

The issues that services need to consider when planning for the delivery of the HEAT target fall into the following categories:

- Are there effective local governance arrangements in place that ensure delivery of the HEAT target without impacting negatively on clinical outcomes?
- Are there data capture systems in place that enable monitoring of access times and clinical outcomes?
- Is the service designed to effectively and efficiently meet the needs presenting?
- Are staff appropriately trained and supervised?

Effective Governance

- Is there an identified NHS Board lead for the target at executive director level, and an identified project lead for the implementation of the target?
- Are there project governance approaches in place to manage local implementation eg project initiation plans, communications strategies etc?
- Is there a mechanism whereby information on the progress towards meeting the target can be fed back at NHS Board level?
- Is there a Psychological Therapies steering group to take an organisational overview of the target?
- Has there been an audit of staff delivering psychological therapies, their level of training, and the availability of psychological therapies supervision?
• Is there a mechanism for ensuring that all staff have relevant qualifications for delivering Psychological Therapies, and appropriate levels of supervision?

**Measurement of outcomes**

• Is there routine monitoring of outcomes using reliable and validated outcome measures?

• Are outcome measures being analysed and reported, and used to drive service improvement?

**Effective Data Capture Systems**

• Have all services which deliver Psychological Therapies been identified, and are arrangements in place to collect data from these services?

• Are there effective data capture systems in place to monitor waiting times?

• Is there dedicated IT support to configure data collection and analysis?

• Is there a plan to engage staff in developing the processes around the monitoring and delivery of the target, and to offer them the necessary information, training and support to collect the data routinely.

• Is the patient information system easy to use in clinical practice, based on electronic recording of data, and can it feed meaningful and clinically relevant information back to staff to inform both direct patient care and service audit and re-design.

**Service Design**

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

• Will there be investment at system level to foster change? Have links been made with your organisations generic improvement structures?

• Is there a mechanism for involving service users, carers and other key stakeholders in service re-design?

In order to ensure the sustainability of a matched/stepped-care approach, and maximum service impact with existing resources:
• Is there a process for developing and refining stepped/matched care systems which have clear access thresholds and criteria for allocation to different levels of treatment, self-correcting mechanisms, and can demonstrate effective delivery through clinical outcomes.

• Are there systems in place to effectively manage demand, capacity and queues (waiting lists)?

**Training and Supervision of Staff**

• 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?

• Is there access to, and protected time for, regular supervision and CPD appropriate to level of service delivery?

• Do staff have protected time in which to make use of their skills?

The Psychological Therapies Access Target **Driver Diagram** (produced by the Mental Health Collaborative) summarises the key parts of the Mental Health System which need to be improved to deliver the psychological therapies HEAT target. It provides more detailed guidance on the issues identified above and highlights specific changes which can be made to improve that aspect of the system. It also provides links to useful resources to support local areas in making changes. It can be found at 

http://www.evidenceintopractice.scot.nhs.uk/media/139673/psychological_therapies_driver_diagram_working_draft_v6.pdf

**Service Availability/Access Questions**

• Are there psychological interventions and therapies services in place to meet the needs of the main patient populations and diagnostic groups, and the needs of patients in key Government priority areas?

• What are the gaps in service?

• What are the priorities for development and re-design?
• In any particular service, what percentage of the potential patient population is accessing the service?

• How will increased access be demonstrated for the spectrum of service users, including ‘hard to reach’ groups?
The development of ‘The Matrix’ – Evidence Tables

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>
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<tr>
<td>A</td>
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<tr>
<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 randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation (evidence level-I) without extrapolation</td>
<td>At least one high quality meta-analysis or systematic review, or RCT of high quality aimed at target population</td>
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<tr>
<td>B</td>
<td>B</td>
<td>B</td>
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<tr>
<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>
<td>Well-conducted non randomized clinical studies or RCT of lower quality on the topic of recommendation directly applicable to the target population, and demonstrating overall consistency of results</td>
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<tr>
<td>C</td>
<td>C</td>
<td>C</td>
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<tr>
<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>
<td>Expert opinions and/or clinical experiences of respected authorities.</td>
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(b) Recommendation

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<tr>
<td>B</td>
<td>Recommended</td>
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<tr>
<td>C</td>
<td>No evidence to date but opinion suggests that this therapy might be helpful</td>
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<tr>
<td><strong>Matrix: Level of evidence</strong></td>
<td><strong>Recommendation</strong></td>
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<tr>
<td><strong>A</strong> At least one meta-analysis, systematic review, or RCT of high quality and consistency aimed at target Population</td>
<td><strong>A</strong></td>
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<tr>
<td><strong>B</strong> 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><strong>B</strong></td>
</tr>
<tr>
<td><strong>C</strong> Widely held expert opinion but no available or directly applicable studies of good quality.</td>
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# The Matrix
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<td>Brief Exposure Instruction (Therapist-Delivered)</td>
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</tr>
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<td></td>
<td></td>
<td></td>
<td>Stepped-care programme comprising educational booklet; detailed self-help manual; five x 2-hour group CBT</td>
<td>A(^1)</td>
</tr>
<tr>
<td>Mild</td>
<td>Primary Care</td>
<td>Low</td>
<td>Minimal Therapy Contact CBT (4-6 hrs) with</td>
<td>A(^{5, 13})</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(a) Bibliotherapy</td>
<td>A(^{3, 4, 9, 10, 18})</td>
</tr>
<tr>
<td>Level of Severity</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>Moderate</td>
<td>Primary Care</td>
<td>Low</td>
<td>Therapist – Supported CBT (6-12hrs) augmented by CBT Self-Help</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>a) Bibliotherapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>b) Computer Assisted (e.g. FearFighter)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>c) Internet-Delivered CBT with Therapist Contact (up to 6 hrs)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>d) Group CBT (8-18hrs)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>A&lt;sup&gt;5, 11, 16&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>A&lt;sup&gt;8, 14&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>A&lt;sup&gt;4, 9, 10, 18&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>A&lt;sup&gt;11, 17, 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></td>
</tr>
<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>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>A&lt;sup&gt;2, 6, 12, 13, 15&lt;/sup&gt;</td>
</tr>
<tr>
<td>Level of Severity</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>Chronic or Treatment Resistant</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 PHOBIAS

<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>A&lt;sup&gt;1, 2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Moderate</td>
<td>Primary Care, Voluntary settings</td>
<td>High</td>
<td>Behaviour therapy: Exposure</td>
<td>A&lt;sup&gt;3, 4, 5&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CBT: Exposure + Cognitive restructuring</td>
<td>A&lt;sup&gt;3, 6&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Social Skills Training</td>
<td>B&lt;sup&gt;3, 4, 5&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Interpersonal Therapy</td>
<td>B&lt;sup&gt;7&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Psychodynamic, Humanistic-Person-Centred-Experiential</td>
<td>C</td>
</tr>
<tr>
<td>Severe: Generalised Social Phobia</td>
<td>Primary Care/ Secondary Care</td>
<td>High</td>
<td>Same as moderate</td>
<td>A&lt;sup&gt;8&lt;/sup&gt;</td>
</tr>
<tr>
<td>Avoidant PD</td>
<td>Primary Care/ Secondary Care</td>
<td>High</td>
<td>CBT (20 sessions)</td>
<td>A&lt;sup&gt;8&lt;/sup&gt;</td>
</tr>
</tbody>
</table>
### 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</td>
<td>B&lt;sup&gt;2, 6&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Large group psychoeducation</td>
<td>B&lt;sup&gt;7&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Brief counselling</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>A&lt;sup&gt;1, 5&lt;/sup&gt;</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>B&lt;sup&gt;3, 4&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

---

**Abbreviations:**

- CBT: Cognitive Behavioral Therapy
- GAD: Generalized Anxiety Disorder

**References:**

1. Example Reference 1
2. Example Reference 2
3. Example Reference 3
4. Example Reference 4
5. Example Reference 5
6. Example Reference 6
7. Example Reference 7
**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;, 2, 3</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;, 3, 4, 5</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;, 3, 4, 5</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;, 6</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(^{14}))</td>
<td>(A^{1-14})</td>
</tr>
<tr>
<td>Severe/ enduring</td>
<td>Secondary care</td>
<td>High</td>
<td>Family Interventions</td>
<td>(A^{3, 14, 19, 20})</td>
</tr>
</tbody>
</table>

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

| Moderate                | Primary Care / Specialist Service | High                      | Cognitive Behavioural Therapy                           | \(B^{21-23}\)  |

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

| Severe/ enduring        | Secondary care         | High                      | Detection of Relapse                                   | \(A^{24-31}\)  |
|                         |                        |                           | Cognitive Behavioural Therapy for Relapse               | \(B^{32}\) |

* Strongest evidence indicates effectiveness of CBT for those with persistent and distressing psychotic experiences, rather than those in the acute phase of psychosis\(^{3}\)

**Insufficient Evidence:**

* There is currently insufficient evidence to recommend use of Cognitive Remediation as a Routine Therapy for Schizophrenia\(^{14, 33, 34}\)
# 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</td>
<td>Secondary Care</td>
<td>High</td>
<td>CBT in relapse prevention in stable individuals.</td>
<td>A (^1)</td>
</tr>
<tr>
<td>in recovery</td>
<td></td>
<td></td>
<td>Group Psychoeducation</td>
<td></td>
</tr>
<tr>
<td>from bipolar affective</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>disorder in addition to</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>medication (i.e. euthymic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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 for those who have past history of less than 12 episodes.</td>
<td>A (^2, 3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>Interpersonal and Social Rhythm Therapy (IPSRT)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>A (^4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All the interventions</td>
<td>Secondary Care</td>
<td>High</td>
<td></td>
<td></td>
</tr>
<tr>
<td>in an acute episode</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of bipolar affective</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>disorder and are in</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>addition receiving</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>medication.</td>
<td></td>
<td></td>
<td></td>
<td></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/</td>
<td>Low (formal caregivers)</td>
<td>Reminiscence</td>
<td>B (1, 8)</td>
</tr>
<tr>
<td></td>
<td>Day Hospital</td>
<td></td>
<td>Validation Therapy</td>
<td>C (1, 9)</td>
</tr>
<tr>
<td>Moderate/Severe</td>
<td>Secondary Care/</td>
<td>High (specialist)</td>
<td>Behaviour that Challenges.</td>
<td>B (1, 3, 4)</td>
</tr>
<tr>
<td></td>
<td>Specialised</td>
<td></td>
<td>Cognitive Stimulation Therapy</td>
<td>A (1, 2, 3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cognitive Rehabilitation/Cognitive Training</td>
<td>C (1, 6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cognitive Behaviour Therapy for depression in Dementia</td>
<td>B (1, 3, 5, 6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Caregiver Interventions</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>Guided self help based on CBT or behavioural principles</td>
<td>A1,2,3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low</td>
<td>Computerized CBT Within the context of guided self help (CCBT)</td>
<td>A1,4,5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low</td>
<td>Behavioural activation.</td>
<td>A1,6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>CBT.</td>
<td>A 1,8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>IPT.</td>
<td>A1,9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>Structured exercise.</td>
<td>B1,10,11</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>Short term psychodynamic psychotherapy</td>
<td>B1,12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low</td>
<td>Problem solving therapy</td>
<td>B1,13</td>
</tr>
<tr>
<td>Relapsing</td>
<td>Primary Care/ Secondary Care</td>
<td>High</td>
<td>Mindfulness based cognitive therapy in a group setting may be considered as a treatment option to reduce relapse in patients with depression who have had three or more</td>
<td>B 1,14</td>
</tr>
<tr>
<td>Severe</td>
<td>Secondary Care</td>
<td>Highly Specialist</td>
<td>For people with moderate or severe depression, provide a combination of antidepressant medication and a high-intensity psychological intervention (CBT or IPT).</td>
<td></td>
</tr>
<tr>
<td>--------</td>
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<td>------------------</td>
<td>------------------------------------------------------------------</td>
<td></td>
</tr>
</tbody>
</table>
# 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             |

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>
<tbody>
<tr>
<td>Mild to Moderate (hazardous and Harmful Drinker)</td>
<td>Primary Care/Non-Specialist Health Setting including, for example, Antenatal Care</td>
<td>Low</td>
<td>Structured CBT orientated programme</td>
<td>B 1, 2, 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Provide a brief intervention*:</td>
<td>A 1, 2, 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Simple brief interventions – one session lasting 5-10 minutes/</td>
<td>B 1, 2, 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Extended brief interventions – one/several 20-45 minute session/s</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Two 15 minute feedback, advice and drink diary</td>
<td></td>
</tr>
<tr>
<td>Moderate to Severe (Alcohol Dependence)</td>
<td>Secondary Care/Specialist including residential settings.</td>
<td>High</td>
<td>Behavioural Self Control Training/Motivational Enhancement Therapy/Community</td>
<td>A 1, 2, 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Reinforcement Approach/ Coping and Communication Skills Training/</td>
<td>A 1, 2, 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Social Behaviour Network Therapy/12 Step Facilitation</td>
<td>B 1, 2, 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Alcoholic Anonymous Attendance</td>
<td>B 1, 2, 3</td>
</tr>
</tbody>
</table>
## 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</td>
<td>Primary Care/Secondary Care</td>
<td>High</td>
<td>Cognitive Behavioural Therapy</td>
<td>A₁, ²</td>
</tr>
<tr>
<td>Cannabis with co-morbid anxiety and/or depression</td>
<td></td>
<td></td>
<td>Group Cognitive behaviour Therapy + Gradual Tapering (10 Weeks)*</td>
<td>A₁, ²</td>
</tr>
<tr>
<td>Stimulants with Co-morbid anxiety and/or Benzodiazepines with Panic Disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of severity</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>Moderate to Severe Stimulants</td>
<td>Community/Inpatient/Residential/Criminal Justice</td>
<td>High</td>
<td>Contingency Management, Behavioural Couples Therapy</td>
<td>A&lt;sup&gt;1, 2&lt;/sup&gt;</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&lt;sup&gt;1, 2&lt;/sup&gt;</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&lt;sup&gt;18&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>C&lt;sup&gt;17&lt;/sup&gt;</td>
<td></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&lt;sup&gt;18&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>C&lt;sup&gt;18&lt;/sup&gt;</td>
<td></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>
</table>
| Subclinical/ Mild | Primary Care     | Low                       | Evidence-based self-help programme  
Guided CBT self-help | B 6, 17, 20*, 22  
B 13 |
| Moderate          | Secondary Care   | Low                       | Evidence-based self-help programme  
Guided CBT self-help  
CBT for bulimia nervosa (CBT-BN). 16 to 20 sessions over 4 to 5 months.  
Interpersonal Psychotherapy (IPT). 8 to 12 months to achieve same results as CBT> | B 6, 4, 17, 20*, 23  
B 13  
A 1, 7, 9*, 14*, 15, 17, 21, 23  
B 13, 7, 17 |

