NHS
Dorset
Clinical Commissioning Group

Review and Design of the Mental Health Acute Care Pathway

For people with a serious mental illness

Applicable NICE Standards and Guidance

Reviewed September 2016

1. Introduction

This paper provides a summary of the NICE standards and guidelines that are relevant to Dorset's mental health acute care pathway review.

1.2 There are a number of NICE Guidance and standards documents that as part of the project have been reviewed and summarised briefly below to enable the project team (Stage one: Needs and data analysis) and subsequently the coproduction groups in (Stage three: Modelling) to be sure that in any development these standards will be achievable.

2. NICE Quality Standards

QS14	Service user experience in adult mental health
Key Area	**Quality Statements developed from recommendations in CCG136**
	• People using mental health services, and their families or carers, feel optimistic that care will be effective. • People using mental health services, and their families or carers, feel they are treated with empathy, dignity and respect. • People using mental health services are actively involved in shared decision-making and supported in self-management. • People using community mental health services are normally supported by staff from a single, multidisciplinary community team, familiar to them and with whom they have a continuous relationship. • People using mental health services feel confident that the views of service users are used to monitor and improve the performance of services. • People can access mental health services when they need them. • People using mental health services understand the assessment process, their • Diagnosis and treatment options, and receive emotional support for any sensitive issues. • People using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy with an agreed date to review it. • People using mental health services who may be at risk of crisis are offered a crisis plan. • People accessing crisis support have a comprehensive assessment, undertaken by a professional competent in crisis working. • People in hospital for mental health care, including service users formally detained under the Mental Health Act, are routinely involved in shared decision-making. • People in hospital for mental health care have daily one-to-one contact with mental healthcare professionals known to the service user and regularly see other members of the multidisciplinary mental healthcare team. • People in hospital for mental health care can access meaningful and culturally • Appropriate activities 7 days a week, not restricted to 9am to 5pm. • People in hospital for mental health care are confident that control and restraint, and compulsory treatment including rapid tranquillisation, will be used competently, safely and only as a last resort with minimum force. • People using mental health services feel less stigmatised in the community and

	NHS, including within mental health services.

3.0 NICE Guidance

CG185	Bipolar Disorder – assessment and management
Key Area	**Care for adults, children and young people across all phases of bipolar disorder**
	• As early as possible negotiate with the person with bipolar disorder and their carers about how information about the person will be shared.
Key Area	**Recognising and managing bipolar disorder in adults in primary care**
	• Ensure that people with bipolar depression are offered a psychological intervention that has been developed specifically for bipolar disorder or a high-intensity psychological intervention.
Key area	**Managing mania or hypomania in adults in secondary care**
	• If a person develops mania or hypomania and is not taking an antipsychotic or mood stabiliser, offer Haloperidol, Olanzapine, Quetiapine or Risperidone. • If the person is already taking Lithium, check plasma Lithium levels to optimise treatment.
Key area	**Managing bipolar depression in adults in secondary care**
	• Ensure that people with bipolar depression are offered a psychological intervention that has been developed specifically for bipolar disorder or a high intensity psychological intervention. • If a person develops moderate or severe bipolar depression and is not taking a drug to treat their bipolar disorder, offer Fluoxetine combined with Olanzapine or Quetiapine on its own. • If a person develops moderate or severe bipolar depression and is already taking lithium, check their plasma lithium level.
Key area	**Managing bipolar disorder in adults in the longer term in secondary care**
	• Offer a structured psychological intervention (individual, group or family), which has been designed for bipolar disorder. • Offer lithium as a first line, long term pharmacological treatment for bipolar disorder.
Key area	**Recognising, diagnosing and managing bipolar disorder in children and young people**
	• Diagnosis of bipolar disorder in children or young people should be made only after a period of intensive, prospective longitudinal monitoring by a healthcare professional or multidisciplinary team trained and experienced in the assessment, diagnosis and management of bipolar disorder in children and young people, and in collaboration with the child or young person's parents or carers. • To treat mania or hypomania in young people see NICE's technology appraisal guidance on aripiprazole for treating moderate to severe manic episodes in adolescents with bipolar I disorder and also consider the recommendations for adults in section 1.5. Refer to the BNF for children to modify drug treatments, be aware of the increased potential for a range of side effects, and do not routinely continue antipsychotic treatment for longer than 12 weeks. • Do not offer valproate to girls or young women of childbearing potential. • Offer a structured psychological intervention to young people with bipolar depression. The intervention should be of at least 3 months' duration.

