Evidence Tables

Matrics Cymru / Matrics Plant

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The Evidence Tables

A Rationale for the Matrics Cymru Evidence Tables: evidence-based practice (EBP) and practice-based evidence (PBE)

In the field of psychological therapy, there has long been a drive to "bridge the gap" between practice and research[1]. This has led to recognition that both **evidence-based practice (EBP)** and **practice-based evidence (PBE**) are necessary to the dissemination of high quality interventions which can be delivered in routine clinical settings.

Evidence-Based Practice is informed by high quality research studies such as randomised controlled trials (RCTs) in which the primary focus is on controlling variables such as presenting difficulty, diagnosis and the presence or otherwise of comorbidities, 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, often including an option for no active treatment. Systematic reviews and meta-analyses draw together findings from these studies to provide an overview of the evidence for specific interventions. Systematic reviews have an important role in summarising the quality and strength of evidence across a range of sometimes contradictory studies and ordinarily form the mainstay of clinical guidelines published by organisations such as the National Institute for Health and Care Excellence (NICE), the Scottish Intercollegiate Guidelines Network (SIGN) and the World Health Organization (WHO). These guidelines have provided scientific support for the continued provision of effective therapies.

There are, however, issues arising from relying on this type of guideline in isolation[2]. Issues of concern include the use of diagnostic classification or distinct presenting problems in most RCTs[3] and under representation of some groups of people (e.g., older adults, people from some ethnic minorities where cultural differences may be particularly important) in many trials.

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 terms of its practical application to many service users. In addition, some therapies lend themselves more easily to

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, D (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

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evaluation through RCTs than others, which is likely to bias the evidence base in their favour. Further, reliance on diagnoses to guide treatment is recognised to have implications and limitations. Matrics Cymru, in setting out levels of practice, highlights the key role of formulation and supervised practice-based on best evidence. The use of guidance developed from best evidence for clinical work should be informed by an awareness of the issues raised in relevant critiques[4].

There is however, a significant and substantive body of evidence-based on functional diagnosis which has informed the development of agreed clinical guidance and practice. Where there are apparent gaps in the evidence to support some interventions, this does not necessarily indicate that treatments that are excluded from such guidelines have been shown to be ineffective; it can simply mean that studies of sufficient methodological rigour have not yet been completed and reported. In the absence of RCT based evidence, EBP may sometimes be informed by studies of lower methodological quality, such as non-randomised comparison studies, cohort studies or case control series. Treatment guidelines normally identify the level of evidence involved in supporting specific recommendations in order to make this transparent to the reader.

Practice-Based Evidence [PBE][5] involves the collection and evaluation of evidence collected from service users within clinical services. Practice-based evidence is of greatest value when it is collected systematically on a continuous basis and when it is used to evaluate the impact of specific clinical and service-related interventions. PBE offers an opportunity to use benchmarking and case tracking to incorporate observations from clinical practice and compare these against anticipated outcomes based on evidence-based guidance. Evidence from the Practice Research Network (PRN) for improving access to psychological therapies (IAPT)[6] 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 relies on the practice of continuous monitoring and recording of outcomes during and at the end of interventions.

The routine collection and analysis of practice-based evidence can be seen as a complementary to evidence-based practice. These two forms of evidence have great potential to feed into each other, so that the routine collection of practice-based evidence can inform service delivery where the findings of trial based research may not be fully representative of the kinds of diverse and co-occurring difficulties service users may experience and present with for therapy.

A mechanism for robustly evaluating PBE in Wales is currently being developed and there is early support from clinicians and service

4 Division of Clinical Psychology, Classification of behaviour and experience in relation to functional diagnosis: Time for a Paradigm shift, British Psychological Society, 2013 and Power Threat Meaning Framework 2018, British Psychological Society. Available: https://www.bps.org.uk/power-threat-meaning-framework

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

6 https://www.nice.org.uk/about/what-we-do/our-programmes/nice-advice/iapt

users from across Wales for a National Repository for Practice-Based Evidence. Development of a repository is likely to help to support the introduction of models of implementation science (e.g., the Hexagon model)[7]. This would potentially enable clinicians in Wales to make use of routine data collection to take an evidence informed approach and to consider modifications that might be required to established interventions in order to make them more accessible and appropriate for populations in Wales in a way that is consistent with extant policy. In the more immediate future, it is highly likely that reviews of evidence (particularly for those areas where research is limited) will indicate, where necessary, evidence that is less rigorous and is more akin to practice-based evidence. Research will be graded accordingly for transparency but in the context of a robust assessment and formulation, clinicians may choose to offer an intervention supported by PBE.

The Evidence Tables

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

The various SIGN[8] 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 Matrics Cymru tables. As evidence tables are updated and new ones added, these will be incorporated in the document available on the Improvement Cymru website. The date at which the table was developed/last reviewed will be clearly indicated in the titles e.g., Bipolar-Disorder (2017), Post Traumatic Stress Disorder (2021).

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.

To develop the initial Matrics Cymru evidence tables in 2017, Wales-based clinicians were invited to scrutinise the Scottish Matrix (2015) 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 contemporary research studies.

A process for collaborative review and updating the tables, ensuring that they consider evidence related to the needs of service users across the life span, alongside the needs of specific populations (such as those with learning disabilities) and with wider scope to transdiagnostic models of practice where these are frequently

7 Metz, A. & Louison, L. (2018) The Hexagon Tool: Exploring Context. Chapel Hill, NC: National Implementation Research Network, Frank Porter Graham Child Development Institute, University of North Carolina at Chapel Hill. Based on Kiser, Zabel, Zachik, & Smith (2007) and Blase, Kiser & Van Dyke (2013).

8 https://www.sign.ac.uk/

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delivered in statutory services, was commenced in 2020. A structured methodology (qualitative collaborative review (QCR)), based on the approaches used by NICE and SIGN, was developed with the intention that this should be followed in updating existing tables and in developing new tables. The methodology specified that small working groups of clinicians and academics with specialist knowledge of the field would be developed to review changes in the evidence and with the involvement of individuals with lived experience, develop new and updated tables. The Matrics Cymru Leadership and Infrastructure Project (MCLIP) has developed a collaboration with colleagues updating the Matrix Tables in Scotland to allow adoption of tables developed by the other country. In order to inform adjustment and development of tables appropriate to each nation, both Scotland and Wales agreed to invite representation from the other nation in table update groups. This collaborative approach is both prudent and efficient in ensuring that the available research resources in both countries are used to best effect.

