

aphasia or cognitive problems) before considering antidepressant medication.

4.10.1.1C People with mild or moderate symptoms of psychological distress, depression or anxiety after stroke should be given information, support and advice and considered for one or more of the following interventions:

- > increased social interaction;
- > increased exercise;
- > other psychosocial interventions such as psychosocial education groups.

4.10.1.1D People with aphasia and low mood after stroke should be considered for individual behavioural therapy e.g. from an assistant psychologist.

4.10.1.1F People with severe or persistent symptoms of emotional disturbance after stroke should receive specialist assessment and treatment from a clinical neuropsychologist/clinical psychologist.

4.10.1.1G People with persistent moderate to severe emotional disturbance after stroke who have not responded to high intensity psychological intervention or pharmacological treatment should be considered for collaborative care. Their care should involve collaboration between the GP, primary and secondary physical health services and case management, with supervision from a senior mental health professional and should include long term follow-up.

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Psychology concise guide for stroke 2016

This profession-specific concise guide contains recommendations extracted from the National Clinical Guideline for Stroke, 5th edition, which contains over 400 recommendations covering almost every aspect of stroke management. The reference number of each recommendation is provided so that they can be found in the main guideline www.strokeaudit.org/guideline. The recommendations below have direct implications for clinical neuropsychologists/clinical psychologists. This concise guide should not be read in isolation, and as members of the stroke multidisciplinary team, clinical neuropsychologists/clinical psychologists should consider the guideline in full.

Resources

It is recommended that a 0.2 WTE clinical neuropsychologist/clinical psychologist is required for every five beds on a Hyperacute Stroke Unit (HASU) and a 0.2 WTE clinical neuropsychologist/clinical psychologist is required for every five beds on an acute stroke unit (Table 2.1). A stroke rehabilitation unit should have a single multi-disciplinary team, including clinical neuropsychology/clinical psychology (2.4.1). It is acknowledged that this will require a considerable increase in the provision of clinical neuropsychology/clinical psychology services (2.4.3).

Transfers of care from hospital to home

2.7.1C A stroke early supported discharge (ESD) team should be organised as a single multi-disciplinary team, including a specialist in clinical neuropsychology/clinical psychology.

Psychological care - organisation and delivery

2.12.1A Services for people with stroke should have a comprehensive approach to delivering psychological care that includes specialist clinical neuropsychology/clinical psychology input within the multi-disciplinary team.

2.12.1B Services for people with stroke should offer psychological support to all patients regardless of whether they exhibit specific mental health or cognitive difficulties, and use a matched care

model to select the level of support appropriate to the person's needs.

2.12.1C Services for people with stroke should provide training to ensure that clinical staff have an awareness of psychological problems following stroke and the skills to manage them.

2.12.1D Services for people with stroke should ensure that the psychological screening and assessment methods used are appropriate for use with people with aphasia and cognitive impairments.

2.12.1E Services for people with stroke should provide screening for mood and cognitive disturbance within six weeks of stroke (in the acute phase of rehabilitation and at the transfer of care into post-acute services) and at six and 12 months using validated tools and observations over time.

2.12.1F Services for people with stroke should include specialist clinical neuropsychology/clinical psychology provision for severe or persistent symptoms of emotional disturbance, mood or cognition.

2.12.1G Services for people with stroke should consider a collaborative care model for the management of people with moderate to severe neuropsychological problems who have not responded to high-intensity psychological interventions or pharmacological treatments. This care model should involve collaboration between the GP, primary and secondary physical health services and case management,

with supervision from a senior mental health professional and should include long-term follow-up.

Cognitive impairment

4.3.1.1A People with stroke should be considered to have at least some cognitive impairment in the early phase. Routine screening should be undertaken to identify the person's level of functioning, using standardised measures.

4.3.1.1B Any person with stroke who is not progressing as expected in rehabilitation should receive a detailed assessment to determine whether cognitive impairments are responsible, with the results explained to the person, their family and the multidisciplinary team.

4.3.1.1D People with cognitive problems after stroke should receive appropriate adjustments to their multidisciplinary treatments to enable them to participate, and this should be regularly reviewed.

4.3.1.1E People with acute cognitive problems after stroke whose care is being transferred from hospital should receive an assessment for any safety risks from persisting cognitive impairments. Risks should be communicated to their primary care team together with any mental capacity issues that might affect their decision-making.