* 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>
<tbody>
<tr>
<td>Chronic primary insomnia</td>
<td>Primary/ Specialist Health Settings</td>
<td>*****Low (4-10 sessions)</td>
<td>CBT (individual or small group)</td>
<td>*A&lt;sup&gt;1-13&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Best validated/ most efficacy data for</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Sleep Restriction</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Stimulus Control</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Progressive Relaxation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Paradoxical Intention components</td>
<td></td>
</tr>
<tr>
<td>Chronic insomnia associated with medical or psychiatric illness</td>
<td>Specialist Health Settings</td>
<td>*****Low (4-10 sessions)</td>
<td>CBT</td>
<td>**A&lt;sup&gt;12,13&lt;/sup&gt;</td>
</tr>
<tr>
<td>Insomnia in older adults</td>
<td>Primary/ Specialist Health Settings</td>
<td>*****Low (4-10 sessions)</td>
<td>CBT</td>
<td>***A&lt;sup&gt;2,3,10,17,18&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of Severity</td>
<td>Level of Service</td>
<td>Intensity of Intervention</td>
<td>What Intervention?</td>
<td>Recommendation</td>
</tr>
<tr>
<td>Chronic insomnia (unselective) clinical</td>
<td>Primary care</td>
<td>*****Low (4-10 sessions)</td>
<td>CBT (delivered by trained nurses)</td>
<td>A&lt;sup&gt;16,19,20&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

INSOMNIA CONTINUED...
<table>
<thead>
<tr>
<th>Effectiveness studies</th>
<th>Chronic insomnia</th>
<th>Primary/ Specialist Health Settings</th>
<th>*****Low (4-10 sessions)</th>
<th>These are therapeutic components with as yet unproven efficacy (from high quality RCTs)</th>
<th>B/C²³</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Intensive Sleep-Retraining</td>
<td>C²¹</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Multicomponent Cognitive Therapy</td>
<td>B²²</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Imagery Training</td>
<td>C²⁴</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Mindfulness Training</td>
<td>B²³,²⁶</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Self-Help</td>
<td>B²⁵</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

**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>
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<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>A¹-⁴</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>A(^1, 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>A(^5)</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>Low</td>
<td></td>
<td>The Heart Manual is a 6 week CBT tool.</td>
<td>B 4</td>
</tr>
<tr>
<td>Prevention of coronary heart disease (depression is both a primary and secondary cause of 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>
The consequences to the individual of exposure to psychologically traumatic events vary widely. In many cases there will be no adverse impact on their wellbeing. In others it may cause or contribute towards a range of psychological disorders as well as social and physical problems. The nature and timing of the traumatic exposure may, in part, determine the individual’s response to it. A different pattern and range of symptoms is usually seen in those exposed to prolonged and repetitive trauma, often in childhood (so-called type 2, or complex trauma) compared with those exposed to a single (type 1) traumatic event.

It is now recognised that PTSD is only one possible psychiatric outcome following Type 1 trauma exposure. The development of depressive and anxiety disorders is probably more common. Where there has been exposure to Type 2 trauma, the evidence suggests that mood, psychotic, substance misuse and personality disorders are all more likely to develop.

This section will focus on the prevention and treatment of PTSD, where there is a reasonable evidence base, and the management of complex trauma, where the evidence for effective treatments is much sparser.
In recent years, early psychological interventions, such as psychological ‘debriefing’ have been increasingly used following psychological trauma. Debriefing has two principal intentions. The first is to reduce the psychological distress that is found after traumatic incidents. The second, is to prevent the development of psychiatric disorder, usually PTSD. Rose et al’s (1) updated review of single session psychological ‘debriefing’ identified twelve published trials. (2-13)

There is no evidence that debriefing reduces the risk of developing PTSD. Two trials with the longest follow-up both reported adverse effects, in that debriefing appears to increase long-term traumatic distress.

There is also no evidence that debriefing has any effect on any other psychological outcome including depression, anxiety or general functioning.

At present the routine use of single session individual debriefing in the aftermath of individual trauma is not recommended.

However, preliminary information suggests that delivering more formalised interventions, such as brief trauma focussed CBT, over a number of sessions and aimed at those with overt distress (such as Acute Stress Disorder) may be worthwhile. Treatment should be targeted at symptomatic patients and not those who are asymptomatic. Rose et al identified four such published trials of trauma focussed CBT type interventions. (14-17)
## PREVENTING POST TRAUMATIC STRESS 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>Trauma Focussed CBT (4-5 sessions): aimed at those with overt distress</td>
<td>B (^{(14-17)})</td>
</tr>
</tbody>
</table>

Routine ‘debriefing’ **not recommended**. Could increase long-term traumatic distress.
## TREATING POST-TRAUMATIC STRESS 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 Carer</td>
<td>Low</td>
<td>Watchful Waiting with Follow-up in One Month</td>
<td>C (^{18,23})</td>
</tr>
<tr>
<td>Moderate To Severe</td>
<td>Secondary Care</td>
<td>High</td>
<td>Trauma-Focused CBT (8-12 Sessions) EMDR (8-12 Sessions)</td>
<td>A (^{18,19,20,24}) A (^{18,21,22})</td>
</tr>
<tr>
<td>Severe &amp; Chronic</td>
<td>Secondary Care/Specialist Trauma Service</td>
<td>High</td>
<td>Alternative Form of Trauma-Focused Treatment (e.g. try EMDR if no response to Trauma-Focused CBT)</td>
<td>C (^{18,25})</td>
</tr>
</tbody>
</table>
TREATMENT OF COMPLEX TRAUMATIC STRESS DISORDERS

Courtois & Ford (26) have defined complex psychological trauma as “involving traumatic stressors that (1) are repetitive or prolonged; (2) involve direct harm and/or neglect and abandonment by caregivers or ostensibly responsible adults; (3) occur at developmentally vulnerable times in the victim’s life, such as early childhood; and (4) have great potential to compromise severely a child’s development”. Traumatic experiences early in childhood have been particularly associated with poor mental health in adulthood. Effects may include affect deregulation and impaired self-concept, dissociation, somatic dysregulation, and disorganized attachment patterns leading to inter and intra-personal difficulties in adult life (27, 28). These are in addition to DSM-IV PTSD symptoms of re-experiencing of the traumatic events, avoidance of the reminders and hyperarousal.

Courtois and Ford (26) have concluded that there is limited treatment outcome research on complex traumatic stress and further research in the area is required. This is in part because it is a heterogeneous condition and most outcome studies in the area of psychological trauma have screened out patients with complex trauma.

There is therefore insufficient high quality evidence available to allow the development of evidence-based recommendations. However, expert opinion can give some insights into current best practice. It is widely thought that a phased based intervention programme is indicated. The assessment and formulation process is essential initially along with the development of the therapeutic relationship. It is also recommended that interventions that specifically target problem areas such as affect deregulation, dissociation, and somatic dysregulation are addressed first, with an initial focus on safety, emotion regulation, and patient education. When this has been achieved the treatment can move on to the processing of traumatic memories using CBT or EMDR. Finally the patient can be helped to reintegrate with others in their life.
# TREATMENT OF COMPLEX TRAUMATIC STRESS DISORDERS

<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>
| Moderate to severe| Specialist Trauma Service| High                      | Phased Based Intervention Programme  
**Phase 1 Safety and Stabilisation**  
Establish therapeutic alliance  
Training in affect regulation  
Education about trauma and its impacts  
Phase 2 Processing of traumatic memories  
**Narrative reconstruction of memories with careful use of CBT interventions including exposure where appropriate**  
Phase 3 Reintegration  
The continued development of trustworthy relationships. Work on intimacy, sexual functioning, parenting etc  
Duration of treatment 16-30 sessions. For some treatment may be much longer. |

C:\26, 29
REFERENCE SECTION

PANIC DISORDER WITH/WITHOUT AGORAPHOBIA


SOCIAL ANXIETY/SOCIAL PHOBIA


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.


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.

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.

No evidence for cognitive training and insufficient evidence for individualised cognitive rehabilitation in dementia

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


**TRAUMA**


16. Bryant, R., Harvey, A., Dang, S., Sackville, T., Basten, C. Treatment of acute stress disorder; a comparison of cognitive behaviour therapy and supportive counselling. Journal of Counselling and Clinical Psychology 1998; 66(5); 862-6


<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.                                     |
| 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.  |
<table>
<thead>
<tr>
<th>Condition</th>
<th>Expert</th>
</tr>
</thead>
</table>
| 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**  
Consultant Clinical Psychologist, Head of Adult Mental Health, Psychology in East Lothian, NHS Lothian |
| Insomnia                           | **Dr Jason Ellis**  
Associate Director of University of Glasgow Sleep Centre, Sackler Institute of Psychobiological Research/Section Of Psychological Medicine |
| 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. |
| Trauma                             | **Professor Kevin Power**  
Director of Psychological Therapies Services, NHS Tayside  
**Dr. Anne Douglas**  
Professional Lead for Trauma Services, NHS Greater Glasgow and Clyde  
**Dr. Keith Brown**  
Consultant Psychiatrist and Chair of SIGN, NHS Forth Valley  
**Dr Thanos Karatzias**  
Health and Clinical Psychologist, Edinburgh Napier University |
# 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><strong>A</strong></td>
<td><strong>A</strong></td>
</tr>
<tr>
<td>At least one meta-analysis, systematic review, or RCT of high quality and consistency aimed at target population</td>
<td>Highly Recommended</td>
</tr>
<tr>
<td><strong>B</strong></td>
<td><strong>B</strong></td>
</tr>
<tr>
<td>Well-conducted clinical studies but no RCTs on the topic of recommendation directly applicable to the target population, and demonstrating overall consistency of results</td>
<td>Recommended</td>
</tr>
<tr>
<td><strong>C</strong></td>
<td><strong>C</strong></td>
</tr>
<tr>
<td>Widely held expert opinion but no available or directly applicable studies of good quality</td>
<td>No evidence to date but opinion suggests that this therapy might be helpful</td>
</tr>
</tbody>
</table>
## Matrix

### Evidence-based Psychological Interventions for Children and Young People

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</table>
Notes:

The information in this document has been informed by:

SIGN, QIS and NICE guidance where it exists, in addition to a selected review of recently published outcome studies undertaken for each chapter. NB this has not been undertaken with the rigour employed by SIGN, NICE or Cochrane and evidence summaries should be read with that in mind.


Evidence of the long-term effects of very early experience and of the cost effectiveness of early intervention is growing. Early intervention is consequently a priority in several Scottish Government targets.

The National Scientific Council on the Developing Child (NSCDC; 2007)\textsuperscript{26} clearly outlines the case for intervening before emotional or behavioural issues find expression as frank problems. In addition, its publications cogently argue that increased short term expense can greatly reduce the potential financial costs incurred later down the line. For example, economic analyses suggest that the costs of early intervention may be paid back within 4 years, as the need for further services is reduced over the longer term (Olds et al. 1998)\textsuperscript{32}. Translating this into a Scottish context, it is known that maintaining secure care for an adolescent costs more than £200,000 a year (Early Years Framework, 2009)\textsuperscript{37}. This, and other costs such as the long-term economic impact of untreated conduct disorder (Scott et al. 2001)\textsuperscript{36}, far exceed the financial cost of implementing early interventions which can assist young children to grow into happy and healthy adults. While the most impressive evidence-base for early interventions is found in interventions with slightly older children, infant mental health represents an increasingly promising area of preventive value.

The Bright Futures guidelines\textsuperscript{15}, provide a number of ‘warning signs’ that an infant’s emotional health may be being placed at risk. These include abnormal sleeping patterns; lack of weight gain or vomiting/diarrhoea; lack of responsiveness to caregiver; wariness of or fearfulness towards caregiver; flat affect; lack of joyful response towards caregivers or others; lack of vocal communication; lack of active/exploratory behaviour; and lack of responsiveness to parents’ calming. ‘Failure to thrive’ can also present as a result of factors which are associated with low mental wellbeing in infants (El-Baba et al., 2009)\textsuperscript{11}. The relationship between an infant and its caregiver can have an impact on non-organic failure to thrive through psychosocial deprivation such as neglect (physical and emotional), lack of bonding and living in a high conflict environment.

While these features of infant behaviour may be indicative of disturbance, it is important to recognize that the real focus within the infant mental health field is primarily on the relationships that scaffold the infant’s development. This relationship approach to assessment and treatment is a recent development and challenges remain in developing new methodologies to determine short and longer-term effects. Nonetheless, the evidence-base for effective infant mental health interventions is emerging. This progress has been supported by an increase in research confirming the exceptional significance of the very earliest life experiences for future development.
The Significance of Infancy for Mental Health

Infancy is known to be a period of immense physical, mental and emotional change. Research in developmental neuro-physiology has now demonstrated that brain development is incredibly active in the antenatal period and into infancy. A dramatic proliferation of brain cells creates exceptional levels of possibility in terms of the multitude of different neural connections that can potentially become established. This is followed, however, by a period of “pruning” when those neural connections that are exercised are strengthened while those that are not fade. This “use it or lose it” principle means that the social experiences a baby has literally shape the architecture of its brain and thereby create a template for future development. Environmental factors are implicated in this process (Gunnar & Cheatham, 2003 Balbernie, 2001; Glaser, 2000) and can be seen, for example, in the effects of antenatal maternal stress/anxiety (O’Connor et al. 2002, Glover and O’Connor, 2002) and maternal mental health (e.g. postnatal depression, Murray et al., 2010; NSCDC, 2009) on the infant’s early relationship experiences and development (e.g. Lovejoy et al. 2000, Bergman et al. 2010).

The consequences of early relationship experiences can also be seen in the development of the attachment relationship between mother and infant. Interventions with a behavioural focus on maternal sensitivity are more likely to promote security of attachment in infants (Bakermans-Kranenburg, 2003). Of particular clinical relevance, however, is the emergence of a disorganized pattern of attachment where the infant is unable to resort to any of the traditional attachment patterns. Interventions aimed directly at tackling the onset of disorganized attachment are in their own infancy, though a recent meta-analysis by Bakermans-Kranenburg et al. (2005) has outlined the factors important in such an intervention. Additionally, the evidence of Cicchetti et al. (2006) suggests that early intervention with infants of maltreating families can impact on rates of disorganized attachment.

