

Cognitive behavioural therapy for children and adolescents

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Purpose of review

The aim is to summarize recent evidence from the National Institute for Health and Clinical Excellence clinical guidelines and high-quality systematic reviews for the use of cognitive behavioural therapy to treat children and adolescents with mental health problems.

Recent findings

Data from meta-analyses of randomized controlled trials suggest that the best evidence for the potential of cognitive behavioural therapy is in the treatment of children and adolescents with generalized anxiety disorder, depression, obsessive compulsive disorder and posttraumatic stress disorder. More limited evidence suggests that attention deficit hyperactivity disorder and behavioural problems may also respond to cognitive behavioural therapy. We found no or insufficient evidence to determine whether cognitive behavioural therapy is useful for the treatment of antisocial behaviour, psychotic and related disorders, eating disorders, substance misuse and self-harm behaviour.

Summary

Clinical guidelines and recent systematic reviews establish that cognitive behavioural therapy has a potentially important role in improving the mental health of children and adolescents.

Keywords

adolescents, children, cognitive behavioural therapy

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Introduction

The National Institute for Health and Clinical Excellence (NICE) guideline on Depression in Children and Young People [1] recommended that pharmacological approaches should not be the first-line approach to the treatment of depression in this age group. Instead, the guideline recommends the initial use of psychosocial interventions, including cognitive behavioural therapy (CBT), for all severities of depression. If a child or adolescent with mild to moderate depression is unresponsive to a specific psychological intervention after four to six sessions, the addition of fluoxetine should be considered. The combination of CBT and fluoxetine appears to reduce the increased risk of self-harm associated with the use of this (and other selective serotonin reuptake inhibitors; SSRIs) for depressed children and adolescents. This is the first major national guideline in the UK on the treatment of depression in children and young people.

Prior to the publication of the Childhood Depression Guideline, it became apparent that the published evidence upon which most guidelines are based was overly

positive, an effect resulting from the failure by the pharmaceutical industry to publish or make available data from the more negative trials [2]. The systematic review of the published and unpublished trials of SSRIs in the treatment of depression in children and young people by Whittington *et al.* [2] showed the powerful impact upon clinical decision making and guideline development of selective publishing by the pharmaceutical industry. (This paper was awarded the ‘Lancet Paper of the Year Award’ for 2004.) This finding of selective publishing of trials by the pharmaceutical industry has been recently confirmed in two publications looking at comparable data sets in adults [3^{**},4^{*}]. Importantly, the meta-analysis of the full data set of randomized controlled trials (RCTs) submitted to the Medicines and Healthcare products Regulatory Agency (MHRA) on the use of SSRIs in childhood depression revealed that the balance of benefit and harm only favoured the use of fluoxetine [5].

In this context, it is particularly important to examine alternatives to pharmacological treatment, particularly among children, given the adverse reactions often associated with the treatment of this age group with drugs such

as SSRIs, and the unknown longer term effects of these and other medicines used in the treatment of a wide range of mental health problems in children and young people.

This article therefore undertakes a narrative synthesis of systematic reviews addressing the use of CBT in the treatment of a range of child and adolescent mental health problems. In particular, we focus on depression, anxiety, externalizing disorders, disorders with psychotic symptoms and other disorders. Where NICE guidelines have been developed, systematic reviews (including meta-analyses) from these are used, and wherever possible confirmed by additional independent systematic reviews conducted since publication of the guideline. Where no guideline has been developed, other systematic reviews are used. We have limited this synthesis to systematic reviews so as to examine only the most reliable evidence currently available. The outcomes highlighted are those that provide relatively clear evidence of potential benefit (or not) for CBT in the treatment of children and young people with mental health problems.

Recent evidence for the use of cognitive behavioural therapy

The following narrative describes recent relevant systematic reviews retrieved from searches as described, either to update those undertaken for NICE guidelines or to fill in the gaps where guidelines have not been completed.

