Canterbury
District Health Board
Te Poari Hauora ō Waitaha

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31 May 2022

9(2)(a) [redacted]

RE Official Information Act request CDHB 10870

I refer to your letter dated 22 April 2022 which was received in our office on 6 May 2022 requesting the following information under the Official Information Act from Canterbury DHB. Specifically:

1. **CDHB or MoH policy, procedures, standards, statements and information on the diagnosis, treatment and provision of social supports for the following mental disorders:**
    a. **Severe traumatic brain injury /acquired brain injury**
    b. **Concussion**
    c. **Post-concussion syndrome (DSMIV) / Neurocognitive Disorder (DSM5)**
    d. **Cognitive Disorder**
    e. **Paranoia**
    f. **Delusion**
    g. **Intellectual disability**
    h. **Suicidal ideation, and Risk / threats of self-harm**

(Please refer to **Appendix 1a -** Specialist Mental Health Service Policy and Procedures for adults: Suicidal ideation, and risk threats to self-harm and **Appendix 1b** - Clinical Risk Assessment and Management Protocol Ref: 2405255

    i. **Depression, major depression, severe**
    j. **Dementia**
    k. **PTSD / Post traumatic stress disorder**
    l. **Autistic spectrum disorders and Asperger's syndrome**
    m. **Full function decline**
    n. **Loss of capacity to undertake basic self-care and to keep self-safe**
    o. **Panic attacks / severe anxiety**

Diagnosis
There are no Canterbury DHB documents that specifically relate to the diagnosis of mental disorders. Diagnosis is based on a clinician's professional judgement and informed by their training and national/international evidence and guidelines.

Related Policies and procedures

HealthPathways offers clinicians locally agreed information to make the right decisions, together with patients, at the point of care. Clinical judgement is used as to what is applicable to each situation.
Note the following documents are available on HealthPathways which is not publicly available[1].
Please refer to the attached appendices 1-4 for the following information:

Appendix 1 - Deliberate Self-Harm
Appendix 2 – Major Depressive Disorder
Appendix 3 - Acute psychosis
Appendix 4 - Cognitive Impairment

HealthInfo, which is publicly available, provides information to the general public on a range of health issues including Mental Health and Wellbeing. https://www.healthinfo.org.nz/

[1] *HealthPathways is designed and written for use during a clinical consultation. Each pathway provides clear and concise guidance for assessing and managing a patient with a particular symptom or condition. Pathways also include information about making requests to services in the local health system.*
Content is developed collaboratively by general practitioners, hospital clinicians, and a wide range of other health professionals. Each pathway is evidence-informed, but also reflects local reality, and aims to preserve clinical autonomy and patient choice. HealthPathways serves to reduce unwarranted variation and accelerate evidence into practice.

Social supports

All consumers have access to social workers and registered nurses who are able to coordinate provision of social supports. Consumers are provided with the following information on admission. Please find attached as **Appendix 5** 'Sources of Support and Advocacy'

2. **CDHB or MoH policies, procedures, standards, statements and information on the diagnosis, treatment and provisions of social supports on the following neurological disorders**
    a. **Thermodysregulation / dysthermia**
    b. **Hypersomnolence**
    c. **Nerve damage / paralysis**
    d. **Neural fatigue**

Burwood Hospital provides complex adult rehabilitation services with a neurological focus to 16-65 year olds in the Canterbury catchment.

Admissions are mostly from Christchurch hospital with occasional referrals for patients directly from the community GP or healthcare provider, using Health Pathways The referral is assessed by the Interdisciplinary Team (IDT) team and triaged.

3. **Information, policies and procedures on the criteria for accessing single point of entry, sector base and specialist mental health services**

Anyone can be referred to Single Point of Entry. All contacts including referrals by GPs are triaged and referred to community teams and/or speciality services. The Adult Community Mental Health service provides assessment, treatment and support services to adults in the community for severe mental illness or crisis mental health needs.

4. **Information, policies and procedures on the criteria for accessing Burwood Brain Injury Unit.**

The Canterbury DHB does not hold the ACC Traumatic Brain Injury Residential Rehabilitation (TBIRR) contract, so these patients re not admitted to Burwood Hospital.

5. **Information on the types of services that can or are involved with Community Treatment Orders (CTO) under the Mental Health (Compulsory Assessment and Treatment) Act; how community orders are structured; and the criteria.**

Consumers subject to a CTO have access to the whole range of community mental health services at the Canterbury DHB. They have an assigned responsible clinician and a second health professional involved in their care as a minimum but could also have more clinicians directly involved in their care. The care is coordinated through a multi-disciplinary team (MDT). The legally required structured points of review of community orders are outlined in the mental health legislation, but it is practise for consumers to be reviewed more frequently as determined by clinical need.

Information about CTO can be found as part of the Mental Health (Compulsory Assessment and Treatment) Act at the following links:

New Zealand Legislation
https://www.legislation.govt.nz/act/public/1992/0046/latest/DLM262176.html

The Ministry of Health guidelines
Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992 | Ministry of Health NZ
Community Law overview
Overview of the mental health laws - Community Law

MOH CTO forms can be found:
https://www.health.govt.nz/our-work/mental-health-and-addiction/mental-health-legislation/mental-health-compulsory-assessment-and-treatment-act-1992/mental-health-act-forms

Canterbury DHB forms are attached as **Appendix 6**:

I trust that this satisfies your interest in this matter.

Please note that this response, or an edited version of this response, may be published on the Canterbury DHB website after your receipt of this response.

Yours sincerely

Ralph La Salle
Senior Manager, OIAs
Canterbury DHB & West Coast DHB

Clinical risk assessment and management

Purpose

To outline the philosophy, principles and practice of risk assessment and management which guide clinical care.

Policy

All Specialist Mental Health Service (SMHS) clinicians will seek to minimise the likelihood of adverse events by:

- Conducting a clinical risk assessment, based on the structured clinical risk assessment framework, during all clinical interactions.
- Additional specific risk assessment should be completed, following training, where relevant e.g Family Safety Assessment, CASPI, DASA or HCR 20.

Implementing effective clinical risk management strategies.

Documenting the assessment, risk scenarios and management strategies.

Communicating results of the assessment and management plans with consumers and family/whanau/caregivers (unless clinically indicated not to).

SMHS will ensure that clinicians are competent to carry out risk assessment and know when to seek a more specialised assessment.

Scope

All SMHS clinicians involved in the care and treatment of consumers are responsible for assessing and monitoring clinical risk, in line with their scope of practice

The process of clinical risk assessment and management applies to all SMHS consumers regardless of their legal status and is an integral part of their clinical care.

Definitions

Risk: The likelihood of particular adverse events occurring with a particular consumer under particular circumstances within a specified period of time. Risk refers to all forms of risk to self and to others.

Risk assessment: A process of clinical evaluation to determine risk, including the likelihood, imminence and severity of risk. Risk management: The development of an intervention plan which aims to reduce risk based on the assessment and at risk scenarios.

