

Matrics Cymru - The Evidence Tables



Written by the National Psychological Therapies Management Committee, supported by Public Health Wales

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THE EVIDENCE TABLES

A Rationale for the Matrics Cymru Evidence tables: EBP and PBE

In the field of psychological therapy there has long been a drive to “bridge the gap” between practice and research¹. This has led to recognition that both evidence-based practice (EBP) and practice-based evidence (PBE) are necessary to deliver high quality interventions which can be delivered in routine clinical settings.

Evidence-Based Practice is characterised by randomised controlled trials (RCTs) in which the primary focus is on controlling variables such as age, diagnosis and level of deprivation in order to make a valid comparison between the treatment effect of different therapies. Participants in these studies are randomly assigned to different treatment groups including an option for no active treatment. Systematic reviews and meta- analyses then draw together these primary research studies to provide an overview of the evidence for specific interventions. These have formed the mainstay of clinical guidelines such as the National Institute for Health and Clinical Excellence (NICE) and the Scottish Intercollegiate Guideline Network (SIGN). These guidelines have provided scientific support for the continued provision of effective therapies.

There are, however, problems associated with relying on this type of guideline in isolation². Issues of concern include the use of diagnostic classification in most RCTs³. Hence, RCTs may be seen to be unrepresentative of the real clinical world because mental health problems rarely occur in isolation. Clinicians might conclude that guidance based only on RCTs is of limited value in its application to service users. In addition some therapies lend themselves more easily to evaluation through RCTs which is likely to bias the evidence base in their favour.

Where there are apparent gaps in the evidence this does not necessarily indicate that treatments excluded have been shown to be ineffective; it can simply mean that studies of sufficient methodological rigour have not yet been completed and reported.

A further limitation is that the methods of EBP do not enable an understanding of the mechanism of change and may not adequately reveal common factors underlying the effectiveness of therapy, such as client preference⁴, or therapeutic relationship factors^{5 6}.

The Practice-Based Evidence [PBE⁷] approach includes a wider base of evidence from “real-world” settings rather than from RCTs. PBE offers an opportunity to use benchmarking and case tracking to incorporate observations from clinical practice.

1 Barkham, M. & Mellor-Clark, J. (2003) ‘Bridging Evidence-Based Practice and Practice-Based Evidence: developing a Rigorous and Relevant Knowledge for the Psychological Therapies’. *Clinical Psychology and Psychotherapy*. (2003), 10, 319-327

2 Healy, 2016 <http://www.newsavoypartnership.org/2016presentations/david-healy.pdf>

3 Johnstone, L. (2014) *A Straight Talking Diagnosis to Psychiatric Diagnosis*. Ross-on-Wye: PCCS Books

4 Markowitz, J. C. (2015) Is Psychotherapy for Personality Disorders Worth It? *The Journal of Clinical Psychiatry*. 76(11): e1472-e1473

5 Budd, R. & Hughes, I. (2009) The dodo bird verdict-controversial, inevitable and important: A commentary on 30 years of meta-analyses. *Clinical Psychology and Psychotherapy*, 16, 510-22

6 Also see appendix 1 of Guidance

7 Barkham, M. and Margison, F. ‘Practice-based evidence as a complement to evidence-based practice: From dichotomy to chasmus’, in Freeman, C. & Power, M. (ed), *Handbook of evidence-based psychotherapies: A guide for research and practice* (Chichester: John Wiley & Sons, Ltd., 2007).

Recent evidence from the Practice Research Network (PRN) for IAPT⁸ shows that the most effective IAPT services in England routinely employ these methods to enable clinicians to monitor, reflect and improve their practice. This approach to improving services emphasises the value of data quality which can be reduced by incomplete data and lack of assurance re treatment fidelity.

The methods of Practice Based Evidence need to be seen as a complementary to Evidence Based Practice⁹. These two forms of evidence have great potential to feed into each other, so that the relevance of practice based evidence can inform service delivery where the findings of rigorous research may not be fully representative of the diversity and co-occurring difficulties in client experience and presentations for therapy.

It is hoped that future revisions of Matrics Cymru will be able to include examples of practice-based evidence.

The Evidence Tables

The evidence tables in the Matrics Cymru use a similar format to those published in the Scottish Matrix evidence tables (2015). The Evidence Tables in the Scottish Matrix (2015) draw upon EBP and are based on existing diagnostic frameworks as used by NICE and more generally in mental health research.

The various SIGN¹⁰ and NICE guidelines represent a transparent and rigorous interrogation of the evidence base for mental health problems and, as for the Scottish Matrix (2015), form the basis of the Matrix tables.

Matrics Cymru tables include new evidence available between the publication of the Scottish Matrix 2011 and our own scrutiny process in Wales (2015).

8 Clarke et al NSP Conference 2016

9 Barkham, Michael, Hardy, Gillian E. and Mellor-Clark, John (ed.), Developing and Delivering Practice-Based Evidence. A Guide for the Psychological Therapies (Chichester: Wiley-Blackwell, 2010).

10 <http://www.sign.ac.uk/>

The Development of the Matrics Cymru Evidence Tables

The Matrics Cymru evidence tables are intended to provide a summary of the information on the evidence base for the effectiveness of particular Psychological Therapies for particular mental health problems.

For the Matrics Cymru 2016, Wales-based clinicians were invited to scrutinise the Scottish Matrix (2011) evidence 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. They were asked to develop similar tables for each diagnostic difficulty by scrutinising relevant recent research studies.

The summary Evidence Tables currently cover:

Mental Health services for Adults and Older Adults

Currently the evidence tables focus on common mental health problems and disorders. The Tables do not yet encompass all diagnoses or mental health service user groups. Readers should be aware that the areas covered here are not entirely coterminous with the Scottish Matrix 2015.

Aspects of Long Term Conditions management and physical health care.

The evidence tables for psychological therapies in physical health is in development but the extensive evidence base for the use of psychological therapies and interventions with these service user groups can be accessed via 'The Matrix (2015) A Guide to Delivering Evidence-Based Psychological Therapies in Scotland'¹¹.

¹¹ [http://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/the-matrix-\(2015\)-a-guide-to-delivering-evidence-based-psychological-therapies-in-scotland.aspx](http://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/the-matrix-(2015)-a-guide-to-delivering-evidence-based-psychological-therapies-in-scotland.aspx)
[http://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/the-matrix-\(2015\)-a-guide-to-delivering-evidence-based-psychological-therapies-in-scotland.aspx](http://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/the-matrix-(2015)-a-guide-to-delivering-evidence-based-psychological-therapies-in-scotland.aspx)

Key areas for development

The intention is to continue to scrutinise and extend Matrics Cymru Evidence Tables in order to provide more comprehensive coverage, and there is a commitment to expanding the evidence tables to incorporate a wider range of conditions and presentations.

Services for children, young people and families (CYP)

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 adult or generic psychological therapies literature.

It is also the case that various forms of psychological therapy contribute to "generic" Children and Adolescent Mental Health Service, (CAMHS) clinical practice and within services for children and young people, given the need for clinicians to develop skills in communicating effectively, for example, with small children or with families. It is noted that the use of diagnostic, rather than developmental, frameworks for describing effective practice may not be appropriate in psychological services for Children and Young People.

Development work with those supporting and leading on delivery for Together for Children and Young People, services for Children and young People and CAMHS will develop guidance on the delivery of psychological therapy to these service users with reference to the BPS strategy document 2015¹² and to the Scottish Matrix 2015 evidence tables. Currently, these documents may inform practice in the commissioning of appropriate psychological therapy services alongside the key principles and standard outlined in the current document.

