Association for Family Therapy and Systemic Practice

NICE Clinical Guidelines recommending Family and Couple Therapy

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NICE Clinical Guidelines recommending Family and Couple Therapy

Introduction

This document is an up to date summary of the recommendations made by NICE (the National Institute for Health and Care Excellence) in clinical guidelines and updated clinical guidelines, between March 2012 and July 2016, about using family, couple and systemic therapies, and/or the involvement of families and carers when working with people with various mental and physical health problems. This document can be read in conjunction with the Summary of Family and Couple Interventions, Jeni Webster, March 2012, which summarises NICE guideline recommendations up to March 2012. NICE clinical guidelines give recommendations for Health and Care Professionals, and for people and their carers, about the most effective care and interventions, based on the best available evidence (as defined by NICE).

A full list of guidelines that were reviewed is included in the Appendix (see page 11). Guidelines which do not include recommendations for family, couple and systemic therapies, or the involvement of family members and carers, have not been included in this document. However, this does not mean that families and carers should be excluded when working with any mental or physical health problem.

Section 1 outlines Clinical Guidelines with an evidence base that meets NICE standards. Section 2 encompasses evidence that recommends the involvement of families and carers. Further information and full guidance is available from the NICE website (www.NICE.org.uk).

Both Sections 1 and 2 have a Quick Reference Table to refer to when seeking guidance about the recommended form of interventions for each clinical presentation. Further explanation about the method of delivery of treatment can be found in the main body of the text.

Quick Reference

TABLE 1: RECOMMENDATIONS FOR FAMILY AND COUPLE THERAPIES

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CG115 – ALCOHOL USE DISORDERS: DIAGNOSIS, ASSESSMENT AND MANAGEMENT OF HARMFUL DRINKING AND ALCOHOL DEPENDENCE

1.3.3 Interventions for harmful drinking and mild alcohol dependence
1.3.3.2 For people who drink to harmful levels and people with mild alcohol dependence who have a regular partner who is willing to participate in treatment, offer behavioural couples therapy.
1.3.3.6 Behavioural couples therapy should be focused on alcohol-related problems and their impact on relationships. It should aim for abstinence, or a level of drinking predetermined and agreed by the therapist and the service user to be reasonable and safe. It should usually consist of one 60-minute session per week for 12 weeks.

1.3.6 Interventions for moderate and severe alcohol dependence after successful withdrawal
1.3.6.2 After a successful withdrawal for people with moderate and severe alcohol dependence, consider offering acamprosate or oral naltrexone in combination with behavioural couples therapy to service users who have a regular partner and whose partner is willing to participate in treatment (see section 1.3.3).

1.3.7 Special Considerations for Children and Young People who Misuse Alcohol
1.3.7.8 For children and young people aged 10–17 years who misuse alcohol offer: individual cognitive behavioural therapy for those with limited co-morbidities and good social support.
- Multi-component programmes (such as multidimensional family therapy, brief strategic family therapy, functional family therapy or multi-systemic therapy) for those with significant co-morbidities and/or limited social support.

Delivering psychological and psychosocial interventions for children and young people
1.3.7.10 Multidimensional family therapy should usually consist of 12-15 family focused structured treatment sessions over 12 weeks. There should be a strong emphasis on care coordination and, if necessary, crisis management. As well as family sessions, individual interventions may be provided for both the child or young person and the parents. The intervention should aim to improve:
- alcohol and drug misuse
- the child or young person’s educational and social behavior
- parental well-being and parenting skills
- relationships with the wider social system.
1.3.7.11 Brief strategic family therapy should usually consist of fortnightly meetings over 3 months. It should focus on:
- engaging and supporting the family
- using the support of the wider social and educational systems
- identifying maladaptive family interactions
- promoting new and more adaptive family interactions.

1.3.7.12 Functional family therapy should be conducted over 3 months by health or social care staff. It should focus on improving interactions within the family, including:
- engaging and motivating the family in treatment (enhancing perception that change is possible, positive reframing and establishing a positive alliance)
- problem solving and behavior change through parent training and communication training
- promoting generalisation of change in specific behaviors to broader contexts, both within the family and the community (such as schools).

