1 Background information

Quick info:
This pathway is intended to improve screening, assessment and planning of personal health and wellbeing in order to support improving health outcomes.

While there is a focus upon improving health outcomes for the vulnerable, at risk population groups [5,14,19] the pathway and supporting framework is also designed for the continuum of mental health and alcohol and other drug presentations more common to general practice [14].

Key considerations:

• health presentations rarely occur in isolation [14]. Health and wellbeing therefore requires a whole system/person assessment [5,14,19]
• people who experience serious mental [7] illness and/or addiction die much earlier, with a two to three times greater risk of premature death [6] (compared to general population). Two thirds of this premature mortality is due to cardiovascular disease, cancer and other physical illnesses [5]
• alcohol use is causally related to more than 60 different medical conditions [5,11]
• there are strong links between socio-economic status and mental health and addictions [5,8,9,10,14]

The way forward
To positively affect these issues, a collaborative approach to service delivery is required. This applies to person/service [20] collaboration, service/service collaboration and person/service/community collaboration.
A common assessment and wellbeing framework is advocated across services with wellbeing plans developed which actively support and promote healthy lifestyles.
An integrated system of person, service provider and community is required to improve personal [5,8,17,18,14] and population health. Consistent health messaging and shared, accessible knowledge and expertise are an expectation [19].

Risks
Systematic reviews have identified a negative impact of psychotropic medication on physical health due to their contribution to obesity, cardiovascular disease, poor oral health and type 2 diabetes [12,19].
Medication should always be prescribed judiciously as the potential risk is of creating secondary problems that require further, more complex interventions e.g. benzodiazepine dependence [13].
Medication should therefore not be prescribed because it is expected or offers an immediate quick fix without an associated plan being developed to address related or causal issues [5,19].
Medication alone will not resolve lifestyle choices, systemic problems or provide education and the required support to effect a longer term solution to high prevalence, common mental health disorders.
Medication can offer temporary symptomatic relief without any real resolution.
Stigma and discrimination by health professionals has been identified as a key barrier to accessing healthcare for people with mental health disorder and/or addictions [14].
Overt focus upon diagnoses for mental health and addictions impacts upon the quality of health care received and the associated health outcomes [14].
In respect of ‘common mental health disorders’ an individual presenting with an episode of anxiety or depression is likely to have a lifetime occurrence of over 4 ‘clinical’ presentations. This does not include the possible ‘sub-clinical’ dysthymic norm.

Risk Mitigators:

• Risk Mitigators

Family Violence (FV)
Family violence is a significant NZ issue and everyone’s business. FV screening as an integral part of health pathways offers an opportunity for both planned and opportunistic screening.
Disclosure is often made after repeated routine screening questions are used. Health and Wellbeing Assessments are a good opportunity to use FV questions:

• Family Violence Questions

Children of Parents with Mental Illness and/or Addictions (COPMIA)
Identifying and supporting the children of persons with mental health and addictions (COPMIA) is a positive step towards improving the health and wellbeing of families.

Key framework/pathway messages are supported by:

• Bringing together physical and mental health Kings Fund
• Integrating Mental Health Services into primary care
• Te Pou
Information resources for patients & carers

Quick info:

Patient and Carer information / Resources:

Health and Wellbeing:

- **LIVE WELL.pdf**

**DEPRESSION**

- **Beating the Blues NZ** - An online treatment programme for depression and anxiety using cognitive behavioural therapy (CBT). Talk to your doctor if you think Beating the Blues could be helpful for you (requires doctor referral).
- **Depression Calculator App** - App for iPhones. Use this app to help assess whether you may be depressed. The app also provides information on depression and antidepressants. Information is written by a team of independent GPs and provides evidence-based health information.
- **The Journal [NZ]** - Fronted by Sir John Kirwan, The Journal is designed to teach you skills that can help manage mild to moderate depression. You will be taught the most effective self-help techniques.
- **MoodPanda App** - App for iPhones or android, or web based. MoodPanda lets you to measure your daily moods and track the scores over time. You can connect to Twitter or Facebook to share your scores and be part of the supportive Moody Pandas community. MoodPanda can be used to show your website/forum/group member's happiness or your local regions happiness (through Mood Maps).
- **Moodscope App** - Moodscope enables you to measure your ups and downs with a simple scoring system and track these scores over time. Your scores can be automatically shared with friends who have agreed to buddy you, includes a supportive daily email from the Moodscope staff.
- **Moodgym** - The programme at Moodgym is based on cognitive behaviour therapy and interpersonal therapy. It may can help with managing depression and stinking thinking.
- **My Happy Place** - App for iPhones. Created by the Mental Health Foundation (UK) and the University of Bristol, this app is a mood management tool that harnesses a new training method developed by the university’s researchers. They've found that training ourselves to recognise positive emotions in faces instead of negative emotions can improve our mood over time. Small charge applies.
- **The National Depression Initiative [NZ]** - An interactive website with a focus on self-management. Self-test and detailed information about depression and options for management and treatment.
- **Recovery via the Internet from Depression (RID)** - The programmes are designed to help people manage their depression by providing relevant information and working through a number of exercises.
- **This Way Up** - Australian online self-help programme for individuals. Has courses for stress management, worry and sadness, and shyness, with self-tests to monitor progress.

**ANXIETY**

- **Beating the Blues [NZ]** - An online treatment programme for depression and anxiety using cognitive behavioural therapy (CBT). Talk to your doctor if you think Beating the Blues could be helpful for you (requires doctor referral).
- **CalmKeeper [NZ]** - App for iPhones. Designed by clinical psychologists, this app assists with managing anxiety and panic attacks. Charge applies.
- **Mood Diary App - The Phobic Trust** - App for iPhones. Understand and manage panic and anxiety; create a ‘careplan’ to keep you well — and what to do when if you are unwell; set alarms for medications or exercise; graph sleep, anxiety and mood and email reports to yourself or a clinician, and receive information and news about anxiety disorders.
- **SAM – Self Help for Anxiety Management app** - The SAM app has been developed by a university team, the content is accurate and based on current psychological models... [read our review].

**STRESS**

- **CALM Website, Computer Assisted Learning for the Mind [NZ]** - An online resource created and managed by Dr Antonio Fernando, a senior lecturer at the University of Auckland. The website has tools for coping with stress and managing life.

**YOUTH**

- **thelowdown** - An interactive website for young people and the subject of depression. The site gives access to a team of counsellors who provide email, phone, webcam and text-based support.
- **ReachOut.com** - Australian youth mental health information service, includes a variety of apps and tools:
  - **Smiling Mind App**: for web or iPhones: relaxation techniques and meditation exercises
  - **SMS tips**: daily tips and challenges on themes like stress, problem solving, self-awareness and random acts of kindness
• **Reach Out Central**: an online game where you can learn and test skills like problem solving and optimistic thinking in a virtual setting.

**SPARX** - A self-help computer programme for young people with symptoms of depression. SPARX uses a 3D fantasy game environment and a custom-made soundtrack. The programme teaches skills to manage symptoms of depression. Young people learn cognitive behavioural therapy techniques for dealing with symptoms of depression.

Healthcare provider information.

**Nice Guidelines:**
- NICE Bipolar carer guidelines
- AOD youth link

### 3 Updates to this care map

**Quick info:**
Localised Map: Version 1.
DATE, November 2016.

This care map has been updated in line with consideration to evidenced based guidelines. For further information on contributors and references please see the care map’s Provenance.

### 4 Hauora Maori

**Quick info:**
As a practitioner you will work with Maori whanau/families. Each Maori whanau is diverse with their own set of values and beliefs, inherited, practised and passed down from generation to generation.

