



*National Institute for
Health and Clinical Excellence*

Quick reference guide

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Schizophrenia

Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care

This is an update of NICE clinical guideline 1

About this booklet

This is a quick reference guide that summarises the recommendations NICE has made to the NHS in 'Schizophrenia: core interventions in the treatment and management of schizophrenia in adults in primary and secondary care' (NICE clinical guideline 82).

This guidance is an update of NICE clinical guideline 1 (published December 2002) and NICE technology appraisal guidance 43 (published June 2002).

Who should read this booklet?

This quick reference guide is for healthcare professionals and other staff who care for people with schizophrenia.

Who wrote the guideline?

The guideline was developed by the National Collaborating Centre for Mental Health, which is based at the Royal College of Psychiatrists and the British Psychological Society. The Collaborating Centre worked with a group of healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

For more information on how NICE clinical guidelines are developed, go to www.nice.org.uk

Where can I get more information about the guideline?

The NICE website has the recommendations in full, reviews of the evidence they are based on, a summary of the guideline for patients and carers, and tools to support implementation (see inside back cover for more details).

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NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions in the NHS in England and Wales.

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

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Introduction

This guideline covers the treatment and management of schizophrenia and related disorders¹ in adults (18 years and older) with an established diagnosis of schizophrenia (with onset before age 60). The guideline does not address the specific treatment of young people under the age of 18, except those who are receiving treatment and support from early intervention services.

Schizophrenia is a major psychiatric disorder, or cluster of disorders, characterised by psychotic symptoms that alter a person's perception, thoughts, affect and behaviour. Each person with the disorder will have a unique combination of symptoms and experiences.

A diagnosis of schizophrenia is still associated with considerable stigma, fear and limited public understanding. The first few years after onset can be particularly upsetting and chaotic, and there is a higher risk of suicide. Once an acute episode is over, there are often other problems such as social exclusion, with fewer opportunities to return to work or study and problems forming new relationships.

There is now a new emphasis on services for early detection and intervention, a focus on long-term recovery and promoting people's choices about their management. Most people will recover, although some will have persisting difficulties or remain vulnerable to future episodes. Most people find ways to manage acute problems, and compensate for any remaining difficulties.

Carers, relatives and friends of people with schizophrenia are important during the assessment process and in the long-term successful delivery of effective treatments.

¹ Includes schizoaffective disorder, schizophreniform disorder and delusional disorder.

Key priorities for implementation

Access and engagement

- Healthcare professionals working with people with schizophrenia should ensure they are competent in:
 - assessment skills for people from diverse ethnic and cultural backgrounds
 - using explanatory models of illness for people from diverse ethnic and cultural backgrounds
 - explaining the causes of schizophrenia and treatment options
 - addressing cultural and ethnic differences in treatment expectations and adherence
 - addressing cultural and ethnic differences in beliefs regarding biological, social and family influences on the causes of abnormal mental states
 - negotiating skills for working with families of people with schizophrenia
 - conflict management and conflict resolution.
- Mental health services should work in partnership with local stakeholders, including those representing black and minority ethnic (BME) groups, to enable people with mental health problems, including schizophrenia, to access local employment and educational opportunities. This should be sensitive to the person's needs and skill level and is likely to involve working with agencies such as Jobcentre Plus, disability employment advisers and non-statutory providers.
- Healthcare teams working with people with schizophrenia should identify a lead healthcare professional within the team whose responsibility is to monitor and review:
 - access to and engagement with psychological interventions
 - decisions to offer psychological interventions and equality of access across different ethnic groups.

Primary care and physical health

- GPs and other primary healthcare professionals should monitor the physical health of people with schizophrenia at least once a year. Focus on cardiovascular disease risk assessment as described in 'Lipid modification' (NICE clinical guideline 67) but bear in mind that people with schizophrenia are at higher risk of cardiovascular disease than the general population. A copy of the results should be sent to the care coordinator and/or psychiatrist, and put in the secondary care notes.

Psychological interventions

- Offer cognitive behavioural therapy (CBT) to all people with schizophrenia. This can be started either during the acute phase² or later, including in inpatient settings.
- Offer family intervention to all families of people with schizophrenia who live with or are in close contact with the service user. This can be started either during the acute phase³ or later, including in inpatient settings.

