# Addressing Parity of Esteem in National Clinical Audit – A Guide: Appendix IV – Parity of esteem in NICE Clinical Guidelines and Quality Standards

Detailed below are a selection of NICE Clinical Guidelines and Quality Standards that consider both mental and physical health and are relevant to national clinical audit topics currently managed by HQIP. They are divided into those with a main focus on a physical or mental health condition, as well as those with as integrated main topic focus.

## Integrated physical and mental health Clinical Guidelines and Quality Standards

**Depression in Adults with a Chronic Physical Health Problem – www.nice.org.uk/guidance/cg91**

1.3.1.1 Be alert to possible depression (particularly in patients with a past history of depression or a chronic physical health problem with associated functional impairment) and consider asking patients who may have depression two questions, specifically:

- During the last month, have you often been bothered by feeling down, depressed or hopeless?
- During the last month, have you often been bothered by having little interest or pleasure in doing things?

1.3.1.2 If a patient with a chronic physical health problem answers 'yes' to either of the depression identification questions (see 1.3.1.1) but the practitioner is not competent to perform a mental health assessment, they should refer the patient to an appropriate professional. If this professional is not the patient's GP, inform the GP of the referral.

**Multi-morbidity: Clinical Assessment and Management – www.nice.org.uk/guidance/ng56**

1.2.1 'Consider an approach to care that takes account of multimorbidity if the person requests it or if any of the following apply:

- They find it difficult to manage their treatments or day-to-day activities
- They receive care and support from multiple services and need additional services
- They have both long-term physical and mental health conditions
- They have frailty or falls
- They frequently seek unplanned or emergency care
- They are prescribed multiple regular medicines

1.6.5 Be alert to the possibility of:

- Depression and anxiety (consider identifying, assessing and managing these conditions in line with the NICE guideline on common mental health problems)
- Chronic pain and the need to assess this and the adequacy of pain management

## Mental health Clinical Guidelines and Quality Standards

**Psychosis and schizophrenia in adults: prevention and management – www.nice.org.uk/guidance/cg178**

1.1.3.1 People with psychosis or schizophrenia, especially those taking antipsychotics, should be offered a combined healthy eating and physical activity programme by their mental healthcare provider.

1.1.3.2 If a person has rapid or excessive weight gain, abnormal lipid levels or problems with blood glucose management, offer interventions in line with relevant NICE guidance.

1.1.3.3 Offer people with psychosis or schizophrenia who smoke help to stop smoking, even if previous attempts have been unsuccessful. Be aware of the potential significant impact of reducing cigarette smoking on the metabolism of other drugs, particularly clozapine and olanzapine.

1.1.3.6 Routinely monitor weight, and cardiovascular and metabolic indicators of morbidity in people with psychosis and schizophrenia. These should be audited in the annual team report.

1.1.3.7 Trusts should ensure compliance with quality standards on the monitoring and treatment of cardiovascular and metabolic disease in people with psychosis or schizophrenia through board-level performance indicators.

1.3.3.1 Carry out a comprehensive multidisciplinary assessment of people with psychotic symptoms in secondary care…The assessment should address the following domains:

- …Medical, including medical history and full physical examination to identify physical illness (including organic brain disorders) and prescribed drug treatments that may result in psychosis
- Physical health and wellbeing (including weight, smoking, nutrition, physical activity and sexual health)…

1.3.3.4 Write a care plan in collaboration with the service user as soon as possible following assessment, based on a psychiatric and psychological formulation, and a full assessment of their physical health. Send a copy of the care plan to the primary healthcare professional that made the referral and the service user.