There are some important things that you should be mindful of when working with Maori individuals and their whanau from a holistic approach to working in a Whanau ora or family / whanau centred way.

Key enablers that you should be aware of when working with Maori whanau/families are:
- **building relationships and gaining trust**
- **effective communication with whanau /families**
- **understanding and involving whanau/ families** in the treatment planning and care management
- **practical things to be mindful of when working with Maori whanau** so that you do not breech Tikanga/Principles and practices that are important in Te Ao Maori/the Maori world

**Common terms and definitions** are noted here.

### 5 Pasifika

**Quick info:**
Our pasifika community:
- is a diverse and dynamic population
  - more than 22 nations represented in New Zealand
  - each with their own unique culture, language, history, and health status
  - share many similarities which we have shared with you here in order to help you work with pasifika patients more effectively

The main Pacific nations in New Zealand are:
- Samoa, Cook Islands, Fiji, Tonga, Niue, Tokelau and Tuvalu

Acknowledging **The FonoFale Model** (pasifika mode of health) when working with pasifika peoples and families. Acknowledging general pacific guidelines when working with pasifika peoples and families:
- **cultural protocols and greetings**
- **building relationships** with your pacific patients
- **involving family support, involving religion**, during assessments and in the hospital
- **home visits**
6 Information resources providers

Quick info:

**Provider Resources:**
- Guide to therapy and levels in stepped care
- Substance withdrawal management guidelines
- Screening-assessment-and-evaluation-aod-smoking-and-gambling
- Bringing together physical and mental health Kings Fund
- CHAT - brief screening questions covering tobacco, alcohol, drug misuse, gambling, depression, anxiety, anger, family violence and exercise. Positive responses can link through to more comprehensive screening tools
- AUDIT Alcohol Tool
- ASSIST Tool - alcohol and other drugs
- K10 - distress related to anxiety and/or depression
- PHQ-9 - Depression
- GAD7 - Anxiety
- EPDS - Post natal depression
- ORS/SRS measures the impact of presentation in 4 domains (ORS) and the quality of the therapeutic relationship (SRS)
- ORS Key Messages
- ORS Administration and Scoring Manual
- NZ depression guidelines
- MOCA - If cognitive impairment suspected complete Montreal Cognitive Assessment - see Dementia Suspected Pathway

Healthcare provider information.

**Nice Guidelines:**
- NICE Borderline PD guidelines
- NICE guidelines Bipolar
- NICE guidelines for Borderline Personality Disorder

**Metabolic Syndrome:**
- Diagnosis and Management of the Metabolic Syndrome
- Metabolic Syndrome Treatment and Management

**Child and Adolescent Mental Health:**
- Werry Centre
- Supporting Parents

It is well documented that whanau/family interventions to reduce the effects of mental illness improve outcomes for children and young people affected by mental illness in their family/whanau. Being a parent can be stressful at times, but there is hope. For parents who experience mental illness, parenting often provides the motivation and reason to do all they can to become well and look after their physical and mental health:
- WDHB supporting parents, healthy children
- Implementation Plan Supporting Parents Healthy Children (COPMIA) Guidelines for MH & A Services
- Supporting Parents Healthy Children - A guideline for mental health and addiction services
- Supporting Families Wanganui COPMIA Referral Form

7 Medication

Quick info:

**WARNING STATEMENT**

Medication should be prescribed in a careful considered manner. Benzodiazepines and SSRI's do not address causal relationships to presentations or lifestyle choices.
ON CALL / ADVISORY RESOURCES
A telephone psychiatric advisory/consult service is available Mon - Fri for messaging and call back or direct availability between 11:30 and 12:15 on 021 901 384.
On call psychiatric advice is available 24/7 for more immediate review/advice either via Community Mental Health and Addiction services Mon - Fri 08:30 - 17:00 on 06 348 1207
OR via MENTAL HEALTH ASSESSMENT AND HOME TREATMENT team on 0800 653 358.

Antipsychotics/Atypicals:
- Reference for Antipsychotics
- Clozapine
- Quick Reference Clozapine
- Clozapine Protocol/Constipation
- Clozapine Protocol/Constipation 1
- Antipsychotic side effects

Benzodiazepine/Hypnotics:
- Benzodiazepine withdrawal management
- Benzodiazepine doses
- Diazepam reduction regime
- Benzodiazepine absorption rate

Important: benzodiazepine indications:
- benzodiazepines are indicated for the short-term relief (2 to 4 weeks only) of anxiety that is severe, disabling, or causing the patient unacceptable distress, occurring alone or in association with insomnia or short-term illness
- the use of benzodiazepines to treat short-term ‘mild’ anxiety is inappropriate
- benzodiazepines should be used to treat insomnia only when it is severe, disabling, or causing the patient extreme distress
- if possible, avoid sedatives and hypnotics in the elderly due to the increased risk of ataxia, confusion and falls. Hypnotics and sedatives are not generally indicated for use in children
- benzodiazepines should be limited to a short course of treatment, and repeat prescriptions should not be provided without a clinical review

BPACNZ - Appropriate use of zopiclone and benzodiazepines for the treatment of insomnia.

Dependence and withdrawal
Avoid abrupt withdrawal have the potential to produce convulsion, delirium and psychosis.

The benzodiazepine withdrawal syndrome may develop at any time up to 3 weeks after stopping a long-acting benzodiazepine, but may occur within a day in the case of a short-acting one. It is characterised by insomnia, anxiety, loss of appetite, weight loss, tremor, perspiration, tinnitus, and perceptual disturbances. Some symptoms may be similar to the original complaint and encourage further prescribing; some symptoms may continue for weeks or months after stopping benzodiazepines.

A benzodiazepine can be withdrawn in steps of about one-eighth (range one-tenth to one-quarter) of the patient’s daily dose every fortnight. A suggested withdrawal protocol for patients who have difficulty is as follows:
- counselling recommended during and after tapering doses
- transfer patient to equivalent daily dose of diazepam (see below) preferably taken at night
- reduce diazepam dose every 2–3 weeks; if withdrawal symptoms occur, maintain this dose until symptoms improve
- reduce dose further, if necessary in smaller steps; it is better to reduce too slowly rather than too quickly
- stop completely; period needed for withdrawal can vary from about 4 weeks to a year or more

Substance Withdrawal Management Guidelines

Hypnotics and Anxiolytics:
Safe Prescribing for Hypnotics and “Sleep Hygiene”:
- establish cause of insomnia
- treat underlying factors
- alcohol consumption
- discuss unrealistic sleep expectations

Long Acting Hypnotics (preferred when):
- sedation the day after is acceptable
Short Acting Hypnotics (preferred when):

- sleep onset insomnia
- for elderly
- daytime sedation unacceptable

Mood Stabilisers:

- Lamotrigine

8 Presentation and Screening Assessment

Quick info:

**At initial presentation consider:**

- What does the person want?
- What is their preferred outcome?
- What might this overt presentation be indicative of?

**SCREENING**

Baseline screening measure can help assess the impact and severity of the symptomatic presentation.

For quick screening across multiple domains use:

- **CHAT** - brief screening questions covering tobacco, alcohol, drug misuse, gambling, depression, anxiety, anger, family violence and exercise. Positive responses can link through to more comprehensive screening tools
- **AUDIT Alcohol Tool**
- **ASSIST Tool** - alcohol and other drugs
- **K10** - distress related to anxiety and/or depression
- **PHQ-9** - Depression
- **GAD7** - Anxiety
- **EPDS** - Post natal depression
- **ORS/SRS** measures the impact of presentation in 4 domains (ORS) and the quality of the therapeutic relationship (SRS)
- **ORS Key Messages**
- **ORS Administration and Scoring Manual**

These free to use tools require that the attached licence agreement be downloaded:

- [outcome ratings scale manual](#)

If cognitive impairment suspected complete **Montreal Cognitive Assessment (MOCA)**

If there is a positive screen then follow the **RED Moca link** above which will lead to the **Dementia Suspected** Pathway
aggression, violence, use of alcohol, prescription drugs, or illicit drugs, amount and quality of support from family/whanau (see acute node and/or Intervention/therapy node in this pathway).

