SCOTTISH EXECUTIVE

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Dear Colleague

PSYCHOLOGICAL INTERVENTIONS

The attached document concisely describes the contributions to all fields of healthcare which can be made by various forms of psychological interventions, and for which there is a clear evidence base. It complements the findings of the recently launched SNAP/PHIS report on liaison psychiatry and psychology services.

In the major programmes we are undertaking in cancer and cardiovascular disorder, the ambitions we have for improvement in service delivery and quality of outcome are just not realisable without psychological interventions at a number of points in the patient journey.

There is a strong public preference for psychological interventions being available to complement pharmacological interventions for mental health problems.

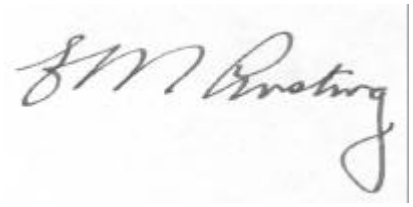
The Health Technology Board for Scotland has reported recently that in the prevention of relapse in alcohol dependence, psychological interventions are clinically and cost effective for all patients once they have undergone detoxification and are newly abstinent. (Recent work sponsored by SE-HD suggests that dealing with health problems arising from alcohol costs NHSScotland at least £96million per year).

NHSScotland faces a major task in helping individuals who are living with the effects of a chronic health problem.

For some disabling conditions such as chronic fatigue syndrome/ME, psychological interventions are one of the few evidence based treatments available.

I commend this report to a wide audience within NHS Scotland.

Yours sincerely



DR E M ARMSTRONG

NHS Education for Scotland

Recent Psychological Research of significance to the delivery of Healthcare in Scotland

CMO Psychology Advisory Committee Briefing Paper

April 2003

Further copies of this paper can be obtained from

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BRIEFING PAPER ON RECENT PSYCHOLOGICAL RESEARCH WHICH IS OF SIGNIFICANCE TO DELIVERY OF HEALTHCARE IN SCOTLAND

Foreword by the Chief Medical Officer, Dr Mac Armstrong.

It is a well known axiom that patients have problems, not just diseases. Whether or not there are physical aspects to the problem, such as a cancer, there are always social and psychological aspects too.

In dealing with these problems, I do not believe it is possible to separate those relating to the mind from those relating to the body in the whole care and treatment of patients.

Indeed there are many reasons to suppose that this is highly undesirable.

It is disappointing that the enormous advances made in the treatment of physical health problems has sometimes diverted attention from the equally important advances made through good sound research in the rational treatment of psychological problems.

I hope that in Scotland we are redressing this imbalance.

The inclusion of the responsibility for the training of clinical psychologists within the remit of NHS Education for Scotland, and the proposals for increasing the number of psychologists means that more psychologists will be available when needed to contribute to the management of patient's psychological problems as an integral part of their health care.

These skills are needed in all fields of healthcare.

In the major programmes we are undertaking in cancer and cardiovascular disorder, the ambitions we have for improvement in service delivery and quality of outcome are just not realisable without psychological interventions at a number of points in the patient journey.

The Health Technology Board for Scotland has recently shown that in the prevention of relapse in alcohol dependence, psychological interventions should be available to all patients once they have undergone detoxification and are newly abstinent because they are clinically and cost effective.

In these, as in many other areas, NHS Scotland faces a major task in helping individuals who are living with the effects of a chronic health problem. Here psychology has another key role to play, in supporting patients in controlling their own lives and by providing and supporting interventions which can make a difference to the individual's perception of the situation, and thus of his or her quality of life. For some disabling conditions such as chronic fatigue syndrome/ME, psychological interventions are one of the few evidence based treatments available.

I therefore welcome this briefing paper on recent research in this field. It complements the findings of the recently launched SNAP/PHIS report on liaison psychiatry and psychology services. I commend it to a wide audience within NHS Scotland.

Introduction

Psychologists have long made contributions to the Health Service in terms of clinical interventions and research. Although a very small profession within the Health Service, these contributions have been significant in that they underpin the work of many different services, and not just those provided directly by psychologists.