CG178	Psychosis and schizophrenia in adults: treatment and management
Scope	
	• Psychotic disorders including Schizophrenia, Schizoaffective disorder, Schizophreniform disorder and Delusional disorder
	• Adults aged 18 years and over
Key Area	**Person Centred Care**
	• Work in partnership with people with Schizophrenia and their carers • Offer help, treatment and care in an atmosphere of hope and optimism • Take time to build supportive and emphatic relationships as an essential part of care
Key area	**Physical Health**
	• Offer a combined healthy eating and physical activity programme • Where rapid/excessive weight gain, abnormal lipid levels or problems with blood glucose refer to relevant NICE guidelines • Offer help to stop smoking (with awareness of impact upon metabolism of other drugs particularly Clozapine and Olanzapine. • Routinely monitor weight, and cardiovascular and metabolic indicators of morbidity.
Key area	**Support for carers**
	• Offer assessment of their own needs • Advise of statutory right to formal carer's assessment via social services • Provide clear written and verbal information on diagnosis and management of psychosis and schizophrenia; positive outcomes and recovery; types of support for carers; role of teams and services; getting help in a crisis. • Negotiate and agree how information about the service user will be shared emphasising importance in relation to risk. Regularly review how information is shared. • Include cares in decision making where service user agrees. • Offer carer focused education and support programme as early as possible.
Key area	**Peer Support & Self-management**
	• Consider peer support for people with psychosis or schizophrenia to help improve service user experience and quality of life. • Consider a manual self-management programme delivered face to face with service users. • Programmes should include information and advice about psychosis and Schizophrenia; effective use of medication; identifying and managing symptoms; accessing mental health and other support services; coping with stress and other problems; what to do in a crisis; building a support network; preventing relapse and setting personal recovery goals.
Key area	**Preventing Psychosis**
	• Referral for assessment without delay. • Where there is an increased risk of developing psychosis – offer individual CBT with or without family intervention; interventions recommended for people with anxiety disorders, depression and emerging personality disorder or substance misuse. • Where there is an increased risk of developing psychosis – do not offer anti-psychotic medication with the aim of decreasing the risk of or preventing psychosis.

	• Where symptoms persist following treatment but a clear diagnosis cannot be made, monitor regularly for symptom change and functioning for up to 3 years using structured and validated tools. Frequency should be determined by severity of symptoms, level of impairment and/or distress, and degree of family concern. • In the event of patient initiated discharge – offer follow up appointments and an option to self-refer in the future.

Key area	1st Episode of Psychosis
	• EIS should be accessible to all people with a 1st episode / presentation of psychosis irrespective of age or duration of untreated psychosis. • People presenting to EIS should assessed without delay. • Assessment should follow a MDT approach and cover psychiatric, medical, physical health and wellbeing, psychological and psychosocial, developmental, social, occupational and educational, quality of life, and economic status factors. • Assessments should consider presence of Post-Traumatic Stress Disorder and other reactions to trauma. • EIS should provide a full range of pharmacological, psychological, social, occupational and educational interventions. • Service users should be routinely monitored for coexisting conditions particularly in the early phases of treatment. • Facilitate alternative educational/occupational activities with a view to returning to mainstream services/activities. • Offer oral anti-psychotic medication in conjunction with psychological interventions. • Choice of anti-psychotic medication should consider metabolic, extrapyramidal, cardiovascular, hormonal and other subjective experiences in the decision making process. • Prior to starting medication, record baseline investigations including: weight, waist circumference, pulse & blood pressure, fasting blood glucose, glycosylated haemoglobin, blood lipid profile and prolactin levels; assessment of any movement disorders; and assessment of nutritional status, diet, and level of physical activity. These factors should be subsequently recorded regularly and systemically throughout treatment (especially during titration). • An ECG should be offered in circumstances where it is specified in the summary of product characteristics, high blood pressure is present; there is a history of cardiovascular disease or the service user is being admitted as an inpatient. • All treatment with anti-psychotic medication should be considered as an explicit individual therapeutic trial. • Monitoring of physical health and effects of medication should remain the responsibility of secondary care services for a minimum of 12 months or until the persons condition has stabilised (whichever is longer). Thereafter this can be transferred to primary care under a shared care arrangement. • Patients must be advised of possible interference from the use of tobacco, alcohol, prescription/non-prescription medication and illicit drugs upon the therapeutic effects of mediation and psychological treatments. • Psychological interventions should be delivered on a 1:1 basis over at least 16

	planned sessions; should follow a treatment manual; and include at least one of the following: people monitoring their own symptoms; promoting alternative ways of coping; reducing distress, and improving functioning. • Those staff providing psychological interventions must have an appropriate level of competence and training, and be regularly supervised by a competent therapist and supervisor. • Treatment beyond 3 years should be considered where a person has not made a stable recovery.
Key area	**Subsequent acute episodes of psychosis or schizophrenia & referral into crisis**
	• Where level of risk exceeds capacity of EIS or other community teams offer crisis resolution and home treatment team as a first line service. • CRHT should be single point of entry to all other acute services in the community and in hospitals. • Consider community treatment within CRHT before admission to an in-patient unit as a means to enable timely discharge from inpatient units. Crisis houses and acute day facilities may be considered in addition to CRHT. • Where admission I unavoidable, ensure the setting is suitable for the person's age, gender and level of vulnerability, support their carers and follow NICE guidelines on service user experience in adult mental health. • Offer oral anti-psychotic medication in tandem with a reviewing existing medication. • Offer CBT either during the acute phase or later (including in inpatient settings). • Consider offering arts therapy particularly for the alleviation of negative symptoms (therapies should be provided by a suitably registered practitioner with experience of working with this service user group). • Do not routinely offer counselling and supportive psychotherapy to people with psychosis or schizophrenia. • Do not offer adherence therapy to people with psychosis or schizophrenia. • Do not routinely offer social skills training (as a specific intervention) to people with psychosis or schizophrenia. • Where immediate risk to self or others is posed follow relevant NICE guidelines in respect of using rapid tranquillisation. • Where rapid tranquillisation has been used offer the service user the opportunity to discuss their experiences with provision of clear explanation for decision to use urgent sedation. The service user should also be offered the opportunity to record their experience in their clinical record. This should be actively encouraged. • In the event that medication is to be withdrawn, undertake gradually and continue monitoring for relapse indicators for at least 2 years.
Key area	**Promoting recovery and possible future care**
	• Consider intensive management for people who are likely to disengage from treatment or services. • Review antipsychotic medication annually including benefits and any side effects. • For those that have responded effectively to treatment and remain stable offer a return to primary care. • Where relapse is apparent within primary care follow actions within agreed crisis plan