References [25,26].

RISK
Are there any risk indicators to warrant accessing acute node within this pathway?
If there is an immediate presentation of overdose or serious injury, risk to self or others attributable to mental health state/disorder then refer immediately to the Emergency Department/emergency services.
Access acute node if:

• serious suicidal intent
• psychotic symptoms
• severe self-neglect
• suspected eating disorder
• significant but not immediate risk of harm to self/others related to mental health disorder
• suspected new-onset bipolar disorder
• treatment resistant

The following pathway can be reviewed for additional resource links and guidance. Please be mindful that all resources or some specific guidance notes may **NOT** be applicable at a locality level:

• self harm - primary care management

References [25,26].

LIFESTYLE
What are the immediate health and lifestyle factors that require consideration to develop a plan which will improve the functional impact of presentation e.g. sleep hygiene rather than hypnotics, reducing intake of stimulants/depressants, promoting exercise and an understanding of the positive impact upon mood state of sleep, exercise, hydration and nutrition.
Deliver health messaging and use this to support developing a plan of care that could also either limit or avoid unnecessary use of hypnotics, benzodiazepines and SSRI’s.

RESOURCES
Use smartphone apps, online and other appropriate resources e.g. peer support services (see information resources for patients and carers node and health and wellbeing node) to support health and wellbeing.

HEALTH MESSAGING
Deliver clear health messaging:

• impact of alcohol and drugs on mood and functioning
• the relationship of diet, sleep and exercise to wellbeing

Health and Wellbeing
LIVE WELL.pdf
Use health messaging to develop health and wellbeing plan.

CONTEXTUAL ASSESSMENT
Developing a collaborative understanding of the contextual aspects of the person’s life is essential. See comprehensive assessment and planning node.
Reference [25].

FAMILY VIOLENCE
Family Violence is a significant NZ issue. Disclosure is often made after repeated routine screening questions are used. Health and Wellbeing Assessments are a good opportunity to use FV questions:

• Family Violence Questions

Access guidance and support to assist with decision making in cases where there is uncertainty about what might be required to support the person to meet their health needs.

Mental health and addictions contact numbers:

• contact numbers

9 Diagnoses

Quick info:

Diagnoses should always be considered with caution:
• the Diagnostic Statistical Manual (DSM) and the International Classification of Disorders (ICD) are the diagnostic references widely known and accessed by psychiatrists
• the contextual aspects of presentation and a comprehensive assessment should always support the development of health and wellbeing plans rather than a singular focus upon diagnostics
• false positives can occur from utilising diagnostic screening tools in isolation of comprehensive, contextual assessments

DSM 4 TR is included as a reference.

MYHEALTHAPPS has a directory of health apps covering ADHD, anxiety, autism spectrum disorder, depression, mental health, obsessive-compulsive disorder, panic-disorder, phobia, stress.
The acuity of presentation can inform alignment of appropriate resources to meet the needs of the person.

Guide to therapy and levels of stepped care

10 Health and Wellbeing Resources

Quick info:

HEALTH AND WELLBEING

Comprehensive assessment and consideration of health and lifestyle factors is paramount to developing and supporting the health and wellbeing of individuals, families and communities.

The following links, apps and resources are available to support better health:
• Live Well Module
• Happier App - App for iPhones. Happier is a simple way to be reminded to do more of what makes you happier
• Wellbeing Podcasts
• Podcasts and Videos - Free audio podcasts from the UK Mental Health Foundation that can help you relax and improve your sense of wellbeing

Healthy Eating and Nutrition:
• Health Navigator
• Healthy Food

For help with weight loss go to:
• Food Switch
• Fat Secret
• Losing Weight

Other smartphone apps to try include for weight loss:
• Fooducate
• Shopwell
• Sidechef
• Myfitnesspal
• Lifesum

Physical Activity:
• Sports Wanganui
• Health Navigator/Physical Activity
• Strength and Flexibility
• Couch to 5K
• Physical Activity/Mental Health

Other Smartphone apps to try include for physical activity:
• Fit
• Motiontraxx
• Spotify running
• Daily Yoga

Sleep:
• Health Navigator/Sleep
**Health and Wellbeing (Mental Health and Addictions)**

- **NHSUK Sleep**

Other smartphone apps to try include for sleep:
- **Pzizz**
- **Relax and Sleep Well**
- **Relax Melodies**
- **Sleep Pillow Sounds**

**Housing:**
- **Energywise**
- **Healthy Housing**
- **Housing NZ**

**Healthy Homes Maintenance Checklist:**
- **Healthy Housing Checklist**

**Renter’s Healthy Homes Checklist – ACC (really good for checking all homes):**
- **Renter’s Healthy Home Checklist ACC**

**Housing and Tenancy Advisors:**
- **Keys Social Housing** tel 06 348 7016 mobile 027 687 7298

**Occupational Activity / Employment:**
- Providing Access to Health Solutions (PATHS) at **Work and Income** tel 06 965 8075

**Smartphone app:**
- **MyMSD**
- **Supported Employment Service** (Whanganui Disability Resources Centre) at tel 06 347 1176
- **Whanganui Learning Centre** at tel 06 348 4950
- **YMCA Wanganui** tel 06 349 0197
- **WorkBridge**

**Hobbies/ Social connection**

**Dental:**
- Dental apps available include:
  - **Brush DJ**
  - **Dental Expert**
  - **Dental Phobia**
  - **Virtual Dentist**

**11 Acute**

Quick info:

**Emergency Services Referral (dial 111)**

Refer to emergency services at any stage if:
- if immediate acute risk to self or others due to perceived mental health disorder. Note emergency services have an MOU with Mental Health Assessment and Home Treatment Service through which a mental health and wellbeing assessment will be arranged. The priority with acute immediate risk is to ensure the physical safety of the person
- suicidal intent (see suicide box)
- psychotic symptoms with an associated degree of risk
- severe self-neglect
- if there is a presentation with an overdose or serious injury refer immediately to the Emergency Department. Access emergency services if required (dial 111)
- Emergency Department, Whanganui Accident and Medical and the General Hospital can access the Mental Health Assessment and Home Treatment team for specialist mental health and addictions assessment post emergency intervention (see following pathway)
Health and Wellbeing (Mental Health and Addictions)

Mental Health > Health and Wellbeing > Health and Wellbeing (Mental Health and Addictions)

• MHAHT Pathway

Urgent Referral
Mental Health Assessment and Home Treatment 0800 653 358.
Refer at any stage if:
• significant but not immediate risk of harm to self/others due to mental health disorder
• suspected new-onset bipolar disorder
• suspected first onset psychosis
• treatment resistant and expressed hopelessness (risk indicator)
• eating disorder esp if BMI <17 (impaired cognitive functioning) see SCOFF questionnaire

Consider need for routine (up to 3 week wait for face/face assessment) or urgent (via MHAHT) based upon acuity and risk (4 hours response). See MHAHT pathway 2:

