

References

References are graded A-C, I-V, as discussed in the Introduction and in the key on page 15.

1 Birchwood M. Early intervention in schizophrenia: theoretical background and clinical strategies. *Br J Clin Psychol* 1992; 31: 257–278. (BIV)

For more information about the early detection of psychosis, see the Early Psychosis Prevention and Intervention Centre (EPPIC). *The Early Psychosis Training Pack*. Cheshire: Gardiner-Caldwell Communications, 1997. Tel: 0393 422800.

2 World Health Organization. *Schizophrenia: An International Follow-up Study*. Chichester: Wiley, 1979. (AIV)

Large outcome study with a 2-year follow-up that showed that only 10–15% of patients did not recover from their illness in that 2 years. Another, shorter-term follow-up study showed 83% of first-episode psychotic patients treated with antipsychotic medication remitting by 1 year post-inpatient admission. Lieberman J, Jody D, Geisler S *et al*. Time course and biologic correlates of treatment response in first episode schizophrenia. *Arch Gen Psychiatry* 1993; 50: 369–376.

3 Kavanagh DJ. Recent developments in expressed emotion and schizophrenia. *Br J Psychiatry* 1992; 160: 601–620. (AIII)

Family support and education, which promotes a more supportive family environment, can reduce relapse rates substantially.

4 Driver and Vehicle Licensing Agency. *At a Glance Guide to Medical Aspects of Fitness to Drive*. Swansea: DVLA, 1998.

Further information is available from: Senior Medical Adviser, DVLA, Driver Medical Unit, Longview Road, Morriston, Swansea SA99 1TU.

5a Mental Health Commission. *Early Intervention in Psychosis: Guidance Note*. Wellington: Mental Health Commission, 1999.

b Falloon I, Coverdale J, Laidlaw T *et al*. Family management in the prevention of morbidity of schizophrenia: social outcome of a two-year longitudinal study. *Psychol Med* 1998; 17: 59–66.

Involvement of the family is vital. Education is important for engaging individuals and families in treatment and promoting recovery. Psychological therapies may be helpful.

6 Atypical antipsychotics appear to be better tolerated, with fewer extrapyramidal side-effects, than typical drugs at therapeutic doses. Even at low doses, extrapyramidal side-effects are commonly experienced with typical drugs. Whether atypicals improve the long-term outcome has yet to be established. Risperidone, amisulpride and possibly olanzapine have a dose-related effect. Selected references (BII):

a American Psychiatric Association. Practice guidelines: schizophrenia. *Am J Psychiatry* 1997; 154(Suppl 4): 1–49.

Reports that 60% of patients receiving acute treatment with typical antipsychotic medication develop significant extrapyramidal side-effects.

b Zimbroff D, Kane J, Tamminga CA. Controlled, dose-response study of sertindole and haloperidol in the treatment of schizophrenia. *Am J Psychiatry* 1997; 154: 782–791.

Haloperidol produced extrapyramidal symptoms at 4 mg day⁻¹.

c Mir S, Taylor D. Issues in schizophrenia. *Pharmaceut J* 1998; 261: 55–58.

Reviews evidence on the efficacy, safety and patient tolerability of atypical antipsychotics.

d Duggan L, Fenton M, Dardennes RM, El-Dosoky A, Indran S. Olanzapine for schizophrenia. Cochrane Library, Oxford 1999. Update software.

e Kennedy E, Song F, Hunter R, Gilbody S. Risperidone versus conventional antipsychotic medication for schizophrenia. Cochrane Library, Oxford 1998, issue 2.

7 People suffering a first episode of psychosis develop side-effects at lower doses of antipsychotic drugs than patients used to these drugs. For patients treated with high-potency typical antipsychotics who are used to the drugs, the mean dose at which extrapyramidal side-effects appear is below the average clinically effective dose. The average clinically effective dose for those suffering a first episode has not yet been established, but clinical practice indicates that it is significantly lower than for patients used to the drugs. Selected references (BIII):

a McEvoy JP, Hogarty GE, Steingard S. Optimal dose of neuroleptic in acute schizophrenia: a controlled study of the neuroleptic threshold and higher haloperidol dose. *Arch Gen Psychiatry* 1991; 48: 739–745.

First-episode patients developed extrapyramidal side-effects at mean doses of haloperidol of 2.1 ± 1.1 mg day⁻¹, whereas 'experienced' patients did so at a mean dose of 4.3 ± 2.4 mg day⁻¹.

b See reference 6a.

The optimal therapeutic dose for most patients appears to be in the range 6–12 mg day⁻¹ haloperidol or equivalent. Evidence on the optimal dose for first-onset patients is not yet clear.

8 Bollini P, Pampallona S, Orza MJ. Antipsychotic drugs: is more worse? A meta-analysis of the published randomized control trials. *Psychol Med* 1994; 24: 307–316. (AI)

For most patients, higher than moderate doses bring increased side-effects but no additional therapeutic gains.

9 Al Dixon LB, Lehman AF, Levine J. Conventional antipsychotic medications for schizophrenia. *Schizophrenia Bull* 1995; 21: 567–577.

Presents overwhelming evidence that continuing maintenance therapy reduces the risk of relapse. It concludes that it is appropriate to taper or discontinue medication within 6 months to 1 year for first-episode patients who experience a full remission of symptoms.

10 Taylor D, McConnell D, Abel K, Kerwin R. *The Bethlem and Maudsley NHS Trust Prescribing Guidelines*. London: Martin Dunitz, 1999.

Available from: Martin Dunitz, 7–9 Pratt Street, London NW1 0AE. Tel: 020 7482 2202. £14.99 + £2.00 postage and packaging.

11 Consensus (BV). As people reacting to stresses such as unemployment or divorce are at a high risk of developing a mental disorder, studies on prevention in high-risk groups may be relevant. These support the offering of social support and problem-solving. NHS Centre for Reviews and Dissemination. Mental health promotion in high-risk groups. *Effect Health Care Bull* 1997; 3: 1–10.

12 Catalan J, Gath D, Edmonds G, Ennis J. The effects of not prescribing anxiolytics in general practice. *Br J Psychiatry* 1984; 144: 593–602.