4.3.1.1F People with stroke returning to cognitively demanding activities such as driving or work should have their cognition fully assessed.

4.3.1.1G People with continuing cognitive difficulties after stroke should be considered for comprehensive interventions aimed at developing compensatory behaviours and learning adaptive skills.

4.3.1.1H People with severe or persistent cognitive problems after stroke should receive specialist assessment and treatment from a clinical neuro-psychologist/clinical psychologist.

Apraxia

4.3.2.1A People with difficulty executing tasks after stroke despite adequate limb movement should be assessed for the presence of apraxia using standardised measures.

4.3.2.1B People with apraxia after stroke should:

- > have their profile of impaired and preserved abilities determined using a standardised approach;
- > have the impairment and the impact on function explained to them, their family/carers, and the multidisciplinary team;
- > be offered therapy and/or trained in compensatory techniques specific to the deficits identified, ideally in the context of a clinical trial.

Attention and concentration

4.3.3.1A People who appear easily distracted or unable to concentrate after stroke should have their attentional abilities assessed using standardised measures,

4.3.3.1B People with impaired attention after stroke should have cognitive demands reduced by:

- > having shorter treatment sessions;
- > taking planned rests;
- > reducing background distractions;
- > avoiding activities when tired.

4.3.3.1C People with impaired attention after stroke should:

- > have the impairment explained to them, their family/carers and the multi-disciplinary team;
- > be offered an attentional intervention (e.g. time pressure management, attention process training, environmental manipulation), ideally in the context of a clinical trial;
- > be given as many opportunities to practise their activities as reasonable under supervision.

Executive function

4.3.4.1A People with stroke who appear to have adequate skills to perform complex activities but fail to initiate, organise or inhibit behaviour should

be assessed for the dysexecutive syndrome using standardised measures.

4.3.4.1B People with an impairment of executive function and activity limitation after stroke should be trained in compensatory techniques, including internal strategies (e.g. self-awareness and goal setting), structured feedback on performance of functional tasks and external strategies (e.g. use of electronic reminders or written checklists).

4.3.4.1C People with an executive disorder after stroke should have the impairment and the impact on function explained to them, their family/carers, and the multidisciplinary team.

Memory

4.3.5.1A People with stroke who report memory problems and those considered to have problems with learning and remembering should have their memory assessed using standardised measures.

4.3.5.1B People with memory impairment after stroke causing difficulties with rehabilitation should:

- > have the impairment explained to them, their family/carers and the multidisciplinary team;
- > be assessed for treatable or contributing factors (e.g. delirium, hypothyroidism);
- > have their profile of impaired and preserved memory abilities determined, including the impact of other cognitive deficits e.g. attention;
- > have nursing and therapy sessions altered to capitalise on preserved abilities;
- > be trained in approaches that help them to encode, store and retrieve new information e.g. spaced retrieval (increasing time intervals between review of information) or deep encoding of material (emphasising semantic features);
- > be trained in compensatory techniques to reduce their prospective memory problems (e.g. use of electronic reminders or written checklists);
- > receive therapy in an environment as similar as possible to their usual environment.

Perception

4.3.6.1A People who appear to have perceptual difficulties after stroke should have a perceptual assessment using standardised measures

4.3.6.1B People with agnosia after stroke should:

- > have the impairment explained to them, their family/carers and the multi-disciplinary team;
- > have their environment assessed and adapted to reduce potential risks and promote independence;
- > be offered a perceptual intervention, such as functional training, sensory stimulation, strategy training and/or task repetition, ideally in the context of a clinical trial.

Spatial awareness

4.3.7.1A People with stroke affecting the non-dominant cerebral hemisphere should be considered at risk of impaired awareness on the contralateral side and should be assessed if this is suspected, using standardised measures.

4.3.7.1B When assessing problems with spatial awareness in people with stroke, clinicians should use a standardised test battery in preference to a single subtest, and the effect on functional tasks such as dressing and mobility should be included.

Fatigue

4.6.1.A People with stroke who are medically stable but who report fatigue should be offered an assessment for mental and physical factors that may be contributing, particularly when engagement with rehabilitation or quality of life is affected.

Mood and well-being

4.10.1.1A People with stroke with one mood disorder (e.g. depression) should be assessed for others (e.g. anxiety).

4.10.1.1B People with or at risk of depression or anxiety after stroke should be offered brief psychological interventions such as motivational interviewing or problem-solving therapy (adapted if necessary for use with people with