• MHAHT Pathway 2

Adult risk assessment with COPMIA screening tool

Family Violence Screening
Is there any current sexual, physical, or emotional abuse. Family Violence screening questions:
• ‘Within the past year, did anyone scare you or threaten you, or someone you care about? (If so, who did this to you?)’
• ‘Within the past year, did anyone ever try to control you, or make you feel bad about yourself?’
• ‘Within the past year have you been hit, pushed or shoved, slapped, kicked, choked or otherwise physically hurt? (If so, who did this to you?)’
• ‘Within the past year has anyone forced you to have sex, or do anything sexual, in a way you did not want to? (If so, who did this to you? When did this happen (the last time)?)’
• Practice Note: While the purpose of these questions is to ascertain experience of ‘violence’ or ‘abuse’, people experiencing the violent behaviour seldom apply these terms to what is happening to them
• as a consequence, it is important that ALL routine enquiries ask about specific behaviours. Asking a single question, such as ‘Are you safe at home?’ is not effective, and is unlikely to result in disclosures of violence. (link to family violence resources in clinical resource directory)

Suicide
See suicide information box.
The following groups have been identified as the biggest NZ ‘at risk’ groups:
• Rangatahi Maori, aged 15 - 24 years
• males aged 25 - 64 years (the highest proportion of suicides was among those who were unemployed, followed by the ‘construction and trade’ and the ‘farm and forestry’ industries)
• specialist mental health service users (make up 20% of suicides)

Screening via Kessler 10 can ascertain degree of distress associated with anxiety and/or depression to inform decision making regarding care planning - Kessler Psychological Distress Score (K10)

Depression in Adults:
• depression is associated with suicidality. Always ask about suicidal thoughts

Anxiety in Adults:
• anxiety disorders are associated with suicidality. Always ask about suicidal thoughts

Maternal Mental Health
Arrange Mental Health Assessment if any red flags:
• suicidality
• risk of harm to the foetus or baby
• acute psychosis

Preventing Suicide. Guidance for Emergency Departments

New Zealand suicide action plan
The following pathway can be reviewed for additional resource links and guidance. Please be mindful that all resources or some specific guidance notes may NOT be applicable at a locality level:
• emergency management of self-harm
NOTE if the acute pathway is no longer appropriate to the needs of the person then reaccess primary care pathway (see comprehensive assessment and planning node).

12 Comprehensive Assessment and Planning

Quick info:

Comprehensive assessments may require the use of an extended consultation.

The key outcomes are:

- screening and risk assessment
- contextual assessment
- a lifestyle/wellbeing assessment

Extended consultations are an opportunity to develop an understanding of all factors which are contributory to the current presentation. Te Whare Tapa Wha and Hauora offers a culturally responsive and comprehensive model within which comprehensive/contextual assessments can be completed [25,26].

Target groups include vulnerable, at risk population groups [25,26,27] in order to develop health and wellbeing plans aimed at improving the health outcomes for individuals.

Population groups are identified either opportunistically at presentation or within established follow up plans e.g. Long Term Conditions Frameworks [27].

This comprehensive health and wellbeing model requires considering the relationship between baseline screening and a comprehensive assessment [25,26] around lifestyle LIVE WELL.pdf and bio/psycho/social factors.

The collaborative development of this shared understanding will help promote health literacy through identifying and planning as to how best address causal and maintaining factors to presenting problems.

Plans developed are to be mutually agreed with all goals identified being considered appropriate and reasonable to the person. If goals are not considered reasonable and achievable by the person they need to be renegotiated.

AOD screening tools should be considered if there is a positive mental health screen due to the high correlation between mental health and alcohol and other drug use. The converse also applies. CHAT is a brief screening questionnaire covering tobacco, alcohol, drug misuse, gambling, depression, anxiety, anger, family violence and exercise. Positive responses can link through to more comprehensive screening tools.

Establish if person wishes to access AOD services. If not motivated utilise ABC approach and document agreed outcome.

Only make a referral to any service or agency if express, informed consent [29] is given and document this within the health and wellbeing plan.

Access guidance and support to assist with decision making in cases where there is uncertainty about what might be required to support the person meet their health needs.

Mental health and addictions contact Numbers:

- telephone Psychiatric consult is available Mon - Fri on 021 901 384 (available for messages and direct contact 11:30-12:15)
- Urgent i.e. non emergency guidance and support can be accessed 24/7 via Mental Health Assessment and Home Treatment (MHAHT) on 0800 653 358
- Community Mental Health and Addictions services 06 348 1207
- on call duty psychiatrist-accessed via paging system through hospital switchboard 06 348 1234 or via CMH and Addictions (business hours) or MHAHT 0800 653 358

Utilise local resource/service directory with person to help decide what may be required and document this within wellbeing plan as an agreed outcome.

Support documents:

- Guide to therapy and levels in stepped care
- Te Pou Assessment of mental health and wellbeing for matching to therapy

13 AOD

Quick info:

Alcohol and other drug (AOD) presentations do not occur in isolation and require whole person assessment and comprehensive health and wellbeing plans to be developed. AOD Screens can be conducted using AUDIT or ASSIST. Be mindful of completing mental health screen due to high correlation between AOD and mental health disorders CHAT AUDIT
AUDIT is the gold standard for identification of alcohol problems with 96% validity, detecting alcohol problems at their lowest level. It takes no more than 5 minutes and is normally followed by a 10 minute intervention:

- **AUDIT Alcohol Tool**

**ALCOHOL**
These guidelines have been developed to assist nursing and medical practitioners to identify alcohol withdrawal symptoms and to provide safe withdrawal management strategies for people who are dependent:

- Alcohol withdrawal management
- Alcohol Clinical Institute Withdrawal Assessment of Alcohol Scale Revised

A wide range of drug use can be screened using ASSIST:

- **ASSIST Tool**

**Amphetamine Type Stimulants**
These guidelines have been developed to assist nursing and medical practitioners to identify amphetamine-type stimulant withdrawal symptoms and to provide safe withdrawal management strategies for people who are dependent:

- Amphetamine Type Stimulants withdrawal management strategies

**Benzodiazepines**
These guidelines have been developed to assist nursing and medical practitioners to identify benzodiazepine withdrawal symptoms and to provide safe withdrawal management strategies for people who are dependent:

- Benzodiazepines withdrawal management strategies
- Benzodiazepine absorption rate
- Diazepam reduction regime

**Benzodiazepine Withdrawal**
Considerations with benzodiazepine use and prescribing:

- patients who receive benzodiazepines continuously for > 2 months may be dependent on them
- patients, particularly those in the older age group, may not show signs of dependence or adverse effects immediately
- identify those receiving benzodiazepines with no clear indication, not just those with obvious dependence or adverse effects
- aim to discontinue benzodiazepine use before dependence occurs
- it is illegal to prescribe benzodiazepines to treat addiction

**Cannabis**
These guidelines aim to assist nursing and medical practitioners with the assessment and identification of cannabis withdrawal symptoms in order to be able to provide safer withdrawal management:

- Cannabis withdrawal management
- Cannabis Dependency Assessment

**Inhalants**
These guidelines have been developed to assist nursing and medical practitioners to identify inhalant withdrawal symptoms and to provide safe withdrawal management strategies for people who use inhalants regularly and may be dependent:

- Inhalants withdrawal management strategies

**Nicotine:**

- Nicotine drug interactions
- **Nicotine Replacement Therapy**

**Opioid Dependent Withdrawal Management Pathway**
Opioid dependence is characterised by cognitive, behavioural and physiological features. Three of these features need to be present for opioid dependence:

- a strong desire or sense of compulsion to take opioids
- difficulties in controlling opioid use
- a physiological withdrawal state
- tolerance
- progressive neglect of alternative pleasures or interests because of opioid use
- persisting with opioid use, despite clear evidence of overtly harmful consequences [1]

**Consider a urine drug screen, preferably using a sample produced at the surgery.**

**Opioids withdrawal management strategies**
Clinical Opioid Withdrawal Scale (COWS)

Interaction Warning
There are several potentially severe and fatal interactions. The combination of the following medications and drugs is best avoided:

• lorazepam and alcohol, which has been associated with significant respiratory and cardiac depression (this appears to be more likely with lorazepam than with other benzodiazepines)

• amphetamines and monoamine oxidase inhibitors, including moclobemide, which have been associated with a severe hypertensive crisis

The following pathway can be reviewed for additional resource links and guidance. Please be mindful that all resources or some specific guidance notes may NOT be applicable at a locality level:

• substance misuse suspected

14 Psychosis

Quick info:

Psychosis

Psychosis Diagnosis and Management

1. Obtain a full history:
   • risk factors
   • history of the presenting complaint
   • personal history
   • positive and negative psychotic symptoms

2. Assess risk of suicide, harm to others, and exploitation or neglect:
   • patients who are agitated and distressed may become unpredictable
   • consider the needs of any dependent children of the patient

3. Closely assess any unusual statements made by the patient by asking key questions to help determine whether they may be psychotic.