¹² https://www.bps.org.uk/system/files/user-files/DGP%20Faculty%20for%20Children,%20Young%20People%20and%20their%20Families/public/cfcp_3.pdf

How to use the Matrics Cymru Evidence Tables

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:

- 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.
- That there is no clear 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, and it may 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.
- 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 health boards should provide interventions for which there is good evidence of effectiveness.
- 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, there needs to be some flexibility of approach. In a number of areas, for example, there are longstanding services which are recognised as being of benefit to clients in spite of the lack of a tradition of high-quality EBP research. There is no suggestion that these services should be dismantled, but it is crucial that health boards begin to collect their own good quality

evidence [PBE] 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 investments are 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 of 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
- successful outcome measures
- issues of client choice

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Which Therapies - The Evidence Base

Across the UK 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 health boards in a good position both to provide many of the 'high intensity' interventions necessary, and to deliver psychological interventions at the 'low intensity' level appropriate for mild/moderate mental health problems. Most of the evidence-based 'low intensity' options, including self-help, problem-solving, and computerised or online packages, are derived from CBT principles.

It is not expected that health boards will provide all of the therapeutic approaches recommended in the tables for any particular service user group.

The psychological therapies health boards choose to provide will be guided by:

- the services they already have
- the expertise available locally
- successful outcome measures
- the advice of the national and the local Psychological Therapy Management Committees (PTMCs)
- current and future Wales national policy/strategic requirements

It is important that service users, and carers, (where appropriate) are engaged meaningfully in this decision-making process, and that issues of service user preference are given due consideration.

It is also crucial that the field of psychological therapy continues to evolve and therapeutic advances or innovative service developments should not be stifled by the rigid application of current guidelines. Trials of new therapies or of new applications of existing therapies and new

paradigm research trials will generally be organised by national research networks, and the local PTMCs can contribute to this process by facilitating access to service user data (adhering to formal research ethical requirements).

PTMCs 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 the problem 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 structured/manualised, brief interventions aimed at transient or mild mental health problems with limited effects on functioning.

High Intensity / specialist interventions are formal psychological therapies based on a psychological formulation delivered by a relatively specialist psychological therapist and are aimed at mental health problems with more significant adverse effects on functioning

What intervention?

The interventions are those that are recommended by the strongest evidence base.

Level of evidence

This is the level of evidence of efficacy, as detailed below.

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Grading the Evidence Table

SIGN	NICE	MATRICS CYMRU
A At least one meta-analysis, systematic review, or Randomised Control Trial (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	A At least one Randomised Control Trial (RCT) as part of a body of literature of overall good quality and consistency addressing the specific recommendation (evidence level-1) without extrapolation	A At least one meta-analysis or systematic review clearly supports the efficaciousness of the therapy for this problem. OR In the absence of such reviews, there is at least one RCT of high quality that is directly relevant to the problem.
B 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..	B Well conducted clinical studies but no randomised clinical trials on the topic of recommendation	B Well–conducted, but non-randomised, clinical studies, or RCTs of lower quality, as part of a generally consistent literature, and directly relevant to this problem.
C A body of evidence including studies rated as 2 + 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	C 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	C Evidence from case series studies and widely held expert opinion which suggests that this therapy has potential to be efficacious in treating this problem, but no RCTs or other high-quality studies have yet been conducted.

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Adult Mental Health

Bipolar

Level of severity	Level of Service	Intensity of intervention	What Intervention?	Level of Evidence
Severe and Enduring - recently diagnosed	All	Low	"Beating Bipolar" internet-based Psycho-educational programme	B ^{8,9}
Severe and Enduring- in recovery and taking medication	Secondary Care	High	CBT focused on relapse prevention Group Psycho-education (e.g. Bipolar Education Programme Cymru) Family Intervention	A ^{1,6,7} A ^{1,6} B ⁶
Severe and Enduring - in an acute episode of bipolar disorder and taking medication	Secondary Care	High	CBT for patients with fewer than 12 previous episodes Interpersonal and Social Rhythm Therapy	A ^{2,3} A ⁴
Severe and Enduring	Secondary Care	High	Functional remediation for improvement in functional outcomes	A ¹⁰

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Body Dysmorphic Disorder (BDD)

Level of severity	Level of Service	Intensity of intervention	What Intervention?	Level of Evidence
Moderate/Severe	Primary / Secondary Care	High	Group CBT Exposure Response Prevention (ERP) Disorder specific CBT EMDR	B ³ B ⁴ B ⁵ C ¹

Categories

Some dissatisfaction with one's body is a common phenomenon, and therefore would not necessarily be expected to come to the attention of mental health services. It is only when the degree of distress caused by this is significant and it begins to impact on an individual's functioning that it might warrant NHS treatment. As such, services are only likely to see individuals who are moderate/severe in presentation. The evidence base that exists does not distinguish between these levels of severity.

Evidence base

CBT has been tested within RCTs (e.g. 5). The group CBT (3) was tested against waiting list, and was conducted in small groups for eight two-hour sessions. 82% of trial participants no longer met diagnostic criteria by end of treatment, and 77% at follow up; the study sample was of women. Individual CBT was tested (5), albeit with a small sample of only 19 individuals; a 50% reduction in symptoms on the Y-BOCS was achieved.

Behavioural Therapy (BT) in the form of ERP has been tested, albeit only in small trials, most of which were uncontrolled (4). Suggestions that it could be effective were suggested by significant outcomes, which were maintained in those who participated in a maintenance programme.

A number of case studies have also been published.

The Eye Movement Desensitisation and Reprocessing (EMDR) recommendation is based on a case series in which six of seven individuals experienced significant improvement, and five maintained this over time (1).

In general, the studies appear to indicate that psychotherapy has an improved effect when compared with trials of medication alone (2, 6).

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Borderline Personality Disorder

Level of severity	Level of Service	Intensity of intervention	What Intervention?	Level of Evidence
Severe	Secondary Care or Specialist Outpatient	High	DBT Schema-focused CBT STEPPS Transference-focused psychotherapy CBT for personality disorders individual therapy (30 sessions over one year) CAT	A ^{1,2} A ^{1,2} A ^{1,2} A ^{1,2} A ⁴ B ³ – One RCT for a less severely affected group with minimal / low self-harm.
Severe	Secondary / Specialist Partial Day Hospital	High	Mentalisation based Day Hospital	A ^{1,2}

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Depression

Level of severity	Level of Service	Intensity of intervention	What Intervention?	Level of Evidence
Mild-moderate	Primary Care	Low	Computerised CBT (CCBT) within the context of guided self-help Guided self-help based on CBT behaviour principles Multi Modal CBT	A ^{30,31,32} A ³³
		High	Behavioural Activation (BA) CBT Interpersonal Psychotherapy (IPT) Problem-Solving Therapy Brief Psychodynamic therapy Nondirective supportive therapies/person-centred counselling Couples Therapy Interpersonal Counselling	A ^{1,2} A ^{7**, 8*, 15*, 17} A ^{3, 8*, 15*, 16, 17} A ^{8*, 15*, 17} A ¹³ A ^{5, 6, 8*, 9, 10} A ^{20, 21} B ^{18***}
	Secondary Care	High	Art Therapy	C ²⁴
Severe (non-chronic)	Secondary Care	High	CBT	A ¹⁹
Treatment-resistant depression (lack of response after six weeks on standard antidepressant medication)	Primary Care	High	CBT	A ^{12, 12a}
Chronic (>2yrs) Major Depression	Secondary Care	High	Psychological Therapies (in general) + Antidepressant medication Music Therapy	B ⁴ B ⁴
Prevention of relapse in recurrent depression	Primary / Secondary Care	High	CMindfulness-based Cognitive therapy (MBCT)	A ^{14, 22****27}

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* statistically significant effect, but effect size [ES] is small

**ES=0.71, but lower in higher quality studies (0.53) than in lower quality studies (0.90).

*** Advantage for IPC was clearest for first episode, less severely depressed patients

**** But almost half in either condition relapsed in two year follow-up

Therapies which have been specifically developed to treat depression, such as CBT (D), IPT and BA are all clearly- and about equally- efficacious, but the effect sizes are not large. Using methods of delivery other than face-to-face individual therapy appears to be no less effective in delivering CBT within primary care settings (15).