Demonstrates that general practitioner advice and reassurance is as effective as administration of benzodiazepines. The mean time spent by the general practitioner for advice and reassurance was 12 minutes compared with 10.5 minutes for giving a prescription.

13a Department of Health. *Treatment Choice in Psychological Therapies and Counselling: Evidence Based Clinical Practice Guideline*. London, Department of Health, 2001.

Concludes that there is evidence of the benefit from counselling for mixed anxiety/depression in primary care but not for more severe disorders. The evidence is better for counselling used with specified client groups, eg postnatal mothers, bereaved groups.

b Rowland N, Bower P, Mellor Clark J *et al*. *The Effectiveness and Cost-Effectiveness of Counselling in Primary Care*. Cochrane Library, Oxford 2000.

14 Rosenberg H. Prediction of controlled drinking by alcoholics and problem drinkers. *Psychol Bull* 1993; 113: 129–139. (BII)

Qualitative review of the literature. The successful achievement of controlled drinking is associated with less severe dependence and a belief that controlled drinking is possible.

15 NHS Centre for Reviews and Dissemination. Brief interventions and alcohol use. *Effect Health Care Bull* 1993; 1: 1–12. (AI)

Brief interventions, including assessing drinking and related problems, motivational feedback and advice, are effective. They are most successful for less severely affected patients.

16 McCrady B, Irvine S. Self-help groups. In Hester R, Miller W, Wilmsford N (eds), *Handbook of Alcoholism Treatment Approaches*. New York: Pergamon, 1989. (AIV)

Discusses the characteristics of patients who are good candidates for Alcoholics Anonymous (AA). Several studies show AA to be an important support in remaining alcohol-free to patients who are willing to attend.

17 American Psychiatric Association. *Practice Guidelines: Substance Use Disorders*. Washington, DC: APA, 1996. (BIV)

Where patients have mild-to-moderate withdrawal symptoms, general support, reassurance and frequent monitoring are sufficient treatment for two-thirds of them without pharmacological treatment.

18 Duncan D, Taylor D. Chlormethiazole or chlordiazepoxide in alcohol detoxification. *Psychiatr Bull* 1996; 20: 599–601. (AIV)

Describes randomized, controlled trials that show chlordiazepoxide and chlormethiazole to be of equal efficacy, and uncontrolled studies showing that chlormethiazole has generally mild adverse effects, while those of chlordiazepoxide may be very serious.

19 Tallaksen C, Bohmer T, Bell H. Blood and serum thiamin and thiamin phosphate esters concentrations in patients with alcohol dependence syndrome before and after thiamin treatment. *Alcohol Clin Exp Res* 1992; 16: 320–325. (BIV)

20 Kranzler H, Bureson J, Del Boca F *et al*. Bupirone treatment of anxious alcoholics: a placebo-controlled trial. *Arch Gen Psychiatry* 1994; 51: 720–731. (BII)

21 Department of Health, Scottish Office, Welsh Office, DHSS Northern Ireland. *Drug Misuse and Dependence — Guidelines on Clinical Management*, 1999. Stationery Office, London

22 *Brief Interventions Guidelines*. London: Alcohol Concern, 1997.

Available from Alcohol Concern, Waterbridge House, 32–36 Loman Street, London SE1 0EE. Tel: 020 7928 7377.

23 Holder H, Longabaugh R, Miller W, Rubonis A. The cost effectiveness of treatment for alcoholism: a first approximation. *J Stud Alcohol* 1991; 52: 517–540. (AI)

Treatments aim to improve self-control and social skills, eg relationship skills, assertiveness and drink refusal.

24 Hunt G, Azrin N. A community reinforcement approach to alcoholism. *Behav Res Ther* 1973; 11: 91–104. (AI)

This approach uses behavioural principles and includes training in job-finding, support in developing alcohol-free social and recreational activities, and an alcohol-free social club.

25 Ideally a modified form of motivational interviewing that takes account of the additional problems of a patient with a severe mental illness will be used. Drake RE, McFadden C, Mueser K, McHugo GJ, Bond R. Review of integrated mental health and substance abuse treatments for patients with dual disorders. *Schiz Bull* 1998; 24: 589–608; Bellack AS, Diclemente CC. Treating substance abuse among patients with schizophrenia. *Psychiat Serv* 1999; 50: (1), 75–80.

26 Raphael B. Preventive intervention with the recently bereaved. *Arch Gen Psychiatry* 1977; 34: 1450–1454. (BIII)

Demonstrates that 'high-risk' bereaved people who receive counselling have fewer symptoms of lasting anxiety and tension than those who do not.

