

The Mental Health Content of Physical Health Guidelines

This summary document is intended as a quick reference guide to the mental health content of the physical health guidelines produced by the National Institute of Health and Clinical Excellence ([NICE](#)) and the Scottish Intercollegiate Guidelines Network ([SIGN](#)). The mental health content has been taken directly from the guidelines and is separated into two lists under each condition:

- 1) **Specific recommendations** relating to mental and emotional health; which healthcare professionals are expected to adhere to and
- 2) **General comments** in the guidelines that mention issues around mental health.

It is hoped that this will provide a fairly comprehensive guide to the mental health content of these guidelines, but for those wishing to study the full guidelines in more detail, links have been provided.

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Acutely ill patients in hospital:NICE

Specific recommendations

- Handover of care should include... psychological and emotional needs.
- Staff working with acutely ill patients on general wards should be provided with education and training to recognise and understand the physical, psychological and emotional needs of patients who have been transferred from critical care areas.

General comments

- A period of critical illness can have a significant impact on a patient's quality of life and functional status. The longer the period of illness and the greater the complexity of care required in critical care, the greater the potential for residual physical, emotional and psychological morbidity.
- [Patients should have...] help with managing their physical and emotional experiences.
- All three studies presented details on patients' physical and emotional experiences....following transfer, some patients also felt anxious, lonely and isolated, depressed, insecure, exhausted, confused and worried because they were extremely weak physically. Patients commented that attitude, attention and organisation were important aspects of care management on the ward and they desired a high quality of individualised care... Some patients felt 'abandoned' and some experienced being left unattended for varying lengths of time when they needed to go to the toilet or be washed or cleaned. Patients found these experiences hard to cope with and some reported that they felt themselves 'go downhill'.
- Unfortunately the step down of nursing care from 'one-to-one' to 'one-to-many' is sometimes also accompanied by a lack of continuity of care from the critical care and parent teams and a reduction in the depth and breadth of care provided. These factors commonly lead to patient distress.
- Patients being treated in a critical care area will be recovering from a serious illness and will have required a level of dependency on medical, nursing and allied healthcare professionals that is much greater than that found on general wards. Consequently the transition back to the general wards can be anxiety provoking for many patients. The situation can be exacerbated if healthcare professionals on the general wards are not fully aware of the patient's physical, emotional and psychological condition.

Antenatal care: NICE

Specific recommendations

- The environment in which antenatal appointments take place should enable women to discuss sensitive issues such as domestic violence, sexual abuse, psychiatric illness and illicit drug use.
- Women should be asked early in pregnancy if they have had any previous psychiatric illnesses. Women who have had a past history of serious psychiatric disorder should be referred for a psychiatric assessment during the antenatal period.
- Pregnant women should not be offered routine screening, such as with the Edinburgh postnatal depression scale (EPDS), in the antenatal period to predict the development of postnatal depression.
- Pregnant women should not be offered antenatal education interventions to reduce perinatal or postnatal depression, as these interventions have not been shown to be effective.

Brain tumours (improving outcomes for people with brain and other CNS tumours): NICE

Specific recommendations

- Psychological assessment and support should be an integral part of the MDT management of patients with brain and other CNS tumours. Neuropsychology and neuropsychiatry services should be adequately resourced to enable referral of patients who require specialist intervention for cognitive, emotional or behavioural problems.
- One member of the cancer network MDT should be nominated to maintain links with specialist psychology services.
- Ongoing training should be provided for all staff providing psychological support to patients with CNS tumours, their relatives and carers.
- The psychological and social well-being of the patient, their relatives and carers should be considered throughout the course of the illness.
- A coordinated cancer network will be more capable of delivering consistent, efficient and effective psychological/psychiatric support to CNS tumour patients within the network.

General comments

- For some patients and families there is a long delay from first symptoms to reaching a diagnosis, causing considerable stress and anxiety. Prompt identification of patients whose symptoms are likely to be due to a primary CNS tumour ... will reduce the level of anxiety for patients, their relatives and carers.
- The need for neuropsychiatry services is supported by observational evidence that psychiatric states of depression and anxiety are relatively common in patients with CNS tumours, both before and after treatment, with a prevalence of between 17% and 30%.
- The complementary role of neuropsychology in this area is supported by consistent evidence from systematic reviews of therapeutic psychological interventions for depression and anxiety in people with cancer (see NICE guidance 'Improving supportive and palliative care for adults with cancer').

- Cognitive dysfunction may greatly increase the need for psychological/psychiatric, social and physical support.
- CNS tumours can result in a wide range of physical, cognitive and psychological symptoms.
- Most patients will also require input from a variety of healthcare professionals, including... those providing psychological help and support for patients, their relatives and carers.
- The symptoms associated with brain tumours include ... changes of mental, psychological or mood states.
- Patients with CNS tumours may experience psychological difficulties in adjusting to a serious, life-threatening condition in the same way as other patients with cancer. In addition, patients with CNS tumours frequently have cognitive and psychological problems and undergo personality changes. Therefore clinical neuropsychologists, with specialist training and expertise in the assessment and management of cognitive impairment and personality change, and neuropsychiatrists, with specialist training and expertise in the management of patients with severe mental health problems in the context of organic brain disease, have a key contribution to the care of patients with CNS tumours.
- Regular assessment of the psychological needs of patients and monitoring of their cognitive and personality changes are an important part of their continuing care.
- There will be a reduction in psychological distress and improvement in health-related quality of life and some other functional outcomes....The complementary role of neuropsychology in this area is supported by consistent evidence from systematic reviews of therapeutic psychological interventions for depression and anxiety in people with cancer.
- Patients with CNS tumours experience complex physical, cognitive and psychological problems.
- A proportion of patients are significantly disabled physically, cognitively and psychologically by their illness and the consequences of treatment.