1.3.6.1 Before starting antipsychotic medication, undertake and record the following baseline investigations:

- Weight (plotted on a chart)
- Waist circumference
- Pulse and blood pressure
- Fasting blood glucose, glycosylated haemoglobin (HbA1c), blood lipid profile and prolactin levels
- Assessment of any movement disorders
- Assessment of nutritional status, diet and level of physical activity

1.3.6.2 Before starting antipsychotic medication, offer the person with psychosis or schizophrenia an electrocardiogram (ECG) if:

- Specified in the summary of product characteristics (SPC)
- A physical examination has identified specific cardiovascular risk (such as diagnosis of high blood pressure)
- There is a personal history of cardiovascular disease or
- The service user is being admitted as an inpatient

**Psychosis and Schizophrenia in adults – www.nice.org.uk/guidance/qs80**

Statement 6: Adults with psychosis or schizophrenia have specific comprehensive physical health assessments:

- Comprehensive physical health assessments for adults with psychosis or schizophrenia should focus on physical health problems common in people with psychosis and schizophrenia by monitoring the following: weight (plotted on a chart) – weekly for the first six weeks, then at 12 weeks, at one year and then annually waist circumference annually (plotted on a chart) pulse and blood pressure at 12 weeks, at one year and then annually fasting blood glucose, HbA1c and blood lipid levels at 12 weeks, at one year and then annually overall physical health
- Interventions should be offered in line with NICE guidelines on lipid modification, preventing type 2 diabetes, obesity, hypertension, prevention of cardiovascular disease and physical activity

Statement 7: Promoting healthy eating, physical activity and smoking cessation:

- Adults with psychosis or schizophrenia are offered help with healthy eating and physical activity to help prevent weight gain, diabetes and other health problems that are common in adults with psychosis or schizophrenia and often related to treatment. Smoking is also common in adults with psychosis or schizophrenia and those who smoke should be offered help to stop smoking

**Generalised anxiety disorder and panic disorder in adults: management – www.nice.org.uk/guidance/cg113/**

1.2.2 Consider the diagnosis of GAD in people presenting with anxiety or significant worry, and in people who attend primary care frequently who: have a chronic physical health problem or do not have a physical health problem but are seeking reassurance about somatic symptoms (particularly older people and people from minority ethnic groups).

1.4.6 If a person presents in A&E, or other settings, with a panic attack, they should: be asked if they are already receiving treatment for panic disorder undergo the minimum investigations necessary to exclude acute physical problems.

**Depression in adults: recognition and management – www.nice.org.uk/guidance/cg90**

1.1.4.2 In addition to assessing symptoms and associated functional impairment, consider how the following factors may have affected the development, course and severity of a person's depression: any history of depression and comorbid mental health or physical disorders.

1.5.2.1 Discuss antidepressant treatment options with the person with depression, covering: the choice of antidepressant, including any anticipated adverse events, for example side effects and discontinuation symptoms (see 1.9.2.1), and potential interactions with concomitant medication or physical health problems.

1.6.1.3 When prescribing antidepressants for older people: prescribe at an age-appropriate dose taking into account the effect of general physical health and concomitant medication on pharmacokinetics and pharmacodynamics.

1.7.1.2 For people with severe depression and those with moderate depression and complex problems, consider: …providing collaborative care if the depression is in the context of a chronic physical health problem with associated functional impairment.

1.9.1.2 Review with the person with depression the need for continued antidepressant treatment beyond 6 months after remission, taking into account: …concurrent physical health problems and psychosocial difficulties.

**Dementia: supporting people with dementia and their carers in health and social care – www.nice.org.uk/guidance/cg42**

1.1.11.1 Acute and general hospital Trusts should plan and provide services that address the specific personal and social care needs and the mental and physical health of people with dementia who use acute hospital facilities for any reason.

1.4.1.1 A diagnosis of dementia should be made only after a comprehensive assessment, which should include: …physical examination and other appropriate investigations.

1.7.1.1 People with dementia who develop non-cognitive symptoms that cause them significant distress or who develop behaviour that challenges should be offered an assessment at an early opportunity to establish likely factors that may generate, aggravate or improve such behaviour. The assessment should be comprehensive and include: …the person's physical health.

## Physical health Clinical Guidelines and Quality Standards

**Cancer**

Advanced breast cancer: diagnosis and treatment – www.nice.org.uk/guidance/cg81/

1.4.1 'Assessment and discussion of patients' needs for physical, psychological, social, spiritual and financial support should be undertaken at key points (such as diagnosis; at commencement, during, and at the end of treatment; at relapse; and when death is approaching).'

1.5.9 Provide clear, written information about cancer-related fatigue, organisations that offer psychosocial support and patient led groups.

1.5.13 A palliative care team should assess all patients with uncontrolled local disease in order to plan a symptom management strategy and provide psychological support.