Less condition-specific therapies, such as Problem-Solving Therapy, Nondirective supportive therapies/person-centred counselling, and brief Psychodynamic Therapy appear to have some efficacy.

MBCT (a specific cognitive-behavioural therapy incorporating Mindfulness) has some efficacy in the prevention of relapse in recurrent depression, but the most recent study shows less positive results (27).

In treating chronic depression, and “treatment- resistant” depression,

psychological therapies may have some additional benefit to medication. However, “treatment resistant depression” is itself a protean concept (26).

It is unclear whether psychological therapies are efficacious in the treatment of dysthymia.

In treating severe, but non-chronic, depression, CBT enhances recovery rates as compared with antidepressant medication alone (19), but Axis II co-morbidity, which was present in half of the participants and is typical of patients in secondary care services, resulted in much lower recovery rates in both conditions.

In considering factors associated with outcome, there is some evidence that higher initial depression severity, early improvement in therapy, and completing therapy as intended all predict better outcomes, while a personality disorder and negative expectations for treatment predict poorer response (23). It seems possible that more frequent sessions early on, plus positive preparation for therapy, will enhance outcomes.

Cochrane Reviews are currently in development for the psychological treatment of depression and it is recommended that these are consulted when they become available.

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Eating Disorders

Anorexia Disorder

Anorexia Nervosa (AN): is a syndrome in which the individual maintains a low weight as a result of a pre-occupation with body weight, construed either as a fear of fatness or pursuit of thinness. In anorexia nervosa, weight is maintained at least 15 percent below that expected, or in adults body mass index (BMI) is below 17.5kg/m² (National Institute for Clinical Excellence)³⁰.

Level of severity	Level of Service	Intensity of intervention	What Intervention?	Level of Evidence
Mild	Primary Care	Low	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	C ³¹ C ³¹
Mild - Moderate	Secondary Care / Specialist Eating Disorders Services	High	CBT - Enhanced (CBT-E)	A ^{11, 14, 15}
Moderate - Severe	Secondary Care / Specialist Eating Disorders Services	High	Family Interventions Choice of psychological treatments for anorexia nervosa should be available as part of mental health services in all areas. These may include: CBT, IPT, Psychodynamic Therapy, Cognitive Analytical Therapy (CAT), and Motivational Enhancement Therapy (MET).	A ^{8, 10, 19, 20, 21, 27, 32, 37} C ^{30, 31}

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Binge Eating Disorder

Binge Eating Disorder (BED): is a disorder in which individuals engage in uncontrollable episodes of binge eating but do not use compensatory behaviours. (National Institute for Clinical Excellence)³⁰.

Level of severity	Level of Service	Intensity of intervention	What Intervention?	Level of Evidence
Subclinical/Mild	Primary Care	Low	Evidence-based self-help programme Guided self-help Internet based guided self-help	A ^{6,9,30,35,38} A ^{3,29,33} A ^{1,12,13}
Moderate - Severe	Secondary Care	Low	Guided CBT self-help Internet based guided self help	A ^{3,29,33} A ^{1,12,13}
		High	CBT for Binge Eating Disorder (CBT-BED) Cognitive Behavioural Therapy-Enhanced (CBT-E) Interpersonal Psychotherapy (IPT)	A ^{17,21,30} A ^{A11,14,15} A ³⁰

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Bulimia Nervosa

Bulimia Nervosa (BN) is characterised by recurrent episodes of binge eating and secondly by compensatory behaviour (vomiting, purging, fasting or exercising or a combination of these) in order to avoid weight gain. (National Institute for Clinical Excellence)³⁰.

Level of severity	Level of Service	Intensity of intervention	What Intervention?	Level of Evidence
Subclinical/Mild	Primary Care	Low	Evidence-based self-help programme Guided self-help Internet based guided self-help	A ^{6,9,30,35,38} A ^{3,29,33} A ^{1,12,13}
Moderate - Severe	Secondary Care / Specialist Eating Disorders Services	Low	Guided CBT self-help Internet based guided self help	A ^{3,29,33} A ^{1,12,13}
		High	CBT for Bulimia Nervosa (CBT-BN) CBT - Enhanced (CBT-E) Interpersonal Psychotherapy (IPT)	A ^{2,16,17,18,26,28,30,36,39} A ^{11,14,15,40} A ^{16,26,30}

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Generalised Anxiety Disorder

Level of severity	Level of Service	Intensity of intervention	What Intervention?	Level of Evidence
Mild (PSWQ <45)	Primary Care	Low	Multi-Modal CBT Guided self-help Large group psychoeducation based on CBT principles	A ¹¹ B ^{2,4} B ¹⁰
Moderate – Severe (PSWQ 45-60)	Primary / Secondary Care	High	Disorder-specific CBT (8-16 sessions) Applied relaxation (8-16 sessions)	A ^{1,3,6,7} A ^{3,6}

The Penn State Worry Questionnaire (PSWQ, 8) assesses severity of Generalised Anxiety Disorder (GAD) and the Work and Social Adjustment Scale (WSAS, 9) can help to assess the impact of GAD on functioning.

In treating GAD, both CBT and applied relaxation appear to be equally effective in the short-term, but two recent high-quality meta-analyses (3, 6) suggest that CBT is more effective in the longer term.

The research also suggests that there may be better results from newer CBT therapies for GAD, including meta-cognitive therapy, intolerance of uncertainty therapy, and acceptance-based behaviour therapy (5).

The mean number of CBT sessions is reported in one meta-analysis as 16 and in another as no more than 12 (3, 6). Another found no superior efficacy of 15 sessions over 9 sessions (4).

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Health Anxiety

This condition is also known in DSM-V as Illness Anxiety Disorder, and was previously known as hypochondriasis.

This evidence table is not intended to apply to individuals experiencing Somatic Symptom Disorder, or medically unexplained disorders such as Chronic Fatigue Syndrome.

Level of severity	Level of Service	Intensity of intervention	What Intervention?	Level of Evidence
Mild (BAI = 10-18)	Primary Care	Low	Internet based CBT/ mindfulness programme for health anxiety Behavioural stress management Bibliotherapy using CBT literature Disorder-specific, group-based CBT	A ⁴ A ⁷ B ¹ B ^{2,3}
Moderate (BAI = 19-29)	Primary Care	High	Exposure and Response Prevention (ERP) Disorder-specific individual CBT of 6-12 sessions	A ⁵ A ^{6, 7, 11, 14, 15, 16}
Severe (BAI = 30+)	Primary / Secondary Care	High	Disorder-specific individual CBT of 12-16 sessions Disorder-specific Mindfulness Based Cognitive Therapy group (MBCT)	A ^{13,16} A ^{8,10}

All the studies included were based on protocols designed specifically to target health anxiety as opposed to more generic treatment packages.

