
PP Plan of session

Common anxiety symptoms
Main types of anxiety
Social costs: Case example
Epidemiology of anxiety
Summary of CBT effectiveness
Measuring costs and benefits
Results of cost-benefit studies
Delivering the therapy: UK Government pilot studies

PP

Anxiety: Common symptoms

Psychological
Tension, Worry, Panic, Feelings of unreality, Fear of going crazy, Fear of dying, Fear of losing control

Physical
Trembling, Sweating, Heart pounding, Light-headedness, Dizziness, Muscle tension, Nausea, Breathlessness, Numbness, Stomach pains, Tingling sensation

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Common forms of anxiety

Generalized anxiety disorder:
Persistent /excessive worry plus physical symptoms

Panic disorder:
Sudden intense fear plus physical and psychological symptoms

Social phobia:
Fear / avoidance of social situations fear of being criticised plus
physical and psychological symptoms

Agoraphobia

Fear / avoidance of situations where escape is difficult, going to unfamiliar places alone, plus physical and psychological symptoms

There is no doubt that anxiety disorders can have a crippling effect on a person’s life, affecting all aspects of it. But it is also clear that there is a continuum from normal everyday anxiety and simple fears to severe clinical disorders. We can often overcome everyday anxieties by ourselves - for example, when I first started as a University lecturer I became very anxious at first but then it got easier. But anyone who performs in public is likely to experience some anxiety - even professional actors. However, the more severe anxieties can persist for a lifetime unchanged. When a person starts to avoid their anxiety instead of confronting it, anxiety can become a lifelong habit. This is different from depression which, in most cases, goes away within 6 to 18 months.

However, the fact that many anxiety problems are learned is also an advantage – what is learned can be unlearned – and we are now at the stage when we can say that many people are simply suffering unnecessarily. Effective techniques are available but people are not receiving them because of a lack of resources. There is also a great deal that can be done through national self-help organisations of the kind that Enrico Rolla has set up in Italy. I’ll say more about this later.

Here is just one example of the social costs of anxiety taken from my own caseload of clients. She is an attractive, intelligent, witty, person whose life has been totally ruined by social anxiety. She now has very low self-esteem but I believe that if her anxiety problem had been properly treated when it started at the age of 20 she would have saved herself the last 19 years of misery.

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Single female age 39

Brought up in Middle class family with a father who was socially avoidant and critical, otherwise no adverse life circumstances.

Age 20, panic attack while eating at table with a family where she was staying (Client studying at college of music for a degree at the time)

Severe fear of blushing and intense social anxiety.

Various ineffectual therapies. Lived in a psychiatric hostel (not working) for 6 years.

Eventually managed a part-time job, poorly-paid, teaching music to young children. (She can relate to young children without anxiety)

Unable to enter café or restaurant or club
Difficulty eating with even close friends at their home
Unable to perform part of her teaching duties (introducing children’s end of year music concert) unless heavily sedated with valium.
Avoids entering the staff room at her school
Difficult to talk to teachers and parents at her school.
Very difficult to meet unfamiliar adults, especially in groups.
Extremely restricted social life, no intimate relationships for many years
Epidemiology

At present, five European countries have been involved in a random survey of their populations, to find out about their mental health. The Countries are Belgium, France, Germany, Italy, the Netherlands, and Spain.

It has involved a Survey of 21,425 householders

Here are some figures from the results.

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ESEMeD Project 2004 (European Study of the Epidemiology of Mental Disorders).

64/ 1000 Have actually consulted formal Mental Health Services in the previous 12 months

(Service = psychiatric diagnosis, pharmacotherapy, psychological therapy, etc)

Of the total assessed as having a mental health disorder in the previous 12 months:

Depressive mood disorder: 36.5% Consulted services

Anxiety disorder: 26.1% Consulted services

As you can see from these figures, only about a quarter of the people who are assessed as having an anxiety problem are being actively treated.