Caesarean Section (CS) NICE

Specific recommendations

- When a woman requests a CS because she has a fear of childbirth, she should be offered counselling (such as cognitive behavioural therapy) to help her to address her fears in a supportive manner, because this results in reduced fear of pain in labour and shorter labour.
- Women who are having induction of regional anaesthesia for CS should be cared for in theatre because this does not increase patient anxiety.
- Healthcare professionals caring for women who have had a CS should inform women that after a CS they are not at increased risk of difficulties with breastfeeding, depression, post-traumatic stress symptoms.

Cancer (Management of breast cancer in women) SIGN

Specific recommendations

- Group psychological interventions should be available to women with breast cancer who feel it would suit their needs.
- Supportive expressive therapy is recommended for patients with advanced cancer and cognitive behavioural therapy for patients with localised, locoregional or advanced disease.
- Choice of psychological treatment modality in advanced breast cancer should be based on patient preference.
- All women with a potential or known diagnosis of breast cancer should have access to a breast care nurse specialist for information and support at every stage of diagnosis and treatment.
- Contact details and information about the role of the breast care nurse should be available to the patients, their families and all the members of the multidisciplinary team including the primary care team.
- The measurement of the presence of psychological symptoms in women with breast cancer should be tailored to the individual circumstances of the patient (e.g. presence of high level of distress or risk factors for problems).
- Routinely administered questionnaires are not recommended for the detection of clinically significant psychological symptoms in women with breast cancer who do not have risk factors for severe anxiety or distress.
- Breast cancer services should routinely screen for the presence of distress and risk factors for very high levels of distress from the point of diagnosis onwards (including during follow up review phases).
- Multidisciplinary teams should have agreed protocols for distress assessment and management. These should include recommendations for referral and care pathways. Psychological, Group psychological interventions should be available to women with breast cancer who feel it would suit their needs.
- Supportive expressive therapy has been shown to be effective in advanced cancer and cognitive behavioural therapy for localised, locoregional or advanced disease. Cognitive behavioural therapy (in group or individual format according to preference and availability) should be offered to selected patients with anxiety and depressive disorders.
- Computer and telephone-based interventions should not routinely be offered to patients.

General comments

- A number of studies have examined the incidence of psychological and psychiatric morbidity in women with breast cancer. They have shown a high risk of clinically significant levels of anxiety and/or depression, severe sexual difficulties and other problems related to body image. This is in addition to the normal reactions of women to the diagnosis of a potentially life threatening illness and the side effects of treatment.
- Clinical staff frequently fail to identify psychological problems, for various reasons. When clinicians identify clinically significant distress, they may not offer treatment because they see the distress as being a 'normal' reaction to the diagnosis, treatment side effects, or prognosis.
- Significant levels of psychological distress are commonly associated with experiences associated with the diagnosis of and treatment for breast cancer. In a study of 303 women entering a randomised controlled trial, up to 45% of the participants were found to have clinically significant levels of psychological distress using standardised criteria. Identifying distress is a significant task for the multi-professional team caring for patients with breast cancer. Distress can be the result of a range of factors and is not always a manifestation of an emotional or psychological problem. Many patients with high levels of distress are not recognised. Routine screening for distress among people with cancer has been recommended by the US National Comprehensive Cancer Network. The National Health and Medical Research Council of Australia recommends an approach to screening for significant psychological problems that includes advice to document risk factors for the presence of distress.
- Although there have been many studies that have used a range of reliable and valid assessment measures to examine psychosocial aspects of breast cancer, there are few studies that specifically compare the utility of assessment methods.
- A number of measures have been used in an attempt to screen for psychological symptoms in women with breast cancer. The Hospital Anxiety and Depression (HAD) scale is a reliable and valid questionnaire to screen for the presence of psychological symptoms and distress in the clinical setting. The European Organisation for Research and Treatment of Cancer Quality of Life Questionnaire (EORTC QLQ-C30) also has good reliability and validity as an assessment of important quality of life dimensions in research and the clinical settings.
- A large systematic review of the evidence relating to screening for distress in a general hospital setting indicated that the routine administration of questionnaires in screening for distress is a costly exercise with little bearing on psychological outcomes. This is supported by research examining the utility of the HAD in detecting diagnosable mental disorders among women with breast cancer. Decisions to use these questionnaires should be taken when assessment reveals the presence of risk factors for severe psychological problems. Distress is often a manifestation of a physical, social, financial or spiritual concern and it should not be assumed that the presence of distress is always the result of an emotional or psychological problem. The measurement of the presence of psychological symptoms in women with breast cancer should be tailored to the individual circumstances of the patient (e.g. presence of high level of distress or risk factors for problems). Routinely administered questionnaires are not recommended for the detection of clinically significant psychological symptoms in women with

breast cancer who do not have specific risk factors for severe anxiety or distress.