	• Continue to offer CBT to assist in promoting recovery in people with persisting positive and negative symptoms and for people in remission. • Consider offering depot/long acting injectable antipsychotic medication to those who prefer such treatment; where avoiding non-adherence to antipsychotic medication is a clinical priority in the treatment plan. • Where individuals have not responded to treatment – review the diagnosis, establish concordance with prescribed regime, review use of psychological interventions, and consider other causes for non-response (e.g. substance use) • Offer Clozapine to people with schizophrenia who have not responded to sequential use of adequate doses of at least 2 different antipsychotic drugs. • Where there is not an adequate response to Clozapine, consider diagnosis, concordance with medication, use of psychological interventions, comorbid substance use and measuring therapeutic drug levels prior to adding a second antipsychotic medication to augment Clozapine. • Offer supported employment programmes and consider occupational or educational activities including pre-vocational training for people who are unable to work or unsuccessful in finding employment.

CG155	**Psychosis and schizophrenia in children and young people: recognition and management**
Scope	
	• Psychotic disorders including schizophrenia, schizoaffective disorder, schizophreniform disorder and delusional disorder
	• Children and young people considered clinically to be at high risk or prodromal for psychosis and schizophrenia
	• Children and young people up to the age of 18
Key Area	**Person Centred Care**
	• If the service user is under 16, healthcare professionals should follow guidelines in DoH *Seeking consent: working with children* • For individuals transferring between CAMHS and adult mental health services, care should be planned and managed according to best practice - *Transition: getting it right for young people.* Diagnosis and management should be reviewed throughout the transition process with clarity about who the lead clinician is.
Key area	**General Principles of Care**
	• Workforce should be trained and competent to work with all levels of learning ability, cognitive capacity, emotional maturity and development, have an ability to negotiate and work with parents and carers, and manage issues related to information sharing and confidentiality, and manage conflict management and conflict resolution. • Professional skilled in assessing capacity and competence (Gillick Competence) • Understanding application of Children's Act, Mental Health Act, and Mental Capacity Act. • Consider local safeguarding procedures during assessment • Single multidisciplinary teams that prevent unnecessary multiple assessments • Trusting, supportive, emphatic and non-judgemental relationships are essential part of care. • Foster autonomy, promote participation in treatment decisions and support self-management and access to peer support.

	• Maintain continuity of individual therapeutic relationships. • Offer access to trained advocate. • Be clear about limits of confidentiality. • Advise parents and carers about their right to a formal carer's assessment. • Use plain language where possible, clearly explaining any clinical terminology. • Use communication aids (such as pictures, symbols, large print, braille, different languages or sign language) and diverse media including letters, phone calls, emails or text messages. • Provide details about accessing local and national sources of support. • Respect and be sensitive to gender, sexual orientation, socioeconomic status, age, background (including cultural, ethnic and religious) and any disability. • Work with primary care, other secondary and local third sector organisations to services are culturally sensitive and all children have equal access to clinical services. • Ensure transfers of care are planned carefully, structured and phased. • Ensure care plans support effective collaboration with social care and other care providers specifically during endings and transition.
Key area	**Possible psychosis**
	• CAMHS assessment includes a consultant psychiatrist • EIS assessments are multidisciplinary. • Where there is considerable uncertainty about diagnosis, assessment is undertaken by a consultant psychiatrist trained in child and adolescent mental health. • Where clear diagnosis is not possible, monitor regularly for further changes in symptoms and functioning for up to 3 years. • Where discharge is requested, offer follow up appointments and the option to self-refer at a later date. • Where behaviours is not sufficient for a diagnosis of psychosis or schizophrenia consider individual CBT with or without family intervention and offer treatments as recommended by NICE for anxiety disorders, depression, and emerging personality disorder or substance misuse. • Where behaviours are not sufficient for a diagnosis of psychosis or schizophrenia do not offer antipsychotic medication.
Key area	**1st episode of psychosis**
	• During assessment ensure there is enough time to describe and discuss child's problems as well as summarising any conclusions. • Offer support after assessment, particularly if sensitive issues such as childhood trauma have been discussed. • Ensure assessment is multidisciplinary and addresses psychiatric, medical, psychological and psychosocial, developmental, physical health and wellbeing, social, educational and occupational, and economic factors. • Routinely monitor for co-existing mental health problems • Develop a care plan that includes activities that promote physical health and social inclusion. • Support service users to develop strategies, including risk and self-management plans to promote and maintain independence and self-efficacy. • Develop a crisis plan that includes early warning signs of crisis and coping strategies; support available to prevent hospitalisation; where the individual