Roles and responsibilities

Risk assessment, intervention and documentation must be coordinated by the person primarily involved in the consumer's care at the relevant point in time.

This would usually be the case manager or key nurse but may be Duly Authorised Officer (DAO) or other clinician in an urgent situation.

Associated documents

New Zealand standards and legislation

Health Information Privacy Code 1994

Mental Health (Compulsory Assessment & Treatment) Act 1992 and Amendment 1999

NZS 8134: 2008 Health and Disability Services (General) standards

Privacy Act 1993

Canterbury District Health Board policies and procedures

Child Abuse and Neglect: Management (2017)

Child Protection Alerts Management (2014)

Elder Abuse (2010)

Intimate partner violence policy (2018)

Specialist Mental Health Service policies

SMHS Bed management: sleepovers

SMHS Family-whanau involvement in consumer's treatment

SMHS Search for and removal of banned items

SMHS Weapons removal protocol

Guidelines

Ministry of Health (2016) Preventing suicide: Guidance for emergency departments

Ministry of Health (2013) New Zealand suicide prevention action plan, 2013-2016

Ministry of Health (2006) Assessment and management of risk to others: Guidelines and development of training toolkit.

Ministry of Health (2005) Suicide prevention: A review of risk and protective factors, and points of effective intervention

Ministry of Health (2000), Involving families' guidance notes: Guidelines for involving families and whanau of mental health consumers/tangata whai ora in care, assessment and treatment planning.

Associated forms

Core Information portal (Case Manager work station) in Healthlinks

Discharge Letter

Service clinical processes (hospital health pathways or service provision framework)

Treatment Plan

Policy statement

Risk assessment and management is an ongoing process

Assessing clinicians must have an understanding of

(i) static risk factors that may affect a consumer's risk

(ii) the individual consumer's current dynamic internal and dynamic situational risk factors

(iii) the consumer's current protective factors

(iv) family or whanau perspectives on current risk and management strategies

(v) cultural issues that may affect an individual consumer's risk or risk management

Risk assessment is based on clinical reasoning that includes

1 explicit recognition of patterns of risk behaviour based on previous risk events

2 explicit consideration of other factors, including the consumer's static, dynamic internal and dynamic situational risk factors, the individual consumer's current protective factors, and the viewpoints of the consumer's family/whanau

Risk assessment must lead to an identification of at risk scenarios that are likely to result in significant risk behaviours. An individual might have more than one scenario that might lead to significant risk.

Risk management plans should attempt to identify and build on the individual consumer's strengths

The assessment, at risk scenarios and management must be documented in the core information portal in Healthlinks and be reflected in the Treatment Plan.

The consumer's risk assessment must be included in all referral letters, and transfer or discharge summaries. The assessment should be written as a statement on contextual risk (rather than whether or not the person is at risk at that particular point in time).

Appropriate intervals for documenting risk changes include:

- A consumer's first contact with SMHS.
- A consumer's admission to hospital.
- Nursing notes once every shift (if the consumer is an inpatient)
- Formal clinical review.
- Discharge from the Mental Health Act.
- Referral or transfer to a new service or unit including sleepover
- Discharge from a service or unit.
- Significant changes in leave status.
- Any change in risk for any reason.

Any significant increase in risk must be documented before the clinician finishes work for the day.

Policy Owner	Director of Nursing, SMHS
Policy Authoriser	Chief of Psychiatry SMHS
Date of Authorisation	6 March 2019

APPENDIX 1b

Clinical risk assessment and management protocol

Contents

Purpose

The purpose of this protocol is to assist clinicians applying a clinical risk assessment framework, formulating the assessment, implementing effective intervention strategies and documenting these.

This protocol is to be used in conjunction with the Clinical risk assessment and management policy.

Scope/Audience

All Specialist Mental Health Service (SMHS) clinicians involved in the care and treatment of consumers, in line with their scope of practice

Associated documents

CDHB documents or other references directly applicable to this protocol:

Clinical risk assessment and management policy

Associated forms:

Core Information portal (Case Manager work station) in Healthlinks

Treatment Plan

Discharge Letter

Service clinical processes (hospital health pathways or service provision framework)

Crisis Resolution Wellness Plan / Child Adolescent Family Emergency Safety Plan

Definitions

Risk: The likelihood of particular adverse events occurring with a particular consumer under particular circumstances within a specified period of time. Risk refers to all forms of risk to self and to others.

Risk assessment: A process of clinical evaluation to determine risk, including the likelihood, imminence and severity of risk.

At risk scenario identification is a clinical judgement made by an adequately trained mental health professional.

Risk management: The development of an intervention plan which aims to reduce risk based on the assessment and at risk scenarios.

Equipment

Accessibility to the core information portal on Healthlinks.

Relevant training

SMHS training in the use of a Structured Clinical risk assessment framework.

Training for CASPI, DASA and HCR20 is offered to staff working in units where this is part of the clinical process.

1 Assessment

Risk assessment is ongoing and part of all clinical interactions It should include the:

- Identification of an individual's *static risk* factors - situations that are historical (that is, they have already occurred) or are enduring – (factors that lead to risk relative to others in a stated population). This could include information from previous contacts with mental health services.

  Information from risk incidents, should include a factual description of:

  - when they occurred
  - what happened
  - the context (including if possible, an understanding of the dynamic internal and dynamic situational risk factors at the time)
  - the outcome of the risk event
  - the consumer's and the family/whanau's view on what the intent of the risk behaviour was.

- Identification of *dynamic internal* factors - consumer's current mental state (this include mental illness, but also includes other states, such as fear, anger, helplessness etc.) and the consumer's current physical state which could impact on their risk (for example dehydration, delirium, hypoglycaemia, intoxication)
- Identification of the *dynamic situational* factors are factors that are external to the consumer. These can, for example, include factors such as access to means for suicide or harm to others for example weapons, loss of relationships, housing or income, or the actions of other people that affect the consumer's risk.
- Consumer's strengths and protective factors, for risk reduction, from the perspective of the consumer.
- The viewpoints of family/ whanau/ caregivers about the current risk and possible risk management strategies
- In some units additional assessment by using the HCR20 and DASA (for violence risk assessment) is also required.
- Consider long term risk vs more acute changes in presentation. Longitudinal information from family, whanau or significant others can highlight important fluctuations in presentation that are not apparent at the time of assessment.

Assessment of family and child safety issues should follow the relevant CDHB policies.

2 At risk scenarios

Risk assessment must lead to the identification and description of scenarios that are likely to result in risk behaviours.

Risk scenarios are a structured description of the risk information that has been recorded in the history and dynamic internal/situational sections. Scenarios can also be informed by clinical reasoning. A consumer might require more than one scenario as different pathways to violence and suicide may have been identified from the risk assessment.