- Breast cancer services should routinely screen for the presence of distress and risk factors for very high levels of distress from the point of diagnosis onwards (including during follow up review phases).
- Multidisciplinary teams should have agreed protocols for distress assessment and management. These should include recommendations for referral and care pathways.
- Most of the studies evaluating a psychological intervention that has been delivered in a group format have evaluated supportive expressive therapy, cognitive behavioural group therapy or psycho-education in a group format. Supportive expressive psychotherapy has been shown to have positive effects in reducing traumatic stress symptoms, mood disturbance and pain perception among women with advanced breast cancer. This has not been shown in every study. Supportive expressive therapy appears to have no effect on survival for women with advanced breast cancer.
- Cognitive behaviourally focused group therapy in patients with localised breast cancer has been shown to be associated with a reduction in depression, mood disturbance, and with enhanced quality of life. These benefits have also been found in women with advanced breast cancer, where enhanced self esteem was also reported. The sustainability of these benefits is not yet proven, with studies reporting varying results with regard to maintenance of gains. Although patients expressed high levels of satisfaction with their experiences of cognitive existential group psychotherapy (a therapy that combines elements of supportive expressive and cognitive behavioural therapies) an RCT has not shown beneficial psychosocial outcomes. Discussion forums where women share their experiences offer short term benefit in maintaining patient hope.
- Individual psychological interventions that have a psycho-educational or cognitive behavioural emphasis produce significant improvements in mood, coping and distress. They also have potential to ameliorate the specific side effects of cytotoxic chemotherapy. Problem solving, one-to-one approaches to psychosocial support can reduce distress in younger women with breast cancer and have a role in diminishing unreported need. These effects are not sustained once the intervention has finished. The provision of computers and limited training can aid information and patient confidence, but appears to have no effect on quality of life in general.
- Effects on confidence and knowledge are short term. The benefit of computer-based support over more usual means of support is only marginal. Where telephone therapy has been tried it has been widely acceptable but offers little benefit. There is evidence from one RCT that a psychological intervention implemented by clinical psychologists resulted in improved outcomes for participating patients, when compared with the same intervention delivered by other professionals.
- The limited evidence available for the different forms of therapy and support available is in part due to the different standards and ways in which the interventions were used in the research setting. Cognitive behavioural therapy (in group or individual format according to preference and availability) should be offered to selected patients with anxiety and depressive disorders. Computer and telephone-based interventions should not routinely be offered to patients. Psychological interventions should be implemented according to the validated protocols and procedures used in the

trials that have reported benefits within the literature and in consultation with local specialist psychological services.

- A need for clear, accurate information given face to face was identified. Decisions given over the telephone, conflicting or mislaid information from clinicians and poor communication across the different health settings (primary, secondary and tertiary) created increased anxiety for patients.

Cancer (Familial breast) NICE

Specific recommendations

- Support mechanisms (for example, risk counselling, psychological counselling and risk management advice) need to be identified, and should be offered to women not eligible for referral and/or surveillance on the basis of age or risk level who have ongoing concerns.
- Care of women in secondary care (such as a breast care team, family history clinic or breast clinic which can be shared between trusts) should be undertaken by a multidisciplinary team. It should include....access to psychological assessment and counselling.
- Support mechanisms (for example, risk counselling, psychological counselling and risk management advice) need to be identified and should be offered to women not being offered mammographic surveillance who have ongoing concerns.
- In services offering risk-reducing surgery, psychological assessment and counselling should be offered.
- Pre-operative counselling about psychosocial and sexual consequences of bilateral risk-reducing mastectomy should be undertaken.
- Women considering bilateral risk-reducing mastectomy should be offered access to support groups and/or women who have undergone the procedure.
- Any discussion of bilateral oophorectomy as a risk-reducing strategy should take fully into account factors such as anxiety levels on the part of the woman concerned.
- Women considering risk-reducing bilateral oophorectomy should have access to support groups and/or women who have undergone the procedure.
- Women considering risk-reducing bilateral oophorectomy should be informed of possible psychosocial and sexual consequences of the procedure and have the opportunity to discuss these issues.

Cancer (Head and Neck): SIGN

Specific recommendations

- Head and neck cancer patients should be offered emotional support, which may be provided by clinical nurse specialists and non-clinically trained counsellors.
- Leaflets about risk factors, prevention and early detection of head and neck cancer should be available in primary care.
- Early diagnosis clinics should be provided where possible for the investigation of patients with suspected lung cancer, because they are associated with ... less patient anxiety.

General comments

- There is evidence that patients with head and neck cancer suffer from anxiety, depression, disturbance of body image and difficulty in maintaining quality of life. The complex needs of patients with head and neck cancer require psychological support to address the problems they may encounter. There is some evidence that maximum psychological support should continue for three months post-radiotherapy. No studies have addressed the clinical benefit of psychological support, or who should provide the support.
- In some situations it may be appropriate to refer patients to a clinical psychologist.
- Although patients are most anxious at the earliest part of diagnosis, evidence suggests that the time patients experience their most severe depression is at two to three months post-diagnosis.
- Quality of life scores show improvement over time, unless the patient experiences recurrent disease. Patients need social and psychological help and palliative care to support them as they deal with these issues.
- Patients with incurable head and neck cancer often have multiple physical and psychological problems, which may be difficult to manage. They may benefit from input from a wide variety of clinical services.
- [Regarding smoking cessation] symptoms associated with nicotine withdrawal are: depression.
- Cancer and many of its treatments can cause significant fatigue, impacting on patients' quality of life. An essential component of managing fatigue is its recognition by healthcare professionals and the correction of known causal factors such as a poor sleep pattern, anaemia, drug reactions and depression.
- Complementary treatments are usually aimed at symptom relief, often through emotional and psychological support, and are used alongside conventional cancer therapies.
- One study reported that patients suffering from disfigurement who attended a support group had lower life happiness. Women seemed to have more depressive symptoms but also seem to benefit more from support. ...
- Patients should be offered information about support groups.
- Availability of information in primary care reduces anxiety. Both men and women find written information useful. Patient information leaflets about risk factors, prevention and early detection of oral cancer increased knowledge, decreased anxiety and increased patients' intention to have an oral cancer screen.

Cancer (Improving outcomes in head and neck cancers - the Manual): NICE

General comments

- Local support team members [should include]: Psycho-oncology, liaison psychiatry, clinical psychology and/or counselling services.
- Some consultants were reluctant to provide the information that patients wanted. This tended to heighten anxiety.
- A non-randomised study found that anxiety levels were consistently lower among patients who received music therapy, aromatherapy, or guided imagery during radiotherapy than among controls.