	would like to be admitted if required; definitions of the primary and secondary care roles; information about 24 accesses to services; and the names of key clinical contacts. • Where the child or young person is unable to access mainstream school/college, facilitate alternative arrangements in line with capacity. • Treatment for 1st episode of psychosis should include oral antipsychotic medication in conjunction with psychological interventions. • Choice of medication should be made in conjunction with parents/carers (with young person) and take account of benefits & side effects including effect upon metabolic system, extrapyramidal, cardiovascular, hormonal, and other experiences. • Baseline investigations/assessment should be completed including weight and height; waist and hip circumference; pulse and blood pressure; fasting glucose, glycosylated haemoglobin, blood lipid profile and prolactin levels; assessment of any movement disorders; and assessment of nutritional status, diet and level of physical activity. • Offer ECG if specified in SPC, a physical examination has identified cardiovascular risk, there is a personal/family history of cardiovascular disease, and the child/young person is being admitted to hospital. • Treatment with antipsychotic medication should always be considered as an explicit individual therapeutic trial. • Routine monitoring throughout treatment of efficacy, side effects, emergence of movement disorders, weight, height, waist and hip circumference, pulse and BP, fasting blood glucose, glycosylated haemoglobin, blood lipid profile and prolactin levels, adherence and physical health. • Responsibility for monitoring physical health retained by secondary care for a minimum of first 12 months or condition is stabilised. • Advise of possible interference for other substance use including alcohol, tobacco, illicit drugs, and prescribed /non-prescribed medication. • Do not use a loading dose or initiate regular combined antipsychotic medication. • Review medication annually. • Family Psychological intervention should be carried out for between 3 months and 1 year (including at least 10 planned sessions) taking account of development age and emotional maturity and include specific supportive, educational or treatment function and include negotiated problem solving or crisis management work. • Individual CBT should be over a minimum of 16 planned sessions and follow a treatment manual including at least one of the following components – normalising leading to acceptance of their experience; monitoring own thoughts, feelings or behaviours; promoting alternative ways of coping with target symptoms; reducing stress; and improving functionality. • Psychological interventions should routinely monitor a range of outcomes across relevant areas.
Key area	**Preventing Psychosis**
	• Referral for assessment without delay. • Where there is an increased risk of developing psychosis – offer individual CBT with or without family intervention; interventions recommended for people with anxiety disorders, depression, and emerging personality disorder or substance misuse.

	• Where there is an increased risk of developing psychosis – do not offer anti-psychotic medication with the aim of decreasing the risk of or preventing psychosis. • Where symptoms persist following treatment but a clear diagnosis cannot be made, monitor regularly for symptom change and functioning for up to 3 years using structured and validated tools. Frequency should be determined by severity of symptoms, level of impairment and/or distress, and degree of family concern. • In the event of patient initiated discharge – offer follow up appointment and an option to self-refer in the future.
Key area	**Subsequent acute episodes of psychosis or schizophrenia**
	• Offer oral antipsychotic medication in conjunction with psychological interventions (family and individual therapy) • Choice of medication should follow same process for 1st psychosis • Aripiprazole is recommended as an option for Schizophrenia in 15-17 year olds resistant to Risperidone, where Risperidone is contraindicated or symptoms has not been controlled with Risperidone. • Offer CBT • Consider art therapies. • Do not routinely offer counselling and supportive psychotherapy. • Do not offer adherence therapy as a specific intervention. • Do not routinely offer social skills training as a specific intervention.
Key area	**Referral in Crisis and Challenging Behaviour**
	• Should be seen within 4 hours of referral • To avoid admission explore what support systems are in place, offer support in the home environment where possible, make early plans to help the child or young person maintain day to day activities. • Ensure decision to start home treatment depends on level of distress; the severity of the problems; vulnerability of the child or young person and issues of safety and support at home, and the child or young person's cooperation with treatment. • Where hospital admission is required, ensure the setting is appropriate to age and developmental level. • Always consider alternative care within the community wherever possible. • In hospital undertake shared decision making appropriate to developmental level and ensure those of compulsory school age have access to a full educational programme. • A wide range of meaningful activities should also be provided. • Community care coordinators should routinely visit the young person in hospital. • Hospital settings should promote good physical health including healthy eating, exercise and smoking cessation. • Where rapid tranquillisation is required particular caution should be taken when considering high potency antipsychotic medication. The child or young person should be given the opportunity to discuss their experience after the period of rapid tranquillisation.
Key area	**Early post-acute phase**
	• Reflect and make plans for recovery and possible future care. • If withdrawing antipsychotic medication undertaken gradually and monitor regularly for signs and symptoms of relapse.