- 27 Murray Parkes C, Laungani P, Young B (eds), *Death and Bereavement Across Cultures*. London: Routledge, 1997. (AV)
- 28 Manic Depression Fellowship, *Inside Out: A Guide to Self-Management of Manic Depression*. London: MDF, 1995. (BV)
Available from: Manic Depression Fellowship, 8–10 High Street, Kingston-upon-Thames, London KT1 1EY. The advice in this book comes from the shared experience of people with manic depression who have tried these techniques.
- 29 ChouJC-Y. Recent advances in treatment of acute mania. *J Clin Psychopharm* 1991; 11: 3–21. (BII)
The author concludes that antipsychotics are effective in mania and they appear to have a more rapid effect than lithium.
- 30 Rifkin A, Doddi S, Karajgi B *et al*. Dosage of haloperidol for mania. *Br J Psych* 1994; 165: 113–116. (BII)
Concludes that doses of haloperidol > 10 mg day⁻¹ in the management of mania confer no benefit.
- 31 American Psychiatric Association. *Practice Guidelines: Bipolar Disorder*. Washington, DC: APA, 1996. (AII)
Reviews four randomized control trials that show that benzodiazepines are effective in place of or in conjunction with a neuroleptic in sedating acutely agitated, manic patients.
- 32a Cookson J. Lithium: balancing risks and benefits. *Br J Psychiatry* 1997; 171: 113–119. (BIII)
b Dali I. Mania. *Lancet* 1997; 349: 1157–1160.
c Bowden C, Brugger A, Swann A *et al*. Efficacy of divolproex versus lithium and placebo in the treatment of mania. The Depakote Mania Study Group. *J Am Med Assoc* 1994; 271: 918–924.
- 33 Zornberg G, Pope H Jr. Treatment of depression in bipolar disorder: new directions for research. *J Clin Psychopharmacol* 1993; 13: 397–408. (BIII)
Review of nine controlled studies shows a high response rate to lithium for acute bipolar depression. A response may take 6–8 weeks to become evident, however.
- 34a Goodwin G. Lithium revisited: a re-examination of the placebo-controlled trials of lithium prophylaxis in manic-depressive disorder. *Br J Psychiatry* 1995; 167: 573–574. (BIII)
Trials show the prophylactic use of lithium to be effective, although most trials had methodological flaws.
b Berghofer A, Kossmann B, Muller-Oerlinghausen B. Course of illness and pattern of recurrence in patients with affective disorders during long-term lithium prophylaxis: a retrospective analysis over 15 years. *Acta Psychiatr Scand* 1996; 93: 349–354.
The prophylactic effect of lithium can be maintained over at least 10 years.
- 35 See reference 31.
The upper limits of the therapeutic range for lithium is 1.0 meq l⁻¹. However, although the efficacy of lithium at 0.6–0.8 meq l⁻¹ has not been formally studied, this is the range commonly chosen by patients and their doctors as giving the best balance between effectiveness and side-effects.
- 36 Schou M. Effects of long-term lithium treatment on kidney function: an overview. *J Psychiatry Res* 1988; 22: 287–296.
Qualitative literature review.
- 37 Suppes T, Baldessanni RJ, Faedda GL. Risk of recurrence following discontinuation of lithium treatment in bipolar disorder. *Arch Gen Psych* 1991; 48: 1082–1088. (AIII)
- 38 Sachs G, Lafer B, Stoll A *et al*. A double-blind trial of bupropion versus desipramine for bipolar depression. *J Clin Psychiatry* 1994; 55: 391–393. (CII)
Preliminary evidence.
- 39 Reid S, Chalder T, Cleare A, Hotopf M, Wessely S. Chronic fatigue syndrome. In *Clinical Evidence*. London: Br Med J Publications, 1999: 397–405. (BV)
- 40 Joyce J, Hotopf M, Wessely S. The prognosis of chronic fatigue and chronic fatigue syndrome: a systematic review. *Quart J Med* 1997; 90: 223–233. (BIV)
- 41 Price JR, Couper J. Cognitive behaviour therapy for CFS. Cochrane Library, Oxford 1998, issue 4. (AI)
- 42 Fulcher KY, White PD. A randomised controlled trial of graded exercise therapy in patients with the chronic fatigue syndrome. *Br Med J* 1997; 314: 1647–1652. (AII)
- 43 See reference 39. (BIII)
- 44 Carette S, Bell MJ, Reynolds WJ *et al*. Comparison of amitriptyline, cyclobenzaprine, and placebo in the treatment of fibromyalgia. *Arthritis Rheum* 1994; 37: 32–40. (CII)
- 45 Hannonen P, Maliniemi K, Yli-Kerttula U *et al*. A randomised double-blind placebo controlled study of moclobemide and amitriptyline in the treatment of fibromyalgia in females without psychiatric disorder. *Br J Rheumatol* 1998; 37: 1279–1286. (CII)
- 46 Greden JF. Anxiety or caffeineism: a diagnosis dilemma. *Am J Psychiatry* 1974; 131: 1089–1092. (AV)
- 47 Wallin M, Rissanen A. Food and mood: relationship between food, serotonin and affective disorders. *Acta Psychiatr Scand* 1994; 377(Suppl): 36–40. (CV)

Quoted in *Guidelines for the Treatment and Management of Depression by Primary Health Care Professionals*. Wellington: National Health Committee of New Zealand, 1996.

48 Hawton K, Kirk J. Problem-solving. In Hawton K, Salkovskis PM, Kirk J, Clark DM (eds), *Cognitive Therapy for Psychiatric Problems: A Practical Guide*. Oxford: Oxford University Press, 1989. (AII)

49 Glenister D. Exercise and mental health: a review. *J Roy Soc Health* 1996; February: 7–13. (BIII)

50 McCann L, Holmes D. Influence of aerobic exercise on depression. *J Personal Social Psychol* 1984; 46: 1142–1147. (BIII)

Quoted in *Mental Health Promotion: A Quality Framework* London: Health Education Authority, 1997.

51 Consensus, plus some, usually small, trials. For example, Donnan P, Hutchinson A, Paxton R *et al*. Self-help materials for anxiety: a randomised controlled trial in general practice. *Br J Gen Pract* 1990; 40: 498–501. (BV)

An audiotape and a booklet are given to patients with chronic anxiety. Intervention led to reduced scores for depression, as well as for anxiety.

52 The differences in outcome between the active drug and the placebo are less in primary-care depressions than among more severe cases. *Depression in Primary Care*. Clinical Practice Guideline Number 5. US Department of Health Human Services, Agency for Health Care Policy and Research, 1993; *Treatment of Major Depression*. AHCPR Publication 93-0551.

Fluoxetine does not produce better outcomes than tricyclic drugs in general primary-care depression; Simon G, VonKorff M, Heiligenstein J *et al*. Initial antidepressant choice in primary care: effectiveness and cost of fluoxetine versus tricyclic antidepressants. *J Am Med Assoc* 1996; 275: 1897–1902.

Paroxetine and citalopram are both licensed for panic as well as for depression, so they may be useful where panic symptoms are prominent. Both selective serotonin re-uptake inhibitors (SSRI) and tricyclic antidepressants (TCA) may initially worsen anxiety and panic symptoms, so they should be introduced at low doses and slowly increased.

53a Linde K, Mulrow CD. St John's Wort for depression. Cochrane Library, Oxford 1999; issue 1. (AI)

b Philip M, Kohnen R, Hiller K-O. Hypericum extract versus imipramine or placebo in patients with moderate depression: randomized, multi-centre study of treatment for 8 weeks. *Br Med J* 1999; 319: 1534–1539.

54 Thiede HM, Walper A. Inhibition of MAO and CoMT by *Hypericum* extracts and hypericin. *J Geriatr Psychiatr Neurol* 1994; 7(Suppl 1): S54–S56.