4. Consider whether the symptoms may be due to a first episode of psychosis [38]:
   • it is important not to delay referring any young adult who may be having a first episode
   • a long duration of untreated psychosis and a younger age at onset are associated with poorer long-term outcomes

5. Ask about current and recent medications, as some prescription drugs can trigger psychosis e.g., steroids and stimulants. Consider substance misuse, abuse, or withdrawal.

6. Examination:
   • physical and neurological examination
   • if cognitive impairment is suspected, carry out an assessment such as Montreal Cognitive Assessment to assess for delirium or dementia - see Dementia Suspected Pathway

7. Arrange baseline investigations without delaying start of treatment.

8. Determine the most likely cause of the psychosis:
   • a mental disorder e.g., schizophrenia, depression, bipolar disorder, one-off episode, schizoaffective disorder, delusional disorder, borderline personality disorder
   • an organic condition

The following pathway can be reviewed for additional resource links and guidance. Please be mindful that all resources or some specific guidance notes may NOT be applicable at a locality level:

• Psychosis - suspected

References [37,38,39,40,41]

15 Alcohol

Quick info:

Alcohol Intervention: This pathway enables general practitioners to carry out opportunistic screening and brief intervention for harmful drinking.
About alcohol intervention
Harmful alcohol use contributes to over 60 health conditions, many of which are chronic in nature e.g., hypertension, stroke, and cancers of the gut and breast.

For the less severe problematic alcohol users, alcohol interventions can be framed in much the same way as engagement around smoking or diet, using the ABC approach [28]:

- evidence shows that a simple assessment of a patient’s alcohol use (A) followed by a brief discussion (B) of the benefits of reducing their alcohol intake has a beneficial effect on patient alcohol intake
- those patients with more severe alcohol issues can be counselled or referred to specialist alcohol services (C)

Alcohol Intervention Management
At Risk of Hazardous Drinking:

- provide five minute BRIEF Intervention
- encourage the patient to set goals and record them
- provide information on standard drinks and safe drinking levels
- ask the patient to return in 4 to 8 weeks to evaluate their progress

Problem use or mild dependence:

- provide five minute BRIEF Intervention
- agree alcohol reduction plan and follow up with patient
- provide information on standard drinks and safe drinking levels
- if you would like to investigate or manage further, consider carrying out the more detailed 10-15 minute AUDIT screening test and FRAMES intervention
- if the patient shows no progress, consider referral to Alcohol and Drug Helpline or Alcoholics Anonymous Helpline

Moderate to severe dependence:

- if you would like to investigate or manage further, consider carrying out the more detailed 10-15 minute AUDIT screening test and FRAMES intervention
- If client consents consider referral to community mental health and addictions services
- consider medications. Disulfiram (Antabuse) can be useful for problem drinkers who have low impulse control

Medsafe Data sheet - Antabuse
Patient Information - Antabuse

Audit provisional diagnosis
A score of 8 or more possible harmful pattern of drinking.

Section A: (questions 1,2,3) enquire about “at risk” alcohol consumption. A score of 4 (or more) for women, or 5 (or more) for men suggests a level of drinking that places the person at risk of harm.

Section B: (questions 4,5,6) enquires about symptoms of dependence. A score 4 (or more) indicates that person may be psychologically or physically dependent on alcohol.

Section C: (questions 7,8,9,10) enquires about problems relating to drinking. A score of 4 (or more) indicates significant problems already.

The following pathways can be reviewed for additional resource links and guidance. Please be mindful that all resources or some specific guidance notes may NOT be applicable at a locality level:

- suspected alcohol dependence
- alcohol withdrawal

16 Health and Wellbeing Plan / Review

Quick info:

Health and Wellbeing Plan/Review
A review/evaluation requires consideration of the following which will have been completed at earlier points of contact.
What does the person want?
What is their preferred outcome?
What might this overt presentation be indicative of?

SCREENING
Repeat screening tool(s) to help re-assess acuity:
• CHAT - brief screening questions covering tobacco, alcohol, drug misuse, gambling, depression, anxiety, anger, family violence and exercise. Positive responses can link through to more comprehensive screening tools
• AUDIT Alcohol Tool
• ASSIST Tool - alcohol and other drugs
• K10 - distress related to anxiety and/or depression
• PHQ-9 - Depression
• GAD7 - Anxiety
• EPDS - Postnatal depression
• ORS/SRS measures the impact of presentation in 4 domains (ORS) and the quality of the therapeutic relationship (SRS)

Note: if Outcome Rating Scales (ORS) and Session Rating Scales (SRS) are being used the licence agreement requires completion and the ORS/SRS will form the core of the therapeutic process including planning, review and evaluation. Support regarding the utilisation of Outcome Driven Practice tools can be accessed from specialist mental health and addictions services.

The Outcome Driven Practice tool the Outcome Rating Scale (ORS) can be used to measure the impact of the presentation upon four domains.
ORS is used in conjunction with Session Rating Scales (SRS) which measures the qualitative experience of the person. The evidence is that by focusing upon maintaining a positive therapeutic relationship and a treatment focus based upon the person’s needs that clinical outcomes are improved.

These free to use tools require that the attached licence agreement be downloaded.

Reviewing the presentation against baseline screening tools completed at initial presentation can ascertain if there has been a change in acuity.
Planned reviews are an integral component of health and wellbeing plans.
The attached Te Pou documents (Intervention Therapy Review) offer a framework for conducting a review.

CONTEXTUAL ASSESSMENT
Developing a collaborative understanding of the contextual aspects of the person’s life is essential [25,26,27]. As the target population groups are at risk and potentially vulnerable often with a degree of complexity, co-morbidity and associated poor predictive health and wellbeing outcomes it is advised that a contextual assessment of life and lifestyle is undertaken. Te Whare Tapa Wha and Hauora offers a culturally responsive and comprehensive model within which comprehensive/contextual assessments can be completed [25,26].
A collaborative, contextual assessment will likely require an extended consultation. Health and wellbeing plans are developed from consideration of the functional impact (screening assessment process) and a developed contextual assessment (through extended consultations).
The development of an understanding of lifestyle factors that may be causal or maintaining factors to presentation will assist developing a collaborative health and wellbeing plan.

Live Well Module - Please refer to Comprehensive Assessment and Planning Node.
What are the bio/psycho/social factors?
Dr Mason Durie’s te whare tapawha model gives a comprehensive contextual framework within which bio/psycho/social factors can be considered. It is also a model which is culturally appropriate to the NZ population yet is applicable in any area of whole person/wellbeing assessment.
Does the person understand the inter-relationship of bio/psycho/social and the overt presenting problem?
What resources might they need to support developing this understanding e.g. family external agency (peer support), cultural support?
The specific problems and goals identified within the health and wellbeing plan developed from the comprehensive assessment should be reviewed.
The process of assessment, planning, implementation and review is continuous. Collaborative development of health and wellbeing plans is essential to good engagement and improved outcomes which is another strong consideration for utilising ORS/SRS

17 Bipolar

Quick info:
Bipolar Disorder:
• Please access following link Bipolar Disorder
• NICE assessment and management

Acute
Making the diagnosis.