	• Continue monitoring for signs and symptoms of relapse for at least two years.
Key area	**Promoting recovery and providing possible future care in primary care**
	• Ensure children and young people with psychosis and schizophrenia receive physical healthcare from primary care. • Secondary care should continue to maintain responsibility for monitoring and managing any side effects of medication.
Key area	**Promoting recovery and providing possible future care in secondary care**
	• Access to EIS should be available for up to 3 years or till 18th birthday (whichever is longest)

CG133	**Self-harm: longer term management**
Scope	
	• longer-term psychological treatment and management of both single and recurrent episodes of self-harm • all people aged 8 years and older who self-harm
Key Area	**Person Centred Care**
	• Treatment and care should take into account patient's needs and preferences. • People who self-harm should have the opportunity to make informed decisions about their care and treatment in partnership with their health professionals.
Key Area	**Principles of care**
	• Trusting and supportive relationships • Non-judgemental approach • Foster independence • Continuity of therapeutic relationships wherever possible • Staff should be able to advise of local and national support resources • CPA where case is jointly managed. • Plan endings / transfers of care in advance
Key area	**Assessment**

	• Integrated and comprehensive psychosocial assessment of needs and risks including:
	  ○ Skills, strengths and assets
	  ○ Coping strategies
	  ○ Mental health problems and disorders
	  ○ Physical health problems and disorders
	  ○ Social circumstances and problems
	  ○ Psychosocial and occupational functioning and vulnerabilities
	  ○ Recent and current life difficulties, including personal and financial problems
	  ○ Need for psychological intervention, social care and support, occupational rehabilitation, and also drug treatment for any associated conditions
	  ○ Needs of any dependent children
	• For older people aged 65:
	  ○ Particular attention to presence of depression, cognitive impairment and physical ill health
	  ○ Full assessment of social and home situation including role as a carer
	  ○ Higher risk of suicide following self-harm

Key area	**Risk Assessment**
	• Evaluate a wide range of biological, social and psychological factors • Assess risk of repetition of self-harm

	• Consider presence of other risk taking or destructive behaviour • Consider all self harm in older people as evidence of suicidal intent • Risk assessment tools can be considered to help structure risk assessment but not to predict future suicide or repetition of self-harm.
Key area	**Longer term treatment and management**
	• Treatment plans should be multidisciplinary and developed with the service user. • Plans should outline short term and long term goals and include a jointly produced risk management plan • Risk management plans should be clearly identifiable within the care/treatment plan and address specific factors, and include a crisis plan with self-management strategies • Update risk management plans regularly where there is continued risk • Consider offering 3 -12 sessions of psychological intervention • Review treatment and care plans annually as a minimum • Where cessation of self-harm is unrealistic in the short term consider strategies aimed at harm reduction making reference there is no safe way to self-poison

CG120	**Psychosis with coexisting substance misuse: Assessment and management in adults and young people**
Scope	
	• Adults aged 18 and young people (aged 14 and over) who have a clinical diagnosis of psychosis with coexisting substance misuse.
Key Area	**Person Centred Care**
	• Treatment and care should take into account patient's needs and preferences. • People with psychosis and coexisting substance misuse should have the opportunity to make informed decisions about their care and treatment in partnership with their health professionals.
Key area	**Recognition of psychosis with coexisting substance misuse in adults and young people**
	• Healthcare practitioners in all settings should routinely ask people with suspected psychosis about their use of alcohol, prescribed, and non-prescribed (including illicit) drugs. • Assessment should include questions about substances used, quantity, frequency and pattern of use, route of administration, and duration of current levels of use. • Biological / physical tests (blood, urine, hair analysis) should not be used in routine screening for substance misuse in adults / young people with psychosis.
Key area	**Assessment in Secondary Care**

	• Adults with co-existing psychosis and substance misuse should be offered a comprehensive, multidisciplinary assessment including:
	  ○ Personal history
	  ○ Mental, physical and sexual health
	  ○ Social, family and economic situation
	  ○ Accommodation, including history of homelessness and stability of current living arrangements
	  ○ Current and past substance misuse and its impact upon their life, health and response to treatment
	  ○ Criminal justice history and current status
	  ○ Personal strengths and weaknesses and readiness to change their

	substance user and other aspects of their lives • Assessment may take place over several appointments in order to gain a full understanding. • Biological / physical tests (blood, urine, hair analysis) may be useful but need to be agreed with the person as part of a care plan. • Biological / physical tests should not be used in routine screening for substance misuse in adults / young people with psychosis.
Key area	**Secondary Care Treatment**
	• Before starting treatment review diagnosis of psychosis and coexisting substance misuse especially if diagnosis was made during a crisis presentation and the effectiveness of previous or any current treatments. • Discontinue any effective treatments • Take account of the complex and individual relationships between substance misuse, psychotic symptoms, emotional state, behaviour and the person's social context. • Only offer evidence based treatments for both conditions • Tailor treatment plans to the person taking account of the relative severity of both the psychosis and dependence at different times; the persons social context and readiness for change • Do not exclude from contingency management programmes due to psychosis. • Use anti-psychotic medication as per relevant NICE guideline for schizophrenia or bipolar disorder. • Depot/long acting injectable antipsychotics should be used in managing covert non adherence with treatment for psychosis and not as a specific treatment for psychosis with coexisting substance misuse. • When deciding on medication takes account of the level and type of substance misuse especially alcohol and potential impact upon effectiveness / side effects /risk of interaction.
Key area	**Coordinating Care**
	• Consider joint work with specialist addiction services where severe dependence on alcohol, both alcohol and benzodiazepines, opioids and/or cocaine/crack cocaine is evident • Adult community mental health services should continue to provide care coordination and treatment for psychosis within joint working arrangements • Delivery of care and transfer between services should use the Care Programme Approach.
Key area	**In-patient provision**
	• All admissions should be assessed for current substance use and evidence of withdrawal symptoms at the point of admission. • Where planned detoxification is indicated, this should take place in an inpatient setting (preferably in specialist detoxification units or at a minimum designated detoxification beds within inpatient mental health services. • Inpatient mental health units should have policies that promote an environment free from drugs and alcohol including search procedures, visiting arrangements, planning and reviewing leave, drug and alcohol testing, disposal of legal and illicit substances, and other security measures.