In the past, the dominant perception has been that psychologists only contribute to mental health care. However, there is evidence of significant contributions within physical health care, and a more appropriate model would be one of psychological health care across the spectrum, important not just for the nature of services delivered to patients (assessments and treatments) but also to the way in which staff deliver these (consultancy and training).

The modern Health Service places great emphasis on evidence-based practice, which has always been integral to the work of psychologists. More recently, standards have been set for services based on research evidence (e.g. SIGN Guidelines) and Clinical Governance has emphasised the importance of good, well-evaluated practice. Various standard-setting bodies have been established, and it is important that these have the benefit of good advice on psychological healthcare, so that it becomes integral to any standards set.

This Briefing Paper contains a digest of some recent work in psychology which indicates contributions across the spectrum of health care. It is by no means exhaustive and does not cover all the areas in which psychologists work.

"Recent Psychological Research of significance to the delivery of Healthcare in Scotland" was compiled on behalf of the CMO Psychology Advisory Committee by Daryl Foot.

(1) Cancer

There is evidence that oncologists can have difficulties in communicating with patients and their relatives which are not resolved by time or experience alone. These difficulties contribute to low levels of recognition of potentially remediable psychological morbidity in cancer patients. A study in which a communication skills training (CST) course was developed and conducted by a psychologist resulted in subjectively reported improvements after the course in many of these areas of difficulty, with improvement maintained at three months. This course has been shown to be effective in shifting doctors' attitudes to be more patient-centred and less disease – or doctor-oriented. Recently published results of a randomised control trial offer more objective evidence of the efficacy of such communication skills training. This study involved 160 oncologists from 34 UK cancer centres. Further research is ongoing to assess long term follow-up.

(2) Heart Disease

Cardiovascular disease is one of the major challenges facing the NHS in Scotland. There is far too much of it, it is not diminishing as fast as elsewhere, and with an ageing population at least one form of CVD, congestive heart failure, is actually becoming more common. The value of cardiac rehabilitation has been recognised almost universally but delivery in Scotland (and the rest of the UK) is patchy and often fails to reach the patients who most need it. A major review has shown that rehabilitation that involves a significant psychological component is effective in improving quality of life and reducing the risk of subsequent heart disease. Psychologists in Scotland (with funding from the Chief Scientists Office) have published research that could be implemented now to improve clinical care. A recent study in St Andrews demonstrated the effectiveness of brief counselling for patients with myocardial infarction and their spouses, reducing anxiety and depression in both, compared with routine care. Elsewhere, a pain and anxiety reduction package has been developed for patients with angina which has been shown to be effective.

It is notable that in both these studies psychologists were involved in the development of the interventions and the training of the therapists, but other professions delivered the therapy. This indicates the high return that can result from employing clinical and health psychologists.

In addition, the recent CHD and Stroke: Strategy for Scotland (2002) highlights the need for a prevention approach in terms of lifestyle change, and the use of Managed Clinical Networks to improve outcomes for those with established CHD.

(3) Cardiac Rehabilitation

As a corollary of the preceding section, attention is drawn to the Scottish Intercollegiate Guidelines Network (SIGN) Guideline 57 on Cardiac Rehabilitation. This emphasises the important role of psychological factors and approaches, and

states that cardiac rehabilitation programmes should include both psychological and educational interventions as part of comprehensive rehabilitation. It also recommends that patients with moderate to severe psychological difficulties should be treated by staff with specialist training in techniques such as cognitive behavioural therapy. A recent meta-analysis indicates that rehab programmes including psychological and/or educational components, resulted in 34% decrease in mortality and 29% reduction in recurrence of MI over 1-10 year follow-up. A CSO funded project produced the Heart Manual which was based on modifying health beliefs and lifestyle change following an MI. This *home-based approach* reduced health care usage and improved outcome, and is now in use by approximately 300+ NHS purchasers across the UK. A similar approach is being developed for patients post CABG surgery and also for angina.

Psychologists have a strong contribution to make in training and supervising other professions in behavioural change which ensures better secondary prevention and basic counselling interventions. Those with moderate to severe psychological difficulties require treatment by staff with specialist training, (see SIGN 57 for evidence review).