Early and locally advanced breast cancer: diagnosis and treatment – www.nice.org.uk/guidance/cg80

1.2.3 All patients with breast cancer should be offered prompt access to specialist psychological support, and, where appropriate, psychiatric services.

1.13.12 The selective serotonin re-uptake inhibitor antidepressants paroxetine and fluoxetine may be offered to women with breast cancer for relieving menopausal symptoms, particularly hot flushes, but not to those taking tamoxifen.

Prostate cancer: diagnosis and management – www.nice.org.uk/guidance/cg175/

1.1.13 Offer men with prostate cancer and their partners or carers the opportunity to talk to a healthcare professional experienced in dealing with psychosexual issues at any stage of the illness and its treatment.

1.4.9 Consider referring men who are having long-term androgen deprivation therapy, and their partners, for psychosexual counselling.

Lung cancer: diagnosis and management – www.nice.org.uk/guidance/cg121/

1.5.9 Non-drug interventions based on psychosocial support, breathing control and coping strategies should be considered for patients with breathlessness.

1.5.18 Other symptoms, including weight loss, loss of appetite, depression and difficulty swallowing, should be managed by multidisciplinary groups that include supportive and palliative care professionals.

1.3.33 Rapid access clinics should be provided where possible for the investigation of patients with suspected lung cancer, because they are associated with faster diagnosis and less patient anxiety.

Improving supportive and palliative care for adults with cancer – www.nice.org.uk/guidance/csg4/

5.3 Around the time of a diagnosis of cancer, approximately half of all patients experience levels of anxiety and depression severe enough to affect their quality of life adversely. About one quarter continue to be so affected during the following six months. Among those who experience recurrence of disease, the prevalence of anxiety and depression rises to 50% and remains at this level throughout the course of advanced illness. In the year following diagnosis, around one in ten patients will experience symptoms severe enough to warrant intervention by specialist psychological/psychiatric services. Such symptoms can also be seen in 10-15% of patients with advanced disease.

5.7 Patients' psychological symptoms are often not recognised, with the result that they are not offered access to needed services. Health and social care professionals often lack appropriate assessment skills and may underestimate the benefits of psychological support. Some do not know to whom they can turn for advice and support for patients and carers in distress.

5.8 There are insufficient numbers of professionals equipped to offer support to patients and carers in psychological distress, and no uniform agreement exists on the services that should be

provided by relevant professional disciplines. There is also little co-ordination between professionals offering different types of psychological intervention, with the result that many people with cancer do not gain access to needed services of this kind.

5.9 The psychological well-being of patients and carers should be explicitly assessed at key points in the patient pathway.

5.16.1 Commissioners, working through Cancer Networks, should ensure that all patients undergo regular systematic psychological assessment at key points in the patient pathway and have access to an appropriate level of psychological intervention.

5.42.1 An individual (or individuals) should be identified within each cancer site-specific and specialist palliative care team to take responsibility for providing Level 2 care (that is, screening for psychological distress and using simple psychological techniques)

**Cardiovascular disease**

Atrial fibrillation: management – www.nice.org.uk/guidance/cg180/

1.2.1 Offer people with atrial fibrillation a personalised package of care. Ensure that the package of care is documented and delivered, and that it covers: …psychological support if needed.

Myocardial infarction: cardiac rehabilitation and prevention of further cardiovascular disease – www.nice.org.uk/guidance/cg172

1.1.21 Take into account the physical and psychological status of the patient, the nature of their work and their work environment when giving advice on returning to work.

1.1.25 Take into account the patient's physical and psychological status, as well as the type of activity planned when offering advice about the timing of returning to normal activities.

1.1.28 Offer stress management in the context of comprehensive cardiac rehabilitation.

Cardiovascular disease: risk assessment and reduction, including lipid modification – www.nice.org.uk/guidance/cg181

1.1.18 Recognise that standard CVD risk scores will underestimate risk in people who have additional risk because of underlying medical conditions or treatments. These groups include: …people with serious mental health problems.