Here are the results of a similar survey in the UK

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Random survey of private households in UK.

Symptoms in previous week:

164/ 1000 Any “neurotic disorder” (16.4%)
88/ 1000 Mixed anxiety/depression
44/ 1000 Generalised anxiety
32/ 1000 Other anxiety, including Panic Disorder, Phobias

So these figures show that 16% of the population have some kind of neurotic disorder.
Most surveys like this one, show that anxiety problems are much more common than depression.

The current situation, then, is that, on the one hand, many people have an anxiety problem that could be helped with CBT but, for various reasons, only a minority are being treated. On the other hand, there are studies showing the effectiveness of CBT treatments of anxiety going right back to the beginning of behaviour therapy through Wolpe, Rachman, Marks, and many others. It was success in treating anxiety that launched the whole field of behaviour therapy.

Here is a summary of recent studies of Panic Disorder and Generalised Anxiety Disorder

**PP**

**OUTCOME OF COGNITIVE-BEHAVIOUR THERAPY**
- **RANDOMISED CONTROLLED TRIALS**

**PANIC DISORDER (WITH OR WITHOUT AGORAPHOBIA)**

<table>
<thead>
<tr>
<th>Treatment</th>
<th>% Panic Free</th>
<th>Post</th>
<th>6mo FU</th>
<th>2yr FU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barlow et al (1989)</td>
<td>CBT</td>
<td>50%</td>
<td>71%</td>
<td>87%</td>
</tr>
<tr>
<td>Craske et al (1991)</td>
<td>App. Relax.</td>
<td>50%</td>
<td>22%</td>
<td>56%</td>
</tr>
<tr>
<td></td>
<td>Wait List</td>
<td>0%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Beck et al (1992)</td>
<td>CT</td>
<td>94%</td>
<td>77%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supportive Th.</td>
<td>25%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Clark et al (1994)</td>
<td>CT</td>
<td>86%</td>
<td>76%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>App. Relax.</td>
<td>48%</td>
<td>43%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Imipramine</td>
<td>52%</td>
<td>48%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wait. List</td>
<td>7%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Arntz &amp; Van den Hout (1996)</td>
<td>CT</td>
<td>78%</td>
<td>78%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Appl. Relax.</td>
<td>47%</td>
<td>47%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wait List</td>
<td>28%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Williams and Falbo (1996)</td>
<td>Exposure BT</td>
<td>58%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wait List.</td>
<td>11%</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

These results show very consistently that different kinds of CBT, including Cognitive therapy and exposure, result in about 70-80% of patients panic free at follow-up. The results of no treatment at all, in other words, staying on a waiting list, do not lead to spontaneous improvement. For ethical reasons, these control groups are transferred to active treatments and so we do not have long-term follow-up on them. Alternative forms of therapy, including anti-depressants, are better than no treatment at all but their
rates of improvement are in the region of 25-50%, significantly less than CBT. A problem with drug treatment is that patients often relapse when the medication is withdrawn. Another problem is that there are more drop-outs from drug therapy.

Here are the results of a review of drop-outs in different forms of therapy.

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PHARMACOTHERAPY VERSUS COGNITIVE BEHAVIOUR THERAPY

(NB Pharmacotherapy requires ongoing treatment to maintain its effects).


<table>
<thead>
<tr>
<th>Treatment</th>
<th>% Drop-out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benzodiazepines</td>
<td>13.1%</td>
</tr>
<tr>
<td>Anti-depressants</td>
<td>25.4%</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Treatment</th>
<th>% Drop-out</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBT</td>
<td>5.6%</td>
</tr>
</tbody>
</table>

I think this figure of 5.6% underestimates the numbers who drop out in a general service setting. The experimental trials take place in centres of excellence and the participants in the trials are more heavily screened. In fact in one survey of CBT therapy in normal clinical setting, 26% did not complete their therapy. However, in those who did the success rate was very high at 90% panic-free.