(4) Diabetes

Recent Scottish guidelines, such as SIGN (Guideline 55) and the Scottish Diabetes Framework, have highlighted the importance of psychological issues for people with diabetes across the lifespan. Problems range from adjustment to the diagnosis, adherence to insulin therapy, depression, poor self-management, and anxiety disorders. The diagnosis of psychological problems can be complicated by symptom-overlap, with diabetes-related symptoms resembling those of psychological disorders, so specialised assessment is required using appropriate validated psychological tools. The SIGN Guidelines recommend that all people with diabetes should be screened for depression and offered appropriate therapy. Availability of psychologists for these services is patchy, but the need for more active monitoring of psychological well-being is acknowledged. Psychologists are well-placed to provide specialist assessments/screening of psychopathology, draw on a variety of theoretical and treatment models, and can act in a consultancy/training role to share mental health information with other members of the multidisciplinary team.

(5) Chronic Pain

Chronic Pain presents in many ways: as a syndrome; in association with other diagnoses e.g. arthritis, MS, fibromyalgia or after surgery. It is not always possible to identify a clear cause although significant research on neural plasticity has increased understanding of why pain may be present in the absence of findings on investigation. Prevalence is estimated at 10% of the population, a high proportion are aged under 50, remain significantly disabled and high users of the NHS and DSS benefits.

Continuing pain can lead to high levels of depression, emotional distress, loss of physical and social function and reduced quality of life. Inappropriate health beliefs

can lead to anxiety and unhelpful behavioural changes. Therefore psychological treatments play an important role in the treatment and management of chronic pain.

There is clear evidence of effectiveness of a cognitive behavioural model of care. A Meta-analysis and systematic reviews by McQuay (1997) and Morley et al (1999), found cognitive behavioural treatments showed significant effect sizes on pain, coping and function compared with controls. Such treatment is best delivered with psychologists working within a multi-disciplinary Pain Management Programme or as part of a Health psychology service. There are only four within Scotland indicating considerable inequity of access. This is currently being discussed within the Scottish Parliament. There is significant scope for psychologists to work in training other professionals e.g. physiotherapists, in use of cognitive-behavioural approaches to pain.

(6) Children & Adolescents

A recent advice pamphlet called "Drawing on the Evidence" has been produced by the British Psychological Society (BPS) and the Centre for Outcomes Research and Evaluation (CORE). This provides guidance on effective psychological approaches and is based on a comprehensive review of the evidence commissioned by the National Health Service Executive (NHSE). It provides advice about evidence-based psychological treatments for a range of problems and disorders, e.g. conduct, attention, anxiety, depression, psychosis, eating, self-harm, as well as coping with chronic physical illness and disease. Good evidence exists for effective psychological interventions for many of these, particularly those which employ cognitive and behavioural models. Systemic, psychodynamic psychosocial and multi-modal approaches can also have a contribution.

(7) Learning Disabilities

The psychological approach of choice for working with people with intellectual disabilities has traditionally been a behavioural one, focussing on environmental contingencies and their role in maintaining maladaptive behaviour. In particular, these approaches have been used with seriously challenging behaviour.

More recently, regard has also been paid to cognitive aspects such as the pattern of beliefs and thinking styles which can determine emotional well-being. Effective psychological therapies are being developed and evaluated which incorporate the cognitive as well as behavioural theoretical approaches. There is an embryonic literature which provides promising findings about the use of cognitive behavioural approaches for anxiety, depression and interpersonal difficulties in people with learning disabilities. The evolution of psychological work with people with mild to moderate learning disabilities includes active efforts to develop appropriate flexible and conceptually-driven protocols which can be evaluated, and represents a significant development.

(8) Acquired Brain Injury

Over the past two decades there has been increasing emphasis placed on community-based rehabilitation generally and specifically on rehabilitation of problems arising from cognitive impairments and change in personality. These problems are often expressed as chaotic thinking, poor planning and organisation, unreasonable and antisocial behaviour, and are most common in young adults with little physical disability. It is a particular problem in Scotland given the association between the most common causes of traumatic brain injury here (falls and assaults) and alcohol and drug abuse. In the UK, community-based services to treat these problems have largely been set up by clinical psychologists who have specialised in neuropsychology and who tend also to be Directors of these units. The reason for this is the necessary combination of knowledge of neuropsychology, including assessment, and training in models of psychosocial rehabilitation. These bring together both a theory-driven and a practical approach, appropriate for a client group returned to the community and not requiring medical treatment. Research and evaluation are also key components of the neuropsychological approach to acquired brain injury.