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The diagnosis of bipolar disorder:
  • is complex and has lifelong implications
  • may take time and is ideally made by a psychiatrist
  • depends on the phase and type of bipolar disorder
  • Acute mania or hypomania

**Acute mania or hypomania - assessment.**
Consider acute mania or hypomania using the DSM-4 TR criteria if:
  • sustained abnormal mood, plus 3 of the following symptoms, or 4 symptoms if mood is irritable rather than elevated:
    • inflated self-esteem or grandiosity
    • decreased need for sleep
    • more talkative than usual
    • flight of ideas, or subjective experience that thoughts are racing
    • distractibility
    • increase in goal-directed activity e.g., at work or socially
    • excessive involvement in high risk activities e.g., spending recklessly, or sexual indiscretion
    • mania lasting $\geq$ 1 week, or any duration if hospitalisation is necessary
    • hypomania lasting $\geq$ 4 days, less severely elevated mood, with minimal or no functional impairment

**Acute bipolar depression.** Consider using the DSM-4 TR criteria.
Sustained abnormal mood, plus 3 of the following symptoms, or 4 symptoms if mood is irritable rather than elevated:
  • inflated self-esteem or grandiosity
  • decreased need for sleep
  • more talkative than usual
  • flight of ideas, or subjective experience that thoughts are racing
  • distractibility
  • increase in goal-directed activity e.g., at work or socially
  • excessive involvement in high risk activities e.g., spending recklessly, or sexual indiscretion

**Mixed episode - assessment.**
The criteria are the same as for both mania and depressive episodes:
  • occur nearly every day during at least a 1 week long period
  • hopeless and suicidal, but highly energised

**Rapid cycling - assessment:**
  • the criteria are the same as for both mania and depressive episodes
  • occur as $\geq$ 4 mood episodes in 1 year

**Acute assessment:**
1. if mania or hypomania suspected, ask about behavioural changes which are out of character for the patient.

**Behavioural changes:**
  • feeling energised and "wired"
  • excessively seeking stimulation
  • overly driven in pursuit of goals
  • needing less sleep
  • irritable if stopped from carrying out ideas
  • disinhibited and flirtatious
  • offensive or insensitive to the needs of others
  • spending money in an unusual manner or inappropriately
  • indiscreet, and disregarding social boundaries
  • having poor self-regulation
  • making excessively creative and grandiose plans
  • having difficulty discussing issues rationally or maturely
Health and Wellbeing (Mental Health and Addictions)

- reporting enhanced sensory experiences
2. if the patient is cooperative, examine to consider other causes and assess for complications, including:
  - malnourishment or dehydration
  - communicable diseases (including HIV, Hepatitis C) due to risky sexual behaviour
3. consider blood tests e.g., CBC, LFT, TFTs, therapeutic drug monitoring, urine drug screen.
4. obtain corroborative information where possible, especially if suspected psychosis or concerns about harm.

**Bipolar Disorder - established.**
During euthymic periods regularly assess:
- medications and whether symptoms are controlled and side effects minimised. Check compliance as non-compliance is the most common factor in relapse
- any circumstances which may cause increased stress
- physical health e.g., weight, smoking cessation, blood tests. Consider annual health check
- any comorbid illnesses e.g., anxiety, substance abuse
- the needs of any dependent children

**References** [42, 43, 44, 45]

### 18 Depression

**Quick info:**

#### Screening for depression:
Consider targeted screening in certain patients [30,31,32]:
- clinical suspicion
- new patient
- infrequent attendance at general practice
- risk factors
- multiple symptoms
- chronic illness

1. Use screening questions to identify symptoms which significantly impair social or occupational functioning [30,31,32].

   **Screening questions:**
   - during the past month, have you often felt down, depressed, or hopeless?
   - during the past month, have you had little interest or pleasure in doing things?
   - is this something with which you would like help?

   If the answer is yes to either 1 or 2, and yes to 3, then sensitivity is 96% and specificity 89%.

2. In patients who present with depressive symptoms [30,31,32]:
   - consider using the Kessler Psychological Distress Score (K10) to determine severity of symptoms, and for monitoring [1]
   - always ask about a history of elevated mood, as this has important treatment implications for the depressive phase if a bipolar disorder is likely
   - ask about:
     - severity and duration of symptoms
     - degree of distress
     - functional impairment
     - suicidality

3. Consider history [30,31,32]:
   - past personal history of any mental health disorder
   - family history of mental disorders
   - current or past mental health therapies
   - substance misuse
   - comorbid mental health disorders especially anxiety
• chronic health problems
Other risk factors:
• female
• socio-economic deprivation
• loss or stress, including divorce and unemployment
• history of physical or sexual abuse
• ongoing conflict, including spiritual, cultural, or sexual

Medical and medication causes that may cause or aggravate depression.

Medication causes:
• steroids
• oral contraceptives
• some beta blockers
• varenicline (Champix)
• isotretinoin

Medical causes:
• hypothyroidism
• parkinson’s disease
• sleep disturbance
• cardiovascular disease
• diabetes
• dementia
• any physical illness that is life threatening, causes pain, or disability

4. Possible investigations for physical causes of depression [30,31,32].

Many patients will not require investigations, but they are likely to be important in adults aged > 45 years with sudden onset depression:
• CBC
• Thyroid-stimulating hormone (TSH)
• Ferritin
• Liver function test (LFT)
• Creatinine
• Sodium
• Potassium
• B12
• Folate

5. Grade the severity of the depression as this will help with management [30,31,32].

Mild or subthreshold (Kessler 10 score: 20 to 24).

Subthreshold symptoms:
• one key symptom of depression present, but insufficient other symptoms or functional impairment to meet full diagnosis
• depressive symptoms below threshold criteria can be distressing and disabling if persistent
• symptoms may be present for several months and continue, despite active monitoring and low intensity intervention
• dysthymia – symptoms are present for 2 years

Moderate (Kessler 10 score: 25 to 29)

Severe (Kessler 10 score: 30 to 50) Please use screening and contextual assessment from Medtech Advanced form for Mental Health and Addictions.

Patient Health Questionaire for Major Depression (PHQ-9) PHQ-9 score:
• provisional diagnosis
  • 10–14 Mild depression
  • 15–19 Moderate depression
• >20 Severe depression

Please refer to depression algorithm

The following pathways can be reviewed for additional resource links and guidance. Please be mindful that all resources or some specific guidance notes may NOT be applicable at a locality level:

• depression - management
• depression - mild to moderate
• depression - moderate to severe
• depression - severe/complex

19 Maternal Mental Health

Quick info:
For guidance and support regarding maternal mental health contact:

• Maternal Mental Health Clinician via Community Mental Health and Addictions services on:
  • 06 348 1207
  • available Mon -Fri 08:30- 17:00

• Telephone Psychiatric Consult:
  • on 021 901 384
  • available Mon - Fri (available for messages and direct contact 11:30-12:15)

• Urgent i.e. non emergency guidance and support can be accessed 24/7 via Mental Health Assessment and Home Treatment (MHAHT):
  • on 0800 653 358

Guidance information in the attached link should be considered - Maternal Mental Health link

The following pathway can be reviewed for additional resource links and guidance. Please be mindful that all resources or some specific guidance notes may NOT be applicable at a locality level - PMH - primary care

20 Anxiety

Quick info:
Understanding triggers, causal and maintaining factors to anxiety requires a comprehensive assessment (see presentation/screening, extended consult and healthy lifestyle).