1.3.7.13 Multisystemic therapy should be provided over 3–6 months by a dedicated member of staff with a low caseload (typically between three and six cases). It should:
- focus specifically on problem-solving approaches with the family
- use the resources of peer groups, schools and the wider community.

CG192 – ANTENATAL AND POSTNATAL MENTAL HEALTH

Interventions for severe mental illness
1.8.16 Consider psychological interventions for women with bipolar disorder. This includes:
- CBT, IPT and behavioural couples therapy for bipolar depression
- structured individual, group and family interventions designed for bipolar disorder to reduce the risk of relapse, particularly when medication is changed or stopped [new 2014].
1.8.18 Consider psychological interventions (CBT or family intervention) delivered as described in section 1.3.7 of the guideline on psychosis and schizophrenia in adults (NICE guideline CG178) for a woman with psychosis or schizophrenia who becomes pregnant and is at risk of relapse arising from:
- stress associated with pregnancy or the postnatal period
- a change in medication, including stopping antipsychotic medication [new 2014].

CG158 – ANTI SOCIAL BEHAVIOUR AND CONDUCT DISORDERS IN CHILDREN AND YOUNG PEOPLE: RECOGNITION AND MANAGEMENT

Several interventions have been developed for children with conduct disorder and related problems, such as parenting programmes typically focused on younger children and multi-systemic approaches usually focused on older children.

Multimodal interventions
1.5.13 Offer multimodal interventions, for example, multi-systemic
1. Managing bipolar disorder in primary care
Offer people with bipolar depression:
- a psychological intervention that has been developed specifically for bipolar disorder and has a published evidence-based manual describing how it should be delivered or
- a high-intensity psychological intervention (cognitive behavioural therapy, interpersonal therapy or behavioural couples therapy) in line with recommendations 1.5.3.1–1.5.3.5 in the NICE clinical guideline on depression.
- Discuss with the person the possible benefits and risks of psychological interventions and their preference. Monitor mood and if there are signs of hypomania or deterioration of the depressive symptoms, liaise with or refer the person to secondary care. If the person develops mania or severe depression, refer them urgently to secondary care.

1.2.6
Psychological therapists working with people with bipolar depression in primary care should have training in and experience of working with people with bipolar disorder

2. Managing bipolar depression in adults in secondary care
Offer adults with bipolar depression:
- a psychological intervention that has been developed specifically for bipolar disorder and has a published evidence-based manual describing how it should be delivered or
- a high-intensity psychological intervention (cognitive behavioural therapy, interpersonal therapy or behavioural couples therapy) in line with recommendations 1.5.3.1–1.5.3.5 in the NICE clinical guideline on depression.
- Discuss with the person the possible benefits and risks of psychological interventions and their preference. Monitor mood for signs of mania or hypomania or deterioration of the depressive symptoms.

3. Managing bipolar disorder in adults in the longer term in secondary care
Offer a structured psychological intervention (individual, group or family), which has been designed for bipolar disorder and has a published evidence-based manual describing how it should be delivered, to prevent relapse or for people who have some persisting symptoms between episodes of mania or bipolar depression.

4. Recognising, diagnosing and managing bipolar disorder in children and young people
1.11.11
Bipolar Depression: Offer a structured psychological intervention (individual cognitive behavioural therapy or interpersonal therapy) to young people with bipolar depression. The intervention should be of at least 3 months’ duration and have a published evidence-based manual describing how it should be delivered.
1.11.12
If after 4 to 6 weeks there is no or a limited response to cognitive behavioural therapy or interpersonal therapy, carry out a multidisciplinary review and consider an alternative individual or family psychological intervention.
1.11.13
If there is a risk of suicide or self-harm or any other risk outlined in recommendation 1.3.5, carry out an urgent review and develop a risk management plan as outlined in recommendation 1.4.1.
1.11.14
After the multidisciplinary review, if there are coexisting factors such as comorbid conditions, persisting psychosocial risk factors such as family discord, or parental mental ill-health, consider an alternative psychological intervention for bipolar depression for the young person, their parents or other family member or
- an additional psychological intervention for any coexisting mental health problems in line with relevant NICE guidance for the young person, their parents or other family member.