Scenarios should describe the nature and context in which the risk behaviour is most likely to occur, including internal and situational factors that increase the risk. Scenarios should also incorporate statements regarding seriousness, imminence, who the likely victim/s might be, and the availability of the means and opportunity to carry out the harm.

3 Management

Risk management plans should be discussed with the individual consumer and their family or whanau, unless clinically contraindicated, before being enacted.

The management plan should identify interventions for the individual that will reduce or contain risk behaviours, including:

- Interventions to address dynamic internal risk factors contributing to risk (for example, use of medication; use of 'talking' treatments).

- Interventions to address situational factors contributing to risk (for example, interventions to address social stressors including relationships; accommodation and financial situation; access to alcohol and illicit substances; access to weapons; access to potential victims)
- Strategies for building on existing strengths and protective factors to reduce risk.
- Resources which are immediately accessible to the consumer, family/ whanau and clinical team to support risk reduction.
- "Guarantees of safety" or "no-suicide" contracts are contra-indicated and are not to be asked of consumers by clinicians.
- CASPI risk allocation protocol must be applied in services where this is established.
- In certain situations, (continued) admission to hospital will be appropriate, including potential use of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

The management plan must reflect the changes to risk over time, given the dynamic nature of risk.

Risk management strategies should show why strategies were chosen for an individual. In some circumstances it is useful to briefly describe why other strategies were not used (for example, these may have proved unhelpful for the consumer at previous times, the consumer or family considered they would increase risk, or the resource may not have been available)

Risk management strategies should reflect each risk that has been identified

Management of family and child safety issues should follow the relevant CDHB policies.

4 Documentation

4.1 Location

The core information portal on Healthlinks – case manager work station- is the primary place for risk to be documented.

A clinician who does not know a consumer should be able to find key information in the Core Information portal. It should be of a practical nature to assist the clinician to understand high risk situations and the suggested management/ intervention strategies for these.

The template reflects a structured clinical risk assessment framework and is completed for each consumer assessed in SMHS.

4.2 Relationship to other documents

Assessment and Discharge Summaries: A statement about risk should be included in all assessment and discharge summaries. This should be a statement about contextual risk, not whether or not that person is considered a low, medium or high risk at that point in time. This should reflect threat risk scenarios and management sections from the Core Information portal. Other significant risks such as child and family protection issues should be part of this.

Treatment Plan: Overall risk management strategies should be documented in Core Information but the treatment plan may include more detailed strategies. The Treatment Plan and Crisis Plans are the documents shared with the consumer and family, whanau so they must contain relevant aspects of the risk management strategy.

Progress Notes: Day to day assessments of risk should be noted in progress notes with any significant changes transcribed to the Core Information.

4.3 Responsibility for documentation

Responsibility for documentation generally lies with the clinician most involved in the consumer's care, usually the case manager, but in an emergency situation this may be a DAO or anyone else responsible at that point in time.

Updating core risk information should be completed by the person undertaking the risk assessment at any point in time. Other clinicians who are given new risk information are responsible for both informing the consumer's usual coordinating clinician and for documenting this information themselves

The case manager or key clinician is responsible for ensuring that the treatment plan is current and incorporates risk management strategies.

Any significant increase in risk must be documented before the clinician finishes work for the day.

5 Review of Risk

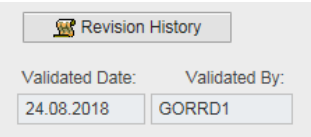
5.1 When to review

Appropriate intervals for reviewing and documenting risk changes include:

- A consumer's first contact with SMHS.
- A consumer's admission to hospital.
- Nursing notes once every shift (if the consumer is an inpatient)
- Formal clinical review.
- Discharge from the Mental Health Act.
- Referral or transfer to a new service or unit including sleepover
- Discharge from a service or unit.
- Significant changes in leave status.
- Any change in risk for any reason, including following a risk event

5.2 Use of the validation field

The validation fields – date and by - are to be used to show when and who reviewed the risk information.



Validation fields are also able to be used in the situation where the information has been reviewed but there is no change required. This reduces the need for clinicians to enter 'place holder' or date lists in the documentation fields.

Fields that have been amended or items deleted are automatically archived and are able to viewed as an historical record – revision history

These fields auto populate the user ID and date when save is clicked.

5.3 Risk warning button

The warning buttons (flag) (low/medium/high) are a VISUAL RISK WARNING tool. They offer a visual flag or identification to other clinicians to help identify that there is history or events of note.

This records the **highest ever risk** e.g. psychotic depression with past CO poisoning would rate a "high" (red), or a consumer with no significant risk history would rate a "low" (green).

All consumers that have been assessed or where risk information has been entered must have the risk warning button completed.

Once a warning flag has been determined it should not be lowered, but can be increased if the risk has increased.

Procedure Owner	Director of Nursing
Procedure Authoriser	Chief of Psychiatry
Date of Authorisation	6 March 2019

APPENDIX 1

Deliberate Self-harm

Background

About deliberate self-harm

About deliberate self-harm

- Self-harm is when somebody intentionally damages or injures their body. It is a way of coping with, or expressing, overwhelming emotional distress.
- Self-harm is a behaviour, not a disorder. It takes a variety of forms including poisoning, overdoses, and physical injury.
- Statistics show 24% of females and 18% of males aged 20 to 24 years self-harmed. [1]
- The mean age of onset is around 17 years, but it is not unusual to start as young as 12 to 14 years of age.
- Self-harm may or may not be an attempt at suicide.
- It can cause disability or death and may be a sign of major mental illness.
- It often occurs in the context of a recent stress, such as relationship conflict.
- More than 90% of people who present to hospital with self-harm have a mental disorder, commonly depression, anxiety, eating disorder, substance abuse disorder, or personality disorder.
- A significant group of people who present with self-harm are also in an environment where they are the victim of physical abuse by parents or intimate partner, or other bullying such as workplace or living situation.

Assessment

Practice point

Debrief with colleagues

By understanding the function of self-harming behaviour, the general practitioner may be able to better assist the patient.

Dealing with patients who self-harm can arouse strong feelings in healthcare professionals, e.g. anxiety, frustration and anger, feeling overwhelmed, or therapeutic impotence. It can be useful to debrief with colleagues.

1. Take a history of the self-harming episode to determine:
    - previous history of self-harm or suicide attempts.
    - method.

- frequency.
- triggers.
- previous successful strategies used to intervene or to avoid.
- what role it plays for the patient, e.g. to self-manage emotions, express to others how they feel, reduce anxiety.

2. Ask about the context of the self-harming episode.

Context of the episode

Ask if:

- there has been a recent relationship breakdown or rejection by a significant person.
- any changes to employment or in financial and occupational status.
- the patient has a support network.
- it was a planned or impulsive episode.
- any other risky or impulsive behaviour.
- there is any current sexual, physical, or emotional abuse. For minors this may require notification to Oranga Tamariki (Ministry for Children), police or other emergency services – See Abuse and Neglect of Children.
- the patient has a peer group where one member, or several, engage in deliberate self-harm (DSH).