Depression

The NICE guideline for depression in children and young people [1] included evidence from a systematic search of CENTRAL, EMBASE, MEDLINE, and PsycINFO (to January 2004) and hand searches of relevant journals and the reference lists of previous reviews and studies. Five studies were included in the review of individual CBT compared with control (waitlist, nondirective supportive therapy, clinical management or another active treatment) in 9-year-olds to 18-year-olds ($n=501$), and eight trials of group CBT compared with control (no treatment, waitlist control, 'standard care' or another active treatment) in 9-year-olds to 18-year-olds ($n=548$). The data presented in the guideline suggest that the best evidence was for group CBT (8–16 sessions of 40–60 min duration for 5–8 weeks). At posttreatment, in three trials of adolescents, 50% of those receiving CBT no longer met DSM criteria for major depression compared with 36% of those receiving no treatment/waitlist [NNT = 7.1, 95% confidence interval (CI), 3.7–100].

Subsequently, Watanabe *et al.* [6^{*}] published a meta-analysis of psychotherapies for depression in children and

adolescents in comparison with no treatment, waitlist controls, attention placebos, and treatment as usual. Their search covered CENTRAL, CINAHL, EMBASE, LILACS, MEDLINE, PsycINFO, and PSYINDEX (to December 2004), and hand searches of relevant journals and the reference lists of previous reviews and studies. The review included 25 comparisons of CBT and two of other psychotherapies involving children and adolescents (aged 6–18 years; $n=1744$). The authors suggest there are significantly improved outcomes with CBT; however, since this meta-analysis included trials that were excluded from the NICE guideline, some with 'non-clinical' populations who may well not have been depressed, we have not included outcomes reported.

Anxiety disorders

The NICE guideline for obsessive compulsive disorder (OCD) [7] included evidence from a systematic search of CENTRAL, EMBASE, MEDLINE, and PsycINFO (November 2003). This is the first comprehensive national guideline developed in the UK examining the evidence base for a number of different treatment modalities. The guideline included one RCT ($n=77$) of children and adolescents with OCD (mean age of 12 years), who were randomized to single family CBT with response prevention (ERP), multifamily CBT with ERP, or a 4–6 week waitlist control condition. The duration of the intervention was 14 weeks, with 3 and 6 months' follow-up. Strong evidence was found for both individual and group CBT when compared with waitlist control in terms of improved OCD symptoms (single family CBT: SMD = -2.73, 95% CI -3.55 to -1.91; multifamily CBT: SMD = -2.54, 95% CI -3.28 to -1.81), with no significant difference between modalities. Based on these results (and another 19 studies, open trials, case series, single case studies and case reports), the guideline suggests that there is evidence for the use of CBT that incorporates ERP in the treatment of OCD in children and young people. Furthermore, outcomes are better when parents are involved in the treatment of their children, especially in CBT protocols incorporating ERP.

In a Cochrane review, O'Kearney *et al.* [8] examined the overall efficacy of CBT or behavioural therapy in children and adolescents with OCD. Their search covered CCDANCTR-Studies and References, EMBASE, MEDLINE, PsycINFO (to August 2005), and hand searches of relevant journals and the reference lists of included studies. The authors identified four RCTs with a total of 222 participants aged 18 years or younger with a diagnosis of OCD. The studies compared standard behavioural and cognitive behavioural techniques, alone or in combination, with waitlist or pill placebo. The authors of the review suggest that the most reliable estimate for the efficacy of behavioural therapy/CBT relative to no treatment came from one RCT [9], which was of higher

quality than the other three trials. It was a small but significant trial that provided strong evidence that CBT/behavioural therapy is an effective treatment for OCD in children and young people. Using a cut-off of more than 10 on the Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS), the study showed that participants who received behavioural therapy/CBT alone ($n=28$) were significantly less likely than those receiving the placebo ($n=28$) to still have OCD posttreatment (61% compared with 96%; NNT = 2.8, 95% CI 1.8–6.3).

James *et al.* [10] authored a Cochrane review of CBT for anxiety disorders in children and adolescents. In this study, the authors provide strong evidence that CBT is a beneficial treatment for children and young people with anxiety disorders by combining results from 13 RCTs in a meta-analysis. Their search process included CENTRAL, EMBASE, MEDLINE, PsycINFO (to January 2004), and hand searches of relevant journals and the reference lists of identified studies. The review included 13 RCTs that aimed to determine whether CBT was an effective treatment for 6-year-olds to 18-year-olds with mild to moderate anxiety disorders [excluding OCD, posttraumatic stress disorder (PTSD) and simple phobia] ($n=498$) in comparison with waitlist or attention controls ($n=311$). The pooled response rate for remission of any anxiety diagnosis was 56% for CBT compared with 28.2% for controls (NNT = 3.0, 95% CI 2.5–4.5). The authors suggest that treatments administered using individual, group and family/parental formats appear to be equally effective.