² Deliver CBT as described on page 12.

³ Deliver family intervention as described on page 12.

Pharmacological interventions

- For people with newly diagnosed schizophrenia, offer oral antipsychotic medication. Provide information and discuss the benefits and side-effect profile of each drug with the service user. The choice of drug should be made by the service user and healthcare professional together, considering:
 - the relative potential of individual antipsychotic drugs to cause extrapyramidal side effects (including akathisia), metabolic side effects (including weight gain) and other side effects (including unpleasant subjective experiences)
 - the views of the carer where the service user agrees.
- Do not initiate regular combined antipsychotic medication, except for short periods (for example, when changing medication).

Interventions for people with schizophrenia whose illness has not responded adequately to treatment

- For people with schizophrenia whose illness has not responded adequately to pharmacological or psychological treatment:
 - review the diagnosis
 - establish that there has been adherence to antipsychotic medication, prescribed at an adequate dose and for the correct duration
 - 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
 - consider other causes of non-response, such as comorbid substance misuse (including alcohol), the concurrent use of other prescribed medication or physical illness.
- Offer clozapine to people with schizophrenia whose illness has not responded adequately to treatment despite the sequential use of adequate doses of at least two different antipsychotic drugs. At least one of the drugs should be a non-clozapine second-generation antipsychotic.

Person-centred care

Treatment and care should take into account people's individual needs and preferences. Good communication is essential, supported by evidence-based information, to allow people to reach informed decisions about their care. Follow Department of Health advice on seeking consent if needed. If the person agrees, families and carers should have the opportunity to be involved in decisions about treatment and care. If caring for young people in transition between paediatric and adult services refer to 'Transition: getting it right for young people' (available from www.dh.gov.uk).

Care across all phases

Optimism

- Work in partnership with people with schizophrenia and their carers, offering treatment and care with hope and optimism. Take time to build supportive and empathic relationships.

Race, culture and ethnicity

- Healthcare professionals working with people with schizophrenia should ensure they are competent in:
 - assessment skills for people from diverse ethnic and cultural backgrounds
 - using explanatory models of illness for people from diverse ethnic and cultural backgrounds
 - explaining the causes of schizophrenia and treatment options
 - addressing cultural and ethnic differences in treatment expectations and adherence, and in beliefs about biological, social and family influences on the causes of abnormal mental states
 - negotiating skills for working with families of people with schizophrenia
 - conflict management and conflict resolution.
- Mental health services should work with local voluntary BME groups to ensure that culturally appropriate psychological and psychosocial treatment is provided. Treatments should be consistent with this guideline and delivered by competent practitioners.
- When working with people with schizophrenia and their carers:
 - avoid using clinical language or keep it to a minimum
 - provide written information about schizophrenia in the appropriate language, and if possible, in audio format
 - provide and work with interpreters if needed
 - offer a list of local education English language teaching providers for people with difficulty speaking and understanding English.
- If needed, seek advice and supervision from healthcare professionals experienced in working with people with schizophrenia from diverse ethnic and cultural backgrounds.

Getting help early

- Facilitate access to assessment and treatment as soon as possible. Promote early access throughout care.

Assessment

- Ensure that people with schizophrenia receive a comprehensive multidisciplinary assessment, including a psychiatric, psychological and physical health assessment. Also address: accommodation, culture and ethnicity, economic status, occupation and education (including employment and functional activity), prescribed and non-prescribed drug history, quality of life, responsibility for children, risk of harm to self and others, sexual health, social networks.
- Routinely monitor for coexisting conditions, including depression and anxiety, particularly in the early phases of treatment.

Comprehensive services provision

- All teams providing services for people with schizophrenia should offer:
 - a comprehensive range of interventions consistent with this guideline
 - social, group and physical activities (including in inpatient settings) and record arrangements in the care plan.

Working in partnership with carers

- Provide information about schizophrenia and its management. Include how families and carers can help throughout treatment.
- Offer a carer's assessment.
- Assess the needs of any children in the family, including young carers.
- Provide details of local support groups and voluntary organisations. Help carers to access these.
- Negotiate confidentiality and information sharing between the service user and carer, if appropriate.