Chronic heart failure in adults: management – www.nice.org.uk/guidance/cg108

1.3.1.1 Offer a supervised group exercise-based rehabilitation programme designed for patients with heart failure. Ensure the patient is stable and does not have a condition or device that would preclude an exercise-based rehabilitation programme. …Include a psychological and educational component in the programme.

1.5.8.1 The diagnosis of depression should be considered in all patients with heart failure.

1.5.8.2 Where depression is likely to have been precipitated by heart failure symptoms then reassessment of psychological status should be undertaken once the physical condition has stabilised following treatment for heart failure. If the symptoms have improved no further specific treatment for depression is required.

1.5.8.3 Where it is apparent that depression is co-existing with heart failure, then the patient should be treated for depression in line with 'Depression: the treatment and management of depression in adults' (NICE clinical guideline 90) and 'Depression in adults with a chronic physical health problem: treatment and management' (NICE clinical guideline 91).

1.5.8.4 For patients with heart failure, the potential risks and benefits of drug therapies for depression should be considered carefully.

1.5.8.5 Patients with heart failure should consult a healthcare professional before using over-the-counter therapies for depression such as St John's wort (Hypericum perforatum).

Peripheral arterial disease: diagnosis and management – www.nice.org.uk/guidance/cg147/

1.1.1 Offer all people with peripheral arterial disease oral and written information about their condition. Discuss it with them so they can share decision-making, and understand the course of the disease and what they can do to help prevent disease progression. Information should include: …how they can access support for dealing with depression and anxiety.

Stroke rehabilitation in adults – www.nice.org.uk/guidance/cg162/

1.1.2 An inpatient stroke rehabilitation service should consist of the following: …access to other services that may be needed, for example: … liaison psychiatry.

1.1.3 A core multidisciplinary stroke rehabilitation team should comprise the following professionals with expertise in stroke rehabilitation: …clinical psychologists.

1.1.13 On transfer of care from hospital to the community, provide information to all relevant health and social care professionals and the person with stroke. This should include: …psychological (cognitive and emotional) needs.

1.2.2 A comprehensive assessment of a person with stroke should take into account: …impairment of psychological functioning (cognitive, emotional and communication).

1.4.1 Screen people after stroke for cognitive deficits. Where a cognitive deficit is identified, carry out a detailed assessment using valid, reliable and responsive tools before designing a treatment programme.

1.4.5 Assess memory and other relevant domains of cognitive functioning (such as executive functions) in people after stroke, particularly where impairments in memory affect everyday activity.

1.4.7 Assess attention and cognitive functions in people after stroke using standardised assessments. Use behavioural observation to evaluate the impact of the impairment on functional tasks.

1.5.1 Assess emotional functioning in the context of cognitive difficulties in people after stroke. Any intervention chosen should take into consideration the type or complexity of the person's neuropsychological presentation and relevant personal history.

1.5.2 Support and educate people after stroke and their families and carers, in relation to emotional adjustment to stroke, recognising that psychological needs may change over time and in different settings.

1.5.3 When new or persisting emotional difficulties are identified at the person's 6-month or annual stroke reviews, refer them to appropriate services for detailed assessment and treatment.

1.5.4 Manage depression or anxiety in people after stroke who have no cognitive impairment in line with recommendations in Depression in adults with a chronic physical health problem (NICE clinical guideline 91) and Generalised anxiety disorder (NICE clinical guideline 113).

**Diabetes**

Diabetes (type 1 and type 2) in children and young people: diagnosis and management – www.nice.org.uk/guidance/ng18/

*Psychological and social issues in children and young people with type 1 diabetes*

1.2.94 Diabetes teams should be aware that children and young people with type 1 diabetes have a greater risk of emotional and behavioural difficulties.

1.2.95 Offer children and young people with type 1 diabetes and their family members or carers (as appropriate) emotional support after diagnosis, which should be tailored to their emotional, social, cultural and age dependent needs.

1.2.96 Assess the emotional and psychological wellbeing of young people with type 1 diabetes who present with frequent episodes of diabetic ketoacidosis (DKA).

1.2.97 Be aware that a lack of adequate psychosocial support has a negative effect on various outcomes, including blood glucose control in children and young people with type 1 diabetes, and that it can also reduce their self esteem.