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Mild

The Bibliotherapy trial (1) was small (40 participants) though was randomised, with a TAU control group. The information used was Understanding Health Anxiety: A self-help guide for sufferers and their families written by Kuchemann and Sanders (1999). The self help was not guided.

The group-based interventions were very small trials (2, 3), only one of which was randomised against a waiting list control. The interventions were variable in terms of content though both were based on CBT protocols.

The Internet based programme is based on one study (4) using a protocol designed by the research group based in Sweden. Though the title of the paper suggests it is aimed at 'severe health anxiety', we recommend caution as the cut-offs for health anxiety on specific measures are not clear, and the sample group appear to be chronically affected (as opposed to severely affected). It was a guided programme including elements of internet contact between participants.

Behavioural Stress Management (BST) was considered by the Cochrane review to be sufficiently different from CBT to be regarded as a separate form of treatment. It involves a form of systematic desensitisation using applied relaxation along with assertiveness, time management and worry control strategies. It gained a significant positive result in one study (7).

Moderate

A Cochrane Review in 2009 (5) was based on six studies considered acceptably rigorous in terms of design. Two studies compared cognition therapy (CT) v waiting list (6, 7), reporting that CT did significantly better than waiting list. Three studies looked at CBT vs other controls, also providing significant results. There are a number of other studies suggesting efficacy using CBT, and it is clearly the most studied form of psychotherapy for use with health anxiety as discussed in a meta-analysis

of CBT trials (16). One study looked at behavioural therapy [ERP] with significant outcomes. It was commented that generally candidates found the treatments acceptable.

Severe

The Cochrane review also assessed any relationship between effect size within studies and the number of treatment sessions offered. It was found that increasing the treatment sessions to 16 resulted in a greater effect, so that it would appear sensible to recommend higher session numbers of CBT for those experiencing more severe problems.

MBCT has only recently been studied in terms of health anxiety. There has been one pilot study (10), a qualitative study and a randomised control study (8). The overall impression is that there appears to be a high rate of acceptability of the treatment, with lower dropout rates than in CBT studies. The randomised study looked at a chronically affected population, many of whom had received psychological treatments previously. As such, it may be that as with depressed mood, there is a suggestion that mindfulness based CBT could be useful for a treatment resistant population.

Other interventions

One study (15) compared a short-term psychodynamic against CBT and waiting list. Those receiving CBT made significant gains, whilst the psychodynamic approach failed to do so.

Other interventions

Health anxiety is a phenomenon that straddles physical healthcare environments as well as mental health. As such, some studies (e.g., 12) have made attempts to look at treating health anxiety in physical healthcare environments. These demonstrate promise, and further studies would be useful to expand on the flexibility of the interventions in terms of location, as well as the practitioners delivering the interventions in Wales.

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Non Psychotic Affective Disorders in the Perinatal Period

Maternal mental health problems during pregnancy and the postpartum present a major public health problem that requires urgent attention^{1, 2}. Depressive and anxiety disorders are the most common mental health problems during pregnancy and the first postnatal year.

A meta-analysis has estimated the prevalence of minor and major depression¹³ across the nine months of pregnancy at 18.4%³, with a 12.7% prevalence estimate for a clinical diagnosis of major depression. Similarly, a second meta-analysis has estimated the prevalence of depression during the first three postnatal months at 19.4%⁴, with a prevalence estimate of 7.1% for major depression.

Less is known about the prevalence of perinatal anxiety disorders. Prevalence estimates for antenatal anxiety disorders range between 11.8% and 15.3%, whereas for postnatal anxiety disorders estimates range between 8% and 20.4%^{5,6,7,8,9,10,11}. The high comorbidity between perinatal depression and anxiety is well recognised and antenatal anxiety is a strong predictor of postnatal depression^{5, 12}.

Psychological interventions for the treatment of perinatal mental health problems are strongly indicated², with such indications most pertinent in the perinatal context given the potential risks to foetal and infant development associated with psychotropic medication exposure^{2, 13}. Yet the evidence base for psychological interventions for the treatment of perinatal mental health problems is underdeveloped and large randomised controlled trials (RCTs) are largely lacking in this area².

The existing evidence base is focused on the prevention and treatment of postnatal depression. The systematic literature search that informed the current evidence table did not identify any RCTs that specifically targeted perinatal anxiety disorders.

Similarly, there are few large scale RCTs for the treatment of antenatal depression. In line with the most recent NICE guidance² for antenatal and postnatal mental health problems, and in the absence of perinatal-

and postnatal mental health problems, and in the absence of perinatal-specific psychological interventions for a particular presenting problem (e.g. OCD), the reader is referred to the other disorder specific evidence tables specified in Matrics Cymru.

The evidence table below does not cover interventions that specifically target either difficulties in the mother-infant relationship or in the infant's mental health and wellbeing. Please see the Scottish Matrix for Children and Young People (2014)¹⁴.

In line with the Scottish Matrix (2014)¹⁵ and NICE (2014)², psychological therapies for non-psychotic affective disorders during the perinatal period should :

- Be timely, with assessment offered within two weeks of referral and interventions offered within one month of assessment
- Be delivered by psychological therapists with an understanding of the unique nature of the perinatal context, the developmental needs of the infant, and the impact that this can have on assessment and treatment
- Be delivered within a stepped care model of service delivery with high intensity interventions offered within two weeks, should a low intensity intervention not result in symptom reduction and/or an improvement in functioning
- Be delivered by psychological therapists with knowledge of the additional clinical features and risk factors associated with perinatal mental health problems
- Consider the service user's preference in terms of the type (e.g. CBT vs. IPT) of intervention and the mode and place of delivery (e.g. group vs. individual; home vs. clinical setting)
- Consider the need for additional perinatal mental health support (e.g. psychological interventions for difficulties in the mother-infant relationship)
- Consider the wider family context and the impact of perinatal mental health on the mother-infant and couple relationships

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Level of severity	Level of Service	Intensity of intervention	What Intervention?	Level of Evidence
Mild/Moderate	Primary Care / Third Sector	Low	Guided self-help: Internet or booklet Behavioural Activation or CBT informed with telephone or face-to-face support for antenatal or postnatal depression Group delivered mindfulness intervention for antenatal anxiety and depression (8 weeks)	A ^{16,17,18} C ^{19,20}
Prevention/Early Intervention	Primary Care / Third Sector / specialist perinatal community mental health service	Low	Individual or group delivered psychoeducational intervention to prevent postnatal depression Individual or group delivered IPT to prevent postnatal depression Individual or group delivered CBT to prevent postnatal depression Group delivered mindfulness-based CBT to prevent postnatal depression Antenatal hypnotherapy to improve postnatal psychological wellbeing Group delivered CBT for perinatal anxiety	A ^{21,22,23} A ^{21,23} A ^{21,24,25} B ²⁶ C ²⁷ C ²⁸
Moderate - Severe	Secondary care/specialist perinatal community mental health service	High	Individual CBT for postnatal depression Individual or group delivered IPT for antenatal or postnatal depression Individual CBT for antenatal depression Individual CBT for postnatal OCD	A ^{25,29} A ^{25,29} B ³⁰ C ³¹

- All the studies included psychological interventions designed specifically to target perinatal affective disorders and the parenthood context as opposed to more generic treatment packages.

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- For the systematic reviews and meta-analyses cited in the evidence table, it is important to hold in mind the following decisions and observations made during the review process. The systematic literature search identified a number of different systematic reviews and meta-analyses on the efficacy of psychological interventions in the perinatal context.