Likewise, interventions such as the Family Nurse Partnership which has a large evidence base, aims to enhance parenting in order to prevent the associated long-term sequelae of infant exposure to unresponsive, coercive or intrusive parenting styles. Other parenting programmes, such as Triple P and the Incredible Years, both of which have been scientifically demonstrated to strengthen parent-child relationships from the pre-school period onwards, are now experimenting with extending their models downwards to the infant age group. Although evidence for the effectiveness of these programmes in this context is limited at present, the early indications are that these approaches will also have much to offer the infant mental health field. Similarly, further evidence for the Mellow Babies intervention is currently in development. A recent review of group based interventions reported significant effects in improving the emotional and behavioural adjustment of children under 3 (Barlow & Parsons, 2010).
## 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>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate/Severe</td>
<td>Tier 2-4</td>
<td>High</td>
<td>Individual interventions:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Video interaction guidance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Attachment and Bio-behavioural Catch up</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nurse-Family partnership</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Watch Wait Wonder</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Group interventions:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mellow Babies</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Circle of Security</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Incredible Years</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Interventions for infants of maltreating families</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Infant Parent Psychotherapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Interventions for very low birth weight infants</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Infant Behavioural Assessment and intervention Program</td>
</tr>
</tbody>
</table>

### Recommendation

Child to Adolescent

- B[^9^, ^18^, ^37^, ^38^, ^39^]
- B[^10^]
- A[^29^, ^30^, ^31^, ^32^]
- B[^7^, ^8^]
- C[^33^, ^34^]
- C[^23^]
- B[^19^, ^41^]
- B[^6^, ^21^]
- B[^16^, ^19^, ^21^, ^24^]
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 5-10% of non-clinical samples (Fonagy et al., 2000)\textsuperscript{12}. The NICE Technology Appraisal 102 (www.nice.org.uk/TA102)\textsuperscript{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)\textsuperscript{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\textsuperscript{18}; Webster-Stratton, 1998\textsuperscript{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)\textsuperscript{9}.

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)\textsuperscript{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\textsuperscript{14}; Scott et al., 2001a\textsuperscript{24}; Webster-Stratton & Hammond, 1997\textsuperscript{31}).
Social learning theory-based group-based parenting is the treatment of choice for young children (NICE technology appraisal 102, Wolpert et al., 2006). 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; Borduin & Schaeffer, 2001).
# 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>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</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>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate</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>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>High</td>
<td>Psychodynamic Psychotherapy</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>
</tr>
<tr>
<td></td>
<td>Tier 2-3</td>
<td>High</td>
<td>Anger Coping Therapy</td>
<td>A 17</td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>High</td>
<td>Functional-Family Therapy</td>
<td>B 2</td>
</tr>
<tr>
<td></td>
<td>Tier 3-4</td>
<td>High</td>
<td>Multi Systemic Therapy</td>
<td>B 1, 4</td>
</tr>
<tr>
<td>Severe</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>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>High</td>
<td>Functional-Family Therapy</td>
<td>A 2</td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>High</td>
<td>Multi Systemic Therapy</td>
<td>B 1</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>
</tr>
</tbody>
</table>
Attention Deficit Hyperactivity Disorder (ADHD)
(taken from SIGN guideline 112, 2009; NHS.QIS Services Over Scotland, 2008; NICE CG72, 2008)

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.

‘The core symptoms of ADHD and HKD have a significant impact on the child’s development, including social, emotional and cognitive functioning and they are responsible for considerable morbidity and dysfunction for the child or young person, their peer group and their family. The secondary effects of ADHD and HKD can be extremely damaging. Affected children are often exposed to years of negative feedback about their behaviour and suffer educational and social disadvantage. These disorders are, in many cases, persistent. It is estimated that up to two thirds of children affected by hyperactivity disorders continue to have problems into adulthood (Barkley, 1998; cited in SIGN 112, 2009 p.1).

‘The core symptoms of ADHD and HKD comprise developmentally inappropriate levels of:

- inattention (difficulty in concentrating)
- hyperactivity (disorganized, excessive levels of activity)
- impulsive behaviour.

In order to meet diagnostic criteria it is essential that symptoms:

- have their onset before the age of seven years (ADHD) or six years (HKD)
- have persisted for at least six months
- must be pervasive (present in more than one setting, e.g. at home, at school, socially)
- have caused significant functional impairment
- are not better accounted for by other mental disorders (e.g. pervasive developmental disorder, schizophrenia, other psychotic disorders, depression or anxiety).’ (SIGN 112, 2009 p.5).

Prevalence rates for ADHD vary across epidemiological studies and in different countries. Much of this variation is attributable to differences in diagnostic criteria (DSM-IV¹ or ICD-10²) 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. However,
a national study by NHS.QIS (2008)\textsuperscript{5} found significant under recognition of the disorder, approximately 0.6\% of Scottish school children had a diagnosis of ADHD/HKD.

# Attention Deficit Hyperactivity Disorder (ADHD)

**SIGN guideline 112 (2009)**

<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>Pre-school children</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild/Moderate/Severe</td>
<td>Tier 2-4</td>
<td>High</td>
<td>Behavioural parent training. This should be delivered by trained facilitators.</td>
<td><strong>B</strong></td>
</tr>
<tr>
<td><strong>School aged children</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td>Tier 2-3</td>
<td></td>
<td>Behavioural approaches at home (parent training programmes) and at school should be considered in the first instance for school aged children</td>
<td>Recommended best practice</td>
</tr>
<tr>
<td>Moderate/Severe</td>
<td>School based</td>
<td>High</td>
<td>Individualised school intervention programme including behavioural and educational interventions.</td>
<td><strong>A</strong></td>
</tr>
<tr>
<td></td>
<td>Tier 3-4</td>
<td>High</td>
<td>A combination of medication and behavioural treatments are recommended for school aged children and young people with ADHD/HKD and comorbid symptoms of ODD and/or aggressive behaviour.</td>
<td><strong>A</strong></td>
</tr>
<tr>
<td></td>
<td>Tier 3-4</td>
<td>High</td>
<td>A combination of medication and behavioural treatments are recommended for school aged children and young people with ADHD/HKD and comorbid generalised anxiety.</td>
<td><strong>B</strong></td>
</tr>
<tr>
<td>Severe</td>
<td>Tier 3-4</td>
<td>High</td>
<td>For school aged children and young people with hyperkinetic disorder (severe ADHD)</td>
<td><strong>A</strong></td>
</tr>
</tbody>
</table>
medication is recommended to treat the core symptoms of ADHD/HKD. Behavioural treatments are recommended to treat symptoms of comorbid ODD+/or aggression +/or anxiety.*

**NICE Clinical Guideline 72 (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/Moderate/Severe</td>
<td>Tier 1-4</td>
<td>High</td>
<td>Parent training/education programmes for parents and carers (as recommended in ‘Parent-training/education programmes in the management of children with conduct disorders’⁴)</td>
<td>First-line treatment</td>
</tr>
<tr>
<td>Moderate</td>
<td>Tier 2-3</td>
<td>High</td>
<td>Parent training/education programmes for parents and carers. This may also include:</td>
<td>First-line treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Group psychological treatment (CBT and/or social skills training) for the younger child.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>• Individual psychological interventions (such as CBT and/or social skills) for older age groups if group approaches have not been effective or refused</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>Drug treatment should be reserved for those</td>
<td></td>
</tr>
<tr>
<td>Severe</td>
<td>Tier 3-4</td>
<td>High</td>
<td>Drug treatment for school-aged children and young people with severe ADHD (hyperkinetic disorder) and severe impairment*. Parents should also be offered a group-based parent training/education programme.</td>
<td>First-line treatment</td>
</tr>
<tr>
<td>--------</td>
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<td>---------------------</td>
</tr>
</tbody>
</table>

* Refer to SIGN 112 and NICE GC72 for guidance for specific pharmacological interventions.

** There was no good quality evidence evaluating psychological interventions to treat core symptoms of ADHD/HKD in adolescents. 
4. Autism spectrum disorders  
(adapted from SIGN guideline, 2008\textsuperscript{13} and selected subsequent publications)

The term autism spectrum disorders (ASD) is used to describe the conditions childhood autism, atypical autism, Asperger’s syndrome and pervasive developmental disorder included in ICD-10. These are complex neurodevelopmental disorders, behaviourally defined, that are characterised by impairments in reciprocal social interaction and communication, and a stereotyped, repetitive or rigid 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)\textsuperscript{28} and the Diagnostic and Statistical Manual of Mental Disorders 4\textsuperscript{th} edition (DSM-IV-TR)\textsuperscript{1}, have similar symptom criteria for diagnosis, based on a triad of impairments, with the behaviours being discrepant from the individual's mental age\textsuperscript{*}:

- social – impaired, deviant and delayed or atypical social development, especially interpersonal reciprocity
- language and communication – impaired and deviant language and communication, verbal and non-verbal. Impairment in pragmatic aspects of language. Impairment of imaginative play
- thought and behaviour – rigidity of thought and behaviour and impoverished social imagination. Ritualistic behaviour, reliance on routines. Stereotyped and repetitive motor mannerisms and preoccupation with non-functional parts of objects

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.

\textsuperscript{*} this final criterion has been included in the current working draft for DSM-V.
Previously published figures suggested an ASD prevalence rate of 70.3 per 10,000 in pre-school children (PHIS, 2001\textsuperscript{14}, MRC, 2001\textsuperscript{12}). Recent UK prevalence figures indicate the overall ASD prevalence rate is 116.1/10,000 in 9-10 year olds with approximately half having an IQ >70 (Baird et al, 2006)\textsuperscript{2}.

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 and attention deficit disorders common to childhood, and depression which tends to emerge later in childhood), 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. Although approaches to intervention are described here within a categorical system it is important to note that a variety of aims may be represented within each category. The benefits of an intervention must be considered in light of its aim, for example, different approaches to parent training may aim to improve aspects of parental well being, while others focus on developing parent-child interactions or achieving improvements in the child’s own condition. Recommendations in other sections of this document may also be relevant (with expert modification) if children or young people have additional difficulties e.g. anxiety disorders. Other detailed recommendations and references about management of autism spectrum disorders in children and adolescents are available in the SIGN guideline, these include descriptions of interventions for which there is insufficient evidence.
## 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>
</table>
| Mild, moderate and severe | Tier 1-3 | Tier 1-3 | 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 | B 6, 10, 24 |
| | Tier 1-3 | Tier 1-3 | Parent mediated intervention | B 3, 5, 8, 11, 16, 18, 20, 24 |
| | Tier 1-3 | Tier 1-3 | Social communication and interaction | C 9, 13, 17, 21, 212, 23, 27 |
| | Tier 1-3 | Tier 1-3 | Communication supports | B 4, 7, 19, 29 |
| | Tier 1-3 | Tier 1-3 | Parent education (pre school children)  
Parent education (children and young people) | B 23 |
Anxiety

Anxiety disorders have been shown to represent one of the most highly prevalent forms of psychopathology in children and adolescents. The point prevalence for anxiety disorders is estimated to range from 3 to 6% in young people aged 10-19 years (ONS study 1999 & 2004). In Scotland this represents between 23,000 to 39,000 young people. Over the course of childhood between 5-18% of all children and young people experience anxiety disorders (Costello, 1995).

High levels of anxiety can have a number of immediate and longer-term consequences for young people. Henker et al. (2002) 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 in children and young people, while common, are very likely to be under recognised and under treated (Emslie, 2008). In a sample of 6 to 19 year olds, 76% of those who met criteria for an anxiety disorder did not get treated (Keller et al., 1992).

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

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). Kovacs and Devlin (1998) 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).
## 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 and separation 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>Mild</td>
<td>School based and Primary Care</td>
<td>Medium</td>
<td>School-based prevention and early intervention programmes (e.g. FRIENDS for Life)</td>
<td>A 3, 5, 7, 19, 21, 25, 27*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low</td>
<td>Bibliotherapy based on CBT principles</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low</td>
<td>Guided self-help</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low</td>
<td>Computerised CBT</td>
<td>C 22</td>
</tr>
<tr>
<td>Moderate/Severe</td>
<td>Secondary Care</td>
<td>High</td>
<td>Individual Cognitive Behaviour Therapy with or without Parental/Family Involvement</td>
<td>A 2, 3, 8, 11, 13, 14, 16, 17, 20, 24, 29, 32, 32</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>Group Cognitive Behaviour Therapy with or without Parental/Family Involvement</td>
<td>A 1, 13, 20, 23, 29, 30, 31, 32</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>Family Anxiety Management</td>
<td>B 32</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>Behavioural: Modelling</td>
<td>B 32</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>Behavioural: In vivo Exposure</td>
<td>B 32</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>Behavioural: Reinforced Practice</td>
<td>B 32</td>
</tr>
<tr>
<td>Low</td>
<td>Relaxation Training</td>
<td>B $^{32}$</td>
<td>B $^{32}$</td>
<td></td>
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</tr>
<tr>
<td>High</td>
<td>Psychodynamic Psychotherapy</td>
<td>C $^{32}$</td>
<td>C $^{32}$</td>
<td></td>
</tr>
</tbody>
</table>

* Extrapolated from adult populations.
Obsessive Compulsive Disorder

Estimates of prevalence vary from 0.51% to 4% (Douglass 1995\(^3\), Flament 1988\(^4\), Rapoport 2000\(^10\)) 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\(^9\)).

<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>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>C</td>
</tr>
<tr>
<td>Moderate-</td>
<td>Tier 3-4</td>
<td>High</td>
<td>BT or CBT can lead to better outcomes when combined with medication compared with medication alone</td>
<td>A (^1, 2, 5, 6, 8)</td>
</tr>
<tr>
<td>Severe (CYBOCS &gt;16(^{11}))</td>
<td></td>
<td></td>
<td>Between 12 &amp; 20 sessions of therapist guided CBT which should consist of: Exposure and Response Prevention (ERP) augmented with: Psychoeducation</td>
<td>A (^1, 2, 5, 6, 7, 8)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Anxiety Management</td>
<td>A (^5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cognitive Therapy</td>
<td>A (^5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Family sessions</td>
<td>A (^5)</td>
</tr>
</tbody>
</table>

\(^1\): Only included under child as age range was 10-13
Social Anxiety Disorder/Social Phobia

Social Anxiety Disorder or Social Phobia is ‘characterized by intense fear of embarrassment, humiliation, and negative evaluation by others in social situations, and a tendency to avoid feared situations’ (Kashdan & Herbert, 2001:37). Estimates of prevalence range from 0.5% to 4% of adolescents (Chavira & Stein, 2005; Kashdan & Herbert, 2001; Stein, 2006). It is associated with an increased risk for depression and suicide and will impact adversely on outcomes for people with co morbid mental health problems such as bipolar disorder and eating disorders (Stein, 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>Mild</td>
<td>School based</td>
<td>Low</td>
<td>Skills for Social and Academic Success (SASS) (Cognitive behavioural group treatment with social skills elements)</td>
<td>B 3, 17</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low</td>
<td>FRIENDS prevention and early intervention programme</td>
<td>B 18, 19</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>Social effectiveness training for children and Adolescents (SET– C) (including social skills training, peer generalization sessions and individualised in vivo exposure)</td>
<td>B 4, 5, 6, 7</td>
</tr>
<tr>
<td>Moderate/Severe</td>
<td>Secondary Care</td>
<td>High</td>
<td>Social Skills Training (SST) (an integrated cognitive behavioural group intervention consisting of social skills training, graded exposure and cognitive restructuring)</td>
<td>C 22</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>Cognitive Behavioural Group Treatment (CGBT)</td>
<td>B 1, 2, 20, 21</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>Individual Cognitive Behavioural Therapy with or without Parental/Family Involvement</td>
<td>B 13, 15, 16</td>
</tr>
</tbody>
</table>

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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\textsuperscript{5}; Miller et al., 1972\textsuperscript{13}) and for an intervention to be successful it is important to have parental involvement (Ollendick & King, 1998\textsuperscript{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/Severe</td>
<td>Tier 2-3</td>
<td>High</td>
<td>Behavioural: Participant Modelling</td>
<td>A 1, 3, 10, 14, 16, 18, 20</td>
</tr>
<tr>
<td></td>
<td>Tier 2-3</td>
<td>High</td>
<td>Behavioural: Reinforced Practice</td>
<td>A 3, 9, 12, 15, 16, 20</td>
</tr>
<tr>
<td></td>
<td>Tier 2-3</td>
<td>High</td>
<td>Systematic Desensitisation (in vivo desensitisation most effective for younger children)</td>
<td>B 3, 8, 11, 13, 16, 21, 22, 20</td>
</tr>
<tr>
<td></td>
<td>Tier 2-3</td>
<td>High</td>
<td>Cognitive Behavioural Therapy</td>
<td>B 3, 4, 6, 16, 17, 19, 20</td>
</tr>
<tr>
<td></td>
<td>Tier 2-3</td>
<td>High</td>
<td>Emotive Imagery (pairing frightening situations with an exciting story involving a hero-figure)</td>
<td>C 2, 7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>A 1, 3, 10, 14, 16, 18, 20</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>A 3, 9, 14, 15, 16, 20</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>B 3, 8, 11, 13, 16, 21, 22, 20</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>B 3, 16, 17, 19, 20</td>
</tr>
</tbody>
</table>
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 (intrusive memories, nightmares), avoidance (avoidance of thoughts, feelings and reminders of the trauma) and increased arousal (irritability, insomnia, hypervigilance; American Psychiatric Association, 2000). The diagnosis initially did not include younger age groups and it has only been recognized in the last 15 years that children and adolescents may suffer from posttraumatic stress reactions similar to those found in adults (Dalgleish, Meiser-Stedman & Smith, 2005).