GENERAL SERVICE SETTING (PANIC DISORDER - UNSELECTED PATIENTS)

Stuart et al (2000) CBT Panic free

<table>
<thead>
<tr>
<th>Treatment</th>
<th>% Scores in normal range</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Post</td>
</tr>
<tr>
<td>CBT</td>
<td>88%</td>
</tr>
</tbody>
</table>

(81 completers) (29 non-completers)

The results of CBT for Generalised Anxiety Disorder are not so impressive as with Panic Disorder but they are still better than the alternative.

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OUTCOME OF COGNITIVE-BEHAVIOUR THERAPY - RANDOMISED CONTROLLED TRIALS

GENERALISED ANXIETY DISORDER

<table>
<thead>
<tr>
<th>Treatment</th>
<th>% Scores in normal range</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Post</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
So, after therapy, we can expect that 40-60% of patients to score in the normal range on questionnaire measures of general anxiety. The effect of applied relaxation by itself is also pretty good at around 40%. There are no waiting-list control groups here but it is accepted that Generalised Anxiety Disorder is a problem that persists and does not go away by itself. As you can see in the Ost study, the number of patients on medication was reduced at follow-up.

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Barlow DH, Gorman JM, Shear MK, & Woods SW (2000)

J Am Med Assoc, 283, 2529-2536

Multi-centre study of CBT and Imipramine for Panic Disorder with mild agoraphobia.

<table>
<thead>
<tr>
<th></th>
<th>Treatment 3 months</th>
<th>Maintenance 6 months</th>
<th>Follow-up 6 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>83</td>
<td>46% (75)</td>
<td>38% (79)</td>
</tr>
<tr>
<td>Imipramine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBT</td>
<td>77</td>
<td>49% (67)</td>
<td>40% (73)</td>
</tr>
<tr>
<td>Pill placebo</td>
<td>24</td>
<td>22% (38)</td>
<td>13% (38)</td>
</tr>
<tr>
<td>CBT+Imip.</td>
<td>65</td>
<td>60% (84)</td>
<td>57% (90)</td>
</tr>
<tr>
<td>CBT+Placebo</td>
<td>63</td>
<td>57% (80)</td>
<td>47% (76)</td>
</tr>
</tbody>
</table>

Summary:

No difference between Imipramine and CBT in Acute and Maintenance treatment phases
At end of Maintenance, Combined CBT+ Imipramine slightly better than CBT alone or Imipramine alone, but not superior to CBT + Placebo

Addition of Imipramine to CBT reduced long-term effectiveness of CBT

More patients taking Imipramine dropped out due to adverse side-effects

Rate of drop-outs with placebo = 66%
Rate of dropouts in active treatment = 10-18%

Let me now turn to the costs of mental Ill-health

The most common form of treatment for anxiety problems in the UK is medication, especially the antidepressants known as the SSRIs or Selective Serotonin Reuptake Inhibitors, the most famous one being Prozac. This is given for both anxiety and depression. In the past, the benzodiazepines were prescribed but this is uncommon now because it can lead to dependency on the drug. Prescription of the benzodiazepines like Valium is now very limited, largely due to pressures from the medical profession and the Government.

These are the figures for the annual cost of anti-depressants from 1991-1999 in the UK. I imagine that the cost has continued to rise and, as I said, this is the usual treatment for anxiety disorders.

PowerPoint

<table>
<thead>
<tr>
<th>Year</th>
<th>Cost (£ million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>15</td>
</tr>
<tr>
<td>1995</td>
<td>167</td>
</tr>
<tr>
<td>1997</td>
<td>296</td>
</tr>
<tr>
<td>1998</td>
<td>349</td>
</tr>
<tr>
<td>1999</td>
<td>395 (SSRI = one third of cost)</td>
</tr>
</tbody>
</table>

Let me now turn to the total costs of mental health in the UK. The actual figures are not so important – it’s a lot of money – but we can look at the proportion of the costs due to anxiety problems.