1.2.98 Offer children and young people with type 1 diabetes and their family members or carers (as appropriate) timely and ongoing access to mental health professionals with an understanding of diabetes because they may experience psychological problems (such as anxiety, depression, behavioural and conduct disorders and family conflict) or psychosocial difficulties that can impact on the management of diabetes and wellbeing.

1.2.99 For the treatment of depression and antisocial behaviour and conduct disorders in children and young people with type 1 diabetes see the NICE guidelines on depression in children and young people and antisocial behaviour and conduct disorders in children and young people.

1.2.100 Diabetes teams should have appropriate access to mental health professionals to support them in psychological assessment and the delivery of psychosocial support.

1.2.101 Offer children and young people with type 1 diabetes who have behavioural or conduct disorders, and their family members or carers (as appropriate), access to appropriate mental health professionals.

1.2.102 Offer specific family based behavioural interventions, such as behavioural family systems therapy, if there are difficulties with diabetes related family conflict.

1.2.103 Consider a programme of behavioural intervention therapy or behavioural techniques for children and young people with type 1 diabetes in whom there are concerns about psychological wellbeing in order to improve:

- Health related quality of life – for example, counselling or cognitive behavioural therapy (CBT), including CBT focused on quality of life
- Adherence to diabetes treatment – for example, motivational interviewing or multisystemic therapy
- Blood glucose control in children and young people with high HbA1c levels (HbA1c above 69 mmol/mol [8.5%]) – for example, multisystemic therapy

1.2.104 Offer screening for anxiety and depression to children and young people with type 1 diabetes who have persistently suboptimal blood glucose control.

1.2.105 Diabetes teams should be aware that children and young people with type 1 diabetes may develop anxiety and/or depression, particularly when difficulties in self management arise in young people and children who have had type 1 diabetes for a long time.

1.2.106 Refer children and young people with type 1 diabetes and suspected anxiety and/or depression promptly to child mental health professionals.

1.2.107 Diabetes teams should be aware that children and young people with type 1 diabetes, in particular young women, have an increased risk of eating disorders. See also the NICE guideline on eating disorders.

1.2.108 Be aware that children and young people with type 1 diabetes who have eating disorders may have associated difficulties with:

- Suboptimal blood glucose control (both hyperglycaemia and hypoglycaemia)
- Symptoms of gastroparesis

1.2.109 For children and young people with type 1 diabetes in whom eating disorders are identified, offer joint management involving their diabetes team and child mental health professionals.

*Psychological and social issues in children and young people with type 2 diabetes*

1.3.33 Diabetes teams should be aware that children and young people with type 2 diabetes have a greater risk of emotional and behavioural difficulties.

1.3.34 Offer children and young people with type 2 diabetes and their family members or carers (as appropriate) emotional support after diagnosis, which should be tailored to their emotional, social, cultural and age dependent needs.

1.3.35 Be aware that children and young people with type 2 diabetes have an increased risk of psychological conditions (for example anxiety, depression, behavioural and conduct disorders) and complex social factors (for example family conflict) that can affect their wellbeing and diabetes management. See also the NICE guidelines on depression in children and young people and antisocial behaviour and conduct disorders in children and young people.

1.3.36 Be aware that a lack of adequate psychosocial support has a negative effect on various outcomes, including blood glucose control in children and young people with type 2 diabetes, and that it can also reduce their self esteem.

1.3.37 Offer children and young people with type 2 diabetes and their family members or carers (as appropriate) timely and ongoing access to mental health professionals with an understanding of diabetes because they may experience psychological problems (such as anxiety, depression, behavioural and conduct disorders and family conflict) or psychosocial difficulties that can impact on the management of diabetes and wellbeing.

1.3.38 For the treatment of depression and antisocial behaviour and conduct disorders in children and young people with type 2 diabetes see the NICE guidelines on depression in children and young people and antisocial behaviour and conduct disorders in children and young people.

1.3.39 Diabetes teams should have appropriate access to mental health professionals to support them in psychological assessment and the delivery of psychosocial support.

1.3.40 Offer screening for anxiety and depression to children and young people with type 2 diabetes who have persistently suboptimal blood glucose control.

1.3.41 Refer children and young people with type 2 diabetes and suspected anxiety and/or depression promptly to child mental health professionals.