(9) Late Life Depression

Meeting the needs of an ageing society is one of the main challenges for Scotland at the beginning of the 21st Century (Wood & Bain, 2001). Depression is generally considered to be the most common psychiatric disorder amongst older adults. Rates of depression in older people vary depending upon the sample considered although levels of depression in community samples are much higher when disability is present. Suicide rates for persons aged 65 years and older are higher than for any other age group, and the suicide rate for persons 85 plus is the highest of all (Beautrais, 2002). It is often presumed that depression is a natural consequence of the losses experienced by older adults in terms of emotional attachments, physical independence and socio-economic hardships. Consequently mental health problems in older people such as depression and anxiety are commonly under-detected and under-treated (Laidlaw et al, 2003a: Laidlaw, 2001).

CBT with its problem-oriented focus upon the symptoms of depression, especially in regard to health-related matters, is particularly relevant for late life depression (Laidlaw et al, 2003a; Morris & Morris, 1991). CBT shows promise as a treatment for depression in Parkinson's disease and in post-stroke depression (Laidlaw et al, 2003a; Laidlaw & Thomson, 1999). CBT has been the most systematically studied psychological treatment for depression in older adults (Karel & Hinrichsen, 2000) and has proven efficacy as a treatment for depression in older people (Laidlaw, 2001; Karel & Hinrichsen 2000; Gatz et al, 1998; Dick et al, 1996; Koder et al, 1996; Scogin & McElreath, 1994). Gatz et al, (1998) report that CBT meets strict American Psychological Association criteria as a probably efficacious treatment. CBT also compares favourably with antidepressant treatment: Gerson et at, (1999) investigated the effectiveness of pharmacological and psychological treatments for depression in older people and concluded "Effective psychological interventions constitute a much-needed addition to antidepressant medication for depressed older patients." In Scotland, psychologists recently reported the outcome of a randomised controlled trial of CBT vs GP usual care for late life depression to the Chief Scientist Office (Laidlaw et al, 2003b). CBT alone in comparison to Treatment as usual in primary care (generally pharmacotherapy) shows promise as an effective treatment alternative to antidepressant medication, as CBT alone demonstrated efficacy as a

treatment for depression. The sample size in this study was too small to produce significant differences between the two treatment alternatives.

(10) Personality Disorder

Individuals with personality disorder are heavy users of mental health services and traditional treatment approaches have had limited success. For people with borderline personality disorder, who tend to have very destructive patterns of behaviour, including repeated self-harm, structured psychological treatments are being developed which appear to be having some success, although studies to date have been limited. Three main approaches have been employed, Dialectical Behaviour Therapy (DBT), psychodynamic psychotherapy, and cognitive behavioural therapy (CBT).

CBT for personality disorder is a structured individual treatment that is problem-focused and less intensive in terms of time than the other two approaches. It has been evaluated in studies which have shown it to be effective in reducing self-harm and self-destructive behaviours in individuals with antisocial and borderline personality disorders, and cost-effective for repeat self-harm. A UK-wide randomised control trial is currently assessing the effectiveness of CBT for borderline personality disorder.

(11) Alcohol Problems

It has been acknowledged that psychological approaches are the most effective treatments for alcohol problems. Treatments that have been shown to be effective are based on principles of social learning theory, working on the premise that drinking behaviour is learned and can be modified using psychological methods of behaviour change.

The recent (HTBS) Health Technology Assessment Advice 3 report (2002) described the following psychosocial interventions as being both clinically and cost effective. These are: Behavioural Self-Control Training, Motivational Enhancement Therapy, Marital/Family Therapy and Coping/Social Skills Training. These treatments have all been developed from psychological theory and research, and the Report recommends that they be offered as treatment options for the prevention of relapse in alcohol dependence. The Report also stated that evidence for effectiveness of pharmacological treatments was obtained from studies in which they were adjunctive to psychosocial interventions. Finally, the Report emphasises the important role of clinical psychologists in delivering a high standard of treatment comparable with the research studied, and in training and supervising others in this field.