Cancer (Improving outcomes in children and young people with cancer - the Manual): NICE

Specific recommendations

- There should be access to expert psychological support with clear routes of referral in principal treatment centres and other treatment settings. This should include identified psychologists or other members of psychological services with expertise in the care of children and young people with cancer. It is important that use is made of existing services and that access to these is facilitated...The role of other members of the MDT in providing psychological and emotional support to patients, families and carers should be acknowledged and appropriate training and support provided.

General comments

- Psychological services have an important role to play at all stages along the patient pathway, including after completion of treatment and into adult life.

Cancer (lung): SIGN

Specific recommendations

- Counselling interventions may be effective in helping patients cope more effectively with the emotional symptoms associated with their disease but the most appropriate way of delivering these remains unclear. All patients should undergo psychosocial assessment and have access to appropriate psychosocial and spiritual support.

General comments

- The studies underline the importance of enabling patients to make informed choices and that accurate information reduces patient anxiety, even when the news is bad.
- Significant psychological distress has been reported in 43% of patients with lung cancer.
- Palliative care is defined as the active holistic care of patients with advanced, progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount.

Cancer (Prostate): NICE

General comments

- Knowledge of disease and treatment options and participation in the decision process were increased with decision aids, but there was no evidence of an effect on satisfaction with decisions, anxiety, or health outcomes.
- Being diagnosed with cancer and the specific nature and side effects of many of the treatments used in prostate cancer can have an effect on a man's sense of masculinity. This will apply to factors such as sexual function, urinary problems, bowel function, pain, fatigue and psychological distress.
- Manne et al (2004) reported that the effects of a structured group psychosocial intervention were modest and psychological distress was not affected. Another study (Thornton et al. 2004) reported partial support for the effectiveness of a single-session communication intervention on patient social/family wellbeing and partners' general stress.
- The management of physical symptoms and the psychological needs of men with metastatic prostate cancer needs to draw on the expertise of many healthcare professionals.

Cancer (Referral for suspected cancer): NICE

Specific recommendations

- [There should be] appropriate assessment for presence of anxiety or depression. [There should be] appropriate assessment of current life stresses and past trauma and abuse.
- Persistent parental anxiety should be a sufficient reason for referral of a child or young person, even when the primary healthcare professional considers that the symptoms are most likely to have a benign cause.

General comments

- The experience of the diagnosis of cancer is a stressful event that is followed by symptoms such as anxiety and depression.
- It has been reported that 15%-40% of cancer patients develop clinical anxiety and/or depression.
- Stratifying by psychological distress did not remove the excess of fatigue in women. 40.1% attributed fatigue to psychosocial issues (work, family, lifestyle), and 16.7% to psychological factors (anxiety, depression); 14.7% gave physical reasons (e.g. surgery, anaemia).
- Fatigued patients were much more likely than controls to have psychometric test scores indicative of depression or anxiety.
- French general practitioners identifying 3784 patients aged 18-64 [found that] depression and psychological problems were diagnosed in 50% of patients.
- People with a history of anxiety and depression were only half as likely to be treated within 90 days.
- The effect of psychological interventions on anxiety and depression in cancer patients [was considered in the] results of two meta-analyses.
- The epidemiology of fatigue and depression [was considered in a French study] that looked at unexplained fatigue syndromes in a multinational primary care sample.

Cancer (Supportive and palliative care - the manual): NICE

Specific recommendations (see the manual for a complete list)

- The psychological well-being of patients and carers should be explicitly assessed at key points in the patient pathway.
- All staff directly responsible for patient care should offer patients general emotional support based on skilled communication, effective provision of information, courtesy and respect.
- Patients and carers found to have significant levels of psychological distress should be offered prompt referral to services able to provide specialist psychological care. A four-level model of professional psychological assessment and intervention is suggested to achieve this (see the manual for more information on the four-level model).
- Provider organisations should nominate a lead person to oversee the development and implementation of services that specifically focus on the needs of families and carers during the patient's life and in bereavement, and which reflect cultural sensitivities.

- Emergency psychiatric services should be available when necessary. Patients with severe mental health problems may require these services in and out of normal working hours.
- Psychological assessments and interventions should be undertaken in facilities that are quiet, comfortable and which confer privacy.
- Staff providing psychological care should be adequately trained and supervised, and mechanisms to ensure support should be available.
- Cancer Networks should develop criteria for referral to specialist psychological support services. Teams should be familiar with these criteria and the mechanisms through which to expedite referral.
- Professionals offering different levels and types of psychological intervention should develop mechanisms to co-ordinate their service provision to ensure that interventions offered are most appropriate to a person's needs. This might include referral guidelines for each type (and level) of psychological intervention. If different specialists within a psychological support service work in an integrated way, referrals could initially be made to the overall service, with a subsequent system of assessment and triage used to decide the appropriate intervention. Final choice of treatment should be guided by patient preference, as there is considerable overlap in the mental health problems for which different therapeutic approaches can be effective.
- Commissioners should ensure that emergency psychiatric services are available for patients who develop acute mental health problems and are a potential danger to themselves or others. They should also ensure that health care professionals have 24- hour, seven days a week access to advice for people caring for patients with acute mental health problems. This will typically be provided by the local mental health team.
- Teams who care for people with cancer and those who care for people with mental health problems should endeavour to promote closer working relationships, developing mechanisms to enable them jointly to meet the needs of patients with cancer who develop mental health problems and those with mental health problems who develop cancer.
- Psychological support services should have agreed processes for transfer of information within their service and with other services, teams and practitioners working with individual patients and carers. Information should include the findings from individual assessments, proposed treatment plans and outcomes of treatment. An agreed formal process for managing sensitive and private issues will be needed within teams.
- Local service directories on supportive and palliative care should include information on psychological support services and the range of support groups available.
- Practitioners responsible for the delivery of psychological care at each of the different levels should be identified.