The NICE guideline for PTSD [11] included evidence from a systematic search of CINAHL, EMBASE, MEDLINE, and PsycINFO (to mid-2004), and hand searches of relevant journals and the reference lists of previous reviews and studies. This national guideline examined a range of treatment options for adults and children with PTSD. Among other effective treatment options, CBT had evidence to support its use, although this evidence is more limited in children and young people than in adults. Seven studies were included in the review of CBT compared with controls (waitlist, nondirective supportive therapy, community care or another active treatment) in 2-year-olds to 16-year-olds ($n=658$). In one trial ($n=67$) of CBT for children under 7 years old and their parents/carers, there was evidence that, when compared with supportive therapy, CBT reduces the severity of externalizing behaviours (SMD = -0.79 , 95% CI -1.29 to -0.28). There was also limited evidence from two trials ($n=212$) suggesting that CBT for children over 7 years old and their parents/carers, when compared with supportive therapy, reduces the severity of PTSD symptoms (SMD = -0.55 , 95% CI -0.83 to -0.28). There was also some evidence that CBT was better than community care and waitlist control at reducing PTSD symptoms.

In a Cochrane review of CBT for children and adolescents who have been sexually abused, Macdonald *et al.* [12] reviewed trials identified by searching CENTRAL, CINAHL, EMBASE, LILACS, MEDLINE, PsycINFO, SIGLE and the register of the Cochrane Developmental, Psychosocial and Learning Problems Group (to November 2005), as well as checking the reference lists of previous reviews and studies. Ten trials involving 847 children and adolescents (aged 2–17 years) were included in the review. The results of the meta-analysis showed that when CBT was compared with waitlist/nondirective supportive therapy, it produced benefits in terms of posttraumatic stress (SMD = -0.43 , 95% CI -0.69 to -0.16) and anxiety (SMD = -0.21 , 95% CI -0.40 to -0.02), which was sustained at a follow-up of at least 1 year. However, there were no statistically significant differences between the CBT and the control group with regard to depression, sexualized behaviour and externalizing behaviour. Overall, there is enough evidence to suggest that CBT in this context, perhaps directed at posttraumatic phenomena, particularly anxiety, would be worth further consideration and research.

Externalizing disorders (attention deficit hyperactivity disorder, antisocial behaviour and behavioural problems)

NICE has recently published a consultation version of a clinical guideline on pharmacological and psychological interventions for attention deficit hyperactivity disorder (ADHD) in children, young people and adults [13]. The draft guideline includes evidence from a systematic search of CENTRAL, CINAHL, EMBASE, ERIC, MEDLINE, and PsycINFO (to December 2007), and the reference lists of included studies. Ten trials met the eligibility criteria, providing data on 549 participants. Of these, four RCTs assessed parent training interventions, two involving parents of preschool-aged children, and two involving parents of school-age children with ADHD, where the mean age of the child was less than 8 years. A further six RCTs were reviewed that examined interventions involving either just the child (two RCTs) or both the child and the family, where the mean age of the child was 8 or 9. For school-age children, CBT/social skills training interventions consisted of between eight and 12 sessions lasting 50–90 min for children and eight sessions lasting 50–120 min for parents, and were delivered by specifically trained facilitators. The evidence reported suggests that CBT interventions can have beneficial effects delivered in the absence of medication or as an adjunct to continued routine medication for children with ADHD. For example, in the two trials ($n=76$) where participants were not receiving ADHD medication, parent-rated core ADHD symptoms at end of treatment favoured the psychological intervention over the control (SMD = -0.87 , 95% CI -1.35 to -0.39). The draft guideline specifies that these findings come from

RCTs evaluating the effects of CBT for children; therefore the conclusions do not necessarily apply to adolescent populations with ADHD.