CG91	**Depression in adults with a chronic physical health problem: Treatment and**

	management
Scope	
	• Adults aged 18 and over who have a diagnosis of depression (mild, moderate or severe as classified by DSM IV) in addition to a chronic physical health problem (such as cancer, heart disease, diabetes, or a musculoskeletal, respiratory or neurological disorder)
Key Area	**Person Centred Care**
	• Treatment and care should take into account patient's needs and preferences. • People with depression and a chronic physical health problem should have the opportunity to make informed decisions, including advance decisions and advance statements, about their care and treatment,
Key area	**Care of all people with depression**
	• Trusting relationships • Treatment options offered in an atmosphere of hope and optimism. • Information provided on self-help groups and other support based resources. • Offer carers assessment including information on carer support groups • Comprehensive assessment that does not rely solely on symptom count. • Consider impact of comorbid mental health problems; physical disorders; past history of mood elevation; past treatment; interpersonal relationships; social environment and living conditions. • Be aware of acquired cognitive impairments / learning disability – where evident provide same interventions with reasonable adjustment as necessary. • Always ask directly about suicidal ideation and intent. • Intervention provided by competent practitioners who are regularly supervised with outcomes measures routinely evaluated. • Where the chronic physical health problem restricts engagement with psychosocial/psychological intervention consider alternative mode of delivery (e.g. telephone) or treatments such as antidepressants. • Provide treatment in line with a stepped care model.
Key area	**Principles for assessment**
	• Be alert to possible depression and consider using screening tool (PHQ2) particularly where there is a past history of depression or chronic physical health problems) • Assessment conducted by competent practitioner. • Use validated measures to inform and evaluate treatment. • Consider Distress Thermometer where there are significant language or communication difficulties. • Assess risk and refer on to specialist mental health services if there are immediate risks to themselves or others • Inform patients of increased risk of agitation, anxiety and suicidal ideation during initial stages of treatment. • Advise patient / carers to be vigilant for mood changes and negativity. • Where risk of suicide apparent – check for toxicity related to possible overdose of medication. • Consider referral to specialist mental health services. • Increase frequency of intervention
Key area	**Interventions - subthreshold symptoms / mild / moderate depression (Step 2)**
	• Low intensity interventions provided to those with persistent subthreshold /

	mild / moderate depression – sleep hygiene, active monitoring, structured group physical activity programme, group based peer support, individual guided self-help based on CBT principles, computerised CBT. • Modify physical activity programmes as appropriate for chronic physical health problem. • Consider peer support for people with psychosis or schizophrenia to help improve service user experience and quality of life. • Consider a manual self-management programme delivered face to face with service users. • Programmes should include information and advice about psychosis and schizophrenia; effective use of medication; identifying and managing symptoms; accessing mental health and other support services; coping with stress and other problems; what to do in a crisis; building a support network; preventing relapse and setting personal recovery goals. • Do not use routinely use anti-depressants • Advise against use of St John's Wort.
Key area	**Interventions – persistent subthreshold symptoms / mild / moderate depression with inadequate response to initial intervention**
	• Consider antidepressant medication (normally SSRI) • High intensity psychological interventions – group based CBT over 6 -8 weeks, individual CBT (where group inappropriate) typically over 6 to 8 weeks, behavioural couples therapy (where relevant) typically 15 -20 sessions over 5-6 months.
Key area	**Interventions – severe depression and chronic physical health problem**
	• Consider combination of individual CBT (over a period of 16 – 18 weeks) and antidepressant medication. • Take account of trajectory of symptoms, previous course and response to treatment, likelihood of adherence to treatment and potential adverse effects, course and treatment of chronic physical health problem, patients' treatment preference and priorities.
Key area	**Anti-depressants**
	• Consider presence of additional physical health disorders during choice of antidepressant. • Consider side effects that may impact on underlying physical disease (SSRI may result in or exacerbate Hypernatremia especially in older people) • Interactions with other medications. • Consider SSRI or Citalopram in first instance as reduced risk of interactions. • Dosulepin should not be prescribed. • Consider toxicity risk where significant risk of suicide exists e.g. venlafaxine, is associated with a greater risk of death from overdose. • Be aware that tricyclic antidepressants (excl. Lofepramine) are associated with the greatest risk in overdose. • Continue treatment for at least 6 months after remission of depressive episode. • When ceasing medication, gradually reduce dose over a 4 week period (drugs with a shorter half-life may require longer periods.