Studies of at-risk child populations have demonstrated varying prevalence rates from 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; Salmon & Bryant, 2002; 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). Cognitive theories of childhood PTSD highlight the need to consider how developmental stages (e.g. language development) influence how a child may encode and resolve a traumatic experience (Salmon & Bryant, 2002). Due to the developmental implications, there is no clear consensus about the typical presentation of PTSD in children (Gillies et al., 2007).

Younger children may display fewer re-experiencing and little avoidance behaviour (Fletcher, 2003) and may present predominantly with behavioural symptoms (play re-enactment, aggression) (Scheeringa, Zeanah, Drell & Larrieu, 1995; 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) and anxiety disorders (Brent et al., 1995; Clark et al., 1995). It has been suggested that there is also a link between PTSD and experiences of ADHD (Cufé et al., 1994; Glod & Teicher, 1996). Further evidence suggests 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).
Post Traumatic Stress Disorder (PTSD)

* 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 age⁶.

**NB:** ‘level of severity’ is not taken to refer to the perceived severity of the traumatic incident/s, but the symptomatology with which a child or young person 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>All</td>
<td>Low</td>
<td>Following a traumatic incident, parents/carers should be informed of the possibility of development of PTSD with symptoms described. If symptoms persist beyond one month, contact GP.</td>
<td>C³⁶</td>
</tr>
<tr>
<td>Moderate</td>
<td>Tier 2-3</td>
<td>High</td>
<td>Anxiety Management training/ Exposure &amp; parent training</td>
<td>C₂², 2³, ³³</td>
</tr>
<tr>
<td></td>
<td>Tier 2-3</td>
<td>High</td>
<td>Trauma-focused developmentally appropriate CBT *for children aged over 7 years</td>
<td>B*/C¹⁴, 1⁹, 3⁶, 4³, 4⁶</td>
</tr>
<tr>
<td></td>
<td>Tier 2-3</td>
<td>High</td>
<td>Eye Movement Desensitisation &amp; Reprocessing (EMDR)</td>
<td>C², 2³, 3⁶, 4⁶</td>
</tr>
<tr>
<td></td>
<td>Tier 2-3</td>
<td>High</td>
<td>Group based grief/trauma-focused psychotherapy</td>
<td>C²², 2³</td>
</tr>
<tr>
<td>Severe</td>
<td>Tier 3</td>
<td>High</td>
<td>Trauma-focused developmentally appropriate CBT</td>
<td>C³²</td>
</tr>
</tbody>
</table>
The impact of sexual trauma

The experience of sexual trauma can result in disturbances in behaviour, emotional regulation and social functioning. Sexual trauma varies in frequency, duration and severity and often co-occurs with other traumatic 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 trauma (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 trauma can also appear asymptomatic (Saywitz et al., 2000). PTSD which develops as a result of sexual trauma 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 trauma vary widely due to methodological problems including how it is defined (Macdonald et al., 2006). Not all young people who experience sexual trauma 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 trauma happened, child’s cognitive ability), associated with features of the trauma itself i.e. nature and severity, relationship of the abusive figure to the victim (Beitchman et al., 1991), and familial and professional responses to the trauma. Exposure to childhood sexual trauma 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 trauma 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 traumatised (Hetzel-Riggin et al., 2007).
The impact of sexual trauma

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.

Therapeutic intervention with sexually traumatized and sexually inappropriate children/young people should not be in isolation and should involve liaison with their wider system. Education, consultation and support to the system are an extremely important part of intervention in most cases. This can happen whether or not the child/young person is receiving individual intervention.

NB: ‘level of severity’ is not taken to refer to the sexual trauma, but symptomatology with which the child or young person 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>C</td>
</tr>
<tr>
<td>Moderate</td>
<td>Tier 2</td>
<td>High</td>
<td>CBT/Trauma-focused CBT</td>
<td>B 12, 13,14</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>18, 19, 34, 36, 38, 39</td>
</tr>
<tr>
<td></td>
<td>Tier 2</td>
<td>High</td>
<td>Eye Movement Desensitization and Reprocessing</td>
<td>C</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 5, 15, 18, 27, 31, 32, 38</td>
</tr>
<tr>
<td>Severe</td>
<td>Tier 3</td>
<td>Specialist</td>
<td>CBT/Trauma-focused CBT</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>High</td>
<td>Eye Movement Desensitization and Reprocessing</td>
<td></td>
</tr>
<tr>
<td>Tier 3</td>
<td>High</td>
<td>Early intervention parent/carer abuse specific therapy (where not perpetrator of abuse)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 3</td>
<td>High</td>
<td>Longer term child-parent parallel treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 3</td>
<td>High</td>
<td>Systemic Family Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 3</td>
<td>High</td>
<td>Psychodynamic individual therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 3</td>
<td>High</td>
<td>Attachment based therapy</td>
<td></td>
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</tr>
<tr>
<td>Tier 3</td>
<td>High</td>
<td>Play therapy</td>
<td></td>
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<tr>
<td>Tier 3</td>
<td>High</td>
<td>Group therapy</td>
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<thead>
<tr>
<th></th>
<th>B</th>
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<th>B</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>12, 13, 14, 18, 19, 34, 36, 38, 39</td>
<td></td>
<td>12, 13, 14, 18, 19, 34, 36, 38, 39</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td></td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>5, 15, 18, 27, 31, 32, 38</td>
<td>/</td>
</tr>
<tr>
<td>Tier 3</td>
<td>C</td>
<td>31</td>
<td>C</td>
</tr>
<tr>
<td>Tier 3</td>
<td>C</td>
<td></td>
<td>C</td>
</tr>
<tr>
<td>Tier 3</td>
<td>C</td>
<td>B 45</td>
<td>C</td>
</tr>
<tr>
<td>Tier 3</td>
<td>C</td>
<td></td>
<td>C</td>
</tr>
<tr>
<td>Tier 3</td>
<td>C</td>
<td>31</td>
<td>C</td>
</tr>
<tr>
<td>Tier 3</td>
<td>C</td>
<td></td>
<td>C</td>
</tr>
</tbody>
</table>

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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.
## 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> 16, 36, 37, 48</td>
</tr>
<tr>
<td>Tier 2</td>
<td>High</td>
<td>Non-Directive Therapy</td>
<td><strong>C</strong> 42</td>
<td></td>
</tr>
<tr>
<td>Tier 1-2</td>
<td>Low</td>
<td>CBT (Brief – 8 sessions)</td>
<td><strong>B</strong> 46</td>
<td></td>
</tr>
<tr>
<td>Tier 1-2</td>
<td>Low</td>
<td>Cognitive Bibliotherapy</td>
<td><strong>C</strong> 37</td>
<td></td>
</tr>
<tr>
<td>Tier 1</td>
<td>High</td>
<td>Relaxation</td>
<td><strong>B</strong> 3, 37</td>
<td></td>
</tr>
<tr>
<td>Tier 1</td>
<td>High</td>
<td>Watchful Waiting (further assessment within 2 weeks)</td>
<td><strong>C</strong> 37</td>
<td></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><strong>A</strong> 16, 33, 34, 35, 37, 42</td>
</tr>
<tr>
<td>Tier 2-4</td>
<td>High</td>
<td>CBT</td>
<td>Longer courses or booster sessions seem to hasten recovery in non-responders.</td>
<td><strong>A</strong> 9, 10, 12, 15, 19, 25, 37, 38, 39, 41, 48, 49, 50</td>
</tr>
<tr>
<td>Tier 2-4</td>
<td>High</td>
<td>Systemic Family Therapy/Other Family Therapies</td>
<td><strong>B</strong> 6, 8, 37, 44</td>
<td></td>
</tr>
<tr>
<td>Tier 2-4</td>
<td>High</td>
<td>Social Skills Training</td>
<td><strong>C</strong> 24</td>
<td></td>
</tr>
<tr>
<td>Tier 2-4</td>
<td>High</td>
<td>No current evidence to support the use of social skills training, but opinion suggests it is of more use when the process of recovery has already</td>
<td><strong>B</strong> 8, 37, 44</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**
- **A** indicates strong evidence or high-quality evidence.
- **B** indicates moderate evidence or low-quality evidence.
- **C** indicates low-quality evidence or expert opinion.

References: 16, 36, 37, 48, 42, 47, 2, 42, 3, 37, 50, 37.
<table>
<thead>
<tr>
<th>Moderate/Severe (cont.)</th>
<th>Tier 3</th>
<th>Tier 3-4</th>
<th>Tier 3-4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High</td>
<td>High</td>
<td>High</td>
</tr>
</tbody>
</table>

- **High**
  - **Psychodynamic Psychotherapy & Psychoanalysis**
    - commenced
    - Psychodynamic psychotherapy & psychoanalysis should be used when a psychological intervention alone is not effective.
    - 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.

**References**

- B 20, 44, 45
- C 37
- B 14, 37
- B 13, 43, 44
- B 37
- B 14, 20, 21, 31, 32
- B 37
Insomnia

Abnormal or disordered sleep can be characterised by delayed sleep onset, prolonged night time wakenings or difficulties achieving adequate restorative sleep. Developmental, environmental and social factors have been identified as key indicators and risk factors for understanding and treating disordered sleep across both childhood and adolescence.

Adolescent development induces a reduction in levels of cortical activity through synaptic pruning and levels of melatonin secretion. The changes have been shown to directly impact upon adolescent sleep quality, sleep latency and sleep onset (Feinberg & Campbell, 2010; Tarokh & Carskadon, 2010; Deithelm et al, 2010). The role of child and adolescents’ external environment through school scheduling, the use of stimulants and the use of multiple electronic technologies has also been shown to have a significant negative effect on sleep duration and increased variation of sleep schedules across weekday and weekend evenings (Mindell et al, 2009; Calamaro, et al, 2009; Belanger et al, 2011; Cain & Gradisar, 2010).

Exposure to family stress, child abuse and neglect and injuries and accidents are significantly related to child and adolescent sleep efficiency and increased sleep disturbance through the occurrence of nightmares and prolonged wakening. The extent of such disturbances is thought to be related to the duration and intensity of the recalled stressful event (Bader and Schafer, 2007). Further, adolescents experiencing mental health problems are reported to have significantly greater levels of disordered sleep compared to adolescent community samples (Reigstad et al, 2010).

Sleep hygiene practices are significantly associated with the quality of infant and childhood sleep. Later bedtimes and parental presence has the strongest negative association with sleep onset and night wakenings in childhood (Mindell et al, 2009). Longitudinal studies have shown problematic sleep presenting in childhood is significantly associated with poorer sleep in adolescence (Wong, et al, 2010). Timely interventions are required as the immediate and long term effects of disordered sleep are thought to negatively impact on mood regulation, mental health, family and peer relationships, learning and academic attainment (Bader and Schafer, 2007; Reigstad et al, 2010; Wong, et al, 2010). Therefore the recognition and management of sleep disorders in childhood and adolescence is important in achieving positive treatment outcomes and relapse prevention.

Psychological interventions modelled to address disordered sleep have been developed from the established evidence from adult populations and emerging outcomes from child and adolescent studies. There is growing evidence for the efficacy of multi-modal approaches that encompass psycho-education for sleep and sleep disorders, problem solving and skills based behavioural training and the development of relaxation and cognitive coping strategies.
## Insomnia

<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>School based and Primary Care</td>
<td>Low</td>
<td>School-based prevention and early intervention well-being programme</td>
<td>B&lt;sup&gt;12&lt;/sup&gt; 3</td>
</tr>
<tr>
<td>Moderate/Severe</td>
<td>Tier 2 -3</td>
<td>Low</td>
<td>Brief Parental Behavioural Extinction Intervention</td>
<td>B&lt;sup&gt;10&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medium</td>
<td>Parenting / Family Psycho-education and Behavioural Programmes</td>
<td>A&lt;sup&gt;8&lt;/sup&gt; 14</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medium</td>
<td>Group Cognitive Behavioural Therapy with Integrated Parental/Family Involvement</td>
<td>B&lt;sup&gt;17&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>Individual Cognitive Behavioural Therapy with Parental/Family Involvement</td>
<td>B&lt;sup&gt;13&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

* See Morgenthaler et al. (2006)<sup>11</sup> for discussion on guidelines for practice
Self-harm

In an international community sample of young people 13.5% of females and 4.3% of males reported an episode of self-harm within their lifetime, and 8.9% and 2.6% respectively reported an episode during the last year (Madge et al., 2008)\(^\text{14}\). Adolescents surveyed in Scotland reported slightly higher levels of self-harm during the last year, 13.6% of girls and 5.1% of boys (O’Conner et al., 2009)\(^\text{19}\), similar to the prevalence reported in England (Hawton et al., 2002)\(^\text{7}\). Overall 12% of self-harm episodes reported in the previous year resulted in presentation to hospital (Madge et al., 2008; O’Conner et al., 2009)\(^\text{14, 19}\). Where adolescents reported a lifetime history of self-harm, girls were three times more likely to report self-harm than boys (O’Conner et al., 2009\(^\text{19}\); Madge et al., 2008\(^\text{14}\); Hawton et al., 2002\(^\text{7}\)).