Be mindful of risk with anxiety.

Medication will only offer symptomatic relief at best and is not to be considered a long term solution in isolation.

Benzodiazepines should be prescribed ideally for short term use and being mindful of tolerance and dependency issues that will arise.

Ask about the severity and duration of symptoms, degree of distress, and functional impairment.

1. Consider [32,33,36]:
   • current or previous therapies
   • substance misuse e.g., alcohol, illicit drugs
   • caffeine, caffeine products, and natural therapies
   • If person positively screens for anxiety always assess use of alcohol, other drugs, caffeine and smoking
   • suicide risk

2. Consider [35]:
   • medical and medication causes (is anxiety related or secondary to medical/medication):
     • hyperthyroidism
     • arrhythmia
     • COPD
     • angina
     • seizure disorders

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Have an open and honest collaborative discussion about deciding whether or not to investigate all health concerns.

3. Grade the severity of the anxiety [32,33].

These groupings are a guide only. Ultimately, the decision is based on clinical judgement.

**Kessler Psychological Distress Scale (K10)** - distress related to anxiety and/or depression:
- score between 10 and 19 - No significant feelings of distress
- score between 20 and 24 - Mild levels of distress consistent with mild depression and or anxiety
- score between 25 and 30 - Moderate levels of distress consistent with moderate depression and or anxiety
- score between 30 and 50 - Severe levels of distress consistent with severe depression and or anxiety

**Generalised Anxiety Disorder (GAD7)** - anxiety:
- mild anxiety Score 5-9
- moderate anxiety Score 10-14
- severe anxiety Score 15-21

The following pathway can be reviewed for additional resource links and guidance. Please be mindful that all resources or some specific guidance notes may **NOT** be applicable at a locality level:
- anxiety - primary care presentation

### 21 Intervention / Therapy Level

**Quick info:**

The Te Pou matching talking therapies framework affords a means of considering, within a stepped care model, what level of intervention is appropriate to the needs of the person - Deciding Therapy Intervention

The brief screen for intervention/therapy can be used to help support clinical decision making regarding current presentation level - Brief screen intervention therapy

### 22 Suicide

**Quick info:**

**Suicide in New Zealand kills more people than road accidents. It is important to ask about suicide risk.**

Asking directly about suicidality does not increase the risk or create a risk.

**NZ ‘at risk’ groups:**
- rangatahi Maori, aged 15-24 years
- males aged 25-64 years (the highest proportion of suicides was among those who were unemployed, followed by the ‘construction and trade’ and the ‘farm and forestry’ industries)
- specialist mental health service users (make up 20% of suicides)

**Related factors to suicide:**
- relationship break-up
- drinking binge
- loss of employment
- legal problems

The following resource information gives a comprehensive framework within which suicidality can be assessed and a management plan developed - Suicide

Whanganui District Health Board Suicide Prevention and Postvention Plan 2015-2017 SPP October 2015

### 23 Severe and Complex Presentations Level 4/5
Quick info:

**Deciding Therapy Intervention:**
- the brief screen for intervention/therapy can be used to help support clinical decision making regarding current presentation level
- Brief screen intervention therapy

**LEVEL 4/5 - Severe and complex presentations: high specialist evidence-based therapy**
Refer to Acute box.

**Presentation**
In secondary care Level 4 is considered to be high intensity community based services and Level 5 is considered to be high intensity inpatient services.

The person may present with:
- severe, complex and/or long-term issues/disorders with high needs
- high levels of distress (Kessler 10 score in high range 30-50)
- co-existing problems (mental health, addiction, physical health, disability, and social issues)
- a recurrent presentation (and/or previous treatment has been unsuccessful)
- a presentation considered to be a-typical and/or psychotic
- risk to self or others (including any previous risk)
- scores on relevant and specific screening measures indicate the severe range

**Intervention**
This level requires comprehensive psychological and/or psychiatric assessment, and an integrated formulation to plan the therapy intervention:
- immediate, acute and crisis intervention may be indicated
- psychometric assessment is required for specific diagnoses, disorders or neuro-psychological problems
- the type and duration of specialist therapy is tailored to the needs of the person
- medication and other treatment may also be recommended
- inpatient and residential treatment may be indicated

By whom:
- specialist secondary care services

24 **Moderate to Severe Presentation / Level 3**

Quick info:
The Te Pou matching talking therapies framework affords a means of considering, within a stepped care model, what level of intervention is appropriate to the needs of the person:

**Deciding Therapy Intervention**
The brief screen for intervention/therapy can be used to help support clinical decision making regarding current presentation level:
- Brief screen intervention therapy

**LEVEL 3 - Moderate to severe presentations: high intensity evidence-based therapy**

**Presentation.**
The person has a mental health and/or addiction problem or disorder such as:
- depression, anxiety, post-traumatic stress, substance use
- distress (Kessler 10 score in moderate range 25-29)
- problems with psychosocial functioning
  and/or:
  - may not have responded to an earlier level of treatment
  - may have co-existing problems (mental health, addiction, physical health, disability, social issues)
  - may have a history of complex and/or long-term problems

Use brief screening tools (CHAT) to identify baseline and acuity. Contextualise presentation through discussion and identification of related factors inc lifestyle and specific triggers.
Wellbeing is supported through self-management and promoting health and wellbeing plan. Lifestyle factors should be identified and addressed within the developed plan.

Assess risk (see ‘Acute’ information box).

Resource/service directory can be accessed to consider what additional resources and support may be useful to promote recovery.

Areas to consider include:

- extended consultations
- information/education/self-care strategies with appropriate support
- enhancing strengths to build resilience
- referral to relevant services/agencies (see resource links/directory)
- access to community resources - financial, housing, education, social services (see resource links/directory)
- support via a whanau ora model if applicable
- guided self-help, smartphone apps (see resource/links directory)
- e-therapies (depending upon clinical assessment, acuity and risk):
  - Depression
  - Moodgym
  - Beating the Blues
- skills groups such as stress and anxiety management
- educational, support and cultural groups
- referral to community services including financial, housing, education, social services

**Intervention**

Options at this level include consideration for evidence-based therapies such as:

- counselling, CBT, Secondary service assessment/review/follow up
- group therapy (depending upon acuity and risk) to develop skills in distress tolerance and managing emotions
- support from family and whanau and peer support services
- referral to community services including financial, housing, education, social services
- medication may also be considered and prescribed at this level

By whom:

- trained and supervised practitioners, therapists and psychologists in primary care in PHOs, NGOs, secondary care support/liaison

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25  Mild to Moderate Presentation / Level 2

**Quick info:**

The Te Pou matching talking therapies framework affords a means of considering, within a stepped care model, what level of intervention is appropriate to the needs of the person:

- Deciding Therapy Intervention

The brief screen for intervention/therapy can be used to help support clinical decision making regarding current presentation level:

- Brief screen intervention therapy

**LEVEL 2 - Mild to moderate presentations: low intensity evidence-based therapy**

**Presentation**

Assessment identifies mental health and/or addiction problems and risk factors for the person such as:

- persistent symptoms that present in the mild to moderate range
- a recognised problem or disorder
- mild to moderate distress (Kessler 10 score in mild range 20-24)
- impairment in psychological and social functioning, and wellbeing
- problems in areas of self-care, relationships or occupation

Use brief screening tools (CHAT) to identify baseline and acuity. Contextualise presentation through discussion and identification of related factors inc lifestyle and specific triggers.