55 Interactions with tyramine-containing foods (eg beans, some cheeses, yeast, Bovril, bananas, pickled herrings) are theoretically possible. However, there is to date an absence of spontaneous reports of these problems occurring.

56 Breckenbridge A. *Important Interactions between St John's Wort (Hypericum perforata) Preparations and Prescribed Medicines*. Committee for Safety of Medicines, 29 February 2000.

Letter advises that *Hypericum* reduces the therapeutic effect of indinavir, warfarin, cyclosporin, oral contraceptives, digoxin and theophylline, and may reduce the effect of other drugs — except topical medicines with limited systemic absorption and non-psychotropic medicines excreted renally. Adverse reactions may occur if combined with triptans (used to treat migraine) or selective serotonin reuptake inhibitor (SSRI) antidepressants.

Information for professionals and the general public is available on the Medicines Control Agency website: URL: <http://www.open.gov.uk/mca/mcahome.htm> or Tel: 020 7273 0000 (health professionals) or NHS Direct: 0845 46 47 (public).

57 McLean J, Pietroni P. Self care — who does best? *Soc Sci Med* 1990; 30: 591–596. (BIII)

Describes a controlled trial of a general practice-based class teaching self-care skills, relaxation, stress management, medication, nutrition and exercise. Significant improvements were maintained after 1 year.

58 Catalan J, Gath DH, Anastasiades P *et al*. Evaluation of a brief psychological treatment for emotional disorders in primary care. *Psychol Med* 1991; 21: 1013–1018. (BII)

Describes a small, randomized controlled trial. Patients receiving problem-solving therapy did significantly better than those receiving routine care. Patients were selected on the basis of higher symptom scores, however. Another group of patients with lower symptom scores who were not treated showed equal improvement to the treated group.

59 Gloaguen V, Cottraux J, Cucherat M *et al*. A meta-analysis of the effects on cognitive therapy in depressed patients. *J Affect Disord* 1998; 49: 59–72. (AI)

Supports cognitive therapy in patients with mild-to-moderate depression.

60 Sheldon T, Freemantle N, House A *et al*. Examining the effectiveness of treatments for depression in general practice. *J Mental Health* 1993; 2: 141–156. (BI)

Review of four randomized controlled trials that concluded that there is some evidence of the effectiveness for cognitive therapy in depression in primary care, but that it is considerably weaker than cognitive therapy in a major depressive disorder in secondary care.

61 Brown S. Excess mortality of schizophrenia: a meta-analysis. *Br J Psychiatry* 1997; 171: 502–508. (AI)

Reports on life expectancy and excess mortality rate, including from physical illnesses, in patients with schizophrenia.

62 Adams CE, Eisenbruch M. Depot versus oral fluphenazine for those with schizophrenia. Cochrane Library, Oxford 1998, issue 2. (AI)

63 Kendrick T, Millar E, Burns T, Ross F. Practice nurse involvement in giving depot neuroleptic injections: development of a patient assessment and monitoring checklist. *Prim Care Psychiatry* 1998; 4: 149–154 (AIV)

Of the 25% of people with schizophrenia who have no specialist contact, many have a practice nurse as their only regular professional contact. The levels of knowledge of schizophrenia and its treatment of those nurses was often no better than that of lay people.

64 Kemp R, Kirov G, Everitt B, David A. A randomised controlled trial of compliance therapy: 18 month follow up. *Br J Psychiatry* 1998; 172: 413–419. (AII)

Patients who received specific counselling about their attitudes towards their illness and drug treatment were five times more likely to take medication without prompting than controls.

65 Mari JJ, Streiner D. Family intervention for people with schizophrenia. Cochrane Library, Oxford 1991, issue 1. (AI)

Families receiving this intervention, which promotes a more supportive family environment, may expect the family member with schizophrenia to relapse less and to be in hospital less.

66 Jones C, Cormac I, Mota J, Campbell C. Cognitive behaviour therapy for schizophrenia. Cochrane Library, Oxford, issue 4, 2001. (AI)

Four small trials show that cognitive-behaviour therapy is associated with substantially reduced risk of relapse.

67 Rabins PV. Psychosocial and management aspects of delirium. *Int Psychoger* 1991; 3: 319–324. (BV)

Reviews 21 papers. The evidence base is very thin.

68 Rummans TA, Evans JM, Krahn LE, Fleming KC. Delirium in elderly patients: evaluation and management. *Mayo Clinic Proc* 1995; 70: 989–998. (BV)

Reviews 55 papers. The evidence base is thin.

69 Eurodem Prevalence Research Group, Hofman PM, Rocca WA, Brayne C *et al*. The prevalence of dementia in Europe: a collaborative study of 1980–1999. *Int J Epidemiol* 1991; 20: 736–748.

70 Ballard C, Grace J, McKeith I *et al*. Neuroleptic sensitivity in dementia with Lewy bodies and Alzheimer's disease. *Lancet* 1998; 351: 1032–1033.

71a Stein K. *Donepezil in the Treatment of Mild to Moderate Dementia of the Alzheimer Type (SDAT)*. Report to the South and West Development and Evaluation Committee (DEC) No. 69, June. Bristol: NHS Executive, 1997.

b Rogers SL, Farlow MR, Doody RS *et al* and Donepezil Study Group. A twenty four week, double blind, placebo-controlled trial of donepezil in patients with Alzheimer's disease. *Neurology* 1998; 50: 136–145.

The limited number of studies available to date show that donepezil produces some improvement in a minority of patients with mild-to-moderate Alzheimer's disease (defined as those with a mini-Mental State Examination score between 10 and 26). There is no evidence to date that donepezil has any effect on the non-cognitive manifestations of Alzheimer's disease.

72 Martinsen E. Physical activity and major depressive disorder: clinical experience. *Acta Psychiatrica Scand* 1994; 377(Suppl): 23–27. (BIV)

Reviews 10 experimental studies that all indicate that aerobic exercise is more effective than no treatment for major depressive disorder.