In 2007, Armelius and Andreasson [14] conducted a Cochrane review looking at the use of various forms of CBT as an intervention for antisocial behaviour in young people in residential settings. Their search process included CENTRAL, Dissertation Abstracts International, ERIC, MEDLINE, and Sociological Abstracts (to May 2005). The review included 12 studies (five of which were RCTs) of CBT compared with a control condition (typically treatment as usual) in young people aged 12–22 years. The pooled estimate from 10 studies ($n = 4441$) was not clinically significantly in favour of CBT in terms of recidivism at 12 months' follow-up (37% compared with 41%; NNT = 25, 95% CI 14.3–100); moreover, the difference between CBT and control also failed to reach statistical significance at 6 or 24 months.

A Cochrane review conducted by Montgomery *et al.* [15] looked at the use of media-based CBT for behavioural problems in children. In this review, the treatment modality was of a behavioural or cognitive behavioural nature and could be delivered by book, video, audiotape or computer (including internet-based packages). The search process included Biosis, CENTRAL, CINAHL, EMBASE, MEDLINE, PsycINFO and Sociofile (to August 2005). Eleven RCTs (including quasi-randomized trials) with 943 participants aged 2–15 years with a wide variety of diagnoses (behavioural problems, learning disabilities, conduct disorder, ADHD and sleep problems) were included. Overall, the most robust evidence for improved behaviour with a media-based intervention came from the parent-rated Eyberg Child Behavior Inventory (intensity subscale) for which data from five trials ($n = 285$) could be pooled (mother rated: SMD = -0.67 , 95% CI -1.36 to -0.42). Interestingly, significant improvements were made with the addition of up to 2 hours of a therapist's time.

Disorders with psychotic symptoms

There is a paucity of research examining the efficacy of CBT in children and adolescents with bipolar disorder, schizophrenia or related psychoses. The NICE guideline on bipolar disorder [16] failed to identify any formal evaluation of psychological interventions for children or adolescents, and the schizophrenia guideline had a lower age limit for intervention studies of 18 years [17]. Moreover, we found no other systematic reviews that examined the use of CBT in children or adolescents with psychotic symptoms.

Other disorders

The NICE guideline for Eating Disorders [18] included evidence from a systematic search of CENTRAL,

CINAHL, EMBASE, MEDLINE, and PsycINFO (to December 2002), and hand searches of relevant journals and the reference lists of previous reviews and studies. Although the guideline applies to adults, adolescents and children aged 8 years and older, there were no suitable RCTs identified that only included children; most excluded participants younger than 18 years old (a few studies did not report exclusion criteria, but mean age was always over 20).

More recently, two reviews have examined the evidence for the treatment of bulimia nervosa [19] and anorexia nervosa [20]. However, no studies were identified (in searches to August 2005) that specifically examined these interventions in children or adolescents.

Recent epidemiological studies have shown an increase of prevalence in substance misuse among young people [21]. The NICE guidelines on psychosocial interventions for drug misuse [22] included evidence from a systematic search of CENTRAL, CINAHL, EMBASE, HMC, MEDLINE, and PsycINFO (to May 2006), and hand searches of relevant journals and the reference lists of previous reviews and studies. The systematic search identified three RCTs of CBT compared with family and social-systems interventions in 458 participants aged 13–18 years with a DSM-IV diagnosis of cannabis misuse or dependence. The evidence suggested there was little difference between interventions in terms of the number incarcerated, hospitalized or with significant substance misuse problems at endpoint (relative risk = 0.97, 95% CI 0.88–1.07).

Finally, the NICE guideline on the management of self-harm [23] gives special consideration to children (aged over 8 years) and adolescents who self-harm. Following a systematic search of CENTRAL, CINAHL, EMBASE, MEDLINE, and PsycINFO (to December 2002), only two RCTs were included that compared CBT with treatment as usual. However, the meta-analysis included other problem-solving type therapies and the trials did not specifically examine the efficacy of CBT for children or adolescents. The guideline recommends that, for young people who have self-harmed repeatedly, developmental group psychotherapy should be offered.