5. Long-term management
1.11.16
After the multidisciplinary review, consider a structured individual or family psychological intervention for managing bipolar disorder in young people in the longer term. Offer a structured psychological intervention (individual, group or family), which has been designed for bipolar disorder and has a published evidence-based manual describing how it should be delivered, to prevent relapse or for people who have some persisting symptoms between episodes of mania or bipolar depression.

CG90 – DEPRESSION IN ADULTS: RECOGNITION AND MANAGEMENT

1.5
Step 3: Persistent sub-threshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions, and moderate and severe depression

1.5.1
Treatment options
1.5.1.1
High-intensity psychological intervention
- behavioural couples therapy for people who have a regular partner and where the relationship may contribute to the
development or maintenance of depression, or where involving the partner is considered to be of potential therapeutic benefit.

1.5.3.5
Behavioural couples therapy for depression should normally be based on behavioural principles, and an adequate course of therapy should be 15 to 20 sessions over 5 to 6 months.

CG28 – DEPRESSION IN CHILDREN AND YOUNG PEOPLE; ASSESSMENT AND MANAGEMENT

Treatment Considerations in all Settings
Steps 4 and 5: Moderate to severe depression
• Offer children and young people with moderate to severe depression a specific psychological therapy (individual CBT, interpersonal therapy, family therapy, or psychodynamic psychotherapy) that runs for at least 3 months [new 2015].

1.6.1 Treatments for moderate to severe depression
1.6.1.1.1
Offer children and young people with moderate to severe depression a specific psychological therapy (individual CBT, interpersonal therapy, family therapy, or psychodynamic psychotherapy) that runs for at least 3 months.

1.6.2.3
Following multidisciplinary review, if the child or young person's depression is not responding to psychological therapy as a result of other coexisting factors such as the presence of co-morbid conditions, persisting psychosocial risk factors such as family discord, or the presence of parental mental ill-health, alternative or perhaps additional psychological therapy for the parent or other family members, or alternative psychological therapy for the patient, should be considered [2005].

1.6.3 Depression unresponsive to combined treatment
1.6.3.2
Following multidisciplinary review, the following should be considered: an alternative psychological therapy which has not been tried previously (individual CBT, interpersonal therapy or shorter-term family therapy, of at least 3 months' duration), or systemic family therapy (at least 15 fortnightly sessions), or individual child psychotherapy (approximately 30 weekly sessions) [2005].

NG18 – DIABETES

Psychological and social issues in children and young people with Type 1 Diabetes
1.2.102
Offer specific family-based behavioural interventions, such as behavioural family systems therapy, if there are difficulties with diabetes-related family conflict. [new 2015]

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 multi-systemic therapy

CG178 – PSYCHOSIS AND SCHIZOPHRENIA IN ADULTS: PREVENTION AND MANAGEMENT

1 Preventing psychosis
• If a person is considered to be at increased risk of developing psychosis (as described in recommendation 1.2.1.1):
  • offer individual cognitive behavioural therapy (CBT) with or without family intervention (delivered as described in section 1.3.7) and
  • offer family intervention to all families of people with psychosis or schizophrenia who live with or are in close contact with the service user (delivered as described in recommendation 1.3.7.2). This can be started either during the acute phase or later, including in inpatient settings [2009].

1.2.3 Treatment options to prevent psychosis
1.2.3.1
If a person is considered to be at increased risk of developing psychosis (as described in recommendation 1.2.1.1):
  • offer individual cognitive behavioural therapy (CBT) with or without family intervention (delivered as described in section 1.3.7)

1.3.4 Treatment options
1.3.4.1
For people with first episode psychosis offer:
• oral antipsychotic medication (see sections 1.3.5 and 1.3.6) in conjunction with
  • psychological interventions (family intervention and individual CBT, delivered as described in section 1.3.7) [new 2014].