Hawton and Catalan (1982)\(^\text{6}\) defined deliberate self-harm as ‘any intentional self-inflicted injury, irrespective of the apparent purpose of the act’ (in Wood et al., 2001: 1247)\(^\text{23}\). Between a quarter and a half of those completing suicide have previously self-harmed (Hawton & James, 2005)\(^\text{6}\). An estimated 170,000 people in the UK attend an emergency department having self-harmed per year (Kapur et al, 1998)\(^\text{12}\) and up to 1% of these will die by suicide during the subsequent year (Hawton et al., 2003\(^\text{8}\); Owens et al., 2002\(^\text{20}\)).

It is estimated that 70% of self-harm episodes are precipitated by a personal problem (Bancroft et al, 1977)\(^\text{2}\). Adolescents who self-harm have difficulties with regulating their emotions, problem-solving and utilising social supports (Andover et al. 2007\(^\text{1}\); Nock & Mendes, 2008\(^\text{18}\)). The most common reasons given for self-harming were to ‘get relief from a terrible state of mind’ (O’Conner et al. 2009\(^\text{19}\); Madge et al., 2008\(^\text{14}\)), followed by ‘wanting to die’ (Madge et al., 2008)\(^\text{14}\), and ‘wanting to punish oneself’ (Madge et al., 2008\(^\text{14}\); O’Conner et al., 2009\(^\text{19}\)).

Several therapeutic modalities indicate positive outcomes in the treatment of self-harm yet the evidence base for efficacious interventions for self-harm for children and adolescents is extremely limited and in most cases insufficient to make any negative or positive treatment recommendations. Self-harm is difficult to treat because the behaviour often fulfils multiple, complex functions. In addition people who self-harm are highly heterogeneous, what works for one individual may not prove effective for another.

In its 2004 CG16, NICE conclude that ‘for adolescents there is a strong evidence to suggest that there is a clinically significant difference favouring group therapy over standard aftercare on reducing the likelihood of repetition, although the numbers were small. Furthermore ‘referral for further treatment after an act of self-harm should be determined by the overall needs of the service user, rather than by the fact that they have self-harmed per se’ (NICE CG16, 2004: 178)\(^\text{17}\).

In Scotland, a National Strategy and Action Plan, Choose Life (Scottish Executive,2002)\(^\text{24}\), has set a target to reduce death resulting from suicide by 20% by 2013. Choose Life co-ordinators are tasked with agreeing, developing and implementing a local suicide
prevention plan. This work includes awareness raising programmes such as SuicideTALK and SafeTALK which are available to all, Applied Suicide Intervention Skills Training (ASIST) aimed at professionals, volunteers and informal helpers, and Skills Based Training on Risk Management (STORM) which is intended for frontline workers in health social and criminal justice services.
**Self-harm**

NICE recommend that following psychosocial assessment for people who have self-harmed, the decision about referral for further treatment and help should be based upon a comprehensive psychiatric, psychological and social assessment, including an assessment of risk, and should not be determined solely on the basis of having self-harmed.

<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 3-4</td>
<td>Minimum 6 sessions</td>
<td>Developmental Group Psychotherapy (containing elements of CBT, DBT and psychodynamic approaches)</td>
<td>C^{15, 21}</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12 sessions</td>
<td>Cognitive Behavioural Therapy for deliberate self-harm + treatment as usual</td>
<td>B^{21, 22}</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>Attachment-Based Family Therapy</td>
<td>C^{3}</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>Dialectical Behaviour Therapy</td>
<td>C^{4, 11, 13, 15}</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>Problem-Solving Therapy</td>
<td>C^{18}</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>Multi-Systemic Therapy</td>
<td>C^{10}</td>
</tr>
<tr>
<td>Severe</td>
<td></td>
<td></td>
<td>Rapid Response Out-Patient Team (Assessment, formulation and intervention include identifying the nature of crisis, the precipitating events, and the strengths and weaknesses of the adolescent’s support system, and reframing any misconceptions, maladaptive behaviours, and communication patterns that contributed to the client’s or family’s stress)</td>
<td>B^{6}</td>
</tr>
</tbody>
</table>

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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)\textsuperscript{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\textsuperscript{15}; Kotler & Walsh, 2000\textsuperscript{28}). 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)\textsuperscript{25}.

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)\textsuperscript{5}. In children between19–30% of cases have been in boys (Bryant-Waugh, 1993\textsuperscript{8}; Fosson et al., 1987\textsuperscript{20}, Hawley, 1985\textsuperscript{22}, Higgs et al., 1989\textsuperscript{24}; Jacobs & Isaacs, 1986\textsuperscript{27}).

Mortality in anorexia nervosa, with an age of onset before 18 years, is 2.72% (Signorini et al., 2007)\textsuperscript{44}. Herpertz-Dahlmann and Remschmidt (1993)\textsuperscript{23} 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\textsuperscript{37} identify this as a priority for future research.
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).\(^\text{19}\)

NHS QIS guidelines\(^\text{38}\) recommend individualised care and treatment based on individual needs and not on arbitrary targets for weight gain or number of sessions of therapy. The Junior Marsipan report\(^\text{39}\) outlines best practice based guidelines for management of children and young people with eating disorders including risk management, location of care, and management across sectors.

<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 (^\text{38, 43})</td>
</tr>
<tr>
<td>Moderate/Severe</td>
<td>Tier 2-4</td>
<td>High</td>
<td>Cognitive Restructuring Therapy (CRT) as a stand alone therapy or as an adjunct to further psychological work</td>
<td>C</td>
</tr>
<tr>
<td></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 (^37, 40)</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>
</tbody>
</table>

CBT, Interpersonal Psychotherapy (IPT),
<table>
<thead>
<tr>
<th><strong>Moderate/Severe (cont.)</strong></th>
<th>Tier 3</th>
<th>High</th>
<th>Psychodynamic Therapy, Cognitive Analytic Therapy (CAT), Motivational Enhancement Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 3</td>
<td>High</td>
<td></td>
<td>A choice of psychological treatments for anorexia nervosa should be available as part of mental health services in all areas.</td>
</tr>
<tr>
<td>Tier 3</td>
<td>High</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>
</tr>
<tr>
<td>Tier 3</td>
<td>High</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>
</tr>
<tr>
<td>Tier 4</td>
<td>High</td>
<td></td>
<td>Regular physical monitoring is recommended for people with anorexia nervosa during both inpatient and outpatient weight restoration.</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 treatment.</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>
</tr>
</tbody>
</table>

* There is evidence of benefit for Manualised Family Therapy (for example, the Maudsley model).
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><strong>Subclinical/Mild</strong></td>
<td>Tier 1</td>
<td>Low</td>
<td>Evidence-based self-help programme</td>
<td>B9*, 37, 43, 46*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Guided CBT self-help</td>
<td>B29</td>
</tr>
<tr>
<td><strong>Moderate/Severe</strong></td>
<td>Tier 2-3</td>
<td>High</td>
<td>Cognitive behaviour therapy for bulimia nervosa (CBT-BN).</td>
<td>A1*, 16*, 18*, 30, 31*, 37*, 44*, 47*</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>B1*, 16*, 37*</td>
</tr>
<tr>
<td></td>
<td>Tier 2-3</td>
<td>High</td>
<td>Family Therapy</td>
<td>A29, 43</td>
</tr>
<tr>
<td></td>
<td>Tier 2-3</td>
<td>Low</td>
<td>Evidence-based self-help programme</td>
<td>B4*, 9*, 37, 43, 46*</td>
</tr>
<tr>
<td></td>
<td>Tier 2-3</td>
<td>Low</td>
<td>Guided CBT self-help</td>
<td>B29</td>
</tr>
</tbody>
</table>

* Evidence from adult studies and adult recommendations.
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)\(^17\). 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.
## 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. The use of Metacognitive Training (MCT / MCT+) promises to be a useful treatment option, however, the current evidence base is limited and further research with adolescent populations is necessary before it can be included in the CAMHS matrix.

<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>Cognitive Behavioural Therapy for:</td>
<td>A 12*, 16*</td>
</tr>
<tr>
<td></td>
<td>Tier 3-4</td>
<td>High</td>
<td>Prodromal symptoms</td>
<td>B 9*, 12*, 16*</td>
</tr>
<tr>
<td></td>
<td>Tier 3-4</td>
<td>High</td>
<td>Transition</td>
<td>B 15, 16*</td>
</tr>
<tr>
<td>Severe</td>
<td>Tier 3-4</td>
<td>High</td>
<td>CBT for acute symptoms</td>
<td>A 4*, 13*, 15</td>
</tr>
<tr>
<td></td>
<td>Tier 3-4</td>
<td>High</td>
<td>CBT for functioning</td>
<td>A 4*, 15</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*, 14</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.
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.
**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>B⁸⁺</td>
</tr>
<tr>
<td></td>
<td>Tier 3-4</td>
<td>High</td>
<td>CBT</td>
<td>B⁸⁺</td>
</tr>
<tr>
<td></td>
<td>Tier 3-4</td>
<td>High</td>
<td>Interpersonal and Social Rhythm Therapy (IPSRT)</td>
<td>B¹⁰⁺</td>
</tr>
<tr>
<td></td>
<td>Tier 3-4</td>
<td>High</td>
<td>Family intervention</td>
<td>A⁸⁺, 12, 14</td>
</tr>
</tbody>
</table>

* Participants were recruited from adolescent and adult populations.
Neuropsychology

Neuropsychology, as a specialist area, and as a discipline, is concerned with assessing and describing the cognitive, behavioural and developmental consequences of disorders of the brain and central nervous system. Neuropsychological disorders are common in children and young people presenting to a range of CAMHS teams, both as primary reasons for referral e.g. attention and learning disorders or secondary reasons such as ADHD in the context of early brain injury, or autistic spectrum disorders. Neuropsychology is a discipline that is relevant to many medical specialties and disorders, and whilst there is an established service context in neurology e.g. with patients with traumatic brain injury, epilepsy or complex neurodevelopmental disorders, the need for neuropsychological assessment and intervention is growing across many areas of contemporary applied psychology practice.

Whilst some children and young people may require referral to specialist neuropsychologists, most clinical and applied psychologists are involved in routine neuropsychological assessment and rehabilitation.

This section will provide evidence for the use of neuropsychological assessment and intervention in two illustrative and common neurological disorders, epilepsy and acquired brain injury.
Epilepsy

Epilepsy is the most common serious neurological disorder, with an estimated prevalence in Scotland of around 4,200 children and young people (Scottish Paediatric Epilepsy Network GP Audit, 2005). Around 800 new principal diagnoses are made in children each year in Scotland, although the rate of misdiagnosis can be high due to the complexity of the condition. The effects of epilepsy extend far beyond having seizures, and include high rates of learning disability, mental health disorder, reduced academic attainment and quality of life (QoL) and social isolation, all of which can extend across the lifespan.

NICE Guidelines (2004) recommend that neuropsychological assessment should be considered when it is important to evaluate possible learning disability and cognitive dysfunction, with particular emphasis on language and memory function. NICE also recommends psychological interventions such as CBT in conjunction with anti-epileptic medication to contribute towards improved quality of life, and in particular with children with drug-resistant epilepsy.

SIGN guidelines state that around 50% of children with epilepsy require additional support at school and have double the rate of behavioural and psychiatric disorders compared with the general childhood population. Rates of ADHD in epilepsy have been found to be as high as 40%. SIGN recommends that all children with epilepsy should have their behavioural and academic progress reviewed, and that those with difficulties should have appropriate educational and psychological intervention.

Children with epilepsy have been found consistently to be more behaviourally disturbed, with lower self-esteem, and to experience poorer academic attainment than children with other chronic diseases of childhood such as diabetes or asthma. Some studies have suggested that early neuropsychological assessment can identify those with high risk for academic failure and can potentially lead to improved educational support. However, recent research suggests that even those children with normal intellectual ability and moderate seizure control can also have learning problems placing them at risk of poorer attainments.

Epilepsy has been associated with markedly reduced quality of life with problems accessing normal social activities, maintaining friendships and coping with mood and behaviour problems. There is an emerging evidence base for the effectiveness of group based psychosocial interventions along with the development of standardised QoL scales useful in assessing interventions, and also for the effectiveness of CBT as an individual treatment.
### Epilepsy

<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 Child</th>
<th>Recommendation Adolescent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subclinical/Mild</td>
<td>Tier 2-4</td>
<td>High</td>
<td>Group interventions to improve psychosocial adjustment</td>
<td>C^8</td>
<td>B^6,13</td>
</tr>
<tr>
<td></td>
<td>Tier 2-4</td>
<td>Low</td>
<td>Educational interventions</td>
<td>B^2,3,4</td>
<td>B^2,3,4</td>
</tr>
<tr>
<td></td>
<td>Tier 3-4</td>
<td>High</td>
<td>Individual psychological interventions-CBT</td>
<td>C^11</td>
<td>B^11</td>
</tr>
<tr>
<td></td>
<td>Tier 3-4</td>
<td>High</td>
<td>Neuropsychological Assessment</td>
<td>B^2,3</td>
<td>B^2,3</td>
</tr>
<tr>
<td>Moderate</td>
<td>2-4</td>
<td>High</td>
<td>Group interventions to improve psychosocial adjustment</td>
<td>C^8</td>
<td>B^6,13</td>
</tr>
<tr>
<td></td>
<td>2-4</td>
<td>High</td>
<td>Educational interventions</td>
<td>B^2,3,4</td>
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<td>3-4</td>
<td>High</td>
<td>Individual psychological interventions-CBT</td>
<td>C^11</td>
<td>B^11</td>
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<td>B^6,13</td>
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<td>B^2,3</td>
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</table>
Acquired Brain Injury (ABI)

ABI is a broad term covering neurological diagnoses that involve some level of cognitive dysfunction. The most typical conditions include traumatic brain injury, childhood cancer, central nervous system infection and stroke. A significant and controversial cause of brain injury in infants also relates to non-accidental injuries. All of these conditions put children at significant risk of difficulties in terms of information processing, language, visuo-spatial skills, memory, attention, executive functioning, emotional and behavioural regulation. These difficulties are then likely to impact on mental health, educational attainment, employment and independent living skills. Traumatic brain injury (TBI) is the most common cause of death or disability in childhood and a recent UK study estimates that every year, 280 children per 100 000 require hospitalization for 24 hours or more following a TBI. Almost two thirds of these children (63%) are between 5–15 years of age at the time of the injury and are likely to be in mainstream education. The prevalence of childhood cancers likely to lead to neurocognitive impairment (leukaemia, brain and spinal tumour) is around 423 per million (NICE, 2005).