New evidence tables will be developed and published as part of a rolling programme according to priorities set out and agreed with the National Psychological Therapies Management Committee (NPTMC) and will cover mental health services for children and young people, adults and older adults. The tables continue to focus on common mental health problems and disorders, but in addition will broaden scope to include new tables on transdiagnostic problems and interventions.

This document will now become a living document, subject to regular updates as new tables are developed. There will be multiple areas of specialism across the document.

Key areas for development

The intention is that future tables should be inclusive of populations such as older adults and people with a learning disability, where increased efforts may be required to ensure engagement and co-creation of research outcomes and the collection of PBE. Unless otherwise indicated, clinicians should be able to extrapolate from the evidence tables to these populations, so that with appropriate adjustments and modifications, recommended therapies can be offered. Feedback from listening groups/engagement events conducted with practitioners across Wales working in multiple specialties and service areas indicate a number of themes for possible modification including extending the period of engagement and socialisation to the intervention, using adapted materials and where appropriate, including carers or significant others.

Services for children, young people (CYP) and families

Psychological therapies play a particularly important role in mental health services for children and young people. This remains an under-researched area compared to mental health therapies for adults and 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 noted that the use of diagnostic, rather than developmental, frameworks for describing effective practice may not always be appropriate in psychological services for children and young people.

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A fuller discussion and clarification of ways of working psychologically with CYP is set out in Matrics Plant[9]. New iterations of the evidence tables will include specific reference to CYP where relevant evidence exists as appropriate, as long as the conceptualisation of the presenting problem is a good fit and sits alongside a developmental and systemic view of the child or young person. Where the table is awaiting review, practitioners are referred to the Scottish Matrix.

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:

- There is evidence in the literature for the effectiveness of the intervention and if this is the case, the intervention will then be rated on the quality of the available evidence
- There is no clear evidence in the literature for the effectiveness of the 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 approach has not yet been adequately evaluated
- There is evidence in the literature the intervention is ineffective, or indeed harmful.

In the first and last cases, the implications are clear:

- Health boards should ensure access to at least one therapy with the highest level evidence for each of the presenting problems shown in the tables and ensure access to an alternative with evidence at level A, B or C. To ensure the provision of prudent, effective care, the alternative therapy provided should be that with the strongest evidence (p26)[10]
- Where an intervention has been demonstrated to be ineffective or harmful, it should not be provided within the NHS
- Where a therapy or intervention has not been adequately evaluated, there needs to be some flexibility of approach. In a number of areas, for example, there are longstanding services which are recognised or have been evaluated as being of benefit to service users 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 systematically collect their own good quality evidence [PBE] around the effectiveness of such services. Not only is this essential for good governance, it engages service users and practitioners ensuring dynamic improving practice and will contribute to the wider evidence base and help ensure that investments are effective in the longer term. The introduction of

9 Matrics Plant Guidance on the Delivery of Psychological Interventions for Children and Young People in Wales (2021) Improvement Cymru.

10 https://phw.nhs.wales/services-and-teams/improvement-cymru/improvement-cymru-programmes/mental-health/psychological-therapies/resources-psychological-therapies/matrics-cymru-guidance-for-delivering-evidence-based-psychological-therapies-in-wales/

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the Improvement Cymru Outcomes Initiative will help to support the routine collection of such evidence.

When using the tables as an aid to strategic planning, it is important to start off by scoping local expertise alongside gaps in service provision 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 equity, empowerment, effectiveness and efficiency[11] should be considered. Cost effectiveness as an aspect of efficiency, is highly relevant in ensuring equitable and increased access of provision for psychological therapies within a finite resource.

Factors which need to be taken into account include:

- the cost of treatment in terms of training, 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 effectively, taking into account levels of skills/knowledge already available within the system
- the sustainability of training to maintain the 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
- relevant outcome measures which can inform practice both at local and national levels
- issues of client choice.

From a clinical standpoint and indeed a human rights perspective, individual need is paramount and access to interventions matched to need should be seamless and should not be based on the part of the service (e.g., primary vs secondary care) in which the individual is being seen.

Which Therapies - The Evidence Base

Currently, the evidence tables continues to support the efficacy of cognitive behavioural therapy (CBT) for many disorders. Health boards would therefore be wise to continue to develop expertise in CBT based approaches. 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.

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

- population need

11 Adult Mental Health Services: A National Service Framework for Wales, 2002, Welsh Government https://www.wales.nhs.uk/news/453

- the services they already have
- the expertise available locally
- findings from existing service evaluation and quality improvement initiatives
- 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) and by developing collaborations with active research groups.

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.

Definitions used in the tables

Term	Definition
Level of Severity	A description of the level of severity of the problem and an indicator of potential level of functioning. Following definitions provided by NICE, the terms mild, moderate and severe are used in this document to describe different levels of mental health problems. A mild mental health problem is when a person has a small number of symptoms that have a limited effect on their daily life. A moderate mental health problem is when a person has more symptoms that can make their daily life much more difficult than usual. A severe mental health problem is when a person has many symptoms that can make their daily life extremely difficult.
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 to moderate mental health problems, ordinarily delivered by practitioners working in an informed and skilled way. High intensity/specialist interventions are formal psychological therapies based on a psychological formulation delivered by a practitioner working at an enhanced or highly specialist level of expertise and are ordinarily aimed at moderate to severe mental health problems.
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.
Level of Efficacy	This refers to the degree of symptom/functional improvement on key outcomes that one might expect from the intervention based on research findings. Level of efficacy is often based on metrics such as "effects size", which describes the degree of improvement of an ntervention group in relation to that of a control condition. Levels of efficacy are described as low, medium or high and reflect improvements in symptoms that are small, moderate or large in size.

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Grading the Evidence Table

SIGN	NICE	Matrics Cymru 2017	Matrics Cymru 2021
A At least one meta-analysis, systematic review, or RCT rated as high quality and with a low risk of bias and directly applicable to the target population OR A body of evidence consisting principally of well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias, directly applicable to the target population and demonstrating overall consistency of results.	A At least one 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.	A At least one meta-analysis, systematic review or high quality RCT, with low risk of bias clearly supporting the efficacy of the intervention for the problem in the target population and as part of a body of literature of overall good quality addressing the specific recommendation.