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References

(1) Oncology

1. Fallowfield, L., Jenkins, V., Farewell, V., Saul, J., Duffy, A., Eves, R. (2002) Efficacy of a Cancer Research UK communications skills training model for Oncologists: a randomised controlled trial. *Lancet,* 359, 650-656.

2. Jenkins, V., Fallowfield, L. (2002) Can communication skills training alter physicians' beliefs and behaviour in clinics? *J. Clin. Oncology,* 20(3), 765-969.

3. Fallowfield, L., Ratcliffe, D., Jenkins, V., Saul, J. (2001) Psychological morbidity and its recognition by doctors in patients with cancer. *British Journal Cancer*, 84, 1011-1015.

4. Fallowfield, L. J., Lipkin, M., Hall, A. (1998). Teaching senior oncologists communication skills: results from phase I of a comprehensive longitudinal program in the UK. *J. Clin. Oncology,* 16, 1961-1968.

(2) Heart Disease

1. Dusseldorp, E., Van Elderen, T., Maes, S., Meulman, J. and Kraaij, V. (1999). A meta-analysis of psychoeducational programs for coronary heart disease patients. *Health Psychology*, 18, 506-519.

2. Lewin, R. J., Furze, G., Robinson, J., Griffith, K., Wiseman, S., Pye, M., Boyle, R., (2002) A randomised controlled trial of a self-management plan for patients with newly diagnosed angina. *British Journal of General Practitioners,* 52, 194-201.

3. Johnston, M., Foulkes, J., Johnston, D. W., Pollard, B., Gudmundsdottir, H. (1999) The impact on patients and partners of inpatient and extended counselling and rehabilitation: a controlled trial: *Psychosomatic Med.,* 61, 225-233.

(3) Cardiac Rehabilitation

1. "Cardiac Rehabilitation: A national clinical guideline" *Scottish Intercollegiate Guidelines Network*, January 2002, guideline 57.

2. Ladwig, K., Keiser, M., Konig, J., et al, (1991) Affective disorders and survival after acute MI. *Eur Heart, J.,* 12, 959-64

3. Frasure-Smith, N., Lesperance, F., Talajic, (1995) M., Depression and 18 month prognosis after MI, *Circulation*, 91, 999-1005

4. Barefoot, J., Helms, M.J., Mark, D., et al, (1996) Depression and long-term mortality risk in patients with coronary artery disease, *Am J Cardiol,* 78, 613-7

5. Allison, T., Williams, D., Miller, T., et al, (1995) Medical and economic costs of psychological distress in patients with coronary artery disease, *Mayo Clin Proc*, 70, 734-42

6. Frasure-Smith, N., Lesperance, F., Gravel, G., et al, (2000) Depression and health care costs during the first year following MI, *J. Psychosomatic Res.*, 48, 471-8

7. Dusseldorp, E., Van Elderen, T., Maes, S., Meulman, J. and Kraaij, V., (1999) A meta-analysis of psychoeducation programmes for CHD patients, *Health Psychology*, 18, 506-519

8. Lewin, R. J., Furze, G., Robinson, J., Griffith, K., Wiseman, S., Pye, M., Boyle, R., (2002) A randomised controlled trial of a self-management plan for patients with newly diagnosed angina. *British Journal of General Practitioners*, 52, 194-201.

9. Johnston, M., Foulkes, J., Johnston, D. W., Pollard, B., Gudmundsdottir, H. (1999) The impact on patients and partners of inpatient and extended counselling and rehabilitation: a controlled trial: *Psychosomatic Med.*, 61, 225-233.

(4) Diabetes

1. "Management of Diabetes: A national clinical guideline" *Scottish Intercollegiate Guidelines Network*, November 2001, guideline 55.

2. *Scottish Diabetes Framework*, NHS Scotland, April 2002.