3. Be aware of any cultural considerations and attitudes towards mental health and self-harm. Some cultures fail to recognise the significance and/or existence of self-harm and may be slow to seek help.
4. Assess for suicidality in adults and in youth.
5. Perform an appropriate physical examination to assess and document the extent and nature of injuries. This may include making a note of any old injuries and/or undisclosed injuries.
6. Consider screening for an underlying mental illness or other issue. This may mean bringing a patient back for a second consult or referral to brief intervention counselling or a health improvement practitioner:
    - Borderline personality disorder in adults or youth.
    - Anxiety in adults or in children and youth
    - Depression in adults or in children and youth
    - Eating disorders in adults or in children and youth.
    - Early psychosis in adults or in children and youth
    - Substance abuse – CRAFFT screening.

      CRAFFT screening

CRAFFT is a mnemonic acronym of first letters of key words in the 6 screening questions. The questions should be asked exactly as written.

If the answer to 2 or more questions is "yes" this is considered a positive score and indicates a high risk of substance abuse and the need for further assessment.

1. "Have you ever ridden in a car driven by someone (including yourself) who was “high” or had been using alcohol or drugs?"
2. "Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?"
3. "Do you ever use alcohol or drugs while you are by yourself, i.e. alone?"
4. "Do you ever forget things you did while using alcohol or drugs?"
5. "Do your family or friends ever tell you that you should cut down on your drinking or drug use?"
6. "Have you ever got in trouble while using alcohol or drugs?"

- Gender dysphoria or gender orientation issues. See Transgender Health in Youth and Transgender Health in Adults.
- Post-traumatic stress disorder (PTSD)
- Bullying
- Chronic physical illness
- Traumatic brain injury

7. With patient consent consider "break privacy seal" in HealthOne for information about the patient's specialist mental health history and access to specialist assessment notes, progress notes and discharge letters.

Patient consent for HealthOne

- HealthOne may be used to prepare for a consultation with a patient, but tell the patient when they attend that their HealthOne record has been accessed.
- If the patient is present in the room, HealthOne may be accessed only with verbal consent.

8. Ask about protective factors for patient:

- Strong connections to family and/or community support systems
- Skills, strengths, assets

9. Assessment of mental health concerns usually takes place over several appointments and often involves both the general practitioner and practice nurse.

- Consider general practice funding options.
- There are no prescriptive checks but consider the HEEADSSS assessment tool.

Management

1. Assess and attend to medical issues in a calm, reassuring manner.
2. If potentially life-threatening overdose or injury, refer to the emergency department.
3. If significant risk of suicide or imminent serious self-harm, request acute mental health assessment according to age:
    - if aged 18 years or older, request acute adult mental health assessment
    - If aged younger than 18 years, request acute child and adolescent mental health assessment
4. Engage and build rapport to provide a secure therapeutic relationship for the patient to discuss their distress. Be open and non-judgemental.
    - Validate any distress the patient is feeling without endorsing self-harm as a way to deal with it.
    - Ask the patient if you may liaise with other health professionals involved in their care, and possibly with parents.
5. Discuss some other possible effective coping mechanisms that could be encouraged, e.g. problem solving, conflict resolution skills.
6. Develop self-harm emergency plan and contact list.
7. If appropriate, give information and offer advice to parents.
8. Manage underlying or associated problems

    Underlying or associated problems

    - Sexual abuse:
        - Previously Undisclosed Sexual Assault
        - Sexual Abuse – Health Professional Concern
    - Family abuse – If concerns about current sexual, physical, or emotional abuse in a minor, consider requesting Oranga Tamariki (Ministry for Children) notification.
    - Traumatic brain injury
    - Substance abuse
    - Eating disorders:
        - Eating Disorders in Adults
        - Eating Disorders in Children and Youth
9. Be alert to any changes in the patient's health status that may impact your responsibilities under the firearms licence notification legislation.
10. If further evaluation is required, consider referral to brief intervention talking therapies.

    Brief intervention talking therapies

- The service offers clinical psychologists, nurses, social workers, occupational therapists and counsellors.
    - Cognitive behavioural therapy (CBT) is primarily used, along with other therapies when clinically appropriate.
    - BIS clinicians will see patients at their general practice, at nearby practices, or in local settings.
    - Referral to other more appropriate services may be suggested.
- Patients are usually eligible for 5 sessions in a 12 month period. More complex cases may be seen for longer.
- Obtain verbal consent to refer to BIS. Give patient information.
- Before referring administer a Kessler Psychological Distress Score (K10).
    - Consider having the practice nurse administer this.
    - A score of 25 or more (moderate-severe) is expected, but this should not override clinical judgement.
    - Include this score in the referral to help with triaging.

11. If difficulty with underlying diagnosis or long-term management, refer to specialist mental health services, or a private psychiatrist, or clinical psychologist. If younger than 18 years, refer as below.

    Difficulty with underlying diagnosis or long term management

- Suspected borderline personality disorder
- Suspected psychosis
- Severe or treatment-resistant major mood disorder
- Recurrent episodes of high risk self-harm (risk of accidental severe injury or death)

Request

- If a potentially life-threatening event or serious injury, refer immediately to he emergency department.
- If significant risk of suicide or imminent serious self-harm, request acute mental health assessment according to age:
    - if aged 18 years or older, request acute adult mental health assessment
    - If aged younger than 18 years, request acute child and adolescent mental health assessment
- If difficulty with underlying diagnosis or long term management, refer according to age:

    Difficulty with underlying diagnosis or long term management

- Suspected borderline personality disorder
- Suspected psychosis
- Severe or treatment-resistant major mood disorder
- Recurrent episodes of high risk self-harm (risk of accidental severe injury or death)
    - if aged ≥ 18 years, refer to specialist mental health service, or a private psychiatrist, or clinical psychologist.
    - if aged younger than 18 years (or 19 years or younger and still at school), refer to Child, Adolescent, and Family Mental Health (CAFLink).

- If ongoing self-harm and distress, but not severe or escalating, consider referral to youth mental health counselling and therapy, BIS, a private psychiatrist or clinical psychologist.

  Brief intervention talking therapies

  - The service offers clinical psychologists, nurses, social workers, occupational therapists and counsellors.
      - Cognitive behavioural therapy (CBT) is primarily used, along with other therapies when clinically appropriate.
      - BIS clinicians will see patients at their general practice, at nearby practices, or in local settings.
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  - Obtain verbal consent to refer to BIS. Give patient information.
  - Before referring administer a Kessler Psychological Distress Score (K10).
      - Consider having the practice nurse administer this.
      - A score of 25 or more (moderate-severe) is expected, but this should not override clinical judgement.
      - Include this score in the referral to help with triaging.
- Consider support for youth or adults via a number of community providers.
- If concerns about current sexual, physical, or emotional abuse in a minor, this may require Oranga Tamariki – Ministry for Children notification.