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B A body of evidence including high quality systematic reviews of case control or cohort studies; or high quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal, directly applicable to the target population and demonstrating overall consistency of results OR Extrapolated evidence from high quality or well conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias.	B Well conducted clinical studies but no RCTs 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.	B Well conducted, but non-randomised, clinical studies, or RCTs of lower quality, as part of a generally consistent literature and directly relevant to the target population and problem and demonstrating overall consistency of results. This might include high quality systematic reviews of case control or cohort studies, or high-quality case control or cohort studies with a very low risk of confounding or bias OR Extrapolated evidence from high quality or well conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias.

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C A body of evidence including 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 OR Extrapolated evidence from high quality systematic reviews of case control or cohort or studies OR Extrapolated evidence from high quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal.	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.	C In the absence of more robust evidence, a body of evidence from well conducted case series or cohort studies with a low risk of confounding or bias, directly applicable to the target population, which suggests that the intervention can be efficacious in improving or treating the problem OR Extrapolated evidence from well conducted systematic reviews of case-control or cohort studies with a low risk of confounding or bias OR Extrapolated evidence from high quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal.

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D Non-analytic studies, e.g., case reports, case series OR Expert opinion OR Extrapolated evidence from well conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal.			D Evidence from non-analytic studies, e.g., case reports, case series OR Expert committee report or opinion of respected and trustworthy authorities (such as NICE, SIGN, WHO, APA[12], BPS[13], RCPsych[14], BABCP[15], ACP[16] or expert consensus guidelines) ratified by the Welsh QUIC-R[17] process. This grading indicates that directly applicable studies of good quality are absent or not readily available OR Extrapolated evidence from well conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal.

12 American Psychological Association

13 British Psychological Society

14 Royal College of Psychiatrists

15 British Association for Behavioural and Cognitive Psychotherapy

16 Association of Child Psychotherapists

17 Quality Improvement Collaborative Review

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Adult and Children and Young Person's Mental Health

Bipolar (2017)

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	A[1,6,7]
			Group psycho-education (e.g., Bipolar Education Programme Cymru)	A[1,6]
			Family intervention	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	A[2,3]
			Interpersonal and social rhythm therapy	A[4]
Severe and enduring	Secondary care	High	Functional remediation for improvement in functional outcomes	A[10]

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Body Dysmorphic Disorder (2017)

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence
Moderate/Severe	All	Low	Group CBT	B[3]
			Exposure response prevention (ERP)	B[4]
			Disorder specific CBT	B[5]
			Eye movement desensitisation and reprocessing (EMDR)	C[1]

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 Yale-Brown obsessive compulsive scale (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 supported by significant outcomes, which were maintained in those who participated in a maintenance programme.

A number of case studies have also been published. 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 (2017)

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence
Severe	Secondary care or specialist outpatient	High	Dialectical behaviour therapy (DBT)	A[1,2]
			Schema-focused CBT	A[1,2]
			Systems training for emotional predictability and problem-solving (STEPPS)	A[1,2]
			Transference-focused psychotherapy	A[1,2]
			CBT for personality disorders individual therapy (30 sessions over one year)	A[4]
			Cognitive analytic therapy (CAT)	B[3] – One RCT for a less severely affected group with minimal/low self-harm.
	Secondary/Specialist partial day hospital	High	Mentalisation based day hospital	A[1,2]

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Depression (2017)

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	A
			Guided self-help based on CBT behaviour principles	A[30,31,32]
			Multi modal CBT	A[33]
		High	Behavioural activation (BA)	A[1,2]
			CBT	A[7**, 8*,15*, 17]
			Interpersonal psychotherapy (IPT)	A[3, 8*,15*,16,17]
			Problem-solving therapy	A[8*,15*,17]
			Brief psychodynamic therapy	A[13]
			Nondirective supportive therapies/person-centred counselling	A[5,6,8*,9,10]
			Couples therapy	A[20,21]
			Interpersonal counselling	B[18***]
		High	Art therapy	C[24]
Severe (non-chronic)	Secondary care	High	CBT	A[19]

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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] C[28,29]
Prevention of relapse in recurrent depression	Primary/Secondary care	High	Mindfulness-based cognitive therapy (MBCT)	A[14, 22****27]

* 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 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.

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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 (2017)

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	C[31]
			Medication should not be used as the sole or primary treatment for anorexia nervosa	C[30,34]
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	A[8,10,19,20,21,27,32,37]
			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, CAT and motivational enhancement therapy (MET).	C[30,31]

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Binge Eating Disorder (2017)

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 Health and Care 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	A[6,9,30,35,38]
			Guided self-help	A[3,29,33]
			Internet based guided self-help	A[1,12,13]
Moderate - Severe	Secondary care	Low	Guided CBT self-help	A[3,29,33]
			Internet based guided self-help	A[1,12,13]
		High	CBT for binge eating disorder (CBT-BED)	A[17,21,30]
			Cognitive behavioural therapy-eITnhanced (CBT-E)	A[11,14,15]
			IPT	A[30]

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Bulimia Nervosa (2021)

Bulimia in Children and Adults – July 2021

Bulimia is a severe form of eating disorder that can result in serious medical morbidity and a range of psychosocial comorbidities[1,2]. The impact of living with and caring for an individual who has bulimia can also be severe. For many people who have bulimia, the long-term course of the condition is chronic, with less than half of people with bulimia who seek treatment achieving full recovery[3,4]. Research indicates that the higher the frequency of binge eating and purging behaviours, the poorer the prognosis for recovery[5,6]. The prevalence of bulimia among women is 0.5% and 0.1% among men[8].

There are many forms of behavioural presentations of bulimia. The condition is characterised by cycling patterns of restriction of food intake, followed by uncontrolled and distressing episodes of binge eating, followed by purging behaviours. Purging behaviours can include a range of compensatory behaviours, including voluntarily vomiting, use of laxatives and excessive exercise, or a combination of these behaviours by the same individual. There is also increasing awareness in clinical services, accompanied by increased need to provide appropriate care and treatment for individuals with Type 1 diabetes who restrict their insulin intake as a method of managing their weight. Detailed screening and assessment are therefore required in order to obtain an accurate profile of how each person is experiencing bulimia as presentations vary extensively. Sensitive and supportive assessment is crucial. Early intervention has been shown to improve outcomes and reduce the cost of treatment for bulimia[8]. The review of services for people with eating disorders by Welsh Government in 2018[9] included a recommendation that treatment for eating disorders should begin within four weeks of referral and within one week in urgent cases. All treatment for bulimia should be undertaken alongside clinically appropriate monitoring of the person's physical health where the severity of their condition warrants this.