General comments

- Psychological distress is common among people affected by cancer and is an understandable and natural response to a traumatic and threatening situation. Patients at every stage of the patient pathway can find themselves dealing with difficult and distressing issues. They can develop problems ranging from sadness or worry to psychological symptoms sufficiently intense to interfere with their ability to function on a day-to-day basis.
- 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.
- People use a variety of resources to respond to this distress, including their own inner resources and emotional support from family and friends. For some patients, however, the level and nature of their distress is such that they would benefit from professional support.
- Patients and carers are likely to benefit from some form of professional psychological support whether they experience mild and transient emotional turmoil or severe depression. The appropriate psychological intervention will depend on the nature and severity of the person's psychological problem, his or her previous psychological problems, the quality of social support available and the prognosis.
- A range of psychological interventions can be offered by both the statutory and voluntary sectors. Health and social care professionals offering day-to-day care provide much general psychological support to patients and carers and play a key role in psychological assessment and prevention and amelioration of distress. More specialised services include counselling, clinical and health psychology, liaison psychiatry and social work. These may be available as an integral part of local cancer services or may be part of generic mental health services, primary care services or hospice care. They can be located in GP practices, hospitals or hospices. The voluntary sector provides additional services, including telephone helplines and self-help and support groups.
- GPs, oncologists and palliative care physicians also have an important role in the psychological care of patients and carers, which includes the prescription of antidepressant and other psychotropic medication.
- 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.
- 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.

- Many patients suggest that the transition from active treatment to 'survivorship' is one of the most psychologically demanding phases of the patient pathway. Patients who have completed active treatment should be informed about the range of support services available and how to access them directly. In the first instance, this is likely to be through a GP or 'key worker', but it should be recognised that such needs can develop a considerable time after treatment has stopped.
- Evaluative research is needed to determine which psychotherapeutic interventions are most effective and cost effective for different groups of patients at different stages of the patient pathway.

Chronic fatigue syndrome / Myalgic encephalomyelitis NICE

Specific recommendations

- Relaxation techniques appropriate to the person with CFS/ME should be offered for the management of pain, sleep problems and comorbid stress or anxiety.
- Encouraging complete rest (cognitive, physical and emotional) during a setback/relapse.
- An individualised, person-centred programme should be offered to people with CFS/ME. The objectives of the programme should be to sustain or gradually extend, if possible, the person's physical, emotional and cognitive capacity, and manage the physical and emotional impact of their symptoms.
- Cognitive behavioural therapy (CBT) and/or graded exercise therapy (GET) should be offered to people with mild or moderate CFS/ME and provided to those who choose these approaches, because currently these are the interventions for which there is the clearest research evidence of benefit.
- If a full CBT or GET programme is inappropriate or not available, components of CBT or GET should be offered.
- When managing setbacks, healthcare professionals should put strategies in place that ... recognise distressing thoughts about setbacks/relapses such as 'this means I'll never get better', but encourage optimism.

Chronic heart failure NICE

Specific recommendations

- Carers and relatives of patients who are cognitively impaired should be made aware of treatment regimens for the patients they care for and be encouraged to identify any need for clinical support.
- The diagnosis of depression should be considered in all patients with heart failure.
- 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.
- Where it is apparent that depression is co-existing with heart failure, then the patient should be treated for depression following the NICE guideline.
- For patients with heart failure, the potential risks and benefits of drug therapies for depression should be considered carefully.
- 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*). Healthcare professionals should be aware of the potential interaction with prescribed medication, and always ask about self-medication, including the use of herbal products.
- Issues of sudden death and living with uncertainty are pertinent to all patients with heart failure. The opportunity to discuss these issues should be available at all stages of care.

Chronic heart failure SIGN

General comments

- Further research: Does the identification of depression or anxiety in patients with heart failure lead to treatment interventions which improve quality of life?
- SIGN recommends [Depression Alliance Scotland](#) as a source of further information
- The studies which exist in this area demonstrate high rates of unmet needs in the areas of symptom management, communication, decision-making, emotional support, co-ordination of care and quality end-of-life care.

Chronic obstructive pulmonary disease (COPD) NICE

Specific recommendations

- Healthcare professionals should be alert to the presence of depression in patients with COPD.
- The presence of anxiety and depression should be considered in patients who are hypoxic....who have severe dyspnoea, who have been seen at or admitted to a hospital with an exacerbation of COPD.
- Patients found to be depressed or anxious should be treated with conventional pharmacotherapy.

General comments

- The presence of anxiety and depression in patients with COPD can be identified using validated assessment tools.
- For antidepressant treatment to be successful, it needs to be supplemented by spending time with the patient explaining why depression needs to be treated alongside the physical disorder.

Diabetes (Type 1) NICE

Specific recommendations

- Children and young people with type 1 diabetes should be offered an ongoing integrated package of care by a multidisciplinary paediatric diabetes care team... with appropriate training in ...mental health.
- Children and young people with type 1 diabetes and their families should be offered appropriate emotional support following diagnosis, which should be tailored to emotional, social, cultural and age-dependent needs.
- Diabetes care teams should be aware that children and young people with type 1 diabetes have a greater risk of emotional and behavioural problems than other children and young people.
- Diabetes care 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.
- Children and young people with type 1 diabetes who have persistently poor glycaemic control should be offered screening for anxiety and depression.
- Children and young people with type 1 diabetes and suspected anxiety and/or depression should be referred promptly to child mental health professionals.
- Children and young people with type 1 diabetes who have behavioural or conduct disorders, and their families should be offered access to appropriate mental health professionals.
- Diabetes care teams should be aware that poor psychosocial support has a negative impact on a variety of outcomes of type 1 diabetes in children and young people, including glycaemic control and self-esteem.
- Children and young people with type 1 diabetes, especially young people using multiple daily injection regimens, should be offered structured behavioural intervention strategies because these may improve psychological well-being and glycaemic control.