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Estimated total cost of mental health problems (all direct and indirect costs)

<table>
<thead>
<tr>
<th>Cost (£ billion)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.8</td>
<td>Lost employment</td>
</tr>
<tr>
<td>4.2</td>
<td>Cost of National Health Services</td>
</tr>
<tr>
<td>1.7</td>
<td>Cost of Local Government Services</td>
</tr>
</tbody>
</table>
This total cost is approximately equal to the entire Gross Domestic Product of New Zealand.

A large proportion of the costs of the National Health Service are taken up with anxiety problems although it is difficult to estimate precisely. It is very rare that people with anxiety disorders are admitted for inpatient treatment and so I estimate that around 15% of the direct costs of mental health are due to anxiety disorders. It’s important to bear in mind two things, firstly, that many people who take drugs or alcohol are doing so to self-treat an anxiety problem. For men especially, alcohol is used to cope with social and agoraphobic fears. Secondly, I am convinced that a large proportion of the costs of physical illness are related to health anxiety, in other words, unnecessary investigations to seek reassurance about imaginary medical illnesses.

PP

Proportion of National Health Service Costs on different kinds of mental health problem

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All Psychoses</td>
<td>38%</td>
</tr>
<tr>
<td>All Neuroses</td>
<td>27%</td>
</tr>
<tr>
<td>Dementia</td>
<td>26%</td>
</tr>
<tr>
<td>Alcohol and drugs</td>
<td>9%</td>
</tr>
</tbody>
</table>

Two thirds of the total costs are spent on in-patient care

7.0% of the NHS budget is spent on outpatient mental health services (including ‘community’ care)

5.2% of the total budget is spent on psychiatric drugs.

As you can see, the proportion of the budget spent on outpatient mental health services, only 7%, is out of proportion with the actual size of the problem presented by anxiety and depression, and almost as much is spent on psychiatric drugs as on outpatient services.

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The costs in the USA are very similar to those in the UK:

National Institute of Mental Health (USA) 1996

Estimated direct and indirect costs of anxiety disorders: $46.6 billion

(Axiety disorders = 13.5% of total mental health costs)

27% of people with Panic Disorder are receiving Welfare or Disability Compensation
(Compared to 16% in Major Depression and 12% with neither disorder)
I think you can see now why economists have become interested in mental health. Here are some more figures about loss of productivity.

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Reduction in productivity (Loss of productive working days in previous month):

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Days per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panic Disorder</td>
<td>4.57</td>
</tr>
<tr>
<td>Generalised Anxiety Disorder</td>
<td>3.11</td>
</tr>
<tr>
<td>Social Phobia</td>
<td>1.11</td>
</tr>
</tbody>
</table>

PowerPoint

ESEMeD Study (2004) Loss of whole days and reduced productivity (weighted 0.5)

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Days per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agoraphobia</td>
<td>9.6</td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>8.7</td>
</tr>
<tr>
<td>Generalised Anxiety Disorder</td>
<td>8.4</td>
</tr>
<tr>
<td>Social Phobia</td>
<td>7.2</td>
</tr>
<tr>
<td>Major Depression</td>
<td>7.5</td>
</tr>
<tr>
<td>Alcohol dependence</td>
<td>6.9</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>5.4</td>
</tr>
<tr>
<td>Diabetes</td>
<td>3.6</td>
</tr>
</tbody>
</table>

Again, as you can see, mental health disorders lead to more loss of productivity than alcohol, heart disease or diabetes.

Measuring the costs and benefits of psychological therapy

I am certainly not an expert on the exact methods of cost-benefit analysis - which is a special area of economic analysis. I can only point out the some of the main components that are considered. These are:

Direct Treatment Costs e.g. Cost of psychological therapy, medication, specialist medical assessments, etc

Direct non-treatment costs e.g. Travel to sessions, Child-care during treatment.