Treatment for Children and Young People

There are two forms of therapy that are consistently reported to be effective in the treatment of bulimia with high efficacy among children and young people. These are family-based treatments[10] and models of CBT[11] that are specifically tailored to address bulimia. The evidence indicates that these approaches are equally effective in the long-term for children and young people who have bulimia[12]. However, if there is a high level of conflict within the family, then a family-based approach is less likely to be helpful and in such circumstances, CBT is more effective[13]. There are a range of other therapies that are supported by evidence for their effectiveness, though less extensively than with family-based treatment and CBT. Dialectical behavioural therapy[14] is supported by a limited amount of evidence for its effectiveness for bulimia, though no direct RCT has as yet been undertaken with children and young people with bulimia. Similarly, emotion-focused family therapy is supported by case reviews but has not yet been studied in a controlled manner. Psychodynamic therapy[15] is supported for use with this population by evidence from a single RCT. These latter three therapies are therefore recommended in circumstances where family-based treatment and CBT are considered by the clinician to not be appropriate for the child or young person, are declined or they prove not to be effective.

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Children and young people are often ambivalent about engaging in psychological treatment for bulimia and attempting therapeutic change. Clinicians should therefore assess, monitor and seek to improve motivation, where necessary, throughout the treatment process. Whereas evidence exists to support the delivery of motivation-focused therapy for adults with bulimia, evidence is not available for the delivery of such therapy with children and young people at this stage. It is important that the child and the family are fully supported throughout the process by eating disorders specialist staff and therefore, when a child is engaged in one-to-one therapy, their family should receive concurrent direct support from the eating disorders team[16]. Moreover, children and young people and their families should have access to peer support when needed[17], which could be available through NHS Wales services or third sector organisations.

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence	Level of Efficacy
All levels	Parts 1 & 2	High	Family-based treatment for bulimia	A[18,19,20,21,22]	High
All levels	Parts 1 & 2	High	A form of CBT that is specific to eating disorders (e.g., CBT-E etc.)	A[22]	High
If the above therapies are considered by the clinician to not be appropriate for the service user, are declined or they prove not to be effective, then the following therapies should be considered:					
All levels	Parts 1 & 2	High	Psychodynamic therapy	B[15]	High
All levels	Parts 1 & 2	High	Emotion-focused family therapy	C[23]	Undocumented
All levels	Parts 1 & 2	High	Dialectical behavioural therapy-informed	D[22]	Undocumented

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Treatment for Adults

A range of therapies have consistent support from the literature as being highly effective in addressing bulimia among adults. These are guided self-help (based on CBT specific to bulimia)[24,25,26,27] models of CBT, specifically tailored to addressing bulimia[24,25,26,28,29,30,31,32,33,34,35,36] and interpersonal psychotherapy[24,31,37,38]. Interpersonal psychotherapy should be available to service users, particularly where the condition is assessed to be a maladaptive interpersonal coping strategy as part of a psychological formulation. As the literature on the effectiveness of family-based treatment for bulimia that has been previously cited extends to late adolescence, this therapy approach is included as a recommendation for adult services to make available for the young adults on their caseloads. This is particularly relevant when they are transitioning from children's services and have successfully engaged with that treatment approach under children's services. In addition, virtual-reality based cue exposure intervention is supported by RCT evidence as effective in addressing any residual episodes of binge eating at the conclusion of an episode of psychological therapy. In circumstances where these therapies are considered by the clinician not to be appropriate for the service user, are declined by the service user or prove not to be effective, then a range of other therapies can be considered. For instance, motivation-focused therapy is supported by a range of RCTs. Both integrated cognitive affective therapy and a mindfulness-based modified form of dialectical behavioural therapy are supported by evidence of high efficacy, though only from a small number of RCTs. Currently, compassion-focused therapy is supported by a series of case studies and an uncontrolled trial and psychodynamic therapy has a number of RCTs indicating its effectiveness, though estimates of its effectiveness is slightly less than that reported for CBT and interpersonal therapy.

Based on the evidence for the effectiveness of guided self-help for bulimia, services sometimes recommend self-help books based on a cognitive behavioural model. Whilst service users often value reading recommendations and report anecdotally that this has been beneficial, clinicians should be aware that there is little research into this unguided approach to self-help for bulimia. Service users should also have access to peer support based on emerging evidence of peer mentorship as an effective adjunctive intervention[39] for people with bulimia. Such peer support could be available through NHS Wales services or third sector organisations.

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Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence	Level of Efficacy
All levels	Parts 1 & 2	Low	Guided self-help based on a form of CBT that is specific to bulimia	A[24,25,26,27]	High
All levels	Parts 1 & 2	High	A form of CBT that is specific to bulimia (e.g., CBT-E; CBT-T etc.)	A[24,25,26,28,29,30,31,32,33,34,35,36,40,41]	High
All levels	Parts 1 & 2	High	Interpersonal psychotherapy	A[24,31,37,38]	High
All levels	Parts 1 & 2	High	Family-based treatment[10]	A[18,19,20,21,22]	High
All levels	Parts 1 & 2	High	Virtual-reality based cue exposure for residual symptoms following completion of other form of psychological therapy	B[42,43]	High
If the above therapies are considered by the clinician to not be appropriate for the service user, are declined or they prove not to be effective, then the following therapies should be considered:					
All levels	Parts 1 & 2	High	Motivation-focused therapy	B[44,45,46]	High
All levels	Parts 1 & 2	High	Integrated cognitive affective therapy	B[47]	High
All levels	Parts 1 & 2	High	Mindfulness-based dialectical behavioural therapy	A[14]	High
All levels	Parts 1 & 2	High	Psychodynamic therapy	A[48]	Medium-High
All levels	Parts 1 & 2	High	Compassion-focused therapy	C[49,50]	Undocumented

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Guidelines for Specific Service User Groups