1.3.42 Ensure that children and young people with type 2 diabetes and their family members or carers (as appropriate) have timely and ongoing access to mental health services when needed.

Type 1 diabetes in adults: diagnosis and management – www.nice.org.uk/guidance/ng17

1.1.6 At the time of diagnosis (or if necessary after the management of critically decompensated metabolism), the diabetes professional team should develop with and explain to the adult with type 1 diabetes a plan for their early care. To agree such a plan will generally require: … psychological wellbeing.

1.7.12 For adults with erratic and unpredictable blood glucose control (hyperglycaemia and hypoglycaemia at no consistent times), rather than a change in a previously optimised insulin regimen, the following should be considered: …psychological and psychosocial difficulties.

1.10.13 If hypoglycaemia becomes unusually problematic or of increased frequency, review the following possible contributory causes: … psychological problems.

1.15.41 Members of diabetes professional teams providing care or advice to adults with type 1 diabetes should be alert to the development or presence of clinical or subclinical depression and/or anxiety, in particular if someone reports or appears to be having difficulties with self management.

1.15.42 Diabetes professionals should:

- Ensure that they have appropriate skills in the detection and basic management of non severe psychological disorders in people from different cultural backgrounds
- Be familiar with appropriate counselling techniques and drug therapy, while arranging prompt referral to specialists of those people in whom psychological difficulties continue to interfere significantly with wellbeing or diabetes self management

1.15.43 Members of diabetes professional teams should be alert to the possibility of bulimia nervosa, anorexia nervosa and insulin dose manipulation in adults with type 1 diabetes with:

- Over-concern with body shape and weight
- Low BMI
- Hypoglycaemia
- Suboptimal overall blood glucose control

1.15.44 The risk of morbidity from the complications of poor metabolic control suggests that consideration should be given too early, and occasionally urgent, referral of adults with type 1 diabetes to local eating disorder services.

1.15.45 Make provision for high quality professional team support at regular intervals with regard to counselling about lifestyle issues and particularly dietary behaviour for all adults with type 1 diabetes from the time of diagnosis.

Type 2 diabetes in adults: management – www.nice.org.uk/guidance/ng28

1.7.16 Erectile dysfunction- following discussion, refer men with type 2 diabetes to a service offering other medical, surgical or psychological management of erectile dysfunction if treatment (including a phosphodiesterase-5 inhibitor, as appropriate) has been unsuccessful.

**Maternal and child health**

Neonatal specialist care – www.nice.org.uk/guidance/qs4/

'The quality standard for specialist neonatal care requires that the physical, psychological and social needs of babies and their families are at the heart of all care given.'

Intrapartum care for healthy women and babies- www.nice.org.uk/guidance/cg190/

1.4.1 When performing an initial assessment of a woman in labour, listen to her story and take into account her preferences and her emotional and psychological needs.

1.12.18 Give ongoing consideration to the woman's emotional and psychological needs, including her desire for pain relief.

1.13.2 Carry out the following observations in the second stage of labour, record all observations on the partogram and assess whether transfer of care may be needed: …Continue to take the woman's emotional and psychological needs into account.

1.13.18 In order for a woman who has had previous third- or fourth-degree trauma to make an informed choice, talk with her about the future mode of birth, encompassing: …the psychological effect of the previous trauma.

1.16.1 Carry out the following observations of the woman after birth: ...Early assessment of the woman's emotional and psychological condition in response to labour and birth.

Caesarean section – www.nice.org.uk/guidance/cg132

4.4 What support or psychological interventions would be appropriate for women who have a fear of vaginal childbirth and request a CS?

- Interventions for evaluation could include: …formal counselling…cognitive behavioural therapy
- Outcomes could include: …psychological outcomes (postnatal depression, post-traumatic stress disorder, self-esteem, mother-infant bonding)
- Interventions that may be appropriate include: …referral to a psychologist or a mental health professional

**Falls and fragility fractures**

Falls in older people: assessing risk and prevention – www.nice.org.uk/guidance/cg161

1.1.7.1 Older people on psychotropic medications should have their medication reviewed, with specialist input if appropriate, and discontinued if possible to reduce their risk of falling.