Likely due to the paucity of individual treatment studies, these reviews typically pooled together a heterogeneous group of psychological interventions that vary in: (1) the individual study design (e.g. the inclusion of RCTs and non-randomised controlled trials in the same meta-analysis/review); (2) the level of severity of the presenting problems under-going treatment both within and across studies; (3) the 'intensity' of the intervention in terms of the number of sessions,

the frequency of contact, the mode of delivery and the hours of face to face contact; (4) the content of the psychological interventions under scrutiny whereby there are wide-ranging definitions of CBT (e.g. studies with a primarily behavioural component are pooled together with studies that include both cognitive and behavioural components). Also, studies that integrate brief CBT techniques into routine clinical care delivered by non-mental health specialists are included with studies that evaluate a manualised group or individualised-formulation-driven treatment delivered by a specialist psychological therapist. Due to these constraints, only the higher quality systematic reviews that focus on RCTs or have conducted meta-analyses that take the aforementioned limitations into consideration were included in the evidence table.

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Obsessive Compulsive Disorder

Level of severity	Level of Service	Intensity of intervention	What Intervention?	Level of Evidence
Mild	Primary Care	Low	Self-help CCBT Telephone intervention	B ¹ B ^{2,4,5} B ³
		High	Disorder-specific CBT (8-16 sessions) Applied relaxation (8-16 sessions)	B ^{6,9} B ⁷
Moderate	Secondary Care	High	CBT (incl. ERP) ERP	A ^{10,11,12} A ¹³
Severe	Secondary Care	High	CBT/ERP	B ¹⁴
Chronic	Secondary Care	High	CBT/ERP + antidepressant medication	B ^{15,16}
Treatment-Resistant OCD	Secondary Care	High	CBT - Intensive session protocol	C ¹⁷
Hoarding	Secondary Care	High	Specialised CBT for Hoarding	B ^{18,19}

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Main findings

- CBT (incl. ERP) is effective in reducing OCD symptoms compared to treatment as usual¹⁰. However, effect sizes are generally lower at follow-up (= .43) compared to post treatment (= 1.39)¹¹ and drop outs for ERP can be as high as 40%ⁱ
- Medication is also effective in treating OCD but there is evidence that ERP/CBT (alone) is more effective than medication (alone)^{6, 13}
- The benefit of adding medication to CBT or ERP in the treatment of OCD has been shown in some studies^{15, 14} but not in others¹³
- Adding Anti-psychotics to an Antidepressant can increase treatment gains in OCD, but this is still inferior to a combination of ERP and Antidepressant¹⁶
- There is some evidence that higher doses of Citalopram, Fluoxetine and Paroxetine (Antidepressants) may be more efficacious than lower doses in treating OCD¹⁴
- Group CBT/ ERP has been shown to be both comparable⁹ and inferior⁸ to 1:1 therapy for OCD
- Some studies show CBT and/or ERP are more effective in OCD than CT¹⁰ but others find them equivalent¹²
- No evidence exists for the efficacy of psychoanalysis in the treatment of OCD, and insufficient evidence is available to support the use of other psychological therapies, hypnosis, or homeopathy,^{10, 14}
- The efficacy of CBT/ ERP is influenced by differences in baseline severity of OCD in some meta-analyses¹⁰, but not others¹¹
- There is some evidence for a positive relationship between increased number of hours of therapist input and reduced OCD symptomatology in some studies², but not in others¹¹. Training family members may also improve ERP outcomesⁱⁱ
- There is some evidence that Guided self help, cCBT and telephone intervention are helpful, but more research is needed as studies have been small, methodologically flawed^{14, 2} or not compared to ERP/CBT treatments that have proven efficacy^{3, 4, 5}
- There is some consensus that intensive 1:1 treatment may be useful for treating treatment resistant OCD, but more research is needed^{14, 17}
- Relapse may occur after successful treatment so people should be re-referred as soon as possible, rather than placed on a routine waiting list¹⁴
- Hoarding appears to be distinct from OCD¹⁸ and may require CBT adapted for Hoarding¹⁹

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Main conclusions: Guidelines

Some new studies have been conducted since both the NICE guidelines for OCD, 2005¹⁴, and the NICE Guidance Update for OCD, 2013 (e.g.^{3, 4, 5, and 16}). However, overall recommendations remain largely the same:

- Adults with mild OCD should be offered self help or group CBT/ERP in the first instance
- If poor response to above, people should be offered more intensive 1:1 CBT/ERP
- Adults with moderate OCD, should be offered intensive CBT/ERP (more than 10 therapy hours) or an antidepressant
- Adults with severe OCD, should be offered intensive CBT/ERP (more than 10 therapy hours) and an antidepressant

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Main conclusions: Research base

Few studies assess the relative effectiveness of CBT/ERP vs. medication; many studies allow for the concurrent use of psychotropic medication and most RCTs consist of small sample sizes with <30 participants per group¹⁰. This presents major confounds in assessing the relative and independent effectiveness of CBT/ERP. Thus, although there are some exceptions (e.g.¹³), more research needs to be done in this area.

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Panic Disorder with/without Agoraphobia

The Panic Disorder Severity Scale (PDSS) provides a measurement of the severity of panic (5).

Level of severity	Level of Service	Intensity of intervention	What Intervention?	Level of Evidence
Subclinical (prevention of PD among those presenting with panic attacks but not meeting PD diagnostic criteria)	Primary Care	Low	Stepped-care programme comprising educational booklet; detailed self-help manual; five x 2 – hour group CBT	A ³²
Mild	Primary Care	Low	Minimal therapy contact CBT (4-6 hours) with a. Bibliotherapy b. Internet-delivery	A ^{16, 18} A ^{2, 3, 12, 26}
Moderate	Primary Care	Low	Therapist-supported self help CBT (6-12 hours) a. Bibliotherapy b. Computer assisted (e.g. Fear Fighter) c. Internet-delivered CBT, with therapist contact (up to 6 hours) d. Group CBT (8-18 hours)	A ^{7, 15, 22} A ^{10, 19} A ^{3, 8, 12, 13, 26} A ^{15, 23, 25}
Moderate to severe, following positive response to CBT	Primary/secondary care	High	Maintenance – CBT following CBT • Reduced change of relapse • Reduced work and social improvement	A ³³ A ^{1, 6, 17, 18, 20, 23}

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Severe	Primary/secondary care	High	Individual Therapist-Directed CBT (16-20 sessions) with supplementary written material Group CBT (14 sessions) Exposure & relaxation/ breathing training Virtual reality exposure Brief CBT (7 sessions)	A ²³ A ²⁴ A ²¹ A ²³
Chronic or treatment resistant	Secondary care/ Specialist service; in-patient care	High	Individual Therapist-Directed CBT (up to 20 sessions)	C

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Schizophrenia/Psychosis

Psychosis is a term used to represent a range of major mental health problems, of which the commonest is schizophrenia, and which includes schizoaffective disorder, schizophreniform disorder, delusional disorder and non-affective psychoses¹. These conditions comprise a cluster of signs and symptoms which reflect changes in perception, mood, behaviour, thinking and speech. There is considerable overlap with other conditions and this gives rise to diagnostic uncertainty and a lack of predictive utility². The causes of these conditions remain uncertain, although an integrated socio-developmental-cognitive model is favoured³.