(5) Chronic Pain

1. Morley, S., Eccleston, C., and Williams, A., (1999) Systematic review and meta-analysis of RCT trials of cognitive behaviour therapy and behaviour therapy for chronic pain, *Pain*, 80, 1-13.

2. McQuay, H., Moore, A., Eccleston, C., Morley, S., Williams, A., (1997) Systematic review of outpatient services for chronic pain control, *Health Technology Assessment*, vol 1: No. 6.

(6) Children & Adolescents

1. "Drawing on the Evidence: Advice for mental health professionals working with children and adolescents" *British Psychological Society and Centre for Outcomes Research and Evaluation*, February 2002.

(7) Learning Disabilities

1. Benson, B. A., and Ivins, J. (1992). Anger, depression and self-concept in adults with mental retardation. *Journal of Intellectual Disability Research*, 36, 169-175.

2. Dagnam, D., and Sandhu, S. (1999) Social comparison, self-esteem and depression in people with intellectual disability. *Journal of Intellectual Disability Research*, 43, 372-379.

3. Jahoda, A., Trower, P., Pert, C., and Finn, D. (2001) Contingent reinforcement or defending the self? A review of evolving models of aggression in people with mild learning disabilities. *British Journal of Medical Psychology*, 74, 305-321.

4. Lindsay, William R., (2002) Research and literature on sex offenders with intellectual and developmental disabilities. *Journal of Intellectual Disability Research*, 46, 74-85.

5. Lindsay, William R., (1999) Cognitive therapy. *The Psychologist*, 12(5), 238-241.

6. Lunsky, Y., Benson, B., A. (2001) Association between perceived social support and strain, and positive and negative outcomes for adults with mild intellectual disability. *Journal of Intellectual Disability Research*, 45, 106-114.

7. Pert, C., Jahoda, A., Squire, J. (1999) Attributions of Intent and Role-Taking: Cognitive Factors as Mediators of Aggression With People Who Have Mental Retardation. *American Journal on Mental Retardation*, 104, 399-409.

8. Prosser, H., (1999) An invisible morbidity? *The Psychologist*, 12(5), 234-237.

9. Taylor, J. L., (2002) A review of the assessment and treatment of anger and aggression in offenders with intellectual disability. *Journal of Intellectual Disability Research*, 46, 57-73.

(8) Acquired Brain Injury

1. McMillan, T. M., Oddy, M. (2001) Service Provision for Social Disability and Handicap After Brain Injury. In: RLI Wood, TM McMillan, *Neuro-behavioural Disability and Social Handicap Following Traumatic Brain Injury*. Psychology Press, Hove, 12, 257-273.

2. Wilson, B. A., (2002) Towards a comprehensive model of cognitive rehabilitation. *Neuropsychological rehabilitation*, 12, 97-110.

(9) Late Life Depression

Beautrais, A. (2002) A case control study of suicide and attempted suicide in older adults. *Suicide & Life Threatending Behaviour*, 32, 1-9.

Dick, L. P., Gallagher-Thompson, D., & Thompson, L. W. (1996) Cognitive-Behavioural Therapy, in Woods, R. T. (ed) *Handbook of the Clinical Psychology of Ageing*, Chichester: John Wiley & Sons.

Gatz, M., Fiske, A., Fox, L. S., Kaskie, B., Kasl-Godley, J. E., McCallum, T. J., & Wetherell, J. L. (1998) Empirically validated psychological treatments for older adults, *Journal of Mental Health and Ageing*, 4, 9.46.

Gerson, S., Belin, T. R., Kaufman, M. S., Mintz, J., & Jarvik, L. (1999) Pharmacological and psychological treatments for depressed older patients: a meta-analysis and overview of recent finding. *Harvard Review of Psychiatry*, 7, 1-28.

Karel, M. J., & Hinrichsen, G. (2000) Treatment of depression in late life: Psychotherapeutic interventions. *Clinical Psychology Review*, 20(6), 707-729.

Koder, D. A., Brodaty, H., & Anstey, K. J. (1996) Cognitive therapy for depression in the elderly. *International Journal of Geriatric Psychiatry*, 11, 97-107.