73 Schuckit M. Alcohol and major depressive disorder: a clinical perspective. *Acta Psychiatrica Scand* 1994; 377: 28–32. (AIV)

74 Schulberg H, Katon W, Simon G, Rush AJ. Best clinical practice: guidelines for managing major depression in primary care. *J Clin Psychiatry* 1999; 60(Suppl 7): 19–24. (BII)

Concludes that recovery rates for an acute episode of major depression in primary care are similar for guideline-driven pharmacotherapy and depression-specific psychotherapies, such as interpersonal therapy and problem-solving treatments. Medication takes 4–6 weeks to show an effect and psychotherapies take 6–8 weeks.

75 Lave J, Frank R, Schulberg H, Kamlet M. Cost-effectiveness of treatments for major depression in primary care practice. *Arch Gen Psychiatry* 1998; 55: 645–651. (BII)

Describes a high-quality randomized controlled trial comparing the standardized treatment by nortriptyline, interpersonal psychotherapy and primary physician's usual care ($n > 90$ for each group) for major depression in primary care. Both standardized therapies were better than usual care, and more expensive. Those taking drugs did slightly better with respect to both quality of life and economic outcomes.

76 Paykel E, Hollyman J, Freeling P, Sedgwick P. Prediction of therapeutic benefit from amitriptyline in mild depression: a general practice, placebo-controlled trial. *J Affective Disord* 1988; 14: 83–95. (BIII)

Antidepressants do not show efficacy in mild acute depression. However, there is some evidence of efficacy in dysthymia (chronic, mild depressive syndrome that has been present for at least 2 years; Lima M, Moncrieff J. A comparison of drugs versus placebo for the treatment of dysthymia: a systematic review. Cochrane Database of Systematic Reviews, Depression, Anxiety and Neurosis Module. Cochrane Library, Oxford 1998, issue 2.

77 NHS Centre for Reviews and Dissemination, University of York. The treatment of depression in primary care. *Effect Health Care* 1993; March: 1–12. (AII)

78 See reference 74.

Another conclusion from this paper is that recent randomized controlled trials conducted in primary care show a 50–60% response rate to all classes of antidepressants in primary-care patients.

79 Prien R, Kupfer D. Continuation drug therapy for major depressive episodes: how long should it be maintained? *Am J Psychiatry* 1986; 143: 18–23. (BII)

Concludes that patients treated for a first episode of uncomplicated depression who respond well to an antidepressant should receive a full therapeutic dose for at least 16–20 weeks after achieving full remission.

80 Reimherr F, Amsterdam J, Quitkin F *et al*. Optimal length of continuation therapy in depression: a prospective assessment during long-term fluoxetine treatment. *Am J Psychiatry* 1998; 155: 1247–1253. (BIII)

- 81 Kupfer D, Frank E, Perel J *et al*. Five-year outcomes for maintenance therapy: possible mechanisms and treatments. *J Clin Psychiatry* 1998; 59: 279–288.
The study was carried out by psychiatric patients. There are no comparable clinical trials of maintenance treatments' efficacy in reducing recurrence of depression in primary care.
- 82 Donaghue J, Taylor D, David M. Sub-optimal use of antidepressants in the treatment of depression. *CNS Drugs* Vol 13(5), May 2000; 365–383. (BIII)
- 83a DeRubeis RJ, Crits-Cristoph P. Empirically supported individual and group psychological treatments for adult mental disorders. *J Consulting Clin Psychol* 1998; 66: 37–52. (BI)
Supports cognitive-behaviour therapy, behaviour therapy and structured problem-solving. The studies reviewed are based in secondary care.
- b Schulberg HC, Bock MR, Madonia MJ *et al*. Treating major depression in primary care practice: eight month clinical outcomes. *Arch Gen Psychiatry* 1996; 53: 913–919. (BII)
Supports interpersonal therapy.
- c Mynors-Wallis LM, Gath DH, Lloyd-Thomas AR, Tomlinson D. Randomised controlled trial comparing problem solving treatment with amitriptyline and placebo for major depression in primary care. *Br Med J* 1995; 310: 441–445. (AII)
Where the therapies have been compared with each other, none appears clearly superior to the others. More variance in outcomes may be due to the strength of the therapeutic relationship rather than to the treatment method used. Problem-solving is the easiest therapy to learn and can be provided by general practitioners and primary-care nurses. Brief cognitive-behaviour therapy is difficult to deliver, even using trained therapists (Scott C, Tacchi M, Jones R, Scott J. Abbreviated cognitive therapy for depression: a pilot study in primary care. *Behav Cogn Psychother* 1994; 22: 96–102), so the time taken is unlikely to be reduced to less than 8–10 hours (Scott J. Editorial: Psychological treatments for depression — an update. *Br J Psychiatry* 1995; 167: 289–292). Evidence for the effectiveness of therapies in depression in primary care tends to be weaker than in major depressive disorder in secondary care.
- 84 Thase M, Greenhouse J, Frank E *et al*. Treatment of major depression with psychotherapy or psychotherapy–pharmacotherapy combinations. *Arch Gen Psychiatry* 1997; 54: 1009–1015.
A Cochrane review on this topic is pending.
- 85 Evans M, Hollins S, De Rubeis R *et al*. Differential relapse following cognitive therapy and pharmacotherapy of depression. *Arch Gen Psychiatry* 1992; 49: 802–808.
- 86 Ostler KJ, Thompson C, Kinmonth ALK *et al*. Influence of socio-economic deprivation on the prevalence and outcome of depression in primary care: The Hampshire Depression Project. *Br J Psychiatry*. Vol 178, 2001, 12–17.
Shows strong link between high indices of deprivation and a poor prognosis for depression in primary care.
- 87 Kaltenbach K, Finnegan L. Children of maternal substance misusers. *Curr Opin Psychiatry* 1997; 10: 220–224.
Most harm caused is indirect, eg via ill-health of the mother, poor antenatal care or cigarette smoking. There is a smaller risk of direct harm caused by heroin — growth retardation — and cocaine and amphetamines.
- 88 Miller W, Rollnick S. *Motivational Interviewing: Preparing People to Change Addictive Behaviour*. New York: Guilford, 1991. (AV)
- 89 Gossop M, Stewart D, Marsden J. *NTORS at One Year: The National Treatment Outcome Research Study. Change in Substance Use, Health and Criminal Behaviour One Year After Intake* London: Department of Health, 1998. (A1)
b Ward J, Mattick R, Hall W. *Maintenance Treatment and Other Opioid Replacement Therapies*. London: Harwood, 1997.
c Carnworth T, Gabbay M, Barnard J. A share of the action: General Practitioner involvement in drug misuse treatment in Greater Manchester Drugs, Education Prevention and Policy Vol 7(3), 2000, 235–250.
- 90 Lader M, Russel J. Guidelines for the prevention and treatment of benzodiazepine dependence: summary of a report from the Mental Health Foundation. *Addiction* 1993; 88: 1707–1708.
- 91 The Task Force to Review Services for Drug Misusers. *Report of an Independent Review of Drug Treatment Services in England*. London: Department of Health, 1995.
- 92 American Psychiatric Association. *Practice Guidelines: Substance Use Disorders*. Washington, DC: APA, 1996. (BII)
Reports a large randomized, controlled trial replicated in a controlled trial comparing drug counselling, drug counselling plus supportive psychotherapy, and drug counselling plus cognitive-behaviour therapy for methadone maintenance patients. Those with moderate-to-high depression or other psychiatric symptoms did better with either therapy in addition to drug counselling. For patients with low levels of psychiatric symptoms, all three treatments were equally effective.
- 93 Khantzian E. The primary care therapist and patient needs in substance abuse treatment. *Am J Drug Alcohol Abuse* 1988; 14: 159–167.
Reviews studies of relapse prevention through, for example, encouraging the improved social and other relationships and activities.
- 94 Department of Health, Scottish Office, Welsh Office and DHSS Northern Ireland. *Drug Misuse and Dependence: Guidelines on Clinical Management*, 1999 Stationery Office, London.
- 95 Although some patients may benefit from maintenance on low doses (eg 10–20 mg day⁻¹), in general, higher doses (> 60 mg day⁻¹, range 60–120, average 70–80) are associated with better outcome; Ball J, Ross A. *The Effectiveness of Methadone Maintenance Treatment*. New York: Springer, 1991 (a prospective cohort study). Doses for stabilization in withdrawal are also often > 60 mg day⁻¹ and are determined by the patient's response based on objective signs of withdrawal. See reference 92.
- 96 Marsch LC. The efficacy of methadone maintenance interventions in reducing illicit opiate use, HIV risk behaviour and criminality: a meta-analysis. *Addiction* 1998; 93: 515–532. (A1)
- 97 Johnson R, Jaffe J, Fudala P. A controlled trial of buprenorphine treatment for opioid dependence. *J Am Med Assoc* 1992; 267: 2750–2755. (CIII)