  Contact Oranga Tamariki (Ministry for Children)

  - Phone: 0508 FAMILY (0508-326-459)
  - Email: cyfcallcentre@cyf.govt.nz

APPENDIX 2

Major Depressive Disorder

Red flags

- Suicidal ideation

Background

About major depressive disorder

About major depressive disorder [1]

Depression accounts for the highest burden of non-fatal disease in New Zealand. It affects about 6% of the New Zealand population (12 month prevalence), 18% of the general practice population, and has a lifetime prevalence of 16%. The ratio is 1.7 to 1, female to male.

While the prevalence is the same for Māori and non-Māori when adjusted for age, sex, education, and income, the outcome is worse for Māori. Māori are nearly 40% more likely to be admitted to hospital for a mental health condition, and younger Māori (especially males) are 2.4 times more likely to commit suicide than non-Māori.

It is 2 to 3 times more common in people who have a chronic physical health problem, occurring in about 20% of this group.

There are effective interventions for depression which can reduce suffering and help recovery.

Assessment

1. Check for classical, physiological, and psychological symptoms.

Psychological symptoms

- Pessimism
- Suicidal ideation
- Hopelessness
- Anhedonia
- Depressive delusions

Physiological symptoms

In hospital patients, these symptoms can be masked by co-existing physical illness.

- Chronic pain
- Lethargy
- Disordered sleep
- Weight change

Classical symptoms

- Slowing of thought and movement
- Depressed mood most of the day, every day
- Significant change in weight or appetite
- Feelings of worthlessness or excessive guilt
- Diminished ability to concentrate or make decisions
- Recurrent thoughts of death or suicidal ideation

2. Assess whether features of depression are reactive, organic, or biological.

Biological

- Based on DSM V criteria
- Presence of the classical and psychological features
- Exclusion of organic or reactive cause

Organic

- Post viral, e.g. influenza, hepatitis, infectious mononucleosis
- Neurological, e.g. Parkinson's, stroke, multiple sclerosis (MS), head injury
- Malignancy, e.g. pancreatic, lung, cerebral, colon
- Immunological, e.g. systemic lupus erythematosus (SLE)

Reactive

Commonly part of a grief response.

Likely to be seen in many inpatients, especially those dealing with a life-changing illness or chronic pain.

3. Assess risk:
    - Ask specifically about suicidal ideation using a phrase such as “have you ever had thoughts of harming yourself?”. This does not increase their likelihood of doing so.
    - Identify risk factors.

      Risk factors

- Gender (females are more likely to have depression but males are more likely to commit suicide)
- Low socio-economic status
- Recent loss, e.g. bereavement, divorce, unemployment
- History of physical or sexual abuse
- Family history of major depressive disorder
- Ongoing conflict, e.g. spiritual, cultural, sexual orientation

4. Check for conditions that could mimic the symptoms of depression:
    - Hypothyroidism
    - Parkinson's disease
    - Sleep disorders
    - Cardiovascular disease
    - COPD
    - Anaemia
    - Diabetes
    - Dementia
5. Check for medications or drugs that could mimic the symptoms of depression:
    - Steroids
    - Beta blockers
    - Varenicline (Champix)
    - Isotretinoin
    - Alcohol use
6. Screen for associated disorders:
    - Bipolar affective disorder (BPAD):
        - Patients are often over-energised
        - Reduced need for sleep
        - Family history of BPAD
    - Psychosis:
        - Patients will commonly have unusual thoughts or experiences
        - See also Acute Functional Psychosis
7. Obtain collateral history from family, friends, or their general practitioner prior to making the diagnosis of major depressive disorder.

8. Establish if the patient has mild, moderate, or severe depression.

   Mild, moderate, or severe

   Depression is a continuous spectrum. Severity is assessed by intensity of symptoms and level of functional decline.

   Severe symptoms include:

   - profound sleep disturbance.
   - significant weight loss.
   - motor retardation.
   - psychotic features.

9. Investigations:
   - These are aimed at excluding organic causes or those conditions that cause similar features.
   - Bloods – CBC, urea and electrolytes, LFTs, renal function, ferritin, B12, folate.

Management

1. For mild depression or moderate depression without risk factors:
   - Reassure the patient this is a treatable illness.
   - Provide education – see information section below.
   - Ensure they have good psychosocial support.
   - On discharge, arrange follow up with their general practitioner to review their symptoms. Many inpatients will have depressive symptoms as a reaction to their current illness, hence the need for review once their physical condition has improved.
2. For moderate depression with risk factors or severe depression:
   - To ensure the patient is reviewed by a member of the Consult Liaison team in hospital, request acute mental health assessment.
   - Provide the same treatment as for those with mild depression.
   - If medications are needed, these will be started under the guidance of the Consult Liaison team.
3. If ongoing suicidal ideation following an attempted suicide, arrange review by the Crisis Resolution team via acute mental health assessment.
4. If the patient is aged:
   - under 16 years, the General Paediatric team will guide management. Request acute paediatric medicine assessment.

- 16 to 18 years, request assessment by the Child, Adolescent and Family (CAF) team.

Request

- If mild depression or moderate depression without risk factors, request general practitioner review within 2 weeks of discharge.
- If moderate depression with risk factors or severe depression, request acute mental health assessment.
- If ongoing suicidal ideation following an attempted suicide, arrange review by the Crisis Resolution team via acute mental health assessment.
- If the patient is aged:
    - under 16 years, request acute paediatric medicine assessment.
    - 16 to 18 years, request assessment by the Child, Adolescent and Family (CAF) team.

APPENDIX 3

Acute Psychosis in Adults

This pathway is for adult inpatients on a general ward.

Red Flags

- Imminent harm to self or others
- First episode of psychosis
- Suspected organic cause, e.g. brain tumour, delirium

Background

About psychosis

About psychosis

Psychoses are severe mental disorders that cause abnormal thinking and perceptions. Psychosis can occur either in a serious mental illness or in an organic condition. For those at greater risk, psychosis can be triggered by personal vulnerabilities or risk factors which interact with environmental stressors.

Common causes:

- Schizophrenia:
  - affects 1% of the population.
  - takes a variable course.
  - usually starts in young adulthood.
  - is characterised by the presence of positive and negative symptoms.

    Positive and negative symptoms

    Positive (psychotic) symptoms reflect the presence of an abnormal mental process:

    - Delusions – false, fixed, or irrational beliefs which are firmly held and are not shared by other people of similar cultural backgrounds.
    - Hallucinations – sensory perceptions which occur without external stimulus. Voices are most common, but can occur in any sensory modality.
    - Disorganised thoughts – non-directional or illogical cognitive processing.

    Negative symptoms reflect the reduction or absence of normal mental, emotional, and social function.