The onset of the condition is characterised by a prodromal phase typified by a dysphoric state with attenuated or brief psychotic symptoms⁴. Approximately a fifth of those at high risk will transition to psychosis within the first year⁵, giving rise to a predicted rate for Wales of around three hundred new presentations a year, of which 80% will be between the ages of 16 and 256. Outcome in schizophrenia is variable, with symptomatic relapse within the first year post diagnosis ranging from 30% to 60%. Only between 17% and 40% of those diagnosed reach fully symptomatic recovery at 7 years post diagnosis (with the variation representing different treatment regimes^{7,8}). The societal and personal costs of schizophrenia and psychosis are high, with low rates of employment, social participation, lower life expectancy, and longer years lived with disability, victimisation and suicide⁹⁻¹⁴.

Treatments for schizophrenia and psychosis have been the subject of considerable empirical study, which is summarised through the various iterations of the UK guidelines published by NICE¹⁵ and SIGN¹⁶. These broad guidelines include psychological and psychosocial therapies that target physical health and behaviour change, symptoms, recovery, social functioning and occupation. Psychological therapies should be seen in

the context of overall approaches to health gain and social participation. Despite a recent update, the NICE recommendations addressing psychological and psychosocial therapies date back to 2009¹⁷ and since then there have been a number additional trials and meta-analysis¹⁸⁻³⁰ which report on additional studies and the risk of bias and its influence on effect size^{31,32}.

Reviews of cognitive behaviour therapy (CBT) for negative and positive symptoms report small to moderate effect sizes for hallucinations and very small effect sizes for delusions. When the risk of study bias is accounted for the effect size falls to very small or no effect depending on the intervention and its target symptom^{16,18-20,23,24}. A large pragmatic trial of Arts Therapy (MATISSE) did not support the previous NICE recommendation for Arts therapy for negative symptoms^{16,18}. Also, supportive therapy and befriending are unlikely to be superior to treatment as usual^{24,25}. Finally, whilst cognitive remediation therapy demonstrates improvements in cognition these are unlikely to be transferred into improved functioning outside of a rehabilitation framework^{28,29}.

In spite of this, there are positive outcomes for the use for family intervention and CBT for people at risk of psychosis or in the early stages of the condition^{22,33}. Family intervention is likely to reduce relapse rates and may reduce family burden across all phases of the condition^{15,34,35}. Social skills training²⁴ and group psychotherapies may improve negative symptoms and social functioning³⁰. PTSD, anxiety and depression are prevalent in schizophrenia and psychosis and therapies targeting these should be offered^{15,36,37}. There is also emerging evidence (with a risk of bias) of the benefits of offering low intensity interventions targeting distress, worry and sleep which although have a small to moderate effect size may be cost effective if delivered at scale^{33,38-42}.

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Level of severity	Level of Service	Intensity of intervention	What Intervention?	Level of Evidence
Ultra-high risk of psychosis (attenuated or brief limited /intermittent psychotic symptoms)	Secondary care	High	Family Intervention CBT for psychosis	A ^{15,34,35} A ²²
		Low	Worry-reduction and sleep improvement CBT; progressive relaxation	A ^{38,39,42}
First episode psychosis, relapse or persistent symptoms in psychosis	Secondary care	High	Family Intervention for reducing relapse and family burden NICE recommended treatments for associated problems such as depression and PTSD Reasoning and Rehabilitation programmes for verbal aggression and problem solving in offenders with psychosis Cognitive remediation within a rehabilitation programme for social functioning and cognitive functioning [‡] Formulation based cognitive behaviour therapy for positive symptoms (greater effect for voices compared to delusions) [‡] . For negative symptoms social skills training [‡] , and group psychotherapy. ^{‡*} Group Art Psychotherapy Music therapy	A ^{15,34,35} A ^{15,36,37} A ⁴³ A ²⁸ A ^{19,20,24} A ^{24,30} B ^{46,49} A ^{47,48}
			Mindfulness for Positive and negative symptoms [‡] Worry-reduction and sleep improvement cognitive behaviour therapy; progressive relaxation; relapse prevention training; Yoga; and distraction techniques Early signs of monitoring	A ⁴⁵ C ⁴⁴ A ³⁸⁻⁴² A ^{50, 51, 52}

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¥ Interventions with small or very small effect sizes.

- * The benefits appear equal across psychotherapies and attributable to nonspecific effects for which non-psychotherapeutic groups may be equally effective i.e. discussion or support groups.

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Social Anxiety Disorder

The Social Phobia Inventory (SPIN) (8) assesses severity of social phobia and the Work and Social Adjustment Scale (WSAS) (20) can help to assess the impact of social phobia on functioning.

Level of severity	Level of Service	Intensity of intervention	What Intervention?	Level of Evidence
Mild (SPIN > 19 indicates social anxiety)	Primary Care	Low	Book prescription using books based on CBT for social anxiety Guided self-help based on CBT for social anxiety	A ^{5,12,18,21,24} A ^{1,2,3,4,15,17,18,21,25,26,27,28,29,30}
Moderate - Severe (SPIN > 30 indicates moderate social anxiety; SPIN > 40 indicates severe social anxiety)	Secondary care	High	14-16 sessions disorder-specific CBT for social phobia N.B. Group CBT is so much less effective than individual CBT that it is not clinically or cost-effective Interpersonal Psychotherapy (IPT) Psychodynamic therapy	A ^{6,7,9,10,11,13,14,16,17,19,21,22,23} 19, 21 A ³¹ A ³²
Social anxiety disorder with avoidant personality disorder	Secondary care	High	14-16 sessions disorder-specific CBT for social phobia delivered by therapists competent in the disorder-specific model	A ⁷

There is no Cochrane review for social anxiety disorder. There have been two recent and significant meta-analyses, one commissioned by NCCMH and published in 2013 (21), and one by Mayo-Wilson et al. published in The Lancet in 2014 (19).

The recommendations in the table above are largely based on these two reviews. Individual CBT is the only psychological treatment that is better than a placebo control (19), and therefore no others are included in this evidence table.

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Specific Phobias

Level of severity	Level of Service	Intensity of intervention	What Intervention?	Level of Evidence
Mild	Primary Care	Low	Group treatment based on BT principles Exposure-based therapy (BT) Manualised self-guided therapy based on Behaviour Therapy (BT) principles Supportive Counselling	A ^{1, 6} A ^{4, 5} B ² B ⁴
Moderate - Severe	Primary Care	High	Disorder specific CBT EMDR Emotion Freedom Technique (EFT)	A ^{5, 9, 10} B ³ B ⁷

Mild

Manualised self guided therapy has been tested with spider phobics, using a specific handout for use with spider phobia (2).

Group treatment has again been tested in a number of small trials (1, 6). Groups of 3/4 are recommended and format varies. Basing this on exposure treatments appears to be the most effective.

Supportive counselling (based on a dynamic and non-directive approach) has been tested and gained significant results in one trial (4). The caution here is that many of the candidates could also have achieved forms of exposure during the treatment process.

Moderate/Severe

Most presentations to services for specific phobias are likely to fall into this category, due to the impact on their social functioning leading the

person to seek treatment. Within this category, exposure based models for treatment have been the most tested and with significant outcomes. Variations on the method of administration are noted. Ost's well studied 3 hour sessions appear to have a wide evidence base. His development of the applied tension technique (8) has also been tested with good results and would be recommended for use as an adjunct with exposure for certain presentations of blood/injury phobia.

Cognitive restructuring within a CT or CBT format has also been tested with good outcomes, particularly with claustrophobia. The results vary, with one study suggesting no further impact beyond those of the exposure based model (9, 10).

EMDR has been tested in case studies, one uncontrolled study and one controlled study (3). The results of the latter were not significant. This form of treatment could be considered if there is a traumatic event

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associated with the phobia's development, or the phobia is difficult to confront (e.g. flying, wasps, thunderstorms). There is a suggestion though, that other forms of imaginal exposure may perform just as well.