Consent, capacity and treatment decisions

- Before taking each treatment decision, healthcare professionals should ensure that they:
 - provide service users and carers with full, patient-specific information about schizophrenia and its management in the appropriate format, to ensure informed consent before treatment starts
 - understand and apply the principles of the Mental Capacity Act
 - are aware that mental capacity is decision specific (if there is doubt about mental capacity, assessment of mental capacity should be made in relation to each decision)
 - can assess mental capacity using the test in the Mental Capacity Act.

These principles should apply whether or not people are being detained or treated under the Mental Health Act and are especially important for people from BME groups.

- When the Mental Health Act is used, inform people with schizophrenia of their right to appeal to a first-tier tribunal (mental health). Support people who appeal.

Advance decisions and statements

- Develop advance statements and advance decisions with the person with schizophrenia, especially if their illness is severe and they have been treated under the Mental Health Act. Record these and include copies in the care plan in primary and secondary care. Give copies to the service user and care coordinator, and their carer if appropriate.
- Whenever possible, honour advance decisions and statements according to the Mental Capacity Act, although these can be overridden by the Act.

Second opinion

- Support the service user or carer if they seek a second opinion on the diagnosis.

Transfer between services

- Discuss any transfer in advance with the service user, and carer if appropriate. Use the care programme approach (CPA) to help ensure effective collaboration with other care providers during transfer. Include details of how to access services in times of crisis.

Initiating treatment (first episode)

Early referral

- Urgently refer all people first presenting with psychotic symptoms in primary care to a local community-based secondary mental health service (early intervention services, crisis resolution and home treatment team, or community mental health team). Choose the appropriate team based on the stage and severity of illness and the local context.
- Carry out a full assessment in secondary care, including assessment by a psychiatrist. Write a care plan with the service user as soon as possible. Send a copy to the referring primary healthcare professional and the service user.
- Include a crisis plan in the care plan, based on a full risk assessment. Define the roles of primary and secondary care in the crisis plan and include the key clinical contacts in case of emergency or impending crisis.

Early intervention services

- Offer early intervention services to all people with a first episode or first presentation of psychosis irrespective of age or duration of untreated psychosis. Refer from primary or secondary care.
- Early intervention services should aim to provide the full range of interventions recommended in this guideline for people with psychosis.

Early treatment

- If it is necessary for a GP to start antipsychotic medication they should have experience in treating and managing schizophrenia (follow 'Using oral antipsychotic medication' below and on page 9).

Using oral antipsychotic medication

- Offer oral antipsychotic medication to people with newly diagnosed schizophrenia.
- Provide information on the benefits and side effects of each antipsychotic and discuss these with the service user.
- Decide which antipsychotic to use in partnership with the service user, and carer if appropriate.
- When deciding on the most suitable medication, consider the relative potential of individual antipsychotics to cause extrapyramidal side effects (such as akathisia), metabolic side effects (such as weight gain), and other side effects (including unpleasant subjective experiences).
- Do not start regular combined antipsychotic medication, except for short periods (for example, when changing medication).

- Before starting antipsychotics offer an electrocardiogram (ECG) if:
 - specified in the summary of product characteristics (SPC)
 - physical examination shows specific cardiovascular risk (such as diagnosis of high blood pressure)
 - there is personal history of cardiovascular disease, or
 - the service user is being admitted as an inpatient.

- Consider treatment with antipsychotic medication as an individual therapeutic trial:
 - Record the indications, expected benefits and risks, and expected time for a change in symptoms and for side effects to occur.
 - Start with a dose at the lower end of the licensed range and titrate upwards slowly within the dose range in the British National Formulary (BNF) or SPC.
 - Justify and record reasons for dosages outside the range specified in the BNF or SPC.
 - Monitor and record the following regularly and systematically throughout treatment, but especially during titration:
 - ◆ efficacy, including changes in symptoms and behaviour
 - ◆ side effects of treatment, taking into account overlap with some of the clinical features of schizophrenia
 - ◆ adherence
 - ◆ physical health.
 - Record the rationale for continuing, changing or stopping medication and the effects of such changes.
 - Carry out a trial of the medication at optimum dosage for 4–6 weeks.

- Discuss with the service user, and carer if appropriate:
 - any non-prescribed therapies (including complementary therapies) the service user wishes to use
 - alcohol, tobacco, prescription and non-prescription medication and illicit drugs.