Additional research is needed, particularly in a UK setting.

98 Bearn J, Gossop M, Strang J. Randomised double-blind comparison of lofexidine and methadone in the in-patient treatment of opiate withdrawal. *Drug Alcohol Depend* 1996; 43: 87–91. (BII)

Concludes that lofexidine is as efficacious as methadone.

99 McLellan AT, Arndt IO, Metzger DS. The effects of psychosocial services in substance abuse treatment. *J Am Med Assoc* 1993; 269: 1953–1959. (BII)

Patients who received employment help, psychiatric care and family therapy had better outcomes than those who received counselling, who in turn had better outcomes than those who received methadone only.

100 Imipramine, desipramine, trazodone and fluoxetine have all shown some efficacy. In the imipramine studies, most patients reduced their symptoms by at least half, and one-third became free of symptoms. Higher doses of fluoxetine are needed than those normally used for treating depression. Several trials of medication may be needed to establish the one most suitable for an individual patient. Fluoxetine is currently the only antidepressant licensed in the UK for bulimia nervosa. Selected references:

a Mitchell J, Raymond N, Specker S. A review of the controlled trials of pharmacotherapy and psychotherapy in the treatment of bulimia nervosa. *Int J Eating Disord* 1993; 15: 229–247. (BIII)

b American Psychiatric Association. *Practice Guidelines: Eating Disorders*. Washington, DC: APA, 1996. B(II)

101 Uncontrolled trials and one small controlled trial have suggested that fluoxetine may help some patients in the weight-maintenance phases, but many patients do not improve with this or any other currently available medication. However, for patients with persistent depression, the use of antidepressants should be considered. Consider medication with fewer cardiovascular side-effects.

Selected references:

a See reference 101b. (AIII)

b Leach A. The psychopharmacotherapy of eating disorders. *Psychiatr Annals* 1995; 25: 628–633.

c Kaye W, Gendall K, Strober M. Serotonin neuronal function and selective serotonin re-uptake inhibitor treatment in anorexia and bulimia nervosa. *Biol Psychiatry* 1998; 44: 825–838. (CIII)

102 Russell GFM, Szmukler GI, Dare C, Eisler I. An evaluation of family therapy in anorexia nervosa and bulimia nervosa. *Arch Gen Psychiatry* 1987; 44: 1047–1056. (CIII)

Shows that patients with anorexia nervosa with onset at or before age 18, and with a duration less than 3 years, did better with family therapy than individual therapy. Moreover, older patients did better with individual therapy. However, a major UK review, while supporting these recommendations, states that there are currently no high-quality reviews of psychological treatments for anorexia nervosa (see reference 59).

103 Whitbread J, McGown A. The treatment of bulimia nervosa: what is effective? A meta-analysis. *Int J Clin Psychol* 1994; 21: 32–44. (BI)

A Cochrane review is currently in progress.

104 Treasure J, Schmidt U, Troop N *et al*. First step in managing bulimia nervosa: controlled trial of a therapeutic manual. *Br Med J* 1994; 308: 686–689. (BIII)

105 Shear K, Schulberg H. Anxiety disorders in primary care. *Bull Menninger Clinic* 1995; 59(2, Suppl A): 73–82. (BI)

Reviews studies of the provision of psycho-education and minimal interventions in primary care. Observations suggests that they show considerable promise as first-line interventions for anxiety disorders in primary care; however, more severely ill patients will require more sophisticated intervention.

106 See reference 12. (BII)

107a Gould RA, Otto MW, Pollack MH, Yap L. Cognitive behavioural and pharmacological treatment of generalised anxiety disorder: a preliminary meta-analysis. *Behaviour Ther* 1997; 28: 285–305. (BI)

Revealed the highest effect sizes for diazepam. Buspirone had a much lower effect size than either benzodiazepines or antidepressants, and its onset is slow (up to 4 weeks). However, problems with dependence and withdrawal are minimal compared with benzodiazepines.

b Lader MH, Bond AJ. Interaction of pharmacological and psychological treatments of anxiety. *Br J Psychiatry* 1998; 173(Suppl 34): 165–168.