EFT has been tested in one small RCT (7) with significant outcomes controlled against a breathing technique. Although based on contested theoretical principles, this alone should not necessarily warrant its exclusion. Virtual reality guided phobia treatment has been well studied

with some good outcomes. It does not appear in this guidance though, as the protocol is likely to be expensive compared to other treatments.

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Substance Misuse

Level of severity	Level of Service	Intensity of intervention	What Intervention?	Level of Evidence
Mild	Opportunistic contact	Low	Opportunistic Brief Intervention (motivationally based)	A ^{1, 2}
Mild-Moderate Cannabis with co-morbid anxiety and/or depression Stimulants with co- morbid anxiety and/or Benzodiazepines with Panic Disorder	Primary/Secondary care	High	CBT Group CBT + Gradual Tapering (10 weeks)	A ^{1, 2} A ^{1, 2}
Moderate - Severe	Community/ Inpatient/ Residential/ Criminal Justice	High	Contingency management Behavioural Couples therapy	A ^{1, 2} A ^{1, 2}
Moderate – Severe Stimulants with co- morbid anxiety and/or depression	Primary care/ Community	High	CBT	A ^{1, 2}

Individuals with co-morbid drug and/or alcohol misuse are often excluded from studies evaluating interventions for PTSD. There is some evidence to suggest that they can benefit from TFCBT but there is also increased risk of disengagement from treatment.

There is a consensus that drug/alcohol misuse should be stabilised before trauma-focused treatment is offered.

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Trauma

The prevention and treatment of PTSD

The consequences to the individual of exposure to psychologically traumatic events vary widely. In many cases there will be no lasting adverse impact on wellbeing. In others it may cause, or contribute to, 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 alternative conditions that might develop, sometimes alongside PTSD. Mental health clinicians should therefore routinely explore for trauma history as a part of their assessment and consider trauma history in their formulation of a service user's difficulties.

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.

Preventing Post Traumatic Stress Disorder

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 (1) updated review of single session psychological 'debriefing' identified twelve published trials.

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 appeared to increase long-term traumatic distress. (2, 3).

There is also no evidence that debriefing has any beneficial effect on any other psychological outcomes, 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, there is evidence (summarised in another systematic review) to suggest that delivering more formalised interventions, such as brief trauma focused CBT, over a number of sessions and aimed at those with overt distress (such as Acute Stress Disorder) may be beneficial (4-7). Treatment should be targeted at symptomatic patients and not at those who are asymptomatic.

Routine 'debriefing' not recommended. Could increase long-term traumatic distress.

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Level of severity	Level of Service	Intensity of intervention	What Intervention?	Level of Evidence
Mild to severe	Primary Care	Low	Individuals should receive a thorough assessment prior to being offered intervention. A period of “watchful waiting” may be appropriate to see if symptoms naturally improve. Some individuals will not feel ready to undertake intervention at an early stage. Clinicians should be mindful of individual readiness to engage in treatment	C ⁸
		High	Trauma-Focused CBT (4-5 sessions): aimed at those with overt distress.	A ^{4,7}

Post Traumatic Stress Disorder (Type 1 Trauma)

Level of severity	Level of Service	Intensity of intervention	What Intervention?	Level of Evidence
Mild	Primary Care	Low	Watchful Waiting with Follow-up in 1 Month	C ^{8,9}
Moderate/ Severe	Secondary Care	High	Trauma-Focused CBT (8-12 sessions)	A ^{8,10}
			EMDR (8-12 sessions). [Therapists should consider individual stress management if the service user is unwilling or unable to engage in TF-CBT or EMDR.] Interpersonal Psychotherapy (IPT)	A ^{8,10} A ²⁰
Severe and Chronic	Secondary Care/ Specialist Trauma Service	High	Alternative form of Trauma-Focused Treatment (e.g. try EDMR if no response to Trauma-Focused CBT). Therapists should consider individual stress management if the service user is unwilling or unable to engage in TF-CBT or EMDR.	C ^{8,10}

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Complex Traumatic Stress Disorders (Type 2 Traumas)

Courtois and Ford (14) have defined complex psychological trauma as “involving traumatic stressors that (i) are repetitive or prolonged; (ii) involve direct harm and/or neglect and abandonment by caregivers or ostensibly responsible adults; (iii) occur at developmentally vulnerable times in the victim’s life, such as early childhood; and (iv) 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. Repeated exposure to interpersonal stressors in adulthood such as domestic violence, torture, sex trafficking and other forms of organised violence are also associated with complex psychological trauma responses (15). Effects may include affect deregulation and impaired self-concept, dissociation, somatic dysregulation, and disorganised attachment patterns leading to interpersonal and intra-personal difficulties in adult life (16, 17). These are in addition to DSMV PTSD symptoms of re-experiencing of the traumatic events, avoidance of the reminders, negative alterations in cognitions, and mood and hyper arousal.

There is limited treatment outcome research on interventions for complex traumatic stress and further research in the area is required (14). The expert consensus task force established by the International Society for Traumatic Stress Studies identified nine RCTs in which complex trauma symptoms were the target of treatment in individuals with complex trauma resulting from childhood physical and/or sexual abuse (15). The models evaluated in these studies were all based on phase based programmes. Although evidence is limited it is widely thought that a phase based intervention approach is indicated for treatment of complex traumatic stress disorders.

A prolonged 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. Medication can sometimes aid the stabilisation process. When sufficient sense of safety and stabilisation has been achieved the treatment can move on to the processing of traumatic memories using CBT or EMDR. Some service users will choose not to undertake this phase and careful consideration of the pros and cons of undertaking processing is needed before this begins. Finally the patient can be helped to reintegrate with others in their life.

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Level of severity	Level of Service	Intensity of intervention	What Intervention?	Level of Evidence
Moderate/ Severe	Secondary Care	High	Phase-Based Intervention Programme: 16-30 sessions (some treatment may be much longer) 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 and/ or EMDR, including exposure where appropriate. Phase 3 – Reintegration The continued development of trustworthy relationships. Work on intimacy, sexual functioning, parenting etc.	A^{18,19} C^{14,15} C^{14,15}

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Older Adults

Psychological therapies with older adults

In the developed and developing world, the older adult population is growing rapidly. Half the total population of the UK is currently aged 50 or older and the number of people aged 60+ outnumbers those aged 18 and under. In Wales, the population aged 65+ is predicted to rise by almost 40 percent over the next 20 years, with one in four people expected to be aged 65+ by the year 2036.

A multitude of social, demographic, psychological and biological factors contribute to a person's mental health and emotional wellbeing; almost all of which are particularly pertinent amongst older adults. These include factors such as poverty, social isolation, loss of independence and loneliness. Older adults are more likely to experience events such as bereavements or physical disability. As such, older adults often present with psychological difficulties and co-morbid physical health problems.

Anxiety disorders in later life

Level of severity	Level of Service	Intensity of intervention	What Intervention?	Level of Evidence
Mild	Primary Care	Low	CBT ACT	A ^{6,7} B ⁸
Moderate to severe	Secondary or tertiary care	High	CBT ACT	A ^{1,2,3,5} A ¹
Chronic/complex with evidence of executive impairment	Psychological therapy services with highly specialist practitioners	High	CBT (adapted for older people with anxiety and executive dysfunction using specialist protocol)	B ⁴

However, there are a number of myths about ageing that have contributed to the perception that psychotherapy with older adults may be less effective, including the notion that it's too late for older people to change, that older people don't want psychotherapy, or that depression is to be expected in later life. In fact, there is a lot of empirical evidence to suggest that older adults can and often do, benefit from psychological therapies. Furthermore, treatment outcomes for older adults have been found to be comparable with those of younger adults (Cuijpers et al., 2009).