Discuss their possible interference with the effects of prescribed medication and psychological treatments. Discuss the safety and efficacy of non-prescribed therapies.

- Follow the box above when prescribing antipsychotic medication on an 'as required' (p.r.n.) basis. Review clinical indications, frequency of administration, therapeutic benefits and side effects each week or as appropriate. Check whether the dosage is above the maximum in the BNF or SPC.
- Do not use a loading dose of antipsychotic medication ('rapid neuroleptisation').
- Warn of a potential photosensitive skin response with chlorpromazine and advise using sunscreen if necessary.

Treating the acute episode

Service-level interventions

- Consider community mental health teams alongside other community-based teams as a way of providing services for people with schizophrenia.
- Crisis resolution and home treatment teams should:
 - be used to support people with schizophrenia during an acute episode in the community
 - pay particular attention to risk monitoring as a high-priority routine activity
 - be considered for people with schizophrenia who may benefit from early hospital discharge.
- Acute day hospitals should be considered alongside crisis resolution and home treatment teams instead of admission to inpatient care and to help early discharge from inpatient care.

Medication for the acute episode

Oral antipsychotic medication

- Offer oral antipsychotic medication to people with an acute exacerbation or recurrence of schizophrenia.
- When choosing a drug, follow 'Using oral antipsychotic medication' on pages 8–9.
- Take into account the clinical response and side effects of previous and current medication.

Rapid tranquillisation

- Consider rapid tranquillisation for people who pose an immediate threat to themselves or others during an acute episode.
- Follow the recommendations in 'Violence' (NICE clinical guideline 25) when managing immediate risk, facing imminent violence or considering rapid tranquillisation.
- After rapid tranquillisation offer the service user the opportunity to discuss and write an account of their experiences. Explain why the procedure was used. Record this and the account of their experiences in their notes.
- Follow the recommendations in 'Self-harm' (NICE clinical guideline 16) when managing immediate risk and acts of self-harm.

Psychological and psychosocial interventions

Principles

- Trusts should provide training to give healthcare professionals the competencies needed to deliver the psychological interventions recommended in this guideline.
- Healthcare professionals providing psychological interventions should have:
 - an appropriate level of competence to deliver the intervention
 - regular supervision during psychological therapy by a competent therapist and supervisor.
- Identify a lead healthcare professional within the team to monitor and review:
 - access to and engagement with psychological interventions
 - decisions to offer psychological interventions and equality of access across different ethnic groups.
- Routinely and systematically monitor a range of outcomes across relevant areas. Include service user satisfaction, and carer satisfaction, if appropriate.
- If psychological treatments (including arts therapies) are started in the acute phase, including in inpatient settings, continue the full course after discharge without unnecessary interruption.

Type of intervention

- Offer CBT to all people with schizophrenia.
 - Offer family intervention to families of people with schizophrenia living with or in close contact with the service user.
 - Consider offering arts therapies, particularly to help negative symptoms of schizophrenia.
 - Start CBT, family intervention or arts therapies either during the acute phase or later, including in inpatient settings.
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- Do not routinely offer counselling, supportive psychotherapy, or social skills training as specific interventions. However, take service user preferences for counselling and supportive psychotherapy into account, especially if CBT, family intervention and arts therapies are not available locally.
 - Do not offer adherence therapy as a specific intervention.

Delivering psychological interventions

- Deliver CBT on a one-to-one basis over at least 16 planned sessions. Follow a treatment manual⁴ so that:
 - people can establish links between their thoughts, feelings or actions and their current or past symptoms, and/or functioning
 - re-evaluation of people's perceptions, beliefs or reasoning relates to the target symptoms.
- CBT should include at least one of the following components:
 - people monitoring their own thoughts, feelings or behaviours with respect to their symptoms or recurrence of symptoms
 - promoting alternative ways of coping with the target symptom
 - reducing distress
 - improving functioning.
- Family intervention should:
 - include the service user if practical
 - include at least 10 planned sessions over a period of 3 months to 1 year
 - take into account preference for single-family intervention rather than multi-family group intervention
 - take into account the relationship between the main carer and the service user
 - have a specific supportive, educational or treatment function
 - include negotiated problem solving or crisis management work.
- Arts therapies should be provided by a Health Professions Council registered arts therapist, with experience of working with people with schizophrenia. Offer arts therapies to groups unless there are issues of acceptability, access or engagement. Psychotherapeutic techniques should be combined with activities aimed at promoting creative expression, which are often unstructured and led by the service user. Arts therapies should help people to:
 - experience themselves differently and develop new ways of relating to others
 - express themselves and organise their experience into a satisfying aesthetic form
 - accept and understand feelings that may have emerged during the creative process (including for some, how they came to have these feelings) at their own pace.