Conclusion

From this narrative synthesis of systematic reviews, some undertaken for the development of NICE guidelines and others developed separately, it appears that the best evidence for the potential of CBT in children and adolescents is in the treatment of generalized anxiety disorder. Not only does the treatment have a very positive effect but the evidence upon which this is based is comparatively robust. Our review also suggests that

CBT has a similarly positive effect in other anxiety disorders (OCD and PTSD), although the number and size of trials are fewer and smaller, respectively. These findings have further confirmation in independent systematic reviews. Nevertheless, some of the trials included in these systematic reviews compare the active treatment with treatment as usual rather than an alternative form of therapy (such as supportive psychotherapy) – a weaker test of efficacy.

There appears to be moderately good evidence that CBT is effective in the treatment of depression in children and young people, although the evidence upon which this is based is also moderate, in particular that controls are a mixture of waiting lists, nondirective supportive therapy, clinical management or other active treatment. Independent review also confirms this finding.

There is some evidence supporting the use of behavioural and cognitive behavioural approaches to the treatment of children with ADHD, although the best evidence is for preschool children. The evidence to support the potential for media-based CBT for general behavioural problems in children and young people is also moderately good. However, the evidence is inconclusive as to whether CBT has a role in the treatment of anti-social behaviour or drug misuse. There is no evidence from systematic reviews or RCTs regarding the use of CBT in the treatment of psychosis and related disorders, eating disorders, or in the treatment of self-harm among children and adolescents.

In conclusion, on the basis of meta-analysis and systematic reviews undertaken mainly during the development of NICE guidelines, current evidence suggests that CBT has significant potential in the treatment of a number of mental health problems in children and adolescents. The best evidence for the effectiveness of CBT appears to be for emotional disorders, especially those characterized by anxiety, but also for depression. Involving the parents of children with some externalizing disorders, most notably ADHD, appears to be a beneficial strategy, especially for preschool-aged children.

The evidence upon which much of these systematic reviews are based (for example, in terms of the samples recruited, the extent to which they reflect clinical populations, and high attrition rates) is, nevertheless, limited. Moreover, many trials have relatively short follow-up periods and a number use outcome measures that are too varied to meta-analyse. Also, a number of these meta-analyses included a mixture of comparators, including waitlist controls, supportive psychotherapy and treatment as usual. Stronger tests should compare CBT with other active psychological treatments. In addition, the relative use of cognitive and behavioural components for differ-

ent age groups could be specified more clearly, especially in the treatment of externalizing disorders.

Nevertheless, in the light of the uncertainty surrounding pharmacological treatments resulting from selective publication of industry-sponsored trials, and the consequently disappointing results surrounding the use of SSRIs in children and young people for many, but not necessarily all, purposes, it is important that this modest but important evidence base for the use of cognitive behavioural psychological treatment should be extended by further primary and secondary research.

References and recommended reading

Papers of particular interest, published within the annual period of review, have been highlighted as:

- of special interest
- of outstanding interest

Additional references related to this topic can also be found in the Current World Literature section in this issue (pp. 423–424).