Indirect financial costs e.g. working days lost, welfare benefits.

Quality-of-life indirect costs e.g. restriction on travel, leisure, domestic tasks, etc

It is almost impossible to put a financial value on quality-of-life but these aspects can be measured and one form of therapy can be compared to another. This is a cost-effectiveness analysis, rather than a cost benefit analysis.

I have already given you one example of the effect of anxiety on quality of life - the young woman I described earlier - and it is obvious to me that she has not been able to
express her full potential in most aspects of her life. She could now be a full-time teacher with good prospects and enjoying her life.

There have been some studies to examine the costs and benefits of CBT and to compare it with drug treatment.

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<table>
<thead>
<tr>
<th>Treatment</th>
<th>No of sessions</th>
<th>Per session</th>
<th>Total (Including drug costs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBT Group treatment</td>
<td>11</td>
<td>48</td>
<td>523</td>
</tr>
<tr>
<td>CBT Individual treatment</td>
<td>12</td>
<td>114</td>
<td>1357</td>
</tr>
<tr>
<td>Pharmacotherapy</td>
<td>13</td>
<td>68</td>
<td>2305</td>
</tr>
</tbody>
</table>

What this shows is that individual sessions of CBT cost more than sessions with a psychiatrist but the total costs, if you include the cost of the drugs as well, is greater, in fact, almost twice as much. You have to bear in mind as well that when the drug is withdrawn, the patient may relapse. The change with CBT is maintained better at follow-up.

A different way of showing the costs is to compare the short-term and the long-term costs. Pharmacotherapy is cheaper in the short term but over one year it costs almost twice as much.

**Powerpoint**

**COST-BENEFIT RATIO - COST PER ONE UNIT CHANGE ON IMPROVEMENT RATING SCALE (DOLLARS)**

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Over 4 Months Therapy</th>
<th>Over One Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBT - Group</td>
<td>$ 246</td>
<td>$ 248</td>
</tr>
<tr>
<td>CBT - Individual</td>
<td>$ 567</td>
<td>$ 646</td>
</tr>
<tr>
<td>Pharmacotherapy</td>
<td>$ 447</td>
<td>$ 1153</td>
</tr>
</tbody>
</table>

I think that the economic arguments for CBT have now been won in the UK, at least for some psychological problems, but this doesn’t mean that it is politically possible to change current practices. For one thing, the drug companies will fight fiercely against it. I do not see much opposition from the general public. These ideological battles were
fought in the 1970s when films like A Clockwork Orange were produced. Behaviour therapists were then seen as people engaged in brainwashing of the kind carried out in wartime against American soldiers in China. The situation now has totally changed and CBT has a good public image. It is seen as practical, sensible and more likely to achieve the results you want than the alternatives. People are also usually against taking drugs.

I will now tell you about some of the initiatives taken by the Government to promote CBT.

One initiative has been to create a semi-independent organisation called the National Institute for Clinical Excellence. This organisation evaluates the costs and benefits of all kinds of treatment for physical and mental ill-health. They then produce guidelines which should be followed as recommend practice in the National Health Service. This doesn’t always happen because there are not enough resources or because there is resistance to change. However, we now have guidelines for depression, anxiety, eating disorders, and post-traumatic stress.

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National Institute for Clinical Evidence - Brief Summary of Guidelines

www.nice.org.uk

No 23 2004 DEPRESSION

Screen high-risk groups
MILD
Anti-depressants are not recommended
Use a guided self-help CBT programme
MILD to MODERATE
Consider problem-solving, CBT, or counselling
Consider SSRI anti-depressants
SEVERE
Consider combined anti-depressants and CBT
Consider CBT for recurrent depression if patient prefers it or anti-depressants have failed