The early post-acute period

- After each acute episode, encourage people to write an account of their illness in their notes.
- Healthcare professionals may consider psychoanalytic and psychodynamic principles to help them understand the service user's experiences and their interpersonal relationships.
- Inform service users about the high risk of relapse if medication is stopped in 1–2 years.
- If withdrawing antipsychotic medication, do this gradually. Regularly monitor for signs and symptoms of relapse for at least 2 years after withdrawal.

⁴ Treatment manuals that have evidence for their efficacy from clinical trials are preferred.

Promoting recovery

Primary care

- Develop and use practice case registers to monitor the physical and mental health of service users.

Monitoring physical health

- Monitor the physical health of people with schizophrenia at least once a year. Focus on cardiovascular disease risk assessment (see 'Lipid modification' [NICE clinical guideline 67]) because people with schizophrenia are at higher risk of cardiovascular disease than the general population.
- Send a copy of the results to the care coordinator and/or psychiatrist, to include in the secondary care notes.
- Follow the appropriate NICE guidance for people at risk of developing cardiovascular disease and/or diabetes or for treating people with established disease⁵.

Re-referral to secondary care

- Consider re-referral to secondary care if there is:
 - poor treatment response
 - non-adherence to medication
 - intolerable side effects from medication
 - comorbid substance misuse
 - risk to the person or others.
- Consult the care plan and consider referral to the key clinician or care coordinator stated in the crisis plan if a person with established schizophrenia has a suspected relapse (for example, increased psychotic symptoms or increased use of alcohol or other substances).
- Re-referral should take account of service user and carer requests, especially for review of the side effects of current treatment, and for psychological treatments or other interventions.
- If the service user plans to move to the catchment area of a different NHS trust, a meeting should be set up to agree a transition plan with the service user and the services involved. The current care plan should be sent to the new primary and secondary care providers.

Monitoring physical health in secondary care

- As part of the CPA, healthcare professionals in secondary care should ensure that the regular physical health checks mentioned above are being carried out in primary care.

⁵ See 'Lipid modification' (NICE clinical guideline 67), 'Type 1 diabetes' (NICE clinical guideline 15), 'Type 2 diabetes' (NICE clinical guideline 66). Further guidance about cardiovascular disease and diabetes is available from www.nice.org.uk

Service-level interventions

- Assertive outreach teams should be provided for people with schizophrenia who:
 - frequently use inpatient services, and
 - have a history of poor engagement with services leading to frequent relapse or social breakdown (homelessness or inadequate accommodation).

Psychological interventions

- Offer CBT to service users with persisting positive and negative symptoms or those in remission (see page 12).
- Offer family intervention to families living with or in close contact with the service user (see page 12). Family intervention may be useful for families of people who have recently relapsed, are at risk of relapse or have persisting symptoms.
- Consider offering arts therapies, particularly to people with negative symptoms (see page 12).

Medication for promoting recovery

Prescribing medication

- Follow 'Using oral antipsychotic medication' on pages 8–9.
- Do not use targeted intermittent dosage maintenance strategies routinely⁶. Consider these for service users who will not accept continuous maintenance treatment or if it is contraindicated.
- Consider offering depot/long-acting injectable antipsychotics when:
 - service users would prefer this after an acute episode
 - avoiding covert non-adherence to medication is a clinical priority.

Using depot/long-acting injectable antipsychotics

- When starting depot/long-acting injectable antipsychotics:
 - consider the preferences and attitudes of the service user towards regular intramuscular injections and their delivery (for example, home visits, location of clinics)
 - consider the criteria listed in 'Using oral antipsychotic medication' on pages 8–9, particularly in relation to the risks and benefits of the drug
 - initially use a small test dose according to the BNF or SPC.

Withdrawing medication

- See 'The early post-acute period' on page 12.

⁶ Defined as the use of antipsychotic medication only during periods of incipient relapse or symptom exacerbation rather than continuously.