Firm conclusions are not possible. Observations suggest using benzodiazepines for treating anxiety initially, as these produce rapid symptomatic improvement; then psychological treatments can take over.

108 Imipramine and paroxetine have both been shown to reduce anxiety symptoms in the short-term. Onset is slower than benzodiazepines but addiction is not a problem. Relapse rates following longer-term use are not known. Selected references (BII):

a Kahn R, McNair D, Lipman R *et al*. Imipramine and chlordiazepoxide in depressive and anxiety disorders II. Efficacy in anxious out-patients. *Arch Gen Psychiatry* 1986; 43: 79–85.

b Rocca P, Fonzo V, Scotta M *et al*. Paroxetine efficacy in the treatment of generalised anxiety disorder. *Acta Psychiatr Scand* 1997; 95: 444–450.

109 Tyrer P. Use of beta blocking drugs in psychiatry and neurology. *Drugs* 1980; 20: 300–308.

110 Gould RA, Otto MW, Pollack MH, Yap L. Cognitive behavioural and pharmacological treatment of generalised anxiety disorder: a preliminary meta-analysis. *Behaviour Ther* 1997; 28: 285–305. (BI)

Cognitive-behavioural therapy (CBT) and anxiety management were the most efficacious of psychological treatments. Medication and psychological therapies were equally efficacious in the short-term. Gains of CBT and anxiety management were maintained at 6 months.

- 111 Kupshik G, Fisher C. Assisted bibliotherapy: effective, efficient treatment for moderate anxiety problems. *Br J Gen Pract* 1999; 49: 47–48. (BIII)
Learning self-help skills through reading, supported by contact with a clinician, led to a significant improvement of symptoms. Greater numbers improved with a greater amount of clinician contact, especially patients with fewer educational achievements.
- 112 See reference 57. (BIII)
- 113 Swinson RP, Soulios C, Cox BJ, Kuch K. Brief treatment of emergency-room patients with panic attacks. *Am J Psychiatry* 1992; 149: 944–946. (BIII)
People presenting to A&E with panic provided with psycho-education and exposure instructions had a significantly better outcome than controls.
- 114 American Psychiatric Association. Practice guideline for the treatment of patients with panic disorder. *Am J Psychiatry* 1998; 155(Suppl): 1–26. (AII)
Concludes that tricyclic antidepressants (TCAs), selective serotonin re-uptake inhibitors (SSRIs), monoamine oxidase inhibitors (MAOIs) and benzodiazepines have roughly comparable efficacy in the short-term. Benzodiazepines are useful in the very short-term in situations where very rapid control of symptoms is critical. TCA side-effects may be problematic. Short-term use of medication commonly results in relapse, so longer-term use is recommended — 2–18 months — after which period the relapse rate is not known.
- 115 Benzodiazepines are effective in many cases in suppressing panic in the short-term. They are not an effective treatment for chronic panics or phobias as there is no evidence that gains made continue when drugs are withdrawn; there is some evidence that they do not. Where patients are undergoing exposure therapy, ie dealing with the fear by gradually facing it, there is some evidence that benzodiazepines may actually interfere with maintaining longer-term therapeutic gains. Selected references (BII):
- a American Psychiatric Association. Practice guideline for the treatment of patients with panic disorder. *Am J Psychiatry* 1998; 155(Suppl): 1–26.
- b Marks I, Swinson P, Basoglu M *et al*. Alprazolam and exposure alone and combined in panic disorder with agoraphobia. A controlled study in London and Toronto. *Br J Psychiatry* 1993; 162: 776–787.
- 116 See reference 13a.
Conclude that 85% of chronic patients stay well between the 1- and 2-year follow-up when treated using cognitive-behaviour therapy.
- 117 Marks I, Swinson RP. Alprazolam and exposure for panic disorder with agoraphobia; summary of London/Toronto results. *J Psychiatric Res* 1990; 24: 100–101. (AII)
Where agoraphobic fear and avoidance is present, with panic, exposure — a behavioural treatment — proved twice as effective as alprazolam.
- 118 Wade WA, Treat TA, Stuart GL. Transporting an empirically supported treatment for panic disorder to a service clinic setting: a benchmarking strategy. *J Consult Clin Psychol* 1998; 66: 231–239. (CIII)
- 119 Dolan B, Coid J. Psychopathic and antisocial personality disorders: treatment and research issues. London: Gaskell/Royal College of Psychiatrists, 1993, pp. 116–119.
- 120 Hawton K, Arensman E, Townsend E *et al*. Deliberate self harm: systematic review of efficacy of psychosocial and pharmacological treatments in preventing repetition. *Br Med J* 1998; 317: 441–447.
- 121 Coccaro EF, Kavoussi RJ. Fluoxetine and impulsive aggressive behaviour in personality-disordered subjects. *Arch Gen Psychiatry* 1997; 54: 1081–1088.
- 122 Greenberg WM. Sedative or antimanic effects of carbamazepine and treatment of behavioural dyscontrol. *Am J Psychiatry* 1986; 143: 1486–1487.
- 123 Stermac L. Anger control treatment for forensic patients. *J Interpersonal Violence* 1986; 1: 446–722.
- 124 Fleming G, Pretzer JL. Cognitive-behavioural approaches to personality disorders. In Hersen M, Eisler M, Miller PM (eds), *Progress in Behaviour Modification*, vol. 26. Beverly Hills: Sage, 1990, pp. 119–151; Appleby L, Joseph P. Management of personality disorder. *Int Rev Psychiatry* 1991; 3: 59–70.
- 125 Linehan MM, Heard HL, Armstrong He. Interpersonal outcome of cognitive-behavioural treatment for chronically suicidal borderline patients. *Am J Psychiatry* 1994; 151: 1771–1776.
- 126 Murray B, Stein M, Michael R *et al*. Paroxetine treatment of generalized social phobia (social anxiety disorder): a randomised controlled trial. *J Am Med Assoc* 1998; 280: 8. (CII)
Symptoms improved in short-term, ie 11-week trial. However, relapse rates are very high after discontinuation, and relapse rates after longer-term treatment are not known; Stein MB, Chartier MJ, Hazen AI *et al*. Paroxetine in the treatment of generalised social phobia: open-label treatment and double-blind, placebo-controlled discontinuation. *J Clin Psychopharmacol* 1996; 16: 218–222.
- 127 DeRubeis RJ, Crits-Cristoph P. Empirically supported individual and group psychological treatments for adult mental disorders. *J Consult Clin Psychol* 1998; 66: 37–52. (AII)
Exposure with cognitive therapy shows efficacy for social phobia; exposure with cognitive-behaviour therapy shows efficacy for agoraphobia. Efficacy of exposure behaviour therapy has proven twice that of alprazolam for agoraphobic fear and avoidance. See reference 118.
- 128 Fichtner C, Poddig B, deVito R. Post-traumatic stress disorder: pathophysiological aspects and pharmacological approaches to treatment. *CNS Drugs* 1997; 8: 293–322. (CII)