1.3.4.2
Advise people who want to try psychological interventions alone that these are more effective when delivered in conjunction with antipsychotic medication. If the person still wants to try psychological interventions alone:
• offer family intervention and CBT
• agree a time (1 month or less) to review treatment options, including introducing antipsychotic medication
• continue to monitor symptoms, distress, impairment and level of functioning (including education, training and employment) regularly [new 2014].

1.3.7.2
Family intervention should:
• include the person with psychosis or schizophrenia if practical
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**SECTION 1: CLINICAL GUIDELINES RECOMMENDING FAMILY AND COUPLE THERAPIES**

- be carried out for between 3 months and 1 year
- include at least 10 planned sessions
- take account of the whole family's preference for either single-family intervention or multi-family group intervention
- take account of the relationship between the main carer and the person with psychosis or schizophrenia
- have a specific supportive, educational or treatment function and include negotiated problem solving or crisis management work [2009].

**1.4.4 Psychological and psychosocial interventions**

**1.4.4.2**

Offer family intervention to all families of people with psychosis or schizophrenia who live with or are in close contact with the service user (delivered as described in recommendation 1.3.7.2). This can be started either during the acute phase or later, including in inpatient settings [2009].

**1.4.4.6**

Do not routinely offer counselling and supportive psychotherapy (as specific interventions) to people with psychosis or schizophrenia. However, take service user preferences into account, especially if other more efficacious psychological treatments, such as CBT, family intervention and arts therapies, are not available locally [2009].

**1.5.4 Psychological interventions**

**1.5.4.2**

Offer family intervention to families of people with psychosis or schizophrenia who live with or are in close contact with the service user. Deliver family intervention as described in recommendation 1.3.7.2 [2009].

**1.5.4.3**

Family intervention may be particularly useful for families of people with psychosis or schizophrenia who have:

- recently relapsed or are at risk of relapse
- persisting symptoms [2009].

**1.5.7.1 For people with schizophrenia whose illness has not responded adequately to pharmacological or psychological treatment:**

- Review engagement with and use of psychological treatments and ensure that these have been offered according to this guideline. If family intervention has been undertaken suggest CBT; if CBT has been undertaken suggest family intervention for people in close contact with their families.

**CG155 – PSYCHOsis AND SCHIZOPHRENia IN CHILDREN AND YOUNG PEOPLE: RECOGNITION AND MANAGEMENT**

A number of psychological interventions, including family intervention, cognitive behavioural therapy (CBT) and arts therapies, have been used but evidence of efficacy is currently unavailable in children and young people and provision of these therapies for children and young people and for adults is variable.

Treatment options for symptoms not sufficient for a diagnosis of psychosis or schizophrenia

- When transient or attenuated psychotic symptoms or other mental state changes associated with distress, impairment or help-seeking behaviour are not sufficient for a diagnosis of psychosis or schizophrenia:
  - consider individual cognitive behavioural therapy (CBT) (delivered as set out in recommendation 1.3.28) with or without family intervention (delivered as set out in recommendation 1.3.27), and
  - offer treatments recommended in NICE guidance for children and young people with any of the anxiety disorders, depression, emerging personality disorder or substance misuse.

**Treatment of subsequent acute episodes of psychosis or schizophrenia**

Offer family intervention (delivered as set out in recommendation 1.3.27) to all families of children and young people with psychosis or schizophrenia, particularly for preventing and reducing relapse. This can be started either during the acute phase or later, including in inpatient settings [3].

**Treatment options for symptoms not sufficient for a diagnosis of psychosis or schizophrenia**

**1.2.5**

When transient or attenuated psychotic symptoms or other mental state changes associated with distress, impairment or help-seeking behaviour are not sufficient for a diagnosis of psychosis or schizophrenia:

- consider individual cognitive behavioural therapy (CBT) (delivered as set out in recommendation 1.3.28) with or without family intervention (delivered as set out in recommendation 1.3.27).