CG90	**Treatment and Management of Depression in Adults**

Scope	Depression as a primary diagnosis
	• Formal diagnosis of depression
	• Sub threshold depressive symptoms
	• Desired outcome is complete relief of symptoms (remission) associated with better functioning and a lower likelihood of relapse
Key Area	**Person Centred Care**
	• People with depression should have the opportunity to make informed decisions about their care and treatment, in partnership with practitioners • Verbal communication and information should be supported by evidence based written information tailored to patient's needs.
Key area	**Principles for Assessment**
	• Comprehensive assessment does not rely on a symptom count • The degree of functional impairment and/or disability associated with the possible depression and the duration of episode are considered. • Culturally sensitive assessment that take account of cultural, ethnic and religious background • Make reasonable adjustment to method of delivery and duration for people with learning disability or acquired cognitive impairment • Always ask people with depression directly about suicidal ideation and intent
Key area	**Effective Delivery of interventions for depression**
	• Stepped Care Model – least intrusive, most effective intervention first • Competent practitioners • Psychological & Psychosocial interventions based on relevant treatment manuals • Regular high quality supervision of practitioners • Routine use of outcome measures that involve the person with depression • Monitoring and evaluation of treatment adherence and practitioner competence
Key area	**Case identification and recognition**
	• Practitioners to be alert to possible depression • Consider risk to self and others • Routine use of two questions where depression suspected: a) During the last month, have you often been bothered by feeling down, depressed or hopeless? b) During the last month, have you often been bothered by having little interest ort pleasure in doing things? • Active monitoring - no formal intervention required, mild depression where intervention declined, sub-threshold depressive symptoms requesting intervention should have a further assessment within 2 weeks. • Contact should be made with individuals who do not attend follow-up appointments
Key area	**Low Intensity psychosocial interventions**
	• Focused upon persistent sub threshold depressive symptoms or mild to moderate depression. • Interventions consist of: a) Guided self-help (based on principles of CBT) – 6 – 8 face to face or telephone sessions over 9 – 12 weeks including follow up b) Computerised CBT (CCBT) – web based programme; takes place over 9 – 12 weeks including follow up c) Structured group physical activity programme – 3 sessions per week over 10

	– 14 weeks
Key area	**Drug Treatment**
	• Anti-depressants should not be used routinely to treat persistent sub threshold depressive symptoms or mild depression. • Anti-depressants should be considered for people with: a) A past history of moderate or severe depression b) Sub threshold depressive symptoms that have been present for a long period (typically at least 2 years) c) Sub threshold depressive symptoms or mild depression that persists after other interventions
Key area	**Treatment for moderate or severe depression (and persistent sub threshold symptoms/mild to moderate with inadequate response)**
	• Combination of antidepressant medication and a high intensity psychological intervention – CBT or Interpersonal Therapy (IPT) • People who decline an antidepressant, CBT, IPT, behavioural activation and behavioural couples therapy consider: a) Counselling for those with persistent sub threshold symptoms/mild to moderate depression b) Short term psychodynamic psychotherapy for mild to moderate depression • People commencing on antidepressants: a) Not considered to be at risk of suicide – review after 2 weeks and regularly thereafter at intervals of 2 to 4 weeks in first 3 months, and longer intervals thereafter if response is good. b) Considered to present increased risk of suicide – review after 1 week and frequently thereafter until risk no longer considered clinically important
Key area	**Treatment for complex and severe depression**
	• Specialist mental health services • Use of crisis resolution and home treatment teams to manage crises in those that present significant risk. • Medication started under the supervision of a consultant psychiatrist • Comprehensive MDT care plans should be developed in collaboration with the individual with depression and should include: • Clear roles and responsibilities of all health & social care professionals involved • A crisis plan that identifies potential triggers and strategies to manage such triggers • Be shared with the individuals GP, the individual, and other relevant people involved in the care • Consider in-patient treatment where significant risk of suicide, self-harm or self-neglect present • Provide full range of high intensity psychological interventions in in-patient settings • Consider ECT for acute treatment of severe depression that is life threatening and when a rapid response is required or other treatment has failed. (Decision to use ECT should be made jointly with individual as far as possible)
Key area	**Continuation and relapse prevention**
	• Continue antidepressant medication for at least 6 months after remission of a depressive episode • For those at risk of relapse resulting in significant risk factors continue