There are a number of issues relating to comorbidities that need to be considered in the delivery of psychological therapies for bulimia, as follows:

- For service users who have comorbid affective or personality disorders, more frequent sessions or a longer duration of therapy may need to be considered[51]
- For service users who are undertaking a form of CBT that is tailored to addressing bulimia and who experience difficulties with mood intolerance, clinical perfectionism, low self-esteem or interpersonal difficulties, modules that directly address these issues should be incorporated into the therapy. However, these additional modules should not be included for service users who do not experience these difficulties, as evidence indicates that this would reduce the effectiveness of the therapy in such cases[52,53]
- A clinician who is delivering psychological therapy to a service user who has bulimia and diabetes should liaise with their local diabetes service to seek consultation on the delivery of the therapy
- For service users who have complex issues relating to a history of trauma, psychological therapy should be delivered by clinicians who are trained and experienced in working with trauma issues
- Service users who have comorbid mental health issues should have access to psychological therapy to address those comorbid issues, unless research indicates that therapy for that condition should not be delivered if the service user has comorbid bulimia.

When working with service users from black and minority ethnic communities, consideration should be given to including their family members in any psychological therapy that is being undertaken[54,55,56,57,58]. Clinicians delivering psychological therapies may also need to consider making adaptations to the treatment that take account of any relevant cultural and/or religious practices that relate to food and/or eating patterns. There is no evidence available regarding the effectiveness of the various psychological therapies cited in these recommendations for males, older adults or adults with learning disabilities, or whether the effectiveness of the therapies is influenced by sexual orientation or gender identity.

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Guidelines for the Delivery of Psychological Therapies

Delivery of the psychological therapies outlined in these recommendations needs to take account of the following principles:

- CBT based guided self-help can be delivered effectively online[59,60,61,62,63,64,65,66,67,68] and so could be made available in this form as an alternative to guided self-help with direct clinician contact, though delivery with direct clinician contact needs to be also available
- CBT based guided self-help can be delivered by unqualified staff when in receipt of appropriate training and supervision
- Therapeutic maintenance and support delivered via an online maintenance programme, or by clinicians via email/text messaging can be considered following completion of an episode of psychological therapy[69,70]
- Psychological therapies can be delivered either on an individual basis or in a group, provided that several individual therapy sessions are initially undertaken before the service user starts in the group[45,71,72,73]. Family-based treatment for children and adolescents can be delivered to families separately or in multi-family group format[74,75]
- Service users may require a series of different forms of psychological therapy in order to fully achieve recovery. The need and appropriateness of further psychological therapy should be considered at the conclusion of each episode
- Therapists should adhere to the particular model of psychological therapy that they are delivering as this maximises the effectiveness of the therapy[76,77]
- All forms of psychological therapies recommended in these guidelines should be delivered by clinicians in specialist roles within specialist eating disorders teams, within an early intervention service model.

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Generalised Anxiety Disorder (2017)

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 care/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 (2017)

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	Low	Internet based CBT/mindfulness programme for health anxiety	A[4]
			Behavioural stress management	A[7]
			Bibliotherapy using CBT literature	B[1]
			Disorder-specific, group-based CBT	B[2,3]
Moderate (BAI = 19-29)	Primary	High	Exposure and response prevention (ERP)	A[6]
			Disorder-specific individual CBT of 6-12 sessions	A[6,7,11,14,15,16]
Severe (BAI = 30+)	Primary/Secondary care	High	Disorder-specific individual CBT of 12-16 sessions	A[13,16]
			Disorder-specific mindfulness based cognitive therapy group (MBCT)	A[8,10]

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

Mild

The Bibliotherapy trial (1) was small (40 participants) though was randomised, with a TAU control group. The information used was Understanding

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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.

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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 aspects

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 (2017)

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 depression[17] 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 indicated[2], 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 RCTs are largely lacking in this area[2]. 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 guidance[2] for antenatal and postnatal mental health problems and in the absence of perinatal-specific psychological interventions for a particular presenting problem (e.g., obsessive compulsive disorder (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 (2015)[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	A[16,17,18]
			Group delivered mindfulness intervention for antenatal anxiety and depression (8 weeks)	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	A[21,22,23]
			Individual or group delivered IPT to prevent postnatal depression	A[21,23]
			Individual or group delivered CBT to prevent postnatal depression	A[21,24,25]
			Group delivered mindfulness-based CBT to prevent postnatal depression	B[26]
			Antenatal hypnotherapy to improve postnatal psychological wellbeing	C[27]
			Group delivered CBT for perinatal anxiety	C[28]

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Moderate/Severe	Secondary care/Specialist perinatal community mental health service	High	Individual CBT for postnatal depression	A[25,29]
			Individual or group delivered IPT for antenatal or postnatal depression	A[25,29]
			Individual CBT for antenatal depression	B[30]
			Individual CBT for postnatal OCD	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
- 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-RCTs 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 (2017)

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	Group CBT Group exposure response prevention (ERP)	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]

Main findings

- CBT (incl. ERP) is effective in reducing OCD symptoms compared to treatment as usual[10]. 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%
- 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 others[13]

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- Adding anti-psychotics to an antidepressant can increase treatment gains in OCD, but this is still inferior to a combination of ERP and antidepressant[16]
- There is some evidence that higher doses of Citalopram, Fluoxetine and Paroxetine (antidepressants) may be more efficacious than lower doses in treating OCD[14]
- Group CBT/ERP has been shown to be both comparable[9] and inferior[8] to 1:1 therapy for OCD
- Some studies show CBT and/or ERP are more effective in OCD than CT[10] but others find them equivalent[12]
- 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-analyses[10], but not others[11]
- There is some evidence for a positive relationship between increased number of hours of therapist input and reduced OCD symptomatology in some studies[2], but not in others[11]. Training family members may also improve ERP outcomes
- 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 list[14]
- Hoarding appears to be distinct from OCD[18] and may require CBT adapted for hoarding[19].

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, 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

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- Adults with severe OCD should be offered intensive CBT/ERP (more than 10 therapy hours) and an antidepressant.