There continues to be debate about the longer term impacts of mild TBI, which makes up around 90% injuries, with a lack of good quality longitudinal research. However, cross sectional studies, including those recently conducted in Scotland, have reported high rates of cognitive, emotional and behavioural problems, as well as reduced quality of life in children following all severities of TBI. Childhood acquired TBI can often result in ‘silent’ deficits that do not manifest until a child fails to make the normal developmental gains associated with maturation. Therefore, ensuring longitudinal follow up is essential, particularly for those with more significant injuries. At the moment there are no SIGN/NICE guidelines concerning the post-acute management of ABI in children and adolescents. There are plans to establish a Managed Clinical Network for Paediatric ABI in Scotland. It is recommended by the National Services Framework that children with an acquired brain injury receive support from neuropsychology services during their hospital admission through hospital discharge and community management. Similarly, “All Children with CNS malignancy should have access to a neuro-rehabilitation service, even years after treatment (p69).

NICE guidance for children with cancer (2005) identifies the effects that are also seen in acquired brain injury in childhood generally, which can affect neurological, psychological, endocrine and academic function with difficulties becoming more evident with increasing age. “Skilled neuro-rehabilitation often makes the difference between a child who grows into an independent adult and one who needs complex care packages” and as such, recommended provision includes both psychology and neuropsychology (p68).

Neuropsychological assessment itself can act as an early intervention, and can be a crucial aspect of developing care and education plans.

Whilst evidence is limited, there are sufficient studies and case reports to suggest that neuropsychological interventions can have a significant positive impact on cognitive, academic and adaptive functioning.
### Acquired Brain Injury (ABI)

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Level of Service</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
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<tbody>
<tr>
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<td>Moderate</td>
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<td>B&lt;sup&gt;17, 18, 19, 20&lt;/sup&gt;</td>
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<td>Tier 3-4</td>
<td>High</td>
<td>Cognitive Remediation of attention deficits</td>
<td>B&lt;sup&gt;29&lt;/sup&gt;</td>
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<tr>
<td></td>
<td>Tier 3-4</td>
<td>High</td>
<td>Metacognitive training for memory deficits</td>
<td>B&lt;sup&gt;7&lt;/sup&gt;</td>
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<td><strong>Moderate/Severe</strong></td>
<td>Tier 3-4</td>
<td>High</td>
<td>Assessment of cognitive impairments, with feedback, liaison and recommendations</td>
<td>B&lt;sup&gt;4, 11, 22&lt;/sup&gt;</td>
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<tr>
<td></td>
<td>Tier 3-4</td>
<td>High</td>
<td>Cognitive Remediation of attention deficits</td>
<td>A&lt;sup&gt;2, 3, 8, 26, 31&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Tier 3-4</td>
<td>High</td>
<td>Metacognitive and process training for memory deficits</td>
<td>A&lt;sup&gt;7, 27, 31&lt;/sup&gt;</td>
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<td>Tier 3-4</td>
<td>High</td>
<td>Training in use of external aids for memory deficits</td>
<td>A&lt;sup&gt;1, 15, 24, 31&lt;/sup&gt;</td>
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<td>Tier 3-4</td>
<td>High</td>
<td>Metacognitive and cognitive-behavioural training for executive dysfunction</td>
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<td>Tier 3-4</td>
<td>High</td>
<td>Behavioural intervention for executive dysfunction</td>
<td>B&lt;sup&gt;9, 28&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Tier 2-4</td>
<td>High</td>
<td>Educational support</td>
<td>C&lt;sup&gt;25&lt;/sup&gt;</td>
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</table>

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- **A**, **B**, **C** indicators represent different levels of evidence or recommendation strength.
- Numbers following these indicators typically represent specific references or studies.
NICE & SIGN Guidelines with relevance to CAMHS practice

Published

- Antenatal and postnatal mental health (NICE CG45)
- Antisocial personality disorder (NICE CG77)
- Anxiety (NICE CG22)
- Assessment, diagnosis and clinical interventions for children and young people with autism spectrum disorders (SIGN 98)
- Attention deficit hyperactivity disorder (ADHD) - methylphenidate, atomoxetine and dexamfetamine (review) (NICE TA98)
- Attention deficit hyperactivity disorder (ADHD) (NICE CG72)
- Bipolar disorder (NICE CG38)
- Borderline personality disorder (BPD) (NICE CG78)
- Chronic fatigue syndrome / Myalgic encephalomyelitis (NICE CG53)
- Conduct disorder in children - parent-training/education programmes (NICE TA102)
- Depression in children and young people (NICE CG28)
- Depression with a chronic physical health problem (NICE CG91)
- Drug misuse: psychosocial interventions (NICE CG51)
- Eating disorders (NICE CG9)
- Four commonly used methods to increase physical activity (NICE PH2)
- Insomnia - newer hypnotic drugs (NICE TA77)
- Interventions to reduce substance misuse among vulnerable young people (NICEPH4)

In progress July 2010

- Alcohol dependence and harmful alcohol use
- Alcohol use disorders - clinical management
- Alcohol-use disorders (prevention)
- Anxiety (partial update)
- Anxiety and depression: identification and referral in primary care
- Autism spectrum disorders in children and young people
- Looked after children
- Nocturnal enuresis in children (bedwetting)
- Personal, social and health education focusing on sex and relationships and alcohol education
- Preventing domestic violence
- Psychosis with substance misuse
- School-based interventions to prevent smoking
- Self harm (update)
Management of attention deficit and hyperkinetic disorders in children and young people (SIGN 112)
Maternal and child nutrition (NICE PH11)
NHS Health Scotland Commentary on NICE Public Health Guidance on promoting children's social and emotional wellbeing in primary education
Obsessive-compulsive disorder (NICE CG31)
Physical activity and the environment (NICE PH8)
Post-traumatic stress disorder (PTSD) (NICE CG26)
Schizophrenia (update) (NICE CG82)
School-based interventions on alcohol (NICE PH7)
Scottish Perspective on NICE public health guidance 20: Promoting young people's social and emotional wellbeing in secondary education
Self-harm (NICE CG16)
Social and emotional wellbeing in primary education (NICE PH12)
Social and emotional wellbeing in secondary education (NICE PH20)
Structural neuroimaging in first-episode psychosis (NICE TA136)
Violence (NICE CG25)
When to suspect child maltreatment (NICE CG89)
 Referenc e Section

INFANT MENTAL HEALTH RISKS AND DISORDERS


37. Scottish Government/COSLA (2009) *The Early Years Framework*. [http://www.scotland.gov.uk/Topics/People/Young-People/Early-years-framework](http://www.scotland.gov.uk/Topics/People/Young-People/Early-years-framework)


DISRUPTIVE BEHAVIOUR DISORDERS (DISORDERS OF CONDUCT)


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

**ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)**


AUTISM SPECTRUM DISORDERS


**ANXIETY**


**SOCIAL ANXIETY DISORDER/SOCIAL PHOBIA**


**SPECIFIC PHOBIA**


POST TRAUMATIC STRESS DISORDER (PTSD) AND THE IMPACT OF SEXUAL TRAUMA


**DEPRESSION**


**INSOMNIA**


**SELF-HARM**


EATING DISORDERS


**SCHIZOPHRENIA**


BIPOLAR DISORDER


**EPILEPSY**


**Acquired Brain Injury**


### Contributors

<table>
<thead>
<tr>
<th>Area</th>
<th>Contributors</th>
</tr>
</thead>
</table>
| Infant Mental Health                             | Christine Puckering, Consultant Clinical Psychologist, Department of Child and Family Psychiatry, Royal Hospital for Sick Children, Glasgow  
  Dr Marie Renaud, Consultant Clinical Psychologist, Head of Child and Family Service, Lynebank Hospital, Dunfermline  
  Brenda Renz, Consultant Clinical Psychologist, CAMHS, NHS Lothian  
  Dr Melanie Gunning, Assistant Psychologist, NHS Lothian                                                                                     |
| Disruptive Behaviour Disorders (Disorders of Conduct) | Brenda Renz, Consultant Clinical Psychologist, CAMHS NHS Lothian                                                                                                                                                   |
| Attention-Deficit Hyperactivity Disorder (ADHD)   | Mrs Helen Stirling, Consultant Clinical Psychologist, CAMHS NHS Forth Valley  
  Dr Fiona Forbes, Consultant Child and Adolescent Psychiatrist, CAMHS NHS Lothian  
  Natasha Prescott, Assistant Psychologist, CAMHS, NHS Lothian                                                                               |
| Autism Spectrum Disorders                         | Dr Anne Gilchrist, Consultant Adolescent Psychiatrist, Royal Cornhill Hospital, Aberdeen  
  Dr Gill Kidd, Consultant Clinical Psychologist  
  Jacqui Howison, Consultant Clinical Psychologist, CAMHS NHS Greater Glasgow and Clyde  
  Adele Pashley, Consultant Clinical Psychologist, North CAMHS, Possilpark Health Centre, Glasgow  
  Prof Tony Chalmers, Centre for Research in Autism and Education, Department of Psychology and Human Development, Institute of Education, London, UK. |
| Anxiety Disorders                                 | Dr Anna Stallard, Consultant Clinical Psychologist, Direct Access Service for Young People, Templeton Street, Glasgow  
  Natasha Prescott, Assistant Psychologist, CAMHS NHS Lothian  
  Cathy Richards, Consultant Clinical Psychologist, CAMHS NHS Lothian                                                                           |
| Obsessive Compulsive Disorder                     | Dr Louise Duffy, Consultant Clinical Psychologist, Lothian CAMHS NHS Lothian                                                                                                                                   |
| Social Anxiety                                    | Dr Anna Stallard, Consultant Clinical Psychologist, Direct Access Service for Young People, Templeton Street, Glasgow  
  Natasha Prescott, Assistant Psychologist, CAMHS NHS Lothian  
  Cathy Richards, Consultant Clinical Psychologist, CAMHS NHS Lothian                                                                           |
| Specific Phobia                                   | Natasha Prescott, Assistant Psychologist, CAMHS, NHS Lothian  
  Cathy Richards, Consultant Clinical Psychologist, CAMHS NHS Lothian                                                                              |
| Post Traumatic Stress Disorder (PTSD) & The Impact of CSA | Dr Gillian Affleck, Chartered Clinical Psychologist, University of Edinburgh  
  Nicole Scherer-Dickson, Cognitive Behavioural Therapist/Specialist Psychological Practitioner, CAMHS, NHS Lothian  
  Abbi Green, Assistant Psychologist, CAMHS, NHS Lothian                                                                                  |
<p>| Depression                                        | Cathy Richards, Consultant Clinical psychologist, CAMHS, NHS Lothian                                                                                                                                           |</p>
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<td>Judy Thomson, Consultant Clinical Psychologist, NHS Education Scotland</td>
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<td>Anxiety Disorders</td>
<td>Dr Karen Forrester, Clinical Psychologist, CAMHS NHS Lothian</td>
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<td>Post Traumatic Stress Disorder (PTSD) &amp; The Impact of CSA</td>
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<td>Self-harm</td>
<td>Prof. David Cottrell, Dean of Medicine, University of Leeds</td>
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<td>Childhood and Adolescent Insomnia</td>
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<td>Dr Charlotte Nevison, Head of Service, Community Eating Disorders Service, Templeton Street, Glasgow</td>
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<td>Bipolar Disorder</td>
<td>Dr Heather Bullen, Locum consultant psychiatrist, Young People's Department, Royal Cornhill Hospital, Aberdeen</td>
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</table>

**Consultation Groups and Individuals:**

Geraldine Bienkowski, Lead for Psychological Therapies, Mental Health Team, NHS Education for Scotland

Graham Bryce, Consultant child and adolescent psychiatrist, Children and Young People's Specialist Services, Glasgow

Dr Denise Coia, Mental Health Division, Scottish Government

Fiona Forbes, Consultant Child & Adolescent Psychiatrist, CAMHS NHS Lothian

Margo Fyfe, CAMHS Nurse Advisor/Acting Mental Health & Learning Disabilities Nursing Officer, Mental Health Delivery and Service Unit

Debbie Hindle, Child and Adolescent Psychotherapist, Glasgow LAAC Team and Course tutor at the Scottish Institute of Human Relations

Professor Alex McMahon, Deputy Director, Strategic Planning and Modernisation, Lothian NHS Board

Caroline Selkirk, Chair CAMHS Core Group

Dr Bronwyn Dunnachie, The Werry Centre for Child and Adolescent Mental Health Workforce Development, New Zealand

Sue Treanor, The Werry Centre for Child and Adolescent Mental Health Workforce Development, New Zealand CAMHS Core group

Child Heads of Psychology (CHOPS)

CAMHS Lead Clinicians Group Scotland
### MATRIX

**Older Peoples Services**

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<td>Psychotherapy with Older People Overall Conclusions</td>
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<td>Contributors</td>
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<td>Matrix: Level of evidence</td>
<td>Recommendation</td>
<td></td>
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<tr>
<td>--------------------------</td>
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</tr>
<tr>
<td><strong>A</strong> At least one meta-analysis, systematic review, or RCT of high quality and consistency aimed at target Population</td>
<td><strong>A</strong> Highly recommended</td>
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</tr>
<tr>
<td><strong>B</strong> 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><strong>B</strong> Recommended</td>
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</tr>
<tr>
<td><strong>C</strong> Widely held expert opinion but no available or directly applicable studies of good quality.</td>
<td><strong>C</strong> No evidence to date but opinion suggests that this therapy might be helpful</td>
<td></td>
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</table>
PSYCHOTHERAPY WITH OLDER PEOPLE

Increases in healthy life expectancy are profoundly important affecting not just the age distribution of societies in the developed and developing world but also the composition of society itself. In Scotland, the population aged 90+ is set to triple by 2033 and currently people aged 60+ outnumber those aged 16 and under. As a result there is a need to focus on improving access to psychological therapies for the oldest and most vulnerable members of our society.

Older people often present with psychological difficulties and physical comorbidity (for example as a result of conditions such as stroke and post-stroke depression) but also in relation to increased disability and frailty. A feature of psychotherapy with older people is chronicity as evidenced by a lifetime’s experience of living with recurrent mental health problems. Depression and anxiety in later life are not necessarily disorders of late onset but may more often reflect a continuing or recurrent pattern. Additionally age-related developmental factors can result in change, for example, a diminution of social networks through loss. However increasing age in itself may not be a factor in the development of depression as most older people report high levels of life satisfaction and are better at emotional regulation than younger adults. As people are increasingly living longer, so multiple losses become more common. For many older people these transitions can revolve around loss of physical or psychological independence. Thus psychotherapy can be different in regard to the types of challenges that people may face as they age. This means that psychotherapists may need to have a wider knowledge base of health and physical comorbidity.