- Families of children and young people with type 1 diabetes should be offered specific support strategies (such as behavioural family systems therapy) to reduce diabetes-related conflict between family members.
- Children and young people with type 1 diabetes and their families should be offered timely and ongoing access to mental health professionals because they may experience psychological disturbances (such as anxiety, depression, behavioural and conduct disorders and family conflict) that can impact on the management of diabetes and well-being.
- Diabetes care teams should have appropriate access to mental health professionals to support them in the assessment of psychological dysfunction and the delivery of psychosocial support.
- For adults with erratic and unpredictable blood glucose control (hyper- 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.
- At the time of diagnosis (or if necessary after the management of critically decompensated metabolism) the professional team should develop with and explain to the person with type 1 diabetes a plan for their early care. To agree such a plan will generally require medical assessment to.....review and detect potentially confounding disease and drugs....and assessment of emotional state to determine the appropriate pace of education.
- Members of professional teams providing care or advice to adults with diabetes should be alert to the development or presence of clinical or sub-clinical depression and/or anxiety, in particular where someone reports or appears to be having difficulties with self-management.
- 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. They should be familiar with appropriate counselling techniques and appropriate drug therapy, while arranging prompt referral to specialists of those people in whom psychological difficulties continue to interfere significantly with well-being or diabetes self-management.
- Special management techniques or treatment for non-severe psychological illness should not commonly be used, except where diabetes-related arterial complications give rise to special precautions over drug therapy.
- Members of multidisciplinary 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 body mass index, poor overall blood glucose control.

General comments

- Areas for future research: Evaluation of the effectiveness of behavioural and social interventions for managing anxiety and depression, eating disorders, behavioural and conduct disorders, and non-adherence to therapy in children and young people with newly diagnosed and established type 1 diabetes, especially in young people.

Diabetes (management of) SIGN

Specific recommendations

- ...Regular assessment for psychological problems, especially maladaptive coping strategies and eating disorders is recommended...Specific psychological problems (e.g. maladaptive coping strategies) linked to future glycaemic control, can be identified at diagnosis and 1-2 years later, using validated tools performed by a trained practitioner...Psychological or educational interventions have positive effects on psychological outcomes, knowledge about diabetes and glycaemic control....Parental support and family communication should be encouraged, with targeted psychological treatment of family disruption and related stress.

General comments

- Factors contributing to an increased risk of young people with diabetes developing psychological problems include ... poor maternal health, especially depression.
- Lifestyle management ...other factors which may be related to their diabetes, such as depression and adverse effects on quality of life.

Epilepsy NICE

Specific recommendations

- Individuals should have access to counselling services if appropriate
- Individuals should have referral to tertiary services if appropriate (tertiary services should include psychiatry and referral criteria should include psychological or psychiatric co-morbidity and suspected non-epileptic seizures).
- Individuals with epilepsy and their families and/or carers should be given and have access to sources of information about...psychological issues.
- In an individual with an attack, a physical examination should be carried out. This should address the individual's mental state.
- Where non-epileptic attack disorder is suspected, suitable referral should be made to psychological or psychiatric services for further investigation and treatment (included in outline care algorithm).
- Referral (to tertiary services) should be considered when...there is psychological and/or psychiatric co-morbidity.
- The expertise of multidisciplinary teams involved in managing complex epilepsy should include psychology, psychiatry...counselling.

General comments

- During adolescence a named clinician should....ensure smooth transition to adult services and be aware of the need for continuing multi-agency support.
- The diagnosis of epilepsy should be reviewed during adolescence (the full guidance states one reason for this is the prior mis-diagnosis of non-epileptic seizure).
- Adherence to treatment and strategies to improve this are recorded as important (Not mentioned in the guideline is the evidence base supporting the need to address psychological and psychiatric issues to improve adherence).

- Psychological interventions (including cognitive behaviour therapy) may be used in conjunction with anti-epileptic drugs...This approach may be associated with an improved quality of life.
- Psychological interventions may be used as an adjunctive therapy.

Falls NICE

Specific recommendations

- 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.
- Individuals at risk of falling, and their carers, should be offered information orally and in writing about: ...the physical and psychological benefits of modifying falls risk.
- Information on the following should be provided orally and in writing... physical/psychological benefits of modifying risk.

General comments

- There is no evidence that cognitive/behavioural interventions alone reduce the incidence of falls in community-dwelling older people of unknown risk status. Such interventions included risk assessment with feedback and counselling and individual education discussions.
- There is no evidence that cognitive/behavioural interventions alone reduce the incidence of falls in community-dwelling older people of unknown risk status. Such interventions included risk assessment with feedback and counselling and individual education discussions. There is no evidence that complex interventions in which group activities included education, a behaviour modification programme aimed at modifying risk, advice and exercise interventions are effective in falls prevention with community-dwelling older people.

Fertility NICE

Specific recommendations

- Couples should be informed that stress in the male and/or female partner can affect the couple's relationship, and is likely to reduce libido and frequency of intercourse which can contribute to fertility problems.
- People who experience fertility problems should be offered counselling because fertility problems themselves, and the investigation and treatment of fertility problems, can cause psychological stress.
- Counselling should be offered before, during and after investigation and treatment, irrespective of the outcome of these procedures.
- Where a specific genetic defect associated with male infertility is known or suspected couples should be offered appropriate genetic counselling and testing.
- Couples considering donor insemination should be offered counselling from someone who is independent of the treatment unit regarding all the physical and psychological implications of treatment for themselves and potential children.

General comments

- Research recommendations include: further research to assess the long-term psychological impact of investigation and treatment of people who perceive problems with their fertility, both in people who subsequently achieve a live birth and people who do not.