1.1.3.2 Following treatment for an injurious fall, older people should be offered a multidisciplinary assessment to identify and address future risk and individualised intervention aimed at promoting independence and improving physical and psychological function.

Hip fracture: management – www.nice.org.uk/guidance/cg124

1.8.1 From admission, offer patients a formal, acute orthogeriatric or orthopaedic ward-based Hip Fracture Programme that includes all of the following: …liaison or integration with related services, particularly mental health.

**Epilepsy**

Epilepsy in children and young people – www.nice.org.uk/guidance/qs27

Statement 4: The care plan should include any issues relating to the following topics… psychological issues

Statement 7: Referral to tertiary services should be considered when one or more of the following criteria are present: …there is psychological or psychiatric comorbidity.

Statement 8: A structured review should cover all aspects of the child's or young person's epilepsy care plan. The physical, psychological and social needs of children and young people with epilepsy should always be considered by healthcare professionals. Attention should be paid to their relationships with family and friends, and at school.

Epilepsies: diagnosis and management – www.nice.org.uk/guidance/cg137

1.5.7 Where non-epileptic attack disorder is suspected, suitable referral should be made to psychological or psychiatric services for further investigation and treatment.

1.6.32 Neuropsychological assessment should be considered in children, young people and adults in whom it is important to evaluate learning disabilities and cognitive dysfunction, particularly in regard to language and memory.

1.6.33 Referral for a neuropsychological assessment is indicated:

- When a child, young person or adult with epilepsy is having educational or occupational difficulties

- When an MRI has identified abnormalities in cognitively important brain regions
- When a child, young person or adult complains of memory or other cognitive deficits and/or cognitive decline

1.9.17.1 Maintain a high level of vigilance for treatment-emergent adverse effects (for example, bone health issues and neuropsychiatric issues.

1.10.2 In children, the diagnosis and management of epilepsy within the first few years of life may be extremely challenging. For this reason, children with suspected epilepsy should be referred to tertiary services early, because of the profound developmental, behavioural and psychological effects that may be associated with continuing seizures.

1.10.4 If seizures are not controlled and/or there is diagnostic uncertainty or treatment failure, children, young people and adults should be referred to tertiary services soon for further assessment. Referral should be considered when one or more of the following criteria are present: … there is psychological and/or psychiatric comorbidity.

1.10.8 The expertise of multidisciplinary teams involved in managing complex epilepsy should include psychology, psychiatry…counselling.

1.11.1 Psychological interventions (relaxation, cognitive behaviour therapy, biofeedback) may be used in conjunction with AED therapy in adults where either the person or the specialist considers seizure control to be inadequate with optimal AED therapy.

1.11.2 Psychological interventions (relaxation, cognitive behaviour therapy) may be used in children and young people with drug-resistant focal epilepsy.

1.11.3 Psychological interventions may be used as adjunctive therapy. They have not been proven to affect seizure frequency and are not an alternative to pharmacological treatment.

**Other**

Chronic obstructive pulmonary disease in over 16s: diagnosis and management – www.nice.org.uk/guidance/cg101

1.2.8.4 Pulmonary rehabilitation programmes should include multi-component, multidisciplinary interventions, which are tailored to the individual patient's needs. The rehabilitation process should incorporate a programme of physical training, disease education, nutritional, psychological and behavioural intervention.

Rheumatoid arthritis in adults: management – www.nice.org.uk/guidance/cg79

1.3.1.5 Offer psychological interventions (for example, relaxation, stress management and cognitive coping skills) to help people with RA adjust to living with their condition.

Rehabilitation after critical illness in adults – www.nice.org.uk/guidance/cg83

1.8 For patients at risk, and patients who started the individualised, structured rehabilitation programme in critical care, perform a comprehensive clinical reassessment to identify their current rehabilitation needs. The comprehensive reassessment should pay particular attention to: …underlying factors, such as pre-existing psychological or psychiatric distress.

1.20 Before discharging patients who were receiving the individualised structured rehabilitation programme during ward-based care, perform a functional assessment which should include the following non-physical dimensions: …anxiety, depression, post-traumatic stress-related symptoms, behavioural and cognitive problems, psychosocial problems.