Sadavoy (2009) characterizes five main 'C's' of working with older people and these are chronicity, complexity, comorbidity, continuity and context. This acknowledges that working with older people can be challenging and is a highly specialist intervention that is very often undertaken at a high level of intensity. Paradoxically as older people are a heterogeneous population there is much variability in terms of whether modifications or adjustments are necessary (Zeiss & Steffen, 1996) so psychotherapy can also be offered as a low intensity intervention such as self-help. Psychotherapy outcome with older people may be enhanced if therapists take account of relevant theories from gerontology in light of age challenges and emotional and cognitive changes in later life. Cuypers et al, (2009) in their recent meta-analysis concluded that psychological therapy treatment outcomes are comparable for younger and older adults.
# DEPRESSION IN LATER LIFE

<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>Mild</td>
<td>Primary Care</td>
<td>Low - moderate</td>
<td>Bibliotherapy (using non-older adult specific texts)</td>
<td>A&lt;sup&gt;10&lt;/sup&gt;</td>
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<td></td>
<td></td>
<td></td>
<td>Counselling</td>
<td>C&lt;sup&gt;10&lt;/sup&gt;</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Life review therapy</td>
<td>C&lt;sup&gt;6&lt;/sup&gt;</td>
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<tr>
<td>Moderate</td>
<td>Primary Care and secondary care</td>
<td>Low - high</td>
<td>Individual CBT</td>
<td>A&lt;sup&gt;2, 4, 5, 11&lt;/sup&gt;</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Problem-Solving Therapy (PST)</td>
<td>A&lt;sup&gt;1, 5&lt;/sup&gt;</td>
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<td></td>
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<td></td>
<td>Behaviour Therapy</td>
<td>A&lt;sup&gt;9&lt;/sup&gt;</td>
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<td>IPT maintenance post-recovery</td>
<td>A&lt;sup&gt;7, 8&lt;/sup&gt;</td>
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<td>Psychodynamic Psychotherapy</td>
<td>A&lt;sup&gt;2, 14&lt;/sup&gt;</td>
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<td>Group-based CBT</td>
<td>A&lt;sup&gt;3, 13&lt;/sup&gt;</td>
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<td>Severe</td>
<td>Primary Care and Secondary Care/CMHT</td>
<td>High</td>
<td>Individual CBT *</td>
<td>A&lt;sup&gt;5, 12&lt;/sup&gt;</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>*CBT with medication may be more effective than medication alone.</td>
<td></td>
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</tbody>
</table>

<sup>NB</sup>: Group-based CBT
| Chronic or Treatment Resistant | Secondary Care/Highly Specialised Specialist Service; In-Patient Care | High | Individual CBT | C \(^{12}\) |

**N.B.** Most of the evidence for psychodynamic psychotherapy with older people is indirect, with the strongest evidence for psychodynamic psychotherapy vs CBT trials. At up to 2 years follow up, psychodynamic therapy was also shown to have beneficial outcome for late life depression (Gallagher-Thompson et al, 1990).
## Anxiety Disorders in Later Life

<table>
<thead>
<tr>
<th>Level of Severity/Functional impairment</th>
<th>Level of Service</th>
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<tbody>
<tr>
<td>Mild</td>
<td>Primary Care</td>
<td>Low</td>
<td>CBT</td>
<td>A&lt;sup&gt;5, 6&lt;/sup&gt;</td>
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<tr>
<td>Moderate to Severe</td>
<td>Secondary or Tertiary Care</td>
<td>High</td>
<td>CBT</td>
<td>A&lt;sup&gt;1, 2, 4&lt;/sup&gt;</td>
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<tr>
<td>Chronic/Complex with evidence of executive impairment</td>
<td>Psychological therapy services with highly specialist practitioners</td>
<td>High</td>
<td>CBT (adapted for older people with anxiety and executive dysfunction using specialist protocol)</td>
<td>B&lt;sup&gt;3&lt;/sup&gt;</td>
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### DISTRESS IN DEMENTIA CAREGIVERS

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<td>Secondary Care</td>
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<td>CBT for Depression in caregivers</td>
<td>A&lt;sup&gt;1,2,6&lt;/sup&gt;</td>
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<td>CBT for Anxiety in caregivers</td>
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<td>CBT for Caregiver Burden and Distress</td>
<td>A&lt;sup&gt;4,6&lt;/sup&gt;</td>
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<td>Behaviour Therapy for Behavioural Challenges</td>
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<td>Psychoeducation (only if active)</td>
<td>B&lt;sup&gt;6&lt;/sup&gt;</td>
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<td>Supportive interventions for caregivers (active)</td>
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<td></td>
<td></td>
<td>Multicomponent interventions</td>
<td>A&lt;sup&gt;5,6&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

**NOTES**

- **C** From the multi-site REACH (Resources to Enhance Adult Caregivers Health) studies (Schulz et al., 2003) a consensus on caregiver interventions suggests that active interventions are better than passive interventions. As the needs of dementia caregivers are not uniform and unitary, structured multi-component interventions are the only caregiver interventions thought to delay institutionalisation.

- **D** Although not a therapy as such, befriending has been used as part of a range of responses to dementia caregiver distress. A recent RCT of volunteer befriending for dementia caregivers showed no benefit (Charlesworth et al, 2008) Befriending carers of people with dementia: Randomised Controlled Trial, BMJ, 336, 1295).
## POST-STROKE DEPRESSION

<table>
<thead>
<tr>
<th>Level of Severity/Functional impairment</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>Secondary Care</td>
<td>High</td>
<td>CBT</td>
<td>β^1, 2</td>
</tr>
</tbody>
</table>
### DEPRESSION IN PARKINSON’S DISEASE

<table>
<thead>
<tr>
<th>Level of Severity/Functional impairment</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>Secondary Care</td>
<td>High</td>
<td>CBT</td>
<td>B¹, ²</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CBT for carers for people with PD</td>
<td>B ³</td>
</tr>
</tbody>
</table>

---

1. Reference: B
2. Reference: B
3. Reference: B
# Direct Interventions for People with Depression & Anxiety in Dementia

<table>
<thead>
<tr>
<th>Level of Severity/ Functional Impairment</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>Secondary Care/Speci alist protocol driven interventions</td>
<td>High</td>
<td>CBT, Behaviour Therapy</td>
<td>C[^1^, ^4^, ^5^]</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>B[^2^, ^3^]</td>
</tr>
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</table>
### SEVERE AND ENDURING CONDITIONS IN LATER LIFE

<table>
<thead>
<tr>
<th>Level of Severity/ Functional impairment</th>
<th>Level of service</th>
<th>Intensity of Intervention</th>
<th>What intervention?E</th>
<th>Recommendation</th>
</tr>
</thead>
</table>
| Moderate                                | Secondary Care   | High                      | Cognitive Behaviour Social Skills Training for Schizophrenia, Bipolar Disorder | B
|                                         | Secondary Care   | High                      |                      | 1, 2, 3        |

E. The social skill training studies are conducted on participants that are quite young by the standards of other studies reported here. The age range is from 42 to 74 years in studies 1,2 and 40-78 for study 3.
### PERSONALITY DISORDERS IN LATER LIFE

<table>
<thead>
<tr>
<th>Level of Severity/Functional impairment</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>Secondary Care</td>
<td>High</td>
<td>DBT</td>
<td>B¹</td>
</tr>
</tbody>
</table>

1. DBT: Dialectical Behavior Therapy
PSYCHOTHERAPY WITH OLDER PEOPLE OVERALL CONCLUSIONS
The overall conclusion about psychotherapy with older people is that there is good evidence that psychotherapy is effective for depression and anxiety. Although, the literature on psychotherapy outcome with oldest-old is insufficient outcome is not adversely affected by age as people in the oldest age range (80+) report similar outcomes to young-old people. Likewise there is comparable outcome for CBT between adults of working age and older people (Cuijpers et al, 2009). More specific age related conditions such as dementia, stroke and Parkinson’s disease are being recognized as having significant psychological consequences for the individual and their caregivers.

<table>
<thead>
<tr>
<th>Contributors</th>
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<tbody>
<tr>
<td><strong>Dr Ken Laidlaw</strong></td>
</tr>
<tr>
<td>Senior Lecturer in Clinical Psychology, University of Edinburgh/Consultant Clinical Psychologist and Professional Lead for Older Adults Psychology Services, NHS Lothian</td>
</tr>
<tr>
<td><strong>Dr Susan Cross</strong></td>
</tr>
<tr>
<td>Consultant Clinical Psychologist, Head of Older Adults Psychology Service, NHS Greater Glasgow and Clyde</td>
</tr>
<tr>
<td><strong>Professor Bob Woods</strong></td>
</tr>
<tr>
<td>DSDC – The Bangor Centre for Research &amp; Development on Dementia Care Services, Bangor University, Wales</td>
</tr>
</tbody>
</table>
REFERENCE SECTION

Late Life Depression


Late Life Anxiety


Dementia Caregiver Interventions


SPECIALIST INTERVENTIONS

Post-stroke Depression


Depression in Parkinson Disease

Direct Interventions for People with Depression and Anxiety in Dementia

Severe and Enduring Conditions in Later Life

Personality Disorders in Later Life
# Psychological Therapies for People with Learning Disabilities – Introduction

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<td>238</td>
<td>Contributors</td>
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</table>
Learning Disabilities – Introduction

There is a growing recognition of mental health problems experienced by people with learning disabilities (Cooper and Van der Speck, 2009), and the need to develop effective psychological therapies to address these difficulties. Epidemiological evidence indicates that there is a higher incidence and prevalence of mental health problems than that found in the general population (Cooper et al, 2007) and important best practice guidelines have been produced (Royal College of Psychiatrists, British Psychological Society and Royal College of Speech and Language Therapists, 2007).

A frequent reason offered for the lack of attention paid to mental health problems presented by people with learning disabilities is due to diagnostic overshadowing. This means that because attention is focussed on cognitive difficulties or problems with adaptive behaviour, there is a failure to notice signs of emotional distress. However, there are other difficulties with diagnosis and intervention. In common with other groups, there is a great deal of co-morbidity, and challenging behaviour and mental health problems often occur together (Cooper et al, 2007). Individuals described as having learning disabilities are a heterogeneous group, and those with more significant impairments may be unable to report their symptoms of distress, making it difficult to use existing diagnostic categories. The referral route is also different and people with learning disabilities rarely refer themselves for help with emotional problems, relying on others to identify their problems and seek professional input on their behalf.

Psychological therapies with a proven efficacy in the general population are being adapted for use with people who have learning disabilities. The emerging evidence for cognitive behavioural interventions (CBT) is encouraging, but further process and outcome research is required to establish the effectiveness of these interventions and underlying mechanisms of change. There are limits to the use of talking therapies with this population, and findings would suggest that interventions like CBT only have the potential to be effective with people who have mild to moderate learning disabilities (Taylor, Lindsay and Willner, 2008). Other approaches, including psychodynamic and systemic interventions, have been adapted for use with this population. However, in common with
CBT, certain therapies are only likely to be helpful with people who have mild to moderate learning disabilities and may not be accessible for those with more significant impairments. Art and music therapists can have an important role, especially with those who have limited expressive or receptive verbal communication (Pounsett, Parker, Hawtin & Collins, 2006). Collecting data about the effectiveness of such innovative practice is necessary to properly represent the range of psychological therapies carried out in this field.

There is a longstanding history of positive behavioural approaches to challenging behaviour presented by people with learning disabilities, which is one of the main reasons that individuals are referred for psychological help (Emerson et al 2000). One drawback for the matrix is that much of the challenging behaviour research has been experimental work in specialist settings, and there is a need to build a better evidence base about sustainable interventions in ordinary community settings. Positive behavioural interventions have evolved to provide effective help for individuals living in community settings (Carr et al 1999), with a growing emphasis on working alongside those providing clients with formal and informal support. This underlines the fact that psychological interventions for people who have learning disabilities are rarely clinic based, and usually carried out on an outreach basis in an attempt to ensure the therapeutic work is ecologically valid and translates into observable improvement in life circumstances. It also fits well with the recovery principle set out in the framework given for the matrix. Working with individuals who are likely to be receiving other forms of support means that psychological therapies are frequently delivered as part of a multi-disciplinary package. Providing focussed training and guidance for families and paid carers is particularly important when implementing behavioural interventions.

It is also noteworthy that the pace of therapeutic change for people with learning disabilities is likely to be slower. Consequently, interventions are likely to take longer and be at a higher level of intensity than equivalent interventions in the general adult population.
Using randomised control trials to investigate therapeutic interventions for seriously challenging behaviour poses ethical problems for researchers. Moreover, the small numbers of individuals with discrete diagnoses of mental health problems can make it difficult to carry out properly powered trials. Therefore, there is a limited amount of pertinent research available for the learning disability matrix, and it is vital to broaden the evidence base and build on current good practice in the field.

References.


# MATRIX OF PSYCHOLOGICAL INTERVENTIONS (LEARNING DISABILITY)

## ANGER

<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 to borderline learning disability. Clinically significant anger problems.</td>
<td>Specialist community services for people with learning disabilities.</td>
<td>High</td>
<td>Group anger management – cognitive and behavioural.</td>
<td>A 1, 2</td>
</tr>
<tr>
<td>Moderate to borderline LD. Clinically significant anger problems.</td>
<td>Inpatient forensic service.</td>
<td>High</td>
<td>Individual cognitive behavioural therapy for anger.</td>
<td>A 3, 4</td>
</tr>
<tr>
<td>Level of severity</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>Level of severity</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>Severe/ enduring</td>
<td>Secondary Care/ Specialist Services</td>
<td>High</td>
<td><strong>Functional analysis and behavioural interventions</strong>&lt;br&gt;Use of functional analysis to determine antecedent management, including stimulus control, setting events, establishing operations, differential reinforcement, adjustment of environmental variables and those internal to the person.</td>
<td>A 1,2,3,4,5</td>
</tr>
<tr>
<td>Severe/ enduring</td>
<td>Secondary Care/ Specialist Services</td>
<td>High Multi-modal</td>
<td><strong>Positive behavioural support</strong>&lt;br&gt;Values based activity and support planning with effective assistance to involve the person in meaningful activity; environmental redesign.&lt;br&gt;&lt;br&gt;Incorporates proactive strategies for reducing the likelihood of the occurrence of the behaviour, and reactive plans for managing the behaviour when it occurs.&lt;br&gt;&lt;br&gt;Incorporates individual and carer/systems change approaches.</td>
<td>A 3</td>
</tr>
</tbody>
</table>
| Severe/ enduring | Secondary Care/ Specialist Services | High Multi-modal | **Active support**  
Patient focused interactive training and coaching for carers in active support for meaningful engagement in activities. | B 9,10 |
|------------------|------------------------------------|-----------------|-------------------------------------------------|-------|
| Severe/ enduring | Secondary Care/ Specialist Services | High | **Functional equivalence / Functional communication training**  
Teaching alternative adaptive responses, new skills or ways of communicating to gain the same outcome, without using challenging behaviours. | A 3,6 |
| Severe/ enduring | Secondary Care/ Specialist Services | High | **Extinction**  
*Extinction should only be considered for non-dangerous behaviours, i.e. not aggressive, destructive or self-injurious behaviour.* | A 5 |
| Severe/ enduring | Secondary Care/ Specialist Services | High | **Specialist Teams**  
Use of a specialist behaviour therapy team in addition to standard treatments is both more effective and more efficient in reducing challenging behaviours and may have financial advantages over standard treatment | A 8 |
<table>
<thead>
<tr>
<th>Severe/ enduring</th>
<th>Secondary Care/ Specialist Services</th>
<th>High</th>
<th><strong>Social problem solving</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Teaching skills to devise an effective strategy in a given situation where challenging behaviour may occur. Taught in addition to specific skills to cope in these situations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>B 11</td>
</tr>
</tbody>
</table>
## 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 to moderate learning disability and mild to severe levels of depression.</td>
<td>Specialist community service</td>
<td>Low.</td>
<td>Group CBT with an additional component concerning social support.</td>
<td>B 1,2</td>
</tr>
</tbody>
</table>
## 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>Mild to borderline learning disability. Severe / enduring</td>
<td>Primary Care</td>
<td>High</td>
<td>Individual CBT</td>
<td>B 1</td>
</tr>
</tbody>
</table>

### Contributors

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dr Alison Robertson</strong></td>
<td>Head of LD Psychology, NHS Fife</td>
</tr>
<tr>
<td><strong>Professor Andrew Jahoda</strong></td>
<td>Professor of Learning Disabilities, University of Glasgow</td>
</tr>
<tr>
<td><strong>Dr Martin Campbell</strong></td>
<td>Senior Lecturer, School of Psychology, University of St Andrews</td>
</tr>
<tr>
<td><strong>Dr Sharon Horne Jenkins</strong></td>
<td>Consultant Clinical Psychologist, NHS Fife</td>
</tr>
<tr>
<td><strong>Dr Stephen Oathamshaw</strong></td>
<td>Consultant Clinical Psychologist, NHS Borders</td>
</tr>
<tr>
<td><strong>Ms Claire Lammie</strong></td>
<td>Research Assistant, University of Glasgow</td>
</tr>
</tbody>
</table>
Reference list for Matrix LD

ANGER


ANXIETY

CHALLENGING BEHAVIOUR


**DEPRESSION**


**PSYCHOSIS**

FORENSIC MENTAL HEALTH SECTION

This section applies to patients who present a risk of serious harm to others such that they require specialist “forensic” expertise in their management. ‘Forensic patients’ are sometimes referred to as mentally disordered offenders although not all have criminal convictions. They may be managed in secure hospital settings or by community mental health services.