Head injury (triage, assessment, investigation and early management of head injury in infants, children and adults) NICE

Specific recommendations

- When a person who has undergone imaging of the head and/or been admitted to hospital experiences persisting problems, there should be an opportunity available for referral from primary care to an out-patient appointment with a professional trained in assessment and management of sequelae of brain injury (for example, clinical psychologist, neurologist, neurosurgeon, specialist in rehabilitation medicine).

General comments

- Patients who do survive significant TBI experience an enormous burden of long term physical disability, neurocognitive deficits, and neuropsychiatric sequelae.
- If the person is still having problems, the GP should be able to arrange an outpatient appointment with someone trained in caring for people after a head injury (for example, a neurologist, clinical psychologist, neurosurgeon or specialist in rehabilitation medicine).
- Post-concussion syndrome refers to problems, including headaches, dizziness, poor concentration, memory problems, speaking or listening difficulties, and emotional and behavioural problems, that can happen in the weeks or months after having a head injury. The syndrome is caused by tiny areas of bruising or other damage to the nerve cells in the brain.
- Early support can help the patient's family or carer(s) prepare for the effects of head injury. This support can reduce the psychological sequelae, experienced by the family or carer and result in better long term outcomes for both the patient and their family.

Head Injury (early management) SIGN

Specific recommendations

- Information should be available in a variety of formats...taking into account...mental and social issues.

General comments

- Up to half of all inpatients with head injury experience long term psychological and/or physical disability.

Multiple Sclerosis NICE

Specific recommendations

- As a minimum, the specialist neurological rehabilitation service should have as integral members of its team,
 - clinical psychologists ...
 - liaison psychiatry
- Any person with MS whose function or happiness is being adversely affected by anxiety should be offered specialist assessment and management.
- In people with MS with marked anxiety, psychologically-based treatment should be offered.
- Pharmacological treatment of anxiety should be through using antidepressants or benzodiazepines.
[Patients] who do not respond to sildenafil should be assessed for the general and specific factors that might cause or worsen erectile dysfunction and that are amenable to treatment (such as depression, anxiety...).
- Every person (or couple) with MS ...should be offered information about locally available counselling and supportive services.

General comments

- Issues for people with MS and their carers: Anxiety within the family and the person: This should be dealt with in the information given to people with MS.
- Adverse events from drugs might include, for example, rashes, feeling fatigued and being depressed.
- MS is a disease that causes emotional distress in many ways.
- [Importance of] 'asking about their [the children of MS patients] physical and emotional health
- Individuals with 'positive' work-ups became less anxious and expressed favourable feelings about the diagnosis despite now facing a chronic disease.
- There are many beliefs held by those with MS, professionals, relatives and others about factors that might precipitate a relapse. There are two cohort studies and two case-control studies of emotional stressors and the evidence suggests that there is conflicting evidence regarding an association between stress and MS relapses. Several studies have shown no significant association between stressful life events and psychological stress with MS relapses.
- The first RCT examined the use of fully trained service dogs for wheelchair mobile people with MS. The results showed significant beneficial effects on all of the eight outcome measures assessed including psychological...needs.
- Local Implementation Points need to specify how to access specialist psychological and psychiatric advice.
- Massage/bodywork and psychological counselling appear to improve depression, anxiety and self-esteem. However, the strength of evidence for any of the therapies was limited as many of the trials suffered from significant methodological flaws.

Obesity NICE

Specific recommendations

- After appropriate measurements have been taken and the issues of weight raised with the person, an assessment should be done, covering...psychological problems...willingness and motivation to change...and psychosocial distress.
- [For children, assessment should also cover] psychosocial distress, such as low self-esteem, teasing and bullying.
- In children aged 12 years and older, treatment with orlistat or sibutramine is recommended only if physical comorbidities (such as orthopaedic problems or sleep apnoea) or severe psychological comorbidities are present.

General comments

- Regular physical activity is associated with higher academic achievement, better health in childhood and later life, higher motivation at school and reduced anxiety and depression.

Obesity (management of obesity in children and young people) SIGN

Specific recommendations

- Obese children showing signs of distress and their families should be considered for referral for psychological assessment and treatment.
- The following groups should be referred to hospital or community paediatric consultants before treatment is considered...children who may have serious obesity-related morbidity that requires weight loss... [including] psychological morbidity.

General comments

- Obese children are more likely to show evidence of psychological distress.
- Obesity in childhood and adolescence is also associated with:
 - Poor self-esteem
 - Being perceived as unattractive
 - Depression
 - Disordered eating
 - Bulimia
 - Body dissatisfaction
- Research recommendation: The prevalence and degree of psychological complications of obesity in children of the UK needs to be defined in a well designed cohort study.