	antidepressants for 2 years at level which was effective during acute phase.
Key area	**Psychological interventions for relapse prevention**
	• Individual CBT should be offered to people who have relapsed despite antidepressant medication and for people with a significant history of depression and residual symptoms despite treatment • Mindfulness-based cognitive therapy for people who are currently well but have experienced three or more previous episodes of depression. • Individual CBT: 16 – 20 sessions over 3 to 4 months • IPT: 16 – 20 sessions over 3 to 4 months • Behavioural activation: 16 – 20 sessions over 3 to 4 months • Behavioural couple therapy: 15 to 20 sessions over 5 to 6 months
CG78	**Borderline Personality Disorder Treatment and Management**
Key Area	**Access to services**
	• PD Diagnosis should not exclude people from services
	Autonomy and Choice
	• Work actively and in partnership with patients • Support them to identify other treatment and life choices
	Developing optimistic and trusting relationships
	• Instil hope and optimism • Build trust by being consistent and reliable • Keep in mind peoples history of rejection, abuse and trauma
	Managing endings and transitions
	• Be sensitive when ending work with patients so that rejection is not reinforced • Support to be given during referral processes to other services to ensure that there is consistency and reduce the fear of rejection
	Assessment
	• CMHT and CAMHS should be responsible for routine assessment, treatment and care management
	Care Planning
	• Multi-disciplinary management • Short term and long term goal setting • Crisis planning identifying risk triggers and response required
	The role of psychological treatment
	• Explicit integrated theoretical approach shared with the person • Structured care • Supervision for therapists
	The role of drug treatment
	• Drug treatment should not routinely be used to manage behaviour or symptoms
	The role of specialist PD services within trusts

	• MH Trusts should develop Multi-Disciplinary Teams and/or services for people with PD
	• The teams should have specific skill and expertise in diagnosis and management of PD
	• Services should:
	  ○ Assess and treat
	  ○ Provide consultation and advice to other services

	○ Give second opinions re diagnosis ○ Develop info sharing protocols ○ Provide range of psychological therapies ○ Work with CAMHS to develop transition protocols ○ Develop lines of communication with other services including primary care ○ Ensure access for minority ethnic groups

CG77	**Antisocial personality disorder – treatment management and prevention**
Key Area	**Principles of care**
	• develop optimistic and trusting relationships • offer treatment in an environment of hope and optimism • non-judgemental attitude • pay particular attention to motivating attendance and engagement with treatment
Key Area	**Access and Assessment**
	• diagnosis should not be a reason to exclude people from any health or social care service • avoid unnecessary transfers of care • take account of higher incidence of co-morbid mental health problems in women • full assessment should include ○ Antisocial behaviours ○ Personality functions, coping strategies, strengths and vulnerabilities ○ Comorbid mental disorders ○ Need for psychological treatment, social care and support, occupational rehabilitation or development ○ Domestic abuse and violence
Key area	**Prevention**
	• identify children at risk of developing conduct problems • provide early interventions for preschool children at risk of developing conduct problems • consider transition to adult services for continuing assessment and intervention
Key area	**Risk Assessment and Management**
	• obtain detailed history of violence and develop future violence risk management plan • focus initial management plan upon crisis resolution and reduction of aggravating factors • refer to forensic services where there is current violence or threat, or where there is a history of serious violence, predatory offending or targeting of children or other vulnerable people • In specialist PD or forensic services consider use of formal risk assessment tools such as HCR-20 to develop risk management strategy.
Key area	**Treatment**
	• evidence base is limited • group based cognitive and behavioural interventions • pharmacological interventions should not be routinely used • ensure there are clear pathways and specialist networks between services

Key area	**Repeated self harm**

	• Harm minimisation strategies should not be offered to people who have self-harmed by poisoning. • Advice regarding self-management of superficial injuries, harm minimisation techniques, alternative coping strategies and how best to deal with scarring should be considered for people who repeatedly self-injure.
Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care	
• Self-harm is defined as 'self-poisoning or injury, irrespective of the apparent purpose of the act'. • Physical, psychological and social assessment and treatment of people in primary and secondary care in the first 48 hours after having self-harmed. • All people aged 8 years of age and older who have self-harmed.	
Respect, understanding and choice	
• Treat the same as any other patient with the addition of accounting for the distress associated with self-harm. • Choice of male or female staff for both assessment and treatment. • Staff with high levels of communication skills • Involve patients in decision making about treatment.	
Staff training	
• People who self-harm should be involved in delivery of training. • Joint training programmes between mental health services and emergency departments focused on psychosocial assessment and early management of self-harm. • All health professionals, including junior psychiatrists, social workers and psychiatric nurses, who undertake psychosocial assessment for people who have self-harmed should be properly trained and supervised to undertake assessment of needs and risk specifically for people who self-harm.	
Assessment and initial management	
• Ambulance Trusts, the emergency department and Mental Health Trusts should work in partnership to develop locally agreed protocols for ambulance staff to consider alternative care pathways to emergency departments for people who have self-harmed, where this is appropriate and does not increase the risks to the service user. • Preliminary psycho social assessment at triage (consider use of Australian Mental Health Triage Scale). • Safe environment that minimises stress and is supportive whilst waiting for assessment. • When assessing people who self-harm, healthcare professionals should ask service users to explain their feelings and understanding of their own self-harm in their own words. • Comprehensive assessment of needs, to include evaluation of the social, psychological and motivational factors specific to the act of self-harm, current suicidal intent and hopelessness, as well as a full mental health and social needs assessment. • All people who have self-harmed should be assessed for risk including identification of the main clinical and demographic features known to be associated with risk of further self-harm and/or suicide, and identification of the key psychological characteristics associated with risk, in particular depression, hopelessness and continuing suicidal intent. • All people older than 65 years of age who have self-harmed should be assessed by mental healthcare practitioners experienced in the assessment of older people who self-harm. Pay particular attention to the potential presence of depression, cognitive impairment and physical ill health, and include a full assessment of social and home situation.	