**Treatment options for first episode psychosis**

**1.3.11**

For children and young people with first episode psychosis offer:

- oral antipsychotic medication [7] (see recommendations 1.3.14–1.3.25) in conjunction with
- psychological interventions (family intervention with individual CBT, delivered as set out in recommendations 1.3.26–1.3.32).

**1.3.12**

If the child or young person and their parents or carers wish to try psychological interventions (family intervention with individual CBT) alone without antipsychotic medication, advise that psychological interventions are more effective when delivered in conjunction with antipsychotic medication. If the child or young person and their parents or carers still wish to try psychological interventions alone, then offer family intervention with individual CBT. Agree a time limit (1 month or less) for reviewing treatment options, including introducing antipsychotic medication. Continue to monitor symptoms, level of distress, impairment and level of functioning, including educational engagement and achievement, regularly.

**1.3.13**

If the child or young person shows symptoms and behaviour sufficient for a diagnosis of an affective psychosis or disorder, including bipolar disorder and unipolar psychotic depression, follow the recommendations in Bipolar disorder (NICE clinical guideline 38) or Depression in children and young people (NICE clinical guideline 28).
How to deliver psychological interventions

1.3.27
Family intervention should:
• include the child or young person with psychosis or schizophrenia
  if practical
• be carried out for between 3 months and 1 year
• include at least 10 planned sessions
• take account of the whole family’s preference for either single-
  family intervention or multi-family group intervention
• take account of the relationship between the parent or carer and
  the child or young person with psychosis or schizophrenia
• have a specific supportive, educational or treatment function and
  include negotiated problem solving or crisis management work
  [6].

1.4
Subsequent acute episodes of psychosis or schizophrenia
1.4.1
For children and young people with an acute exacerbation or
recurrence of psychosis or schizophrenia offer:
• oral antipsychotic medication[7] in conjunction with
• psychological interventions (family intervention with individual
  CBT).

Psychological and psychosocial interventions
1.4.4
Offer family intervention (delivered as set out in recommendation
1.3.27) to all families of children and young people with psychosis
or schizophrenia, particularly for preventing and reducing relapse.
This can be started either during the acute phase or later, including
in inpatient settings [6].

Interventions for children and young people whose illness has
not responded adequately to treatment
• review engagement with and use of psychological interventions
  and ensure that these have been offered according to this
guideline; if family intervention has been undertaken suggest
CBT; if CBT has been undertaken suggest family intervention
for children and young people in close contact with their
families.
SECTION 2: CLINICAL GUIDELINES RECOMMENDING INVOLVEMENT WITH FAMILIES AND CARERS

**CG72 – ADHD: DIAGNOSIS AND MANAGEMENT**

1.5

Treatment for children and young people

1.5.1

Treatment for pre-school children

Parent-training/education programmes are the first-line treatment for parents or carers of pre-school children. These programmes are the same as those recommended for the parents or carers of other children with conduct disorder. If more help is needed the child can be referred to a tertiary service.

1.5.1.4

Group-based parent-training/education programmes, developed for the treatment and management of children with conduct disorders [3], should be fully accessible to parents or carers of children with ADHD whether or not the child also has a formal diagnosis of conduct disorder [2008].

1.5.1.5

Individual-based parent-training/education programmes [3] are recommended in the management of children with ADHD when:

- a group programme is not possible because of low participant numbers
- there are particular difficulties for families in attending group sessions (for example, because of disability, needs related to diversity such as language differences, parental ill-health, problems with transport, or where other factors suggest poor prospects for therapeutic engagement)
- a family’s needs are too complex to be met by group-based parent-training/education programmes [2008].

1.5.1.6

When individual-based parent-training/education programmes for pre-school children with ADHD are undertaken, the skills training stages should involve both the parents or carers and the child. [2008].