Research base is limited. There is evidence of only limited efficacy for a wide range of drugs. Fluoxetine is the most widely studied selective serotonin reuptake inhibitor (SSRI). Phenelzine appears more effective than tricyclic antidepressants (TCAs) for re-experiencing symptoms. The most studied TCAs were imipramine and amitriptyline.

129 See reference 13a.

Concludes that the impact of psychological treatment on the primary symptoms of post-traumatic stress disorder (PTSD) may be limited, but it may reduce symptoms of depression and anxiety. The best evidence of efficacy is for exposure and other cognitive-behavioural methods.

130 Foa EB, Meadows EA. Psychosocial treatments for post-traumatic stress disorder: a critical review. *Ann Rev Psychology* 1997; 48: 449–480. (BII)

Shows that exposure — a behavioural treatment — and supportive counselling are equally effective at the end of treatment, but exposure is superior after 3 months.

131 Boolell M, Gepi-Atee S, Gingell C, Allen MK. Sildenafil: a novel effective oral therapy for male erectile dysfunction. *Br J Urol* 1996; 78: 257–261. (AII)

132 Padma-Natham H, Hellstrom WJG, Kaiser RE *et al.* Treatment of men with erectile dysfunction with transurethral alprostadil. *New Engl J Med* 1997; 336: 1–7. (AII)

133 Linet OI, Ogrine FG. Efficacy and safety of intracavernosal alprostadil in men with erectile dysfunction. *New Engl J Med* 1996; 334: 873–877. (AII)

134 McClusky HY, Milby JB, Switzer PK *et al.* Efficacy of behavioural versus triazolam treatment in persistent sleep-onset insomnia. *Am J Psychiatry* 1991; 148: 121–126. (BVplus)

This small trial found that triazolam had an immediate effect on persistent insomnia, and behavioural treatment took 3 weeks to have an equivalent effect. Behavioural treatment is more effective at 1-month follow-up.

135 Eisen J, MacFarlane J, Shapiro C. Psychotropic drugs and sleep. *Br Med J* 1993; 306: 1331–1334.

136 Rasmussen P. A role of phytotherapy in the treatment of benzodiazepines and opiate drug withdrawal. *Eur J Herbal Med* 1997; 3: 11–21 (CIV); as quoted in Wallcraft J. *Healing Minds: A Report on Current Research, Policy and Practice Concerning the Use of Complementary and Alternative Therapies for a Wide Range of Mental Health Problems*. London: Mental Health Foundation, 1998.

Refers to trials — some in animals — showing that valerian can improve the quality of sleep and without a hangover effect the next day. No studies of the long-term safety of valerian have been reported. The effect on sleep is weak.

137 Bootzin R, Perlis M. Non-pharmacological treatments of insomnia. *J Clin Psychiatry* 1992; 53(6 Suppl): 37–40.

This review found that sleep hygiene training during individual counselling and stimulus control instructions was more effective than relaxation training.

138 World Health Organization. *Insomnia: Behavioural and Cognitive Interventions*. Geneva: Division of Mental Health, WHO, 1993.

139 Goldberg R, Dennis H, Novack M, Gask L. The recognition and management of somatization: what is needed in primary care training. *Psychosomatics* 1992; 33: 55–61. (BV)

140 Smith GR, Rost K, Kashner M. A trial of the effect of a standardised psychiatric consultation on health outcomes and costs in somatising patients. *Arch Gen Psych* 1995; 52: 238–243. (BII)

141 Fishbain DA, Cutler RB, Rosomoff HL, Rosomoff RS. Do antidepressants have an analgesic effect in psychogenic pain and somatoform pain disorder? A meta-analysis. *Psychosom Med* 1998; 60: 503–509. (B1)

142 Pilowsky I, Barrow C. A controlled study of psychotherapy and amitriptyline used individually and in combination in the treatment of chronic intractable psychogenic pain. *Pain* 1990; 40: 3–19. (CIII)

143a Speckens A, van Hemert A, Spinhoven P *et al.* Cognitive behavioural therapy for medically unexplained physical symptoms: a randomized controlled trial. *Br Med J* 1995; 311: 1328–1332. (BII)

Six to 16 sessions of cognitive-behaviour therapy were conducted in medical out-patients. Intervention was effective and acceptable to patients, and gains were maintained at the 12-month follow-up.

b Kashner TM, Rost K, Cohen B *et al.* Enhancing the health of somatization disorder patients: effectiveness of short-term group therapy. *Psychosomatics* 1995; 36: 924–932. (BII)

Random controlled trial of 70 patients in primary care who were offered eight sessions of group therapy. Improvements, both physical and emotional, were maintained at 1 year.

c Guthrie E. Emotional disorder in chronic illness: psychotherapeutic interventions. *Br J Psychiatry* 1996; 168: 265–273.

This review includes eight studies of somatic presentation of psychological problems. Two studies show cognitive-behaviour therapy to be effective in atypical chest pain and functional dyspepsia, and hypnosis to be effective in two studies for irritable bowel syndrome. Compliance is poor, however. Patients with a long history of symptoms and marked abnormal illness behaviour are unlikely to respond to a brief intervention.