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 group[10]. 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 (2017)

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	A[6,18]
			b. Internet-delivery	A[2,3,12,13,26]
Moderate	Primary care	Low	Therapist-supported self-help CBT (6-12 hours)	
			a. Bibliotherapy	A[7,15,22]
			b. Computer assisted (e.g., Fear Fighter)	A[10,19]
			c. Internet-delivered CBT, with therapist contact (up to 6 hours)	A[3,8,12,13,26]
			d. Group CBT (8-18 hours)	A[15,23,25]

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Moderate to severe, following positive response to CBT	Primary care/Secondary care	High	Maintenance – CBT following CBT ▪ Reduced change of relapse ▪ Reduced work and social improvement	A[33]
Severe	Primary care/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[1,6,17,18,20,23] 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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Post Traumatic Stress Disorder

PTSD in Children and Young People (2021)

Prevalence

In the UK, in a recent study[1], just over 30% of young people experienced trauma and 7·8% developed post traumatic stress disorder (PTSD) by the age of 18 years. There is a greater likelihood of PTSD and Complex PTSD (CPTSD)[2] in 'at risk' child populations, i.e., those who have experienced adverse childhood experiences (highly stressful, potentially traumatic events) such as abuse or neglect[3].

Early identification and assessment

Early identification of symptoms is important in children and young people. Questions about exposure to commonly experienced potentially traumatic events should be included during any mental health assessment of children and young people, with screening for the presence of PTSD symptoms, if confirmed. There are many freely available structured interviews and questionnaires available to assess post-traumatic stress symptoms and PTSD in children and young people. The International Trauma Questionnaire for Children and Adolescents (ITQ-CA)[4,5] is a freely available measure of PTSD and CPTSD symptoms in children and adolescents according to ICD-112 diagnostic criteria. A measure based on the DSM-5[6] diagnostic manual is the Child and Adolescent Trauma Screen (CATS)[7]. Should screening measures be utilised, it is important that when a child or adolescent screens positively for PTSD or CPTSD symptoms, this is used alongside a robust clinical assessment of endorsed difficulties.

Working with families

Assessment of children and adolescents should include assessment of the system in which they live, as their symptoms will both influence and be influenced by what else is happening within the system. It is important to consider whether parent(s)/caregiver(s) are experiencing mental health problems, in particular in instances of shared trauma. There is some evidence that parental distress can negatively impact a child's outcomes in treatment[8,9]. Trauma-focused cognitive behavioural therapy (TF-CBT) was found to be less effective in reducing children's PTSD symptoms when both children's pre-treatment PTSD symptoms and caregivers' depression or unhelpful trauma-related beliefs were more severe[8].

Where assessment involves very young children (0-3 years), this should include an evaluation of the behaviour of the child with particular reference to developmental stage and attachment status. An understanding of attachment theory is important for clinicians. In all children, the range of potential post-traumatic mental health problems includes behavioural and attentional problems as well as problems with anxiety and mood. Interventions for comorbid problems such as depression, anxiety and substance use in children and young people who have experienced trauma are as important as for PTSD/CPTSD[10].

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Parents/caregivers need to be involved to some degree to promote continued engagement in therapy such as ensuring that the rationale for the work and strategies is understood (particularly true in TF-CBT) and to have the opportunity to answer questions. Parents and carers play varied and important roles in therapy, including supporting children and young people to attend the sessions, to help them complete any homework tasks and to be able to 'self-regulate'. They often act as co-therapists in order to support practice tasks (such as exposure hierarchies, behavioural experiments), to support generalising learning and reduce dropout rates[11,12].

Intervention

Interventions need to be tailored to meet the developmental needs of an individual child. There are many well validated protocols developed specifically for children and young people and these should be used in preference to modifying an adult protocol[13]. The developmental stage and capabilities of the child should be kept in mind - chronological age does not necessarily equate to levels of cognitive functioning and developmental mastery. Even children as young as 5 can engage with cognitive therapy given age appropriate material[14] and EMDR may be adapted to match a child or young person's developmental stage, attention span, language abilities, verbal reasoning skills and level of insight.

Matrics Plant (NHS Wales)[15] highlights the importance of utilising creative and developmentally appropriate ways of engaging children and young people, including engagement with adults in the young person's system, as children may be dependent on adults to access and benefit from services.

Preventing PTSD

Currently there is limited research informing early interventions to reduce traumatic stress symptoms in children and young people. In line with the NICE guidelines[16], Matrics Cymru recommends against individual single session psychological debriefing based on two studies[17,18] which did not demonstrate any benefit in the reduction of PTSD symptoms and suggested that the intervention may slow recovery. One RCT[19] identified a significant reduction in developing PTSD with a targeted family psychosocial intervention. Whilst not reaching level B evidence rating, one small pilot study[20] demonstrated that self-directed online psychoeducation involving young people exposed to acute trauma was feasible to deliver and was engaging for children. More research is required to explore the effectiveness and reach of web-based interventions.

There are a number of pragmatic approaches that are likely to be helpful for infants, children and young people after a traumatic event. Key is the presence of a safe, respectful, predictable and regulated adult[21]. Re-establishing routines around mealtimes and sleeping can be reassuring and provide a sense of stability and safety to a young person. Encouraging social connections within family members and the extended family is important, as well as keeping connected to religious communities, school communities and youth groups. It is helpful to adopt an approach of active listening to a child or young person and to value a young person's cultural identity as part of the healing process. A period of "active monitoring" in the first month may

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be appropriate to see if symptoms naturally improve and to allow professionals to target those children and young people with impairing traumatic symptoms to access targeted support[16].

Prevention (0-3 Months Post Trauma)

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	Level of Efficacy/Effect
All levels	Parts 1 & 2	High	Psychosocial intervention: Child and family traumatic stress intervention (CFTSI)[19]	B	Medium

Treating PTSD

There is more evidence for the treatment of PTSD in children and young people than for its prevention, although there is less evidence for children than is available for the treatment of PTSD in adults. There are several effective psychological treatments for PTSD in children and young people, including TF-CBT, cognitive therapy for PTSD (CT-PTSD) and prolonged exposure therapy for adolescents (PE-A).

Although there is a greater weight of grade A evidence supporting TF-CBT as an effective treatment for PTSD in children and young people, EMDR also achieves an A grade level of evidence due to the growing amount of research meeting this standard. NICE guidelines[16] recommend EMDR as a second line intervention for children and young people with PTSD who have not responded to or engaged with TF-CBT. A meta-analysis[22] found TF-CBT marginally more effective in reducing PTSD symptoms post treatment than EMDR and therefore, EMDR is graded as 'medium to high' for efficacy.