- Typically, there is a prodromal period before the psychotic event, lasting from a few days to about 18 months and often characterised by some deterioration in personal functioning.
- For diagnosis of schizophrenia, the episode should have lasted for 6 months or longer and include 1 month or more of active psychotic symptoms.
- Bipolar disorder:
    - The patient may develop psychotic symptoms in any mood episode.
    - The delusions will likely be mood congruent.
- Depression – Severe depression may result in psychotic events, which tend to have a negative affective component, with the possibility of somatic hallucinations or delusions.
- One-off event (occurs in about 20% of psychotic episodes) – Brief reactive psychosis is a disorder with psychotic symptoms lasting less than 1 month, due to a stressful event.
- Drug-induced or drug withdrawal psychosis – This can recur with repeat use of the drug.
- Schizoaffective disorder:
    - Mood symptoms (mania or depression) are prominent in addition to the core symptoms of schizophrenia.
    - Psychotic symptoms occur only outside of abnormal mood states.
- Delusional disorder:
    - usually presents in mid-to-late adulthood.
    - is characterised by non-bizarre delusions, e.g. grandiose, persecutory, erotomanic, or somatic.

  Any hallucinations are not prominent.
- Borderline personality disorder – This disorder may present with psychotic features in dissociative states.

Assessment

Practice point

Ask patients about command hallucinations and whether any of their voices suggest or tell them to do something. Treat command hallucinations suggesting violence or self-harm seriously.

1. Assess risk factors. With patient consent, consider "break privacy seal" in HealthOne for information about the patient's specialist mental health history and access to specialist assessment notes, progress notes and discharge letters.

Patient consent for HealthOne

- HealthOne may be used to prepare for a consultation with a patient, but tell the patient when they attend that their HealthOne record has been accessed.
- If the patient is present in the room, HealthOne may be accessed only with verbal consent.

Risk factors

- Other mental health diagnoses which may predispose the patient to psychosis (depression, bipolar disorder)
- Aged 15 to 25 years (most likely age for first episode of psychosis)
- Family history of schizophrenia
- History of a significant head injury or intellectual disability
- Heavy and prolonged substance abuse during adolescence (cannabis, synthetic cannabis, methamphetamines)
- Within one year of a psychotic event (high-risk time for relapse)

2. Assess risk of suicide, harm to others, and exploitation or neglect.

Exploitation or neglect

- A patient with psychosis may:
    - gradually lose capacity to make safe decisions regarding personal care, hygiene, and nutrition.
    - put themselves at risk in their interactions with others.
- Be aware of a background of:
    - intellectual disability.
    - major social problems, e.g. lack of money, accommodation, or employment.
- Consider cultural factors. Some cultural groups are less likely to present due to stigma.

Harm to others

Delusions and hallucinations, especially involving those in close contact with the patient, increase the risk of harm to those people. Look for:

- command hallucinations with threatening content – these should be taken seriously
- persecutory delusions focused on specific known people.
- voices with threatening or disparaging content that the patient identifies as being from someone, or people, that they know.
- preparations to defend self (weapons, barricading).
- pathological jealousy and stalking.

- threats to kill.

Suicide

- Patients are at increased risk of suicide attempts:
    - during active psychosis (due to their psychotic experiences).
    - during remission, as they come to terms with their losses.
- Hallucinations which command the patient to kill themselves, especially those with threatening content, are a specific risk factor for suicide in psychosis.
- See the Suicide Prevention in Adults pathway.
    - Patients who are agitated and distressed may become unpredictable.
    - Consider the needs of any dependent children of the patient.

      Dependent children

        - Children of parents with mental illness and addiction (COPMIA) are a vulnerable group.
        - They may be at risk of child abuse and neglect.
        - Provide information on support agencies.

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

   Key questions

   Have you been:

   - having any thoughts that people might be trying to harm you?
   - feeling unsafe during your hospital stay or in the course of your day-to-day life?
   - hearing voices when no one else is around?
   - finding that content of media or world events relate specifically to you?

   Have people been able to:

   - read your mind?
   - take thoughts out of your mind?
   - insert thoughts into your mind?
   - control your body's actions?

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

   Substance misuse, abuse, or withdrawal

   - Methamphetamine

- Illicit substances, e.g. speed, LSD, cannabis, ecstasy, and magic mushrooms – These can cause psychosis. Symptoms may last hours or days.
- Cannabis – Psychosis with cannabis abuse generally follows prolonged use rather than acute intoxication. This is more likely to occur the younger the initiation of use.
- Concurrent alcohol and drug use – This is very common in patients with psychosis, and it can be difficult to determine whether alcohol or drug withdrawal was the cause of the episode. See Alcohol Withdrawal.

A urine drug screen may be helpful but balance potential benefit against the risk of damage to the doctor-patient relationship. Collateral history from family member or close friend may be adequate.

Treat the psychosis acutely as below.

5. Examination:
    - Perform physical and neurological examination.
    - If cognitive impairment is suspected, consider delirium and dementia.
6. Arrange baseline investigations without delaying start of treatment.

    Baseline investigations

    - CBC, CRP, HbA1c, creatinine, electrolytes, calcium, phosphate, LFTs, thyroid-stimulating hormone (TSH), lipids, prolactin
    - BMI – height and weight

        Calculate BMI

        Body mass index = kg/m^2 (weight divided by height squared)

        Use the Ministry of Health's healthy weight BMI calculator.

        - Less than 18.5 = underweight
        - Between 18.5 and 24.9 = healthy weight
        - Between 25 and 29.9 = slightly unhealthy weight (overweight)
        - Over 30 = very unhealthy weight (obese)
    - Urine microscopy
    - ECG – most anti-psychotic medications prolong QT interval
7. 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 with psychological symptoms.

        Organic conditions

Consider:

- brain tumours or cysts.
- dementia, including Alzheimer disease.
- degenerative brain diseases (e.g., Parkinson disease, Huntington disease) and certain chromosomal disorders.
- HIV and other infections that affect the brain.
- some types of epilepsy.
- stroke.
- delirium – Symptoms due to an organic disorder, e.g. infection, metabolic upset, alcohol and drug withdrawal.

Management

1. If violent or threat of harm to self or others, call 777, inform switchboard of a threat to staff and patient safety and request they call the police. See Aggressive or Agitated Patient for more management options.
2. Request acute adult mental health review. This will be via the relevant service if already under mental health services care, or via the psychiatric Consult Liaison team (CL) if not.
3. Assess the patient's competence.

   Competence assessment

   - If time available, see Mental Capacity.
   - Even if urgent, complete the Assessing Competence in Non-consenting Patients (C240358) pathway to assess and document the patient's competence, and demonstrate patient status influencing clinician decision-making.
4. If substance misuse, abuse or withdrawal is suspected, treat the psychosis acutely and recommend alcohol and drug reduction or withdrawal.
5. Manage any suspected organic cause.
6. Manage relapse in chronic psychosis.