Inadequate response to treatment

- For service users whose symptoms have not responded adequately to treatment:
 - review the diagnosis
 - check that there has been adherence to antipsychotic medication, prescribed at an adequate dose and for the correct duration
 - check that psychological treatments have been offered according to this guideline and review engagement with these; offer CBT if family intervention has been undertaken; if CBT has been undertaken, suggest family intervention for those in close contact with their family
 - consider other causes of non-response, for example comorbid substance or alcohol misuse, concurrent use of other prescribed medication, or physical illness.
- Offer clozapine if symptoms have not responded adequately despite sequential use of at least two different antipsychotics, one of which should be a non-clozapine second-generation antipsychotic.
- If symptoms have not responded adequately to an optimised dose of clozapine, review the diagnosis, adherence to treatment, engagement with and use of psychological treatments, other possible causes of non-response and measure therapeutic drug levels before offering a second antipsychotic to augment clozapine. The second drug should not compound the common side effects of clozapine. An adequate trial of augmentation may need to be up to 8–10 weeks.

Employment, education and occupational activities

- Provide supported employment programmes for those who want to return to work or find a job. These programmes should not be the only work-related activity offered when people are unable to work or cannot find a job.
- Mental health services should work with local stakeholders, including those representing BME groups, to enable access to local employment and educational opportunities. This support should take into account the person's needs and skill level. It is likely to involve working with Jobcentre Plus, disability employment advisers and non-statutory providers.
- Routinely record the daytime activities and occupational outcomes of service users in their care plan.

Returning to primary care

- Service users whose symptoms have responded effectively to treatment and remain stable should have the option to return to primary care management. If the service user wishes to do this, record in the notes and coordinate transfer through the CPA.

Implementation tools

NICE has developed tools to help organisations implement this guidance. These are available on our website (www.nice.org.uk/CG82).

Further information

Ordering information

You can download the following documents from www.nice.org.uk/CG82

- The NICE guideline – all the recommendations.
- A quick reference guide (this document) – a summary of the recommendations for healthcare professionals.
- ‘Understanding NICE guidance’ – a summary for patients and carers.
- The full guideline – all the recommendations, details of how they were developed, and reviews of the evidence they were based on.

For printed copies of the quick reference guide or ‘Understanding NICE guidance’, phone NICE publications on 0845 003 7783 or email publications@nice.org.uk and quote:

- N1823 (quick reference guide)
- N1824 (‘Understanding NICE guidance’).

Updating the guideline

This guideline will be updated as needed, and information about the progress of any update will be available at www.nice.org.uk/CG82

Related NICE guidance

For information about NICE guidance that has been issued or is in development, see www.nice.org.uk

Published

- Medicines adherence. NICE clinical guideline 76 (2009).
- Lipid modification. NICE clinical guideline 67 (2008).
- Type 2 diabetes (update). NICE clinical guideline 66 (2008).
- Drug misuse: opioid detoxification. NICE clinical guideline 52 (2007).
- Drug misuse: psychosocial interventions. NICE clinical guideline 51 (2007).
- Depression (amended). NICE clinical guideline 23 (2007).
- Anxiety (amended). NICE clinical guideline 22 (2007).
- Obesity. NICE clinical guideline 43 (2006).
- Bipolar disorder. NICE clinical guideline 38 (2006).
- Statins for the prevention of cardiovascular events. NICE technology appraisal guidance 94 (2006).
- Obsessive-compulsive disorder. NICE clinical guideline 31 (2005).
- Post-traumatic stress disorder. NICE clinical guideline 26 (2005).
- Violence. NICE clinical guideline 25 (2005).
- Self-harm. NICE clinical guideline 16 (2004).
- Type 1 diabetes. NICE clinical guideline 15 (2004).
- Eating disorders. NICE clinical guideline 9 (2004).

- Guidance on the use of electroconvulsive therapy. NICE technology appraisal guidance 59 (2003).

Under development

- Depression in chronic physical health problems. NICE clinical guideline (publication expected September 2009).
- Depression in adults. NICE clinical guideline (publication expected September 2009).
- Alcohol use disorders: management of alcohol dependency. NICE clinical guideline (publication expected December 2010).
- Psychosis with substance misuse. NICE clinical guideline (publication expected March 2011).

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