**CG170 – AUTISM IN UNDER 19S: SUPPORT AND MANAGEMENT**

1.2

Families and Carers

1.2.1

Offer all families (including siblings) and carers verbal and written information about their right to:

- short breaks and other respite care
- a formal carer’s assessment of their own physical and mental health needs, and how to access these.

1.2.2

Offer families (including siblings) and carers an assessment of their own needs, including whether they have:

- personal, social and emotional support
- practical support in their caring role, including short breaks and emergency plans
- a plan for future care for the child or young person, including transition to adult services.

1.2.3

When the needs of families and carers have been identified, discuss help available locally and, taking into account their preferences, offer information, advice, training and support, especially if they:

- need help with the personal, social or emotional care of the child or young person, including age-related needs such as self-care, relationships or sexuality
• are involved in the delivery of an intervention for the child or young person in collaboration with health and social care professionals.

NG11 – CHALLENGING BEHAVIOUR AND LEARNING DISABILITIES: PREVENTION AND INTERVENTIONS FOR PEOPLE WITH A LEARNING DISABILITY WHOSE BEHAVIOUR CHALLENGES

Support and interventions for family members or carers
When providing support to family members or carers (including siblings):
• recognise the impact of living with or caring for a person with a learning disability and behaviour that challenges
• explain how to access family advocacy
• consider family support and information group if there is a risk of behaviour that challenges, or it is emerging
• consider formal support through disability-specific support groups for family members or carers and regular assessment of the extent and severity of the behaviour that challenges
• provide skills training and emotional support, or information about these, to help them take part in and support interventions for the person with a learning disability and behaviour that challenges
• the person and their family members and carers are fully involved in the assessment process
• the resilience, resources and skills of family members and carers are taken into account.

Consider in-depth assessment involving interviews with family members, carers and others, direct observations, structured record keeping, questionnaires and reviews of case records.

NG26 – CHILDREN’S ATTACHMENT: ATTACHMENT IN CHILDREN AND YOUNG PEOPLE WHO ARE ADOPTED FROM CARE, IN CARE, OR AT HIGH RISK OF GOING INTO CARE

Interventions for children with attachment difficulties include: video feedback programmes to foster carers, special guardians and adoptive parents; intensive training and support and group therapeutic play sessions. Further details about the method of delivery of such interventions can be accessed via the full NICE Guideline.

CG42 – DEMENTIA: SUPPORTING PEOPLE WITH DEMENTIA AND THEIR CARERS IN HEALTH AND SOCIAL CARE

1.4.6.1 – The experience of the diagnosis of dementia is challenging both for people with dementia and family members and for healthcare professionals, so health care professionals should make time available to discuss the diagnosis and its implications with the person with dementia and also with family members (usually only with the consent of the person with dementia). Healthcare professionals should be aware that people with dementia and family members may need ongoing support to cope with the difficulties presented by the diagnosis.

CG137 – EPILEPSIES; DIAGNOSIS AND MANAGEMENT

Management
Healthcare professionals should adopt a consulting style that enables the child, young person or adult with epilepsy, and their family and/or carers as appropriate, to participate as partners in all decisions about their healthcare, and take fully into account their race, culture and any specific needs [2004].

1.3.8
The child, young person or adult with epilepsy and their family and/or carers as appropriate should know how to contact a named individual when information is needed. This named individual should be a member of the healthcare team and be responsible for ensuring that the information needs of the child, young person or adult and/or their family and/or carers are met [2004].

1.3.9
The possibility of having seizures should be discussed, and information on epilepsy should be provided before seizures occur, for children, young people and adults at high risk of developing seizures (such as after severe brain injury), with a learning disability, or who have a strong family history of epilepsy [2004].

1.3.13
Tailored information and discussion between the child, young person or adult with epilepsy, their family and/or carers (as appropriate) and healthcare professionals should take account of the small but definite risk of SUDEP (sudden unexpected death in epilepsy) [2004].