   Relapse in chronic psychosis

1. Check compliance to medication.
2. For patients who previously responded to clozapine, seek mental health advice to arrange referral for re-initiation and monitoring under specialist supervision.
3. Otherwise, restart the last effective dose of antipsychotic that the patient responded to. The dose does not need to be gradually increased. See Antipsychotic Medication.
4. If under mental health services, provide an update about the patient's condition.

5. If psychotic symptoms are not settling rapidly, request acute adult mental health review.
6. Discuss self-help strategies for maintaining mental stability. Recommend healthy eating, exercise, and reducing or eliminating caffeine.

   Self-help strategies

   - Avoid triggers e.g., predictable stressful events or people.
   - Minimise use of substances.
   - Get adequate sleep.
   - Seek support from support people when deterioration begins.
   - Plan for times of stress.
7. Provide education and supports:
   - Involve family/whānau or carers:
     - Consent is not required if there are concerns about risk.
     - Give the number for Crisis Resolution (CR - formerly PES) – 0800-920-092. In Ashburton, 0800-222-955. Write the number on the back of a HealthInfo card, and encourage them to keep it in their wallet.
   - Consider the needs of dependent children of patients with chronic psychosis.

     Dependent children

     - Children of parents with mental illness and addiction (COPMIA) are a vulnerable group.
     - They may be at risk of child abuse and neglect.
     - Provide information on support agencies.

Request

Request acute adult mental health review for the following situations:

- Suspected new onset psychosis
- Concern about imminent harm
- Acute psychotic features impairing normal function
- Treatment resistance
- Diagnostic uncertainty
- Considering starting antipsychotic medication

APPENDIX 4

Cognitive Impairment - Assessment and Management

This pathway is to enable timely diagnosis and comprehensive management of mild-moderate dementia to improve quality of life, reduce harms, and plan ahead. See also:

- Behavioural and Psychological Symptoms of Dementia (BPSD)
- Complex Long-term Disorders

Background

About cognitive impairment

Assessment

The assessment and diagnosis of cognitive impairment or dementia is likely to take several consultations.

1. Ask about features of cognitive impairment, opportunistically in patients with risk factors:

   Risk factors

   - Increasing age, i.e. greater than 65 years
   - Family history of dementia
   - Historical head injury
   - Congenital intellectual disability, especially Down syndrome (screen from age 35 years)
   - Vascular risk factors or disease
   - Alcohol abuse
   - History of depression or major mental illness
   - Significant social isolation

   - Document the time frame of any symptoms.

     Symptoms

     - Cognitive impairments – memory, language, insight, judgement, problem-solving, processing speed, concentration and attention, ability to recognise and use objects, orientation, mathematical ability.

- Behavioural changes – apathy, sleeping problems, restlessness, agitation, calling out, repetitive behaviour, wandering, socially inappropriate behaviour, aggression, disinhibition, changes in eating and drinking behaviour.
- Psychiatric symptoms – depression, anxiety, affective instability, psychosis, personality change.
- Neurological impairments – gait, balance, vision, speech and language, parkinsonism, upper motor neuron symptoms, tremor, dyspraxia, swallowing, seizures.

- Evaluate impairments in daily functioning

Impairments in daily functioning

- Bathing, shaving, hair and teeth care
- Continence and toilet hygiene
- Cooking
- Dressing
- Eating and drinking
- Employment
- Housework and gardening
- Managing money
- Socialising
- Shopping
- Managing transport, e.g. driving a car, catching buses

2. Evaluate presence of potential harms affecting the patient in their context.

Potential harms

- Aggression towards others
- Carer stress or burnout
- Dangers in the home, e.g. appliances (stoves, power tools)
- Elder abuse
- Falls, e.g. clutter, ladder use, steps
- Financial mismanagement
- Getting lost
- Inappropriate or unwanted sexual behaviour
- Medication adherence issues
- Severely compromised self-care

- Taking things (e.g. possessions) of others if in residential care, or from shops
- Unsafe driving

3. Take a collateral history from other sources, e.g. whānau, carers, close friends:
    - Have patient present (if possible).
    - Provide a short IQCODE for family to complete.

      Short IQCODE

      1. Score patient using either the PDF questionnaire or an online version.
      2. Calculate the average score for the Short IQCODE by adding up the score for each question and dividing by the number of questions (16).
      3. The result is a score that ranges from 1 to 5.
          - An average score of 3 means that the patient is rated as "no change".
          - A score of 4 means "a bit worse"
          - A score of 5 is "much worse".
    - Ask about carer stress.
4. Consider non-dementia causes of cognitive impairment.

   Non-dementia causes of cognitive impairment

   More than one cause for cognitive impairment may be present. Identifying any contributing or confounding causes will allow any underlying dementia to be ruled out or more clearly established.

   Many of the following will be reversible or responsive to treatment:

   - Delirium
   - Psychiatric illness, especially depression (called pseudodementia when it causes significant cognitive and functional impairment) or a chronic psychotic illness. Consider if features are consistent with delirium, dementia, or depression.

     Some differential features of the 3Ds (delirium, dementia, and depression)

Feature	Delirium	Dementia	Depression
Onset	Usually sudden, often at twilight	Chronic and generally insidious	Often abrupt and coin with life changes
Duration	Hours to less than one month, rarely longer	Months to years	Months to years
Progression	Abrupt, fluctuating	Slow but even	Variable and uneven

Thinking	Disorganised, slow, incoherent	Scarcity of thought, poor judgement; words hard to find	Intact with themes of helplessness, general negative
Memory	Impaired, sudden (immediate memory loss may be noticeable)	Impaired	Selective or patchy
Sleep	Nocturnal confusion	Often disturbed; nocturnal wandering	Early morning waker
Awareness	Reduced	Clear	Clear
Alertness	Fluctuates; lethargic or hypervigilant	Generally normal	Normal
Attention	Impaired, fluctuates	Generally normal	Minimal impairment easily distracted

- Medications e.g. anticholinergics, opioids, benzodiazepines, zopiclone or other sedatives, anticonvulsants. Check for over-the-counter medications.
- Hazardous drug or alcohol use, including withdrawal.
- Metabolic or electrolyte causes, e.g. vitamin B12 or folate deficiency, hypothyroidism, hyponatraemia or hypernatremia, hypercalcaemia, hepatic and renal dysfunction
- Neurological illness, e.g. subdural haematoma, mass lesion, hydrocephalus, or central nervous system (CNS) infection, especially human immunodeficiency (HIV) or neurosyphilis
- Obstructive sleep apnoea

5. Examination:
    - Assess mental state. Rule out significant signs of depression, anxiety, or psychosis that may mimic dementia. Observe for evidence of cognitive impairment in the interview e.g. repetitive, disorientated, poor comprehension.
    - Assess cognition with the Mini-Addenbrooke's Cognitive Examination (Mini-ACE).

      Mini-Addenbrooke's Cognitive Examination (Mini-ACE)

      The Montreal Cognitive Assessment (MoCA) is no longer freely available for use. The Mini-ACE is now the recommended alternative.