Parkinson's Disease (PD) NICE

Specific recommendations

- Clinicians should have a low threshold for diagnosing depression in PD.
- Clinicians should be aware that there are difficulties in diagnosing mild depression in people with PD because the clinical features of depression overlap with the motor features of PD.
- The management of depression in people with PD should be tailored to the individual, in particular, to their co-existing therapy.
- All people with PD and psychosis should receive a general medical evaluation and treatment for any precipitating condition.
- Consideration should be given to withdrawing gradually antiparkinsonian medication that might have triggered psychosis in people with PD.
- Mild psychotic symptoms in people with PD may not need to be actively treated if they are well tolerated by the patient and carer.
- Typical antipsychotic drugs (such as phenothiazines and butyrophenones) should not be used in people with PD because they exacerbate the motor features of the condition.
- Atypical antipsychotics may be considered for treatment of psychotic symptoms in people with PD, although the evidence base for their efficacy and safety is limited.
- Clozapine may be used in the treatment of psychotic symptoms in PD, but registration with a mandatory monitoring scheme is required. It is recognised that few specialists caring for people with PD have experience with clozapine.
- Although cholinesterase inhibitors have been used successfully in individual people with PD dementia, further research is recommended to identify those patients who will benefit from this treatment.
- Because people with PD may develop impaired cognitive ability, a communication deficit and/or depression, they should be provided with both oral and written communication throughout the course of the disease...and consistent communication from the professionals involved.
- Bilateral subthalamic nucleus (STN) stimulation may be used in people with PD who... have no clinically significant active mental health problems, for example, depression or dementia.
- Bilateral globus pallidus interna (GPi) stimulation may be used in people with PD who... have no clinically significant active mental health problems, for example, depression or dementia.
- Anticholinergics may be used as a symptomatic treatment typically in young people with early PD and severe tremor, but should not be drugs of first choice due to limited efficacy and the propensity to cause neuropsychiatric side effects.
- Good sleep hygiene should be advised in people with PD with any sleep disturbance and includes... a review of all medication and avoidance of any drugs that may affect sleep or alertness, or may interact with other medication (for example, selegiline, antihistamines, H2 antagonists, antipsychotics and sedatives).

General comments

- Although PD is predominantly a movement disorder, other impairments frequently develop including psychiatric problems such as depression and dementia.
- The frequency of depression, psychosis and dementia are emphasised along with the skills needed to diagnose and manage these conditions.
- Cross-sectional studies have shown that depression affects around 40% of patients with PD and has a major impact on quality of life. In most cases, depression is mild to moderate in severity and is often missed by the clinician caring for the patient.
- The guideline development group recommends a study that would screen secondary care Parkinson's disease clinic populations for mild to moderate depression. Participants would then be treated with any SSRI class antidepressant or no such treatment in an open-label fashion. This would be a large-scale pragmatic trial.
- If screening for and treating mild to moderate depression is cost effective, this would add to the evidence base for the management of depression in Parkinson's disease and may have considerable impact on the next update of this guideline.

Postnatal care (routine postnatal care of women and their babies) NICE

Specific recommendations

- Women should be offered information and reassurance on: normal patterns of emotional changes in the postnatal period and that these usually resolve within 10–14 days of giving birth.
- At each postnatal contact, women should be asked about their emotional well-being, what family and social support they have and their usual coping strategies for dealing with day-to-day matters. Women and their families/partners should be encouraged to tell their healthcare professional about any changes in mood, emotional state and behaviour that are outside of the woman's normal pattern.
- Formal debriefing of the birth experience is not recommended.
- All healthcare professionals should be aware of signs and symptoms of maternal mental health problems that may be experienced in the weeks and months after the birth.
- At 10–14 days after birth, women should be asked about resolution of symptoms of baby blues (for example, tearfulness, feelings of anxiety and low mood). If symptoms have not resolved, the woman should be assessed for postnatal depression, and if symptoms persist, evaluated further.
- Women should be encouraged to help look after their mental health by looking after themselves. This includes taking gentle exercise, taking time to rest, getting help with caring for the baby, talking to someone about their feelings and ensuring they can access social support networks.
- If persistent postnatal fatigue impacts on the woman's care of herself or baby, underlying physical, psychological or social causes should be evaluated.
- Healthcare professionals should be aware of the risks, signs and symptoms of domestic abuse and know who to contact for advice and management, following guidance from the Department of Health.

- At the end of the postnatal period, the coordinating healthcare professional should ensure that the woman's physical, emotional and social well-being is reviewed. Screening and medical history should also be taken into account.
- Assessment for emotional attachment should be carried out at each postnatal contact.
- Home visits should be used as an opportunity to promote parent- or mother-to-baby emotional attachment.
- Group based parent-training programmes designed to promote emotional attachment and improve parenting skills should be available to parents who wish to access them.

General comments

- Postnatal depression affects 10–15% of mothers and can lead to cognitive and emotional disturbance in the baby alongside the effects on the mother. Children of depressed mothers are more likely to access Child and Adolescent Mental Health Services (CAMHS) and suffer mental health problems as adolescents and adults. Social isolation is a known risk factor for postnatal depression and reducing this may have a range of clinical and psycho-social benefits.
- A randomised controlled trial is proposed to evaluate the effect on the rate of postnatal depression of providing enhanced peer support compared to standard care for women who are at risk of social isolation after childbirth.
- Outcomes should include quality of life and clinical measures: maternal and infant/child psychological wellbeing, depression, social wellbeing, physical health
- This research would complement research funded by the Health Technology Assessment programme evaluating different models of care in the postnatal period.

Pressure ulcer management NICE

Specific recommendations

- Patients with pressure ulcers should receive an initial and ongoing holistic assessment.... This assessment should include: ...psychological factors...Psychological assessment should include concordance and abilities of the individual to self-care (mood, motivation and aptitude).

General comments

- The presence of a pressure ulcer creates a number of significant difficulties – psychologically, physically and clinically.

Tuberculosis NICE

Specific recommendations

- Clinicians who are planning to start a patient on a course of directly observed therapy (DOT) should consider ways to mitigate the environmental, financial and psychosocial factors that may reduce adherence, including stability of accommodation, prescription charges and transport. The setting, observer and frequency of treatment should be arranged to be most practicable for the person with TB. The person with TB and his or her assigned key worker should be involved in deciding these arrangements. DOT should also be supported by frequent contact with the key worker.

General comments

- The guideline does not extend to comorbidities such as HIV, drug dependencies, diabetes, hepatic disease, renal disease, or mental illness

Urinary incontinence (the management of urinary incontinence in women) NICE

General comments

- Urinary incontinence (UI) is a common condition that may seriously influence the physical, psychological and social wellbeing of affected individuals.

Comments or suggested changes? Email plan@cru.rcpsych.ac.uk

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