CG156 – FERTILITY PROBLEMS: ASSESSMENT AND TREATMENT

1.1.2
Psychological effects of fertility problems

1.1.2.3
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. [2004]

1.14.2
Information and counselling

1.14.2.2
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. [2004]

1.15.3.2
Oocyte recipients and donors should be offered counselling from someone who is independent of the treatment unit regarding the physical and psychological implications of treatment for themselves and their genetic children, including any potential children resulting from donated oocytes. [2004]

NG42 – MOTOR NEURONE DISEASE: ASSESSMENT AND MANAGEMENT

1.5.9
Inform all healthcare professionals and social care practitioners involved in the person’s care about key decisions reached with the
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person and their family members and/or carers (as appropriate) [new 2016].
1.6.3 During multidisciplinary team assessments and other appointments, discuss the psychological and emotional impact of MND with family members and/or carers (as appropriate), and ask whether they have any psychological or social care support needs.
1.6.4 Offer family members and/or carers (as appropriate) information about respite care and sources of emotional and psychological support, including support groups, online forums and counselling or psychology services [new 2016].

CG43 – OBESITY PREVENTION

1.1.2.7 Interventions to improve diet (and reduce energy intake) should be multicomponent (for example, including dietary modification, targeted advice, family involvement and goal setting), be tailored to the individual and provide ongoing support.
1.1.2.16 Families of children and young people identified as being at high risk of obesity – such as children with at least one obese parent – should be offered ongoing support from an appropriately trained health professional. Individual as well as family-based interventions should be considered, depending on the age and maturity of the child.
1.1.2.18 Family programmes to prevent obesity, improve diet (and reduce energy intake) and/or increase physical activity levels should provide ongoing, tailored support and incorporate a range of behaviour change techniques (see section 1.2.4).

CG189 – OBESITY: IDENTIFICATION, ASSESSMENT AND MANAGEMENT

Children
1.1.4 Coordinate the care of children and young people around their individual and family needs. Comply with the approaches outlined in the Department of Health’s A call to action on obesity in England[1] [2006, amended 2014].
1.1.5 Aim to create a supportive environment [2] that helps a child who is overweight or who has obesity, and their family, make lifestyle changes [2006, amended 2014].
1.1.6 Make decisions about the care of a child who is overweight or has obesity (including assessment and agreeing goals and actions) together with the child and family. Tailor interventions to the needs and preferences of the child and the family [2006].
1.1.7 Ensure that interventions for children who are overweight or have obesity address lifestyle within the family and in social settings [2006, amended 2014].

CG175 – PROSTATE CANCER; DIAGNOSIS AND MANAGEMENT

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 [2008].

CG159 – SOCIAL ANXIETY DISORDER: RECOGNITION, ASSESSMENT AND TREATMENT

Working with parents and carers
1.1.15 If a parent or carer cannot attend meetings for assessment or treatment, ensure that written information is provided and shared with them.
1.1.16 If parents or carers are involved in the assessment or treatment of a young person with social anxiety disorder, discuss with the young person (taking into account their developmental level, emotional maturity and cognitive capacity) what form they would like this involvement to take. Such discussions should take place at intervals to take account of any changes in circumstances, including developmental level, and should not happen only once. As the involvement of parents and carers can be quite complex, staff should receive training in the skills needed to negotiate and work with parents and carers, and also in managing issues relating to information sharing and confidentiality. [This recommendation is adapted from Service user experience in adult mental health (NICE clinical guidance 136).]
1.1.17 Offer parents and carers an assessment of their own needs including:

- personal, social and emotional support.
- support in their caring role, including emergency plans.
- advice on and help with obtaining practical support.

CG162 – STROKE REHABILITATION IN ADULTS

If the patient agrees, families and carers should have the opportunity to be involved in decisions about treatment and care. Families and carers should also be given the information and support they need.
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.
## APPENDIX

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<tr>
<td>Antenatal &amp; postnatal mental health clinical management &amp; service guidance – CG192</td>
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<td>Antisocial personality disorder: prevention &amp; management – CG77</td>
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<td>Attention deficit &amp; hyperactivity disorder: diagnosis &amp; management – CG72</td>
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