National Institute for Clinical Evidence - Brief Summary of Guidelines

www.nice.org.uk

No 22 2004 Anxiety

Provide information on anxiety disorders, the side-effects of medication, and on self-help groups
PANIC DISORDER
Benzodiazepines should not be prescribed
Consider either:
- CBT
- SSRI or other anti-depressant
- Self-help based on CBT principles
GENERALISED ANXIETY DISORDER
Benzodiazepines to be used for 2-4 weeks only
Consider either:
- CBT
- SSRI
- Self-help based on CBT

It will take many years before these guidelines are put into practice. There are simply not enough CBT therapists. In some parts of the country, there are none at all. Another problem is finance. The Government has set strict financial targets for the Health Authorities, which means that the number of new jobs being advertised for psychologists has reduced dramatically in the last year. The number being trained has also been reduced. We don’t know how long this situation will continue.

I think I mentioned this morning, an adviser to the Blair Government, called Lord Layard, who is a Professor of Economics from the London School of Economics. He has spent most of his career studying unemployment. In his view, mental ill-health is a bigger problem than unemployment or poverty. One of the indicators of this is the amount of money paid out in Welfare benefits to people who are unable to work for reasons of mental disorder or physical disabilities.

We can look at the trends for one of these forms of welfare called Incapacity Benefit. This is a payment made to people who are unable to work because of mental disorder or physical disabilities.

<table>
<thead>
<tr>
<th></th>
<th>1997</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployment</td>
<td>1.0 million</td>
<td>0.6 million</td>
</tr>
<tr>
<td>Income support (lone parents)</td>
<td>1.6 million</td>
<td>0.6 million</td>
</tr>
<tr>
<td>Incapacity benefits</td>
<td>2.6 million</td>
<td>2.7 million</td>
</tr>
</tbody>
</table>

Incapacity benefit claimants = 7.5 % of working age population.

35% of incapacity benefits due to mental illness.

700,000 new claimants for Incapacity Benefit each year.

As you can see, over the period studied, 1997-2001, the number of unemployed decreased. Payments to single parents also decrease. However, claimants for incapacity benefit have increased slightly. They represent 1 in 13 of the working-age population and 35% of these benefits are claimed for reasons of mental ill health. That is 1 in 38 of the working age population.
In the last few years, the Government has been experimenting with vocational counselling to get people on incapacity benefit back to work. This help involves a skilled work adviser, rehabilitation, and extra financial benefits in the early stages of working. The Government claims that the pilot schemes have been a great success; they double the number of people on incapacity benefit getting back to work.

The Government is now supporting two pilot projects that provide even more intensive therapy and vocational guidance. This will be an economic evaluation of a combination of CBT and work rehabilitation. The CBT is provided under the National Health Service and the vocational counselling is given by a Voluntary Sector organisation.

The project in London, in Newham, is in an area where 60% of the population are from Black and Ethnic minority communities. 7.4% are on incapacity benefit and one third of these claimants have a mental health problem. Newham has the highest refugee population in the UK and 71% of the refugees are unemployed.

I should emphasise that the CBT service is available to everyone in the area - it is not limited to people on welfare benefits.

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NEWHAM PILOT PROJECT

2006-2008
Rapid access for people with anxiety and depression (including self-referral)
Some degree of patient choice in type of therapy
CBT for both mild and severe problems
- psycho-education, self-help, computerised CBT
- group CBT
- individual CBT (maximum 20 hours)
Additional psychotherapy where appropriate
Telephone help line plus employment coaches

Users of the service are involved in planning, delivery and evaluation
Psychological and economic outcomes will be measured (costs and benefits)

For anyone who is interested, I have brought a brochure describing the project. We don’t yet know what the outcome will be but I will be very surprised if it is a failure. I also have a list of references for those who want it.

Bibliography


Kessler R C & Frank R G (1997) The impact of psychiatric disorders on work loss days. Psychol. Med. 27, 861-873


National Institute for Clinical Evidence (UK) www.nice.org.uk

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