There are a number of other therapies with lower strength efficacy that are not included in the table but are of emerging interest. For example, there is insufficient research currently to recommend narrative exposure therapy for children (KIDNET) as an effective therapy for children and young people with PTSD. However, a multi-centre RCT (YOURTREAT)[23] exploring the efficacy of KIDNET as a treatment for young refugees with PTSD versus treatment as usual is underway.

There is also growing evidence to support group-based interventions for young people in the youth justice system (Target-A)[24]. Transdiagnostic or modular approaches that target underlying mechanisms common to different mental health problems is an area of research interest and development.

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Potential targets for intervention in these approaches might include improving social support, or working with maladaptive coping styles, cognitive biases and behavioural avoidance.

Currently, there is a lack of evidence for the treatment of CPTSD in children and young people. It is unclear if specific interventions are required to treat CPTSD as compared with PTSD in children and young people. In the absence of a current evidence base for the treatment of CPTSD, it may be helpful to use the current recommended first line treatments for PTSD, whilst taking into account the disturbances in self-organisation which are a feature of CPTSD. That may result in longer courses of treatment being required[25]. It may be helpful to consider the need for stabilisation work before recommending delivery of a trauma-focused intervention to a child or young person with CPTSD.

Finally, it is important to note that it is beyond the scope of this document to differentiate recommendations around direct psychological therapy provision based on specific age groups, however, consideration should be given to this as evidence continues to emerge.

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Treatment

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence	Level of Efficacy/Effect
Individual intervention					
All levels	Part 1 & 2	High	TF-CBT with child, TF-CBT with child and parent/carer[26,27]	A	High
All levels	Part 1 & 2	High	EMDR[28,29,30]	A	Medium to high
All levels	Part 1 & 2	High	Pre-school TF-CBT	B	Medium
All levels	Part 1 & 2	High	CT-PTSD[31,32]	B	Medium
All levels	Part 1 & 2	High	Prolonged exposure for adolescents (PE-A)[33,34]	B	Medium
Stepped or phased care approach*					
All levels	Part 1 or 2	High	Developmentally adapted version of cognitive processing therapy (D-CPT)[35]	B	High

*Standard care is the reasonable amount of care a person should provide to another. Stepped care is providing the least intrusive and most effective treatment initially, only stepping up to provide more intensive input as clinically needed.

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PTSD in Adults (2021)

The consequences to the individual of exposure to psychologically traumatic events vary widely. For most people 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. Psychological disorders caused, or contributed to, by exposure to traumatic events include PTSD, complex PTSD, depressive disorders, anxiety disorders, substance use disorders, somatic symptom disorders, psychosis and personality disorders. Over 50% of people with PTSD will experience at least one comorbid psychological disorder[1].

Mental health clinicians should routinely explore for trauma history as part of their assessment and consider trauma history in their formulation of a service user's difficulties. A full and comprehensive assessment of mental health needs, undertaken by an individual who has the skills required to do so, is vital in order to determine the nature of an individual's difficulties and needs, an assessment of risk and the co-production of an appropriate management plan.

Preventing PTSD

Currently, there is insufficient evidence to support any single universal intervention (one provided to everyone exposed) to prevent PTSD in the immediate aftermath of a traumatic event[2]. The National Institute for Health and Care Excellence recommends against psychological debriefing but the current evidence for this is not considered strong enough for Matrics Cymru to specifically recommend against its delivery. There is evidence that single session individual debriefing may cause harm to some people[3]; whilst this is not the case for group debriefing, overall there is insufficient evidence to recommend any form of psychological debriefing. It is, therefore, recommended that people involved in traumatic events are offered practical, pragmatic support in an empathic manner.

There is some level B evidence for universal interventions such as single session EMDR, brief dyadic therapy and a self-guided internet-based intervention[2], but the level of efficacy of these interventions is unknown and further evidence would be required before such interventions can be recommended for inclusion in the Matrics Cymru PTSD Prevention Table.

There is better, albeit still limited, evidence for interventions that aim to prevent PTSD by treating early symptoms of PTSD or acute stress disorder. Stepped/Collaborative care involves screening and direct assessment, followed by the provision of flexible and modular interventions (psychological, pharmacological and/or case management) based on an individual's needs[4].

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All people presenting with symptoms within the first few months of traumatic events should be offered an assessment of mental health needs prior to being offered an intervention. A period of "watchful waiting" may be appropriate to see if symptoms naturally improve. All decisions should be co-produced with the affected individual.

Prevention (1-3 Months Post Trauma)

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence	Level of Efficacy/Effect
All levels	Parts 1 & 2	High	Individual CBT with a trauma focus for acute stress disorder and PTSD symptoms	A	Medium
All levels	Parts 1 & 2	High	Stepped/Collaborative care	A	Low
All levels	Parts 1 & 2	High	EMDR for PTSD symptoms	B	Medium

Treating PTSD

There is much better evidence for the treatment of PTSD than its prevention, in terms of both strength of evidence and efficacy[5]. It can be argued that detecting and treating PTSD as early as possible is likely to represent a more clinically and cost-effective use of available resources/services than focusing on prevention. That said, the most effective interventions for the prevention of PTSD are also the most effective interventions for its treatment.

There are a wide range of different interventions that now have enough evidence to be included in the Matrics Cymru Tables with A or B level evidence[5]. In order to be consistent with the aim of Matrics Cymru to focus on interventions with the highest levels of efficacy and the strongest levels of evidence, only those psychological interventions with A strength evidence of a medium or high level of efficacy have been included. There are a number of psychological treatments with lower strength evidence of efficacy that are not included in the Table, such as couples CBT[6] with a trauma focus and reconsolidation of traumatic memories[7].

As highlighted by the Table, five specific individual face to face therapies with a trauma focus have the highest levels of efficacy. Other psychological therapies with a trauma focus, namely narrative exposure therapy and group CBT with a trauma focus, have demonstrated a lower level of efficacy but may still have a role in the treatment of people with PTSD[5]. The same is true for non-trauma-focused CBT and present centred therapy, non-trauma-focused psychological therapies with medium levels of efficacy[5], especially for people with PTSD who are in unstable situations (e.g., ongoing domestic

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violence) that mean trauma-focused work is inappropriate, people with PTSD who do not want to engage in trauma-focused work and those who are unable to tolerate it.