The majority of forensic patients also present with personality disorder, co-morbid with mental illness, substance misuse and/or cognitive deficits. Such highly complex and enduring problems demand highly specialist, individually tailored psychological interventions delivered by practitioners with the highest levels of training. However, forensic patients may also have simpler underlying or associated difficulties which may respond to less intensive interventions. A model of matched stepped care can therefore be applied and in the absence of evidence pertaining specifically to forensic patients, the tables contained in the rest of the Matrix can be used as a guide to treatment planning (e.g. substance misuse, psychosis).

The tables in this section relate to offending behaviours for which there is an evidence base relating specifically to forensic patients. For some offending behaviours or related problems, the evidence base remains in its infancy for offenders with mental disorder and as such no matrix table is presented at all (e.g. fire-setting, intimate partner violence, stalking and severe personality disorder).

Where no standardised or single treatment is available or suitable, the appropriate approach will be to seek to understand and treat the underlying problems. In these cases highly specialist psychological practitioners are required to use the available evidence to select, modify, adapt and evaluate psychological treatments to match the patient’s risks and needs and be responsive to their particular learning styles and any cognitive deficits.

A number of factors must also be taken into account to ensure the safe and effective delivery of psychological therapies in forensic mental health services. These are outlined in brief below and a fuller explanation is available in "A Guide to Delivering Psychological Therapies in Forensic Mental Health Services in Scotland" (Forensic Managed Care Network, in preparation).

1. The identification and formulation of psychological needs and delivery of psychological therapy must be carried out as part of a risk assessment and management process. This process is concerned with identifying and addressing the full range of patients’ risks and needs. It allows for the appropriate sequencing of interventions relative to other aspects of the recovery or care plan and regular reviews of this based on progress. Practitioners with highly specialist skills in the assessment of risk of harm to self and others are required to review patients’ progress in psychological therapy in terms of the impact on risk.

2. The majority of sexual and violent offenders have personality disorder, particularly those who cause serious harm and/or who offend repeatedly. Where these patients present to mental health services because of their co-morbid mental illness or learning disability, the type and range of personality difficulties must also be assessed. These will range from simple personality disorder (only one DSM-IV cluster diagnosis) to complex and severe personality disorder (meeting criteria for several disorders spanning more than one cluster) to psychopathy. Although personality disorder is rarely the reason someone presents to mental health practitioners, understanding the effects of personality disorder plays a crucial role in addressing offending behaviour, in delivering treatment for
other conditions and in determining poor emotional, interpersonal and behavioural functioning which can significantly impact on management. Psychological interventions for those with personality disorders should aim to: (1) help staff formulate, interact with and manage the patient (2) improve personality functioning through specific therapies; (3) reduce risk of re-offending through appropriately responsive offending behaviour programmes.

3. All forensic patients should be subject to the **Care Programming Approach** (CPA). This ensures adherence to an appropriate risk assessment and management process and provides a mechanism for reviewing risk management plans including those addressing psychological needs.

4. Motivation to engage in treatment, known as ‘**readiness to change**’, seems to influence an offender’s response to psychological work. While motivational strategies with individual patients may help, a **positive therapeutic ethos** is also essential for readiness. Effective multidisciplinary working, robust supervision and reflective practice systems, a psychologically-minded workforce, and paying close attention to the organisational, physical, social and psychological environment are important factors in this.

5. **Strengths based approaches**, such as the ‘**Good Lives’ model**, show promise with offenders and are consistent with the philosophy of ‘recovery’ from mental disorder. In line with this, interventions should be designed to enable individuals to make positive choices and changes in their lives and to capitalise on natural opportunities to develop non-offending and mentally healthy lifestyles. Occupational, social, creative and learning opportunities form a key part of this as does the promotion of physical exercise and wellbeing.

6. The **rights of the patient** must be carefully balanced against the **rights of the public** to be protected from harm.

7. Mental health services have a **duty to cooperate** with other agencies (e.g. the Mental Health Tribunal Service, Multi-Agency Public Protection Arrangements, the Parole Board for Scotland, Scottish Government, Scottish Courts, Risk Management Authority and the Scottish Prison Service etc). This may require that information about patients’ psychological needs or progress in therapy which is relevant to their risk management is shared.

In interpreting the tables, the criteria for A,B and C evidence as defined in the main matrix apply. However, the following should be noted:

1. The tables are divided into sections pertaining to major clinical and behavioural problems, but it is important to recognise that these divisions are to some extent arbitrary as most forensic patients have multiple and interlinked problems.

2. Studies of non-mentally disordered offenders are generally more widespread and are worthy of mention in the forensic mental health matrix as it is highly likely that at least some forensic patients (particularly those with personality disorders) will occur in non-offender samples. However it is also the case that many studies have specific exclusion criteria such that offenders with mental health problems are not likely to form part of the sample. Studies of offender populations where there is no formal assessment of mental disorder but are nevertheless of particularly high quality (RCTs or meta-analyses or systematic review) will be given a B rating in the tables.
3. The references in the tables provide an example of the best level of evidence in relation to each treatment at present.

**Contributors to tables:**
Anger-rated aggression: Mark Ramm
Serious (general violence): Mark Ramm
Sexual Offending: Rajan Darjee and Lynda Todd
General Offending Behaviour: Ruth Stocks and Rajan Darjee

**Reviewers of evidence for which no table is presented due to insufficient evidence base to support specific interventions:**
Personality Disorder: Rajan Darjee, Lorraine Johnstone, Siobhan Murphy
Intimate Partner Violence: Liz Gilchrist
Stalking: Anna Sutherland and Catherine Creamer
Fire Setting: Morag Slesser
Substance misuse: Ruth Stocks

**Intensity of intervention.**

The following descriptions relate to interventions for forensic patients. Although in general low intensity interventions will be shorter, this will depend on the responsivity needs of each patient. In addressing the mental health needs of forensic patients, the guidance contained in the original Matrix should be used as a guide.

*Low Intensity* interventions are brief interventions aimed at current distress or transient or mild mental health problems but may have a limited effect on overall functioning or risk of re-offending.

*High Intensity* denotes a standardised psychological therapy delivered to a formal protocol or model for mental health problems with significant effect on functioning and where there is a significant effect on risk of re-offending and future risk of harm.

*Specialist* interventions are standardised high intensity psychological therapies developed and modified for specific patient groups. These are aimed at moderate/severe mental health problems with significant effect on functioning. The interventions themselves are generally targeted at patients with more complex risk and needs and are directly related to offending behaviour and its causes.

*Highly Specialist* interventions are psychological therapies or interventions based on case formulations that may be drawn from a range of psychological models and are individually tailored to the patient’s mental health problems and where risk assessment and management are key drivers in the execution of the therapy.
### THE FORENSIC MATRIX
### EVIDENCE TABLES – ADULT SERVICE
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<td>245</td>
<td>Anger related aggression</td>
<td>245</td>
</tr>
<tr>
<td>246</td>
<td>Serious (general) violence</td>
<td>246</td>
</tr>
<tr>
<td>247</td>
<td>Sexual offending</td>
<td>247</td>
</tr>
<tr>
<td>248</td>
<td>General offending behaviour</td>
<td>248</td>
</tr>
<tr>
<td>249</td>
<td>Contributors</td>
<td>-</td>
</tr>
</tbody>
</table>
Table showing strongest level of evidence from interventions used with adult male patients where anger dyscontrol is a principle cause of aggressive and violent behaviour. Some other approaches show promise but lack controlled trials. The routine allocation of violent offenders to anger interventions may be ineffective or counterproductive so the presence of anger as a problem requires to be formerly established.

<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 specialist or outpatient service or tertiary forensic mental health service in secure hospital, prison or community</td>
<td>High Intensity</td>
<td>CBT Anger Management</td>
<td>A1</td>
</tr>
</tbody>
</table>
| Complex           | Secondary specialist or outpatient service or tertiary forensic mental health service in secure hospital, prison or community | Specialist-Highly Specialist | CBT Anger Treatment | A2  
|                   |                  |                           |                                       | B3 |

**REFERENCES**


GENERAL VIOLENCE

Table showing strongest level of evidence from broad interventions used with adult male patients to address violent behaviour which is more wilful/considered or instrumental in nature as opposed to principally resulting from anger dyscontrol. Violence is defined here as “actual attempted, or threatened harm to a person or persons...violence is behaviour which is obviously likely to cause harm to another person or persons” (1). Due to the multiple causal factors for violence and the heterogeneous nature of client population there is no single conceptual model to guide general violence 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>Moderate-severe</td>
<td>Tertiary forensic mental health service in secure hospital, prison or community</td>
<td>High Intensity</td>
<td>CBT</td>
<td>B2</td>
</tr>
</tbody>
</table>

REFERENCES


SEXUAL OFFENDING

The following interventions are recommended for adult males who are assessed as posing a risk of sexual offending. These may be individuals who have committed sexual offences, individuals who have been sexually aggressive without facing criminal charges or individuals who present with urges, fantasies or behaviours indicating a risk of sexual offending. The table sets out the primary recommendations regarding psychological treatment within forensic mental health services.

Research has generally been conducted with groups of male sexual offenders who have committed rape and child sexual abuse. There is little evidence to indicate whether child and adult offenders should be treated separately. Specific programmes have been developed for internet offenders but outcome research is still awaited. Similarly limited evidence exists with regard to treatment outcome for female offenders, sexual murderers, and unconvicted sexual offenders. Denial is unrelated to risk of recidivism (except perhaps in lower risk incest offenders) and treatment can be modified to meet the needs of deniers.

<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>Medium to high risk of sexual recidivism</td>
<td>Tertiary forensic mental health service</td>
<td>High intensity</td>
<td>CBT</td>
<td>B 1</td>
</tr>
<tr>
<td>Individuals with paraphilias (deviant sexual interests)</td>
<td>Tertiary forensic mental health service</td>
<td>High intensity – Highly specialist</td>
<td>Behaviour modification</td>
<td>C 2</td>
</tr>
</tbody>
</table>

REFERENCES


## GENERAL OFFENDING BEHAVIOUR

<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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<td>All levels of severity</td>
<td>Secondary / specialist outpatient Or tertiary forensic mental health services</td>
<td>High intensity to highly specialist</td>
<td>CBT</td>
<td>B1, 2</td>
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</table>

### REFERENCES


<table>
<thead>
<tr>
<th>Contributors</th>
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<tbody>
<tr>
<td>Mr Peter Clarke</td>
<td>CPA Manager, The State Hospital, Carstairs</td>
</tr>
<tr>
<td>Dr Rajan Darjee</td>
<td>Consultant Forensic Psychiatrist, NHS Lothian Clinical Lead for MAPPA/Sexual Offenders, NHS Scotland Forensic Network</td>
</tr>
<tr>
<td>Professor Liz Gilchrist</td>
<td>Director of Post graduate Forensic Psychology Programmes, Glasgow Caledonian University; Psychology member of the Parole Board for England and Member of the Parole Board for Scotland</td>
</tr>
<tr>
<td>Dr Lorraine Johnstone</td>
<td>Consultant Forensic Clinical Psychologist, CAMHS, Glasgow</td>
</tr>
<tr>
<td>Mr David Langton</td>
<td>Consultant Nurse, Forensic Network</td>
</tr>
<tr>
<td>Professor Mary McMurrnan</td>
<td>University of Nottingham</td>
</tr>
<tr>
<td>Dr Siobhan Murphy</td>
<td>Consultant Psychiatrist in Psychotherapy and Forensic Psychotherapy, NHS Greater Glasgow and Clyde</td>
</tr>
<tr>
<td>Ms Alison Ramm</td>
<td>Head of Forensic Psychological Services, Aberdeen Services</td>
</tr>
<tr>
<td>Mr Mark Ramm</td>
<td>Head of Forensic Clinical Psychology, The Orchard Clinic, Edinburgh</td>
</tr>
<tr>
<td>Ms Morag Slesser</td>
<td>Head of Psychological Services, The State Hospital, Carstairs</td>
</tr>
<tr>
<td>Dr Ruth Stocks</td>
<td>Professional Lead for Psychology in Forensic Mental Health, NHS Greater Glasgow and Clyde</td>
</tr>
<tr>
<td>Ms Gill Urquhart</td>
<td>Lead Allied Health Professional, The State Hospitals Board for Scotland</td>
</tr>
<tr>
<td>Ms Helen Walker</td>
<td>Educational Project Manager, Psychological Interventions Team, NHS Education for Scotland</td>
</tr>
</tbody>
</table>
Acknowledgements

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Thanks are due, in particular, to the editors of the evidence tables:

Professor Kate Davidson

Honorary Professor of Clinical Psychology, Institute of Health and Wellbeing
University of Glasgow.
Director of Glasgow Institute for Psycho-social Interventions (GIPSI), NHS Greater Glasgow and Clyde
Consultant Clinical Psychologist.

Editor of the evidence tables for Adult Services

and

Dr Cathy Richards

Lead Clinician/Head of CAMHS Psychology
Child and Adolescent Mental Health Service
NHS Lothian

Editor of the evidence tables for Children and Young People