**Intervention**

First response to problems is in primary care, at a GP practice level. The use of knowledge and skills in mental health and addictions is recommended to identify and monitor the person’s presentation of vulnerability, and to build resilience. Wellbeing is supported through self-management and promoting health and wellbeing plan. Lifestyle factors should be identified and addressed within the developed plan. Resource/service directory can be accessed to consider what additional resources and support may be useful to promote recovery. Areas to consider include:

- information/education/self-care strategies
- enhancing strengths to build resilience
- phone support - Lifeline, Alcohol/Drug helpline
- extended consultations (especially in the context of associated long term conditions)
- referral to support/self-help groups in the community (see resource links/directory)
- access to community resources - financial, housing, education, social services (see resource links/directory)
- support via a whanau ora model if applicable
- guided self-help, smartphone apps (see resource/links directory)
- e-therapies skills groups such as stress and anxiety management:
  - Depression
  - Moodgym
  - Beating the Blues
- educational, support and cultural groups
- referral to community services including financial, housing, education, social services

By whom:

- provided in primary care by appropriately trained and supported health clinicians and practitioners

26 Early Presentation of Problems or Distress / Level 1

Quick info:
The Te Pou matching talking therapies framework affords a means of considering, within a stepped care model, what level of intervention is appropriate to the needs of the person:

- Deciding Therapy Intervention

The brief screen for intervention/therapy can be used to help support clinical decision making regarding current presentation level:

- Brief screen intervention therapy

LEVEL 1 - Early presentation of problems or distress: monitoring and brief intervention

Presentation:
Assessment may identify that the person has emotional, psychological or social problems such as:

- transitional issues or difficulties – relationship issues, bereavement, work stress
- some level of distress (Kessler 10 score in the mild range 20–24)
- no more than slight impairment in psychological/social functioning
- a long term physical condition
- no formal diagnosis or clear disorder

Use brief screening tools (CHAT) to identify baseline and acuity. Contextualise presentation through discussion and identification of related factors inc lifestyle and specific triggers.

Intervention
First response to problems is in primary care, at a GP practice level. The use of knowledge and skills in mental health and addictions is recommended to identify and monitor the person’s presentation of vulnerability, and to build resilience. Wellbeing is supported through self-management and promoting health and wellbeing plan. Lifestyle factors should be identified and addressed within the plan. Resource/service directory can be accessed to consider what additional resources and support may be useful to promote recovery. Areas to consider include:

- information/education/self-care strategies
- enhancing strengths to build resilience
Eating Disorder

Quick info:

**Anorexia Nervosa - Highest Mortality Rate to Any Mental Disorder: Why?**

A review of nearly fifty years of research confirms that anorexia nervosa has the highest mortality rate of any psychiatric disorder (Arcelus, Mitchel, Wales & Nelson, 2011). Anorexia Nervosa is a life-threatening disorder due to the effects of weight loss and starvation on the body and brain. This is further complicated when purging behaviors are also being used. Purging behaviors may include self-induced vomiting, abuse of laxatives, diuretics, diet pills, appetite suppressants or other stimulants. Sometimes patients even purge by exercising excessively.

Each patient’s risk must be evaluated individually. Their risk is affected by the extent of their food restriction and the extent and combination of any purging behaviors. Other underlying medical diagnoses may also complicate and increase the risks of complications and death.

**ANOREXIA NERVOSA STATISTICS**

**Anorexia Prevalence:**

- it is estimated that 1.0% to 4.2% of women have suffered from anorexia in their lifetime [1]

**Anorexia Mortality Rates:**

- anorexia has the highest fatality rate of any mental illness [2]
- it is estimated that 4% of anorexic individuals die from complications of the disease [3]

**Access to Anorexia Treatment:**

- only one third of individuals struggling with anorexia nervosa in the United States obtain treatment [4]

**BULIMIA NERVOSA STATISTICS**

**Bulimia Prevalence:**

- It is estimated that up to 4% of females in the United States will have bulimia during their lifetime [5]

**Bulimia Mortality Rates:**

- 3.9% of these bulimic individuals will die [6]

**Access to Bulimia Treatment:**

- of those practicing bulimia, only 6% obtain treatment [7]

**BINGE EATING DISORDER STATISTICS**

**Binge Prevalence:**

- 2.8% of American adults will struggle with BED during their lifetime. Close to 43% of individuals suffering from Binge Eating Disorder will obtain treatment [8]

**Binge Eating Disorder Mortality Rates:**

- 5.2% of individuals suffering from eating disorders not otherwise specified, [9] the former diagnosis that BED, among other forms of disordered eating (was included in under the DSM-IV) die from health complications

**Access to Binge Eating Treatment:**

- close to 43% of individuals suffering from Binge Eating Disorder will obtain treatment [10]

**General Statistics on Eating Disorders:**

- eating disorders are a daily struggle for 10 million females and 1 million males in the United States [11]
- four out of ten individuals have either personally experienced an eating disorder or know someone who has [12]

**Over a lifetime, the following percentages of women and men will experience an eating disorder**

**Female Eating Disorder Prevalence Rates:**
• 0.9% of women will struggle with anorexia in their lifetime
• 1.5% of women will struggle with bulimia in their lifetime
• 3.5% of women will struggle with binge eating

Male Eating Disorder Statistics:
• 3% of men will struggle with anorexia
• 5% of men will struggle with bulimia
• 2% of men will struggle with binge eating disorder [13]

Prevalence Rates of Eating Disorders in Adolescents:
• the National Institute of Mental Health reports that 2.7% of teens, ages 13-18 years old, struggle with an eating disorder [14]

Eating Disorder Statistics & Research
Suspected Eating Disorders should be carefully assessed due to risk and care pathway recommendations followed:
• Eating Disorders
Overview
This document describes the provenance of Whanganui Regions Health and Wellbeing (Mental Health & Addictions) Pathway.
The localised pathways were last updated in October 2016.

The purpose of implementing the CCP Programme in our District is to:
- Enhance accuracy of referrals
- Use best practice guidelines
- Have all information found in one place
- Enhance partnerships and collaboration across services
- Improve patient outcomes through seamless care across primary and secondary care

To cite this pathway, use the following format:
Map of Medicine – Mental Health / Mental Health and AOD / Health and Wellbeing (Mental Health & Addictions) - Whanganui View. Map of Medicine; 2016.

Editorial methodology
This care map has been based on a Map of Medicine Care Map developed according to the Map of Medicine editorial methodology. The content of the Map of Medicine care map is based on high quality guidelines and practice-based knowledge provided by contributors with front-line clinical experience (see contributors section of this document). This localised version of the evidence-based, practice informed care map has been peer-reviewed by the WDHB and WRHN Collaborative Clinical Directors and Leaders Forum and with stakeholder groups.

Consumer engagement
Development of the Whanganui Collaborative Clinical Pathways focuses on person-centred care and an experience based co-design approach where consumers are invited to consult with the Health Promoter / Community Developer (who sits on each pathway working group). Consumers are asked prior if possible, or if not at the very start of the pathway process to share their experiences to assist in designing services that work for them and their families, critiquing and feeding back on suitable consumer information and resources which can then be incorporated into the pathways. Feedback obtained ensures we address consumer challenges and needs within the pathway and provide suitable services, information and resources for consumers. Additional information on patient centred care is provided by following this link and experience based co-design of health care services at http://www.kingsfund.org.uk/projects/ebcd.

References
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Disclaimers
CCP Leadership Team, Whanganui.

It is not the function of the CCP Leadership Team to substitute for the role of the clinician, but to support the clinician in enabling access to know-how and knowledge. Users of the Map of Medicine are therefore urged to use their own professional judgement to ensure that the patient receives the best possible care. Whilst reasonable efforts have been made to ensure the accuracy of the information on this online clinical knowledge resource, we cannot guarantee its correctness and completeness. The information on the Map of Medicine is subject to change and we cannot guarantee that it is up-to-date.