There is also strong evidence of medium efficacy for guided internet-based CBT with a trauma focus for people with mild to moderate PTSD[8]. This provides a flexible, cost-effective alternative approach that has the potential to increase choice for people with PTSD and be provided primarily in Part 1 services as part of a stepped/stratified approach to the treatment of PTSD.

The recommended therapies listed in the Table are indicated for people with PTSD as opposed to complex PTSD, which is now formally recognised as a parallel diagnosis to PTSD in the ICD-11 classification system[9]. With the exception of guided internet-based CBT with a trauma focus, the listed therapies have been shown to be helpful to some people with more complex presentations of PTSD[10,11]. Given the current absence of a formal evidence base for the treatment of complex PTSD[12], the Table should help inform possible treatment approaches for complex PTSD. It is particularly important to consider the need for stabilisation work before recommending delivery of a trauma-focused intervention to someone with complex PTSD. Some people with PTSD may also benefit from emotional stabilisation work before trauma-focused treatment. This and additional considerations, also applies to people with PTSD with significant comorbidity. For example, in the case of comorbid PTSD and substance use disorder, although there is evidence that some individuals may benefit from trauma-focused work, stabilisation of substance use is often required before trauma-focused treatment is likely to be optimally beneficial. It is important to note that the evidence the tables is based on is primarily drawn from studies of working age adults and it is unclear how applicable the evidence is to other groups, for example, older people and people with learning disabilities.

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Treatment

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence	Level of Efficacy/Effect
All levels	Part 1 & 2	High	Cognitive processing therapy, cognitive therapy, EMDR*, individual CBT with a trauma focus (undifferentiated), prolonged exposure	A	High
All levels	Part 1 & 2	High	CBT without a trauma focus, group CBT with a trauma focus, narrative exposure therapy, present centred therapy	A	Medium
Mild to moderate	Part 1	High	Guided internet-based CBT with a trauma focus	A	Medium

* NICE recommend EMDR only after a non-combat-related trauma. A marked difference in response to EMDR in adults exposed to combat-related trauma compared to non-combat-related trauma is not supported by practice-based evidence, but more work is needed and it is important that practitioners and people with PTSD are aware that the current, albeit limited, research evidence suggests that EMDR is not effective for combat-related trauma.

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Complex Traumatic Stress Disorders (Type 2 Trauma) 2017

Courtois and Ford (1) 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 (2). 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 (3, 4). 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 (1). 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 (2). 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	Specialist trauma service	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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Schizophrenia/Psychosis (2017)

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 psychoses[1]. 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 utility[2]. The causes of these conditions remain uncertain, although an integrated socio-developmental-cognitive model is favoured[3].

The onset of the condition is characterised by a prodromal phase typified by a dysphoric state with attenuated or brief psychotic symptoms[4]. Approximately a fifth of those at high risk will transition to psychosis within the first year[5], 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 25[6]. 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 seven 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 suicide[9–14].

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 NICE[15] and SIGN[16]. 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 2009[17] and since then there have been a number additional trials and meta-analysis[18–30] which report on additional studies and the risk of bias and its influence on effect size[31,32].

Reviews of 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[16,18–20,20,23,24]. 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 training[24] and group psychotherapies may improve negative symptoms and social functioning[30]. 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

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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].

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]

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First episode psychosis, relapse or persistent symptoms in psychosis	Secondary care	High	Family intervention for reducing relapse and family burden	A[15,34,35]
			NICE recommended treatments for associated problems such as depression and PTSD	A[15,36,37]
			Reasoning and rehabilitation programmes for verbal aggression and problem-solving in offenders with psychosis	A[43]
			Cognitive remediation within a rehabilitation programme for social functioning and cognitive functioning¥	A[28]
			Formulation based cognitive behaviour therapy for positive symptoms (greater effect for voices compared to delusions) ¥	A[19,20,24]
			For negative symptoms social skills training ¥, and group psychotherapy ¥*	A[24,30]
			Group art psychotherapy	B[46,49]
			Music therapy	A[47,48]
		Low	Mindfulness for positive and negative symptoms¥	A[45] C[44]
			Worry-reduction and sleep improvement cognitive behaviour therapy; progressive relaxation; relapse prevention training; yoga and distraction techniques	A[38–42]
			Early signs of monitoring	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 (2017)

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 sever 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] 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 The National Collaborating Centre for Mental Health (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 (2017)

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence
Mild	Primary care	Low	Group treatment based on BT principles	A[1, 6]
			Exposure-based therapy (BT)	A[4, 5,]
			Manualised self-guided therapy based on behaviour therapy (BT) principles	B[2]
			Supportive counselling	B[4]
Moderate – Severe	Primary care	High	Disorder specific CBT	A[5, 9, 10]
			EMDR	B[3]
			Emotion freedom technique (EFT)	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.

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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 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 (2017)

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 comorbid anxiety and/or depression Stimulants with comorbid 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 comorbid anxiety and/or depression	Primary care/Community	High	CBT	A[1, 2]

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Individuals with comorbid 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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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 comorbid physical health problems.

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 focused upon adults of working age.

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Anxiety disorders in later life (2017)

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]
Comorbid 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 (2017)

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]
Mild 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]
Prevention of relapse in recurrent depression	Primary/Secondary care	High	Mindfulness-based CT	C[5,20]

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Depression with anxiety	All	Low	Group CBT	A[24]
		High	CAT	C[7]

References

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Personality disorder in later life (2017)

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence
Moderate	Secondary care	High	DBT	B[2]
			CAT	C[1]

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Severe and enduring conditions (2017)

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 (2017)

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]
			CBT (person with dementia)	C[2,5,6,7,9]
	Secondary care/Community	High	CBT (depression and distress in caregivers)	A[1,3,4]

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Cognition (and quality of life) (2017)

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]
		Low	Cognitive stimulation therapy (improves cognition and quality of life)	A[1,2,3]
Mild/Moderate	All tiers of care including voluntary settings	Low	Maintenance CST	A[4]

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Living well with dementia (2017)

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	C[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 (2017)

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 (2017)

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]

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Moderate – Severe	Community/Secondary care	High	Behavioural management training to reduce caregivers stress and distress Behaviour management to reduce depression in person with dementia	A[8] B[9]

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Specific interventions in response to stress and distress (2017)

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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