Laidlaw, K. & Thomson, A. S. (1999) Psychological consequences of stroke: The psychological management of depression & anxiety following stroke, paper presented at Stanford University Medical School, Veterans Affairs, Palo Alto Health Care System, California, 7 July 1999.

Laidlaw, K. (2001) An empirical review of cognitive therapy for late life depression: Does research evidence suggest adaptations are necessary for cognitive therapy with older adults*? Clinical Psychology & Psychotherapy,* 8, 1-14.

Laidlaw, K., Thompson, L. W., Dick-Siskin, L., & Gallagher-Tjhompson, D. G. (2003a) *Cognitive Behaviour Therapy with Older People*, Chichester: John Wiley & Sons.

Laidlaw, K., Davidson, K., Toner, H., Jackson, G. & Clark, S. (2003b) Chief Scientist Final Report: A Randomised Controlled Trial of Cognitive Behaviour Therapy versus Treatment as Usual in the Treatment of Mild to Moderate Late Life Depression. K/OPR/2/2D367.

Morris, R. G., & Morris, L. W. (1991) Cognitive and Behavioural Approaches with the Depressed Elderly. *International Journal of Geriatric Psychiatry*, 6, 407-413.

Scogin, F. & McElreath, L. (1994) Efficacy of Psychosocial Treatments for Geriatric Depression: A quantitative review. *Journal of Consulting and Clinical Psychology*, 62, 69-74.

Wood, R. & Bain, M. (2001) *The Health and Well-Being of Older People in Scotland: Insight from National Data.* Edinburgh: Information & Statistics Division, NHS Scotland.

(10) Personality Disorders

1. Skodol, AE., Buckley, P., Charles, E. (1983) is there a characteristic pattern to the treatment history of clinical outpatients with borderline personality disorder? *Journal of Nervous and Mental Diseases*, 171, 405-410.

2. Waldinger, R. J. and Gunderson, J. G. (1984) Completed psychotherapies with borderline patients. *American Journal of Psychotherapy*, 38(2), 190-202.

3. Linehan, M. M., Armstrong, H. E., Suarez, A., Allmon, D., Heard, H. L. (1991) Cognitive behavioural treatment for chronically parasuicidal borderline patients. *Archives of General Psychiatry,* 48, 1060-1065.

4. Linehan, M. M., Heard, H. L., Armstrong, H. E. (1993) Naturalistic follow-up of a behavioural treatment for chronically parasuicidal borderline patients. *Archives of General Psychiatry,* 50, 971-974.

5. Bateman, A. and Fonagy, P. (1999) Effectiveness of partial hospitalisation in the treatment of borderline personality disorder: a randomised controlled trial. *American Journal of Psychiatry,* 156, 1563-1569.

6. Bateman, A. W. and Fonagy, P. (2001) Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalisation: an 18 month follow-up. *American Journal of Psychiatry,* 158, 36-42.

7. Davidson K. M. and Tyrer P. (1996) Cognitive therapy for antisocial and borderline personality disorders: single case series. *British Journal of Clinical Psychology,* 35, 413-429.

8. Evans, K., Tyrer P., Catalan, J., Schmidt, U., Davidson, K., Dent, J., Tata, P., Thornton, S., Barber, J., Thompson, S. (1999) Manual-assisted cognitive-behaviour therapy (MACT): a randomised controlled trial of a brief intervention with bibliotherapy in the treatment of recurrent deliberate self-harm. *Psychological Medicine,* 29, 10-19.

9. Byford, S., Jones, V., Ukoumunne O. C. et al., Cost-effectiveness of brief cognitive behaviour therapy versus treatment as usual in recurrent deliberate self harm: the POPMACT study. (submitted)

(11) Alcohol

1. Bandura, A., (1986). Social Foundations of Thought and Action: A Social Cognitive Theory. *Englewood Cliffs, N. J.: Prentice-Hall.*

2. *Health Technology Board for Scotland* (HTBS), December 2002. Health Technology Assessment Advice 3: Prevention of relapse in alcohol dependence, HTBS, Glasgow.

3. Raistrick, D., and Heather, N., (1998). Review of the effectiveness of Treatment for Alcohol Problems. Final Draft (Unpublished).