The following tables summarise the current evidence for the effectiveness of psychological therapies in later life across a variety of mental health problems. However, it is important to remember that many of those therapeutic approaches and interventions recommended for adults of working age (see evidence tables for Mental Health Service for Adults) still benefit adults aged 65 and over, especially given that research in the field of older adults is significantly lagging behind that focussed upon adults of working age.

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Co-morbid anxiety and depression	Part 1, Community, Part 2, care homes, day hospitals, in-patient units	High	Group CBT	A ⁹
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Depression in later life

Level of severity	Level of Service	Intensity of intervention	What Intervention?	Level of Evidence
Mild	Primary Care	Low	Bibliotherapy	A ¹⁷
			Reminiscence therapy	A ^{2,3,12,25}
			Life review therapy	A ^{2,3}
			Counselling	C ¹⁷
Moderate to severe	All	Low	Positive psychology interventions	A ¹⁹
Moderate	Primary and secondary care	Low-High	Problem-solving therapy	A ^{1,11}
			Individual CBT	A ^{6,9,11,12,18,21}
			Group-based CBT	A ^{8,22}
			Psychodynamic therapy	A ^{6,23}
			IPT maintenance post-recovery	A ^{14,15}
			Behaviour therapy	A ¹⁶
Severe	Primary and Secondary care	High	Individual CBT	A ¹¹
Chronic or treatment resistant	Secondary care/ Highly specialised specialist service; in-patient care	High	Individual CBT	C ²¹

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Prevention of relapse in recurrent depression	Primary/secondary care	High	Mindfulness-based CT	C ^{5,20}
Depression with anxiety	All	Low	Group CBT	A ²⁴
		High	CAT	C ⁷

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Personality disorders in later life

Level of severity	Level of Service	Intensity of intervention	What Intervention?	Level of Evidence
Moderate	Secondary care	High	DBT	B ²
		High	CAT	C ¹

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Severe and enduring conditions

Level of severity	Level of Service	Intensity of intervention	What Intervention?	Level of Evidence
Moderate	Secondary care	High	Group-based CBT for older adults with bipolar disorder	C ³
			Cognitive behavioural social skills training for psychosis	B ^{1,2,4}
			Family intervention in psychosis	B ⁵

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Dementia

In Wales, one in 16 people aged 65+ and one in six aged 80+ are affected by dementia. There are currently over 40,000 people in Wales living with dementia and this is set to rise by 30 per cent over the next 10 years. However, despite this there is very little research exploring the efficacy of psychological therapies for this service user group. The following tables summarise the research in this area to date.

Depression and anxiety in the person with dementia and their caregivers

Level of severity	Level of Service	Intensity of intervention	What Intervention?	Level of Evidence
Moderate	Secondary care/ specialist protocol	High	Behaviour therapy	B ^{3,8}
		High	CBT (person with dementia)	C ^{2,5,6,7,9}
	Secondary care/ community	High	Family intervention in psychosis	A ^{1,3,4}

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Cognition (and quality of life)

Level of severity	Level of Service	Intensity of intervention	What Intervention?	Level of Evidence
Mild/Moderate	Secondary care/ Specialist	High/Specialist	Cognitive rehabilitation	A ^{1,2}
Mild/Moderate	All tiers of care including voluntary settings	Low	Cognitive stimulation therapy (improves cognition and quality of life)	A ^{1,2,3}
		Low	Maintenance CST	A ⁴

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Living well with dementia

Level of severity	Level of Service	Intensity of intervention	What Intervention?	Level of Evidence
Mild	Part 1 – Early stage dementia	Low	Pre-assessment and post-diagnostic counselling	C ^{4,7}
		High	Post-diagnostic groups	A ^{2,4,7,12,16}
		High	Creative arts therapies	C ¹
Mild/Moderate	All – Early stage dementia	Low	Peer support	B ^{5,6}
Mild/Moderate	All	Low	Life story work	C ^{8,9,14}
	Secondary/Care home/Day hospital	Low	Reminiscence therapy for mood, including personalised activity	A ^{13,15}
	All	High	Narrative therapy	C ^{10,11}
Moderate/Severe	Secondary care/specialised	High	Reminiscence therapy for mood and some cognitive abilities	A ³

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Insomnia

Level of severity	Level of Service	Intensity of intervention	What Intervention?	Level of Evidence
Mild – Severe	Secondary care/ Specialist	High/ Specialist	Psychological therapy for insomnia in dementia (multi-component caregiver intervention, including daytime activity, sleep hygiene and light exposure)	A ¹⁻⁴

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Stress and distress in dementia

The term stress and distress in dementia is increasingly being used in place of other terms such as challenging behaviour or behaviour that challenges in the literature and amongst those working in older adults services.

The majority of people living with dementia are likely to experience stress and distress at some point during their illness. National Policy and guidance make it clear that many of the behaviours identified as challenging should not be treated as if they are an inevitable consequence of dementia, but instead be recognised as symptoms of human distress, disorientation and misperception.

As such, National Clinical Guidelines (NICE 42) recommend psychosocial

and behavioural interventions as a first line treatment for stress and distress in dementia; that is, prior to the administration of psychotropic drugs. They recommend that any intervention should be tailored to the individual and be based upon a comprehensive assessment that takes into consideration the person with dementia's preferences, skills and abilities.

Despite this, there is still very little empirical research exploring the effectiveness of non-pharmacological approaches to stress and distress in dementia; however, it is generally agreed that individualised formulation-led interventions that focus upon meeting the specific needs of the individual with dementia are most appropriate (James, 2011; BPS, 2013).

Psychological approaches in response to stress and distress in dementia

Level of severity	Level of Service	Intensity of intervention	What Intervention?	Level of Evidence
Mild – Severe	Nursing home	Low	Enhanced psychosocial care (to reduce use of neuroleptic medication)	A ³
Mild – Severe	Secondary care	Low	Psychoeducation for caregivers	B ⁵
Mild – Severe	Community	Low	Multiple component interventions • For caregivers	A ^{1,2,6,7} A ^{2,5}
Mild – Severe	Community/ Secondary Care	High	Behavioural management training to reduce caregivers stress and distress Behaviour management to reduce depression in person with dementia	A ^{1,2,6,7} A ^{2,5}

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Specific interventions in response to stress and distress

The following interventions should be considered in the context of a highly specialist and comprehensive assessment of difficulties which will inform formulation-led interventions specific to the needs of the individual person with dementia based on specific psychological models (including the Newcastle Model and Cohen-Mansfield unmet needs model).

It is recommended at this level that practitioners participate in specialist training in specific theoretical approaches, assessment techniques and tailored interventions. Low or high intensity interventions outlined above may also form part of an intervention plan, if appropriate to the formulation.

Level of severity	Level of Service	Intensity of intervention	What Intervention?	Level of Evidence
Mild to severe	All	High	Music therapy	C 1,7,13,15
Moderate/Severe	Secondary Care	Low	Environmental adaptation	B 4,13,14
		Low	Doll therapy with clear ethical guidelines	B 10,11
			Increasing occupation/stimulation (e.g. music therapy and activities)	A 8
			Stimulated presence therapy (SPT): important to assess suitability for therapy and monitor closely	B 3,16
			Social contact – real or simulated, including animal assisted therapy	B 2,9,16
			Validation therapy	C 12

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