- 1 National Collaborating Centre for Mental Health. Depression in children and young people: identification and management in primary, community and secondary care. London: The British Psychological Society and Gaskell; 2005.
 - 2 Whittington CJ, Kendall T, Fonagy P, *et al.* Selective serotonin reuptake inhibitors in childhood depression: systematic review of published versus unpublished data. *Lancet* 2004; 363:1341–1345.
 - 3 Turner EH, Matthews AM, Linardatos E, *et al.* Selective publication of anti-depressant trials and its influence on apparent efficacy. *N Engl J Med* 2008; 358:252–260.
- This paper confirmed the impact of selective publication of trials by the drug industry, in this case upon the apparent clinical effectiveness of SSRIs in adults with depression. The review examined trials submitted to the Food and Drug Administration (FDA) for licensing and obtained under the Freedom of Information Act in the USA. On meta-analysis, the published trials were significantly more positive with regard to efficacy than the published and unpublished ones combined.
- 4 Kirsch I, Deacon BJ, Huedo-Medina TB, *et al.* Initial severity and antidepressant benefits: a meta-analysis of data submitted to the Food and Drug Administration. *PLoS Med* 2008; 5:e45.
- Kirsch *et al.* undertook a similar study to Turner *et al.* [3**] using many of the same trials obtained through the Freedom of Information Act in the USA from the FDA. Whereas the FDA accepted small but statistically significant changes on depression rating scales as evidence of efficacy, the authors asked whether these changes would reach the level of clinical significance used in the development of the NICE guideline for different levels of depression at initial presentation when compared with placebo. Placebo effects, which appear to be larger for lower levels of depression at presentation, appear to minimize differences with the treatment groups except for those with the most severe depressions.
- 5 Whittington C, Kendall T, Pilling S. Are the SSRIs and atypical antidepressants safe and effective for children and adolescents? *Curr Opin Psychiatry* 2005; 18:21–25.
 - 6 Watanabe N, Hunot V, Omori IM, *et al.* Psychotherapy for depression among children and adolescents: A systematic review. *Acta Psychiatr Scand* 2007; 116:84–95.
- An important meta-analysis including large numbers of children and young people providing confirmation that CBT is a useful treatment approach for depression, especially among adolescent groups.
- 7 National Collaborating Centre for Mental Health. Obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder. London: Gaskell and the British Psychological Society; 2005.
 - 8 O'Keamey RT, Anstey KJ, von Sanden C. Behavioural and cognitive behavioural therapy for obsessive compulsive disorder in children and adolescents. *Cochrane Database Syst Rev* 2006; (4):CD004856.
 - 9 The Pediatric OCD Treatment Study (POTS) Team. Cognitive-behavioral therapy, sertraline, and their combination for children and adolescents with obsessive-compulsive disorder. *JAMA* 2004; 292:1969–1976.
 - 10 James A, Soler A, Weatherall R. Cognitive behavioural therapy for anxiety disorders in children and adolescents. *Cochrane Database Syst Rev* 2005; (4):CD004690.

- 11 National Collaborating Centre for Mental Health. Post-traumatic stress disorder: The management of PTSD in adults and children in primary and secondary care. London: Gaskell and the British Psychological Society; 2005.
- 12 Macdonald GM, Higgins JPT, Ramchandani P. Cognitive-behavioural interventions for children who have been sexually abused. *Cochrane Database Syst Rev* 2006; (4):CD001930.
- 13 National Collaborating Centre for Mental Health. Attention deficit hyperactivity disorder: diagnosis and management of ADHD in children, young people and adults. Draft for consultation. <http://www.nice.org.uk>.
- 14 Armelius B, Andreassen TH. Cognitive-behavioral treatment for antisocial behavior in youth in residential treatment. *Cochrane Database Syst Rev* 2007; (4):CD005650.
- 15 Montgomery P, Bjornstad G, Dennis J. Media-based behavioural treatments for behavioural problems in children. *Cochrane Database Syst Rev* 2006; (1):CD002206.
- 16 National Collaborating Centre for Mental Health. Bipolar disorder: the management of bipolar disorder in adults, children and adolescents, in primary and secondary care. London: The British Psychological Society and Gaskell; 2006.
- 17 Kendall TJG, Pilling S, Barnes TRE, *et al.* Schizophrenia: Full national clinical guideline on core interventions in primary and secondary care. London: Gaskell; 2003.
- 18 Gowers S, Pilling S, Treasure J, *et al.* Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. Leicester: The British Psychological Society and Gaskell; 2004.
- 19 Shapiro JR, Berkman ND, Brownley KA. Bulimia nervosa treatment: a systematic review of randomized controlled trials. *Int J Eat Disord* 2007; 40:321–336.
- 20 Bulik CM, Berkman ND, Brownley KA, *et al.* Anorexia nervosa treatment: a systematic review of randomized controlled trials. *Int J Eat Disord* 2007; 40:310–320.
- 21 Hibell B, Andersson B, Bjarnason T, *et al.* The ESPAD report 2003. Alcohol and other drug use among students in 35 European countries. Stockholm: The Swedish Council of Information on Alcohol and Other Drugs (CAN) and the Pompidou Group at the Council of Europe; 2004.
- 22 National Collaborating Centre for Mental Health. Drug misuse: psychosocial interventions. London: The British Psychological Society and Gaskell; 2007.
- 23 National Collaborating Centre for Mental Health. Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. London: The British Psychological Society and Gaskell; 2004.