        - The Mini-ACE is free, easy to use, and takes around five minutes to complete.
        - The Mini-ACE and accompanying guidance is available at New Zealand Dementia Foundation – Introducing the Mini-ACE.

- First-time users of the Mini-ACE should complete the free online training module.
- The patient should wear their hearing aids and glasses if used.
- The score is out of a maximum of 30.
- The score is not diagnostic by itself. It should always be interpreted in light of other clinical information.
- A score of 25 or less indicates that significant cognitive impairment (i.e. that should result in a formal assessment and/or management plan) is likely to be present if all of the following is taken into account:
    - The test is administered according to the guidelines.
    - The test is completed.
    - English is the patient's first language.
    - The patient's educational attainment is considered.
    - Neurological impairment does not affect the score, e.g. hemiparesis affecting writing, visual impairment affecting drawing
    - Another condition might explain the score, such as delirium, depression, significant anxiety, or significant psychosis.

If repeat tests are required to track progress, two alternative versions are available.

Some editions in languages other than English are also available, but the services of a trained interpreter are recommended if they are to be used.

- Take blood pressure.
- Perform a 5-minute neurological examination.

5-minute neurological examination

It is unusual in Alzheimer disease to have any focal neurological deficits or motor skill problems until late in the disease. In the early stages, examination is usually normal.

Examination	Assessment	Possible diagnosis
Gait and general appearance	Parkinsonism e.g. shuffling gait, reduced arm-swing, reduced facial expression, low speech volume	• If whole body symptoms, suspect dementia with Lew bodies (DLB) or Parkinson disease with dementia (PD ask about visual hallucinat falls, autonomic dysfunctio

		• If lower limb-dominant symptoms, suspect diffuse cerebrovascular disease.
	Unsteady or wide based gait	• Cerebrovascular disease • Normal pressure hydrocep (ask about incontinence)
Cranial nerves		
Eye movements	Asymmetry or diplopia	• Mass lesion • Stroke
Facial nerve	Asymmetry	• Mass lesion • Stroke
Peripheral Exam		
Tone	Parkinsonism e.g. lead pipe or cog-wheel rigidity	• If whole body symptoms, suspect dementia with Lew bodies. • If lower limb-dominant symptoms, suspect diffuse cerebrovascular disease.
	Asymmetric focal increased tone or spasticity	• Mass lesion • Stroke
Reflexes	Increased or asymmetry	• Mass lesion • Stroke
Power	Weakness or asymmetry Initially test finger extension and hip flexion. If weakness detected, perform more thorough examination of power.	• If asymmetric weakness, suspect mass lesion, or stro • If symmetric weakness, consider other neurologica disease i.e. motor neurone disease.
Co-ordination	Dysdiadochokinesia Test by rapid alternating hand movements	• If bilateral, suspect Parkins disease or diffuse cerebrovascular disease. • If unilateral, suspect struct brain lesion.

6. Arrange blood tests as appropriate.

Blood tests

- Arrange CBC, TSH, HbA1c, electrolytes, creatinine, eGFR, calcium, vitamin B_{12}, folate, lipids.
- Consider testing thiamine, albumin, and LFTS if the patient is malnourished or a high alcohol intake is suspected.
- If history of sexual contact with multiple partners, or intravenous drug use, consider human immunodeficiency virus (HIV) and syphilis serology.

7. If non-dementia causes of cognitive impairment have been excluded or treated, and cognitive impairment remains, decide on the most likely diagnosis:
    - Dementia

      Dementia

        - Core features include:
            - gradual onset.
            - progressive deterioration over years.
            - cognitive impairment in more than one area.
            - significant impairment in social, occupational, and daily functioning.
        - Associated features include:
            - psychiatric or personality changes.
            - behavioural changes.
            - neurological changes.
    - Mild cognitive impairment (MCI)

      Mild cognitive impairment (MCI)

      In MCI, there is some memory or other cognitive impairment but it does not significantly impair social or occupational functioning. Activities of daily living are preserved and complex functions are intact or only minimally impaired.

8. Classify the type of dementia, if assessment suggests dementia is highly likely. Dementia typing has important implications for management and prognosis.

   Type of dementia

   Presentation of dementia types can appear quite differently in patients with early-onset dementia.

Type of dementia	Signs and Symptoms
Alzheimer disease	• Short-term memory loss and word-finding difficulties, followed by behavioural changes and impaired functioning, with impaired insight.

Vascular	• Sudden onset or onset within a year of stroke and step-wise decline suggests multi-infarct dementia. • Insidious course without stroke, lower limb parkinsonism, psychomotor slowing, apathy or depression, and more insight suggests sub-cortical ischaemic vascular dementia.
Frontotemporal (FTD)	• Often younger than 65 years, more likely to have family history of FTD or motor neurone disease. • May present with language disturbance, personality change, and social disinhibition while memory is often preserved.
Dementia with Lewy bodies (DLB), or Parkinson disease with dementia (PDD)	• Suspect if dementia with fluctuating course, parkinsonian features, visual hallucinations, syncope, incontinence, sexual dysfunction, or falls. • If clear Parkinson disease preceded the dementia by at least a year, diagnose PDD, otherwise suspect DLB.

9. If scanning would alter management by assisting with classification of type of dementia, arrange a CT head scan.

Management

Tailor management to the priorities at hand, and note that some steps are likely to be actioned over multiple visits as the disease progresses.

1. Communicate the diagnosis to the patient and their whānau, and its implications for them.
    - Sensitively explain the diagnosis. A diagnosis of dementia is usually devastating for a patient and their whānau.

      Explain the diagnosis

        - Find out what the patient already knows.
        - Ask the patient and whānau how much they want to know.
            - This may help avoid overloading them.
            - Give the patient and whānau enough simple information to help them access support but not so much to overwhelm them.
            - Example statement is "You have a dementia illness which is causing the brain problems which you have been telling me about."
        - Ask the patient for consent to share more detailed information with whānau (if the patient does not want to know much).

        - Offer a follow-up consultation with whānau or carers.
        - Example statement is “Whānau always want to know more. Is it okay if I give them more information, and then you can ask them if at a later date you want to know more?”
    - Talk about the diagnosis in the context of the initial management plan to give hope.
    - Check with the patient that they are coping and managing the speed of the conversation as it evolves.

    See Canterbury (Community) Education Event Videos, March 2019 – Older Persons Mental Health: Cognitive Impairment: password – educate. (A role-play about breaking the news starts at 17 minutes, 30 seconds.)

- Provide written information about memory loss and dementia.
- Refer at the earliest opportunity all patients and their carers, (after gaining permission) to Dementia Canterbury for ongoing support. This service provides important support, education, and dementia service navigation for patients and carers.

2. Advise about brain-protection strategies:

    - Encourage exercise.

      Exercise

      Research shows a slower deterioration in cognitive function in patients at all stages of dementia who exercise regularly.[2] Encourage the patient to exercise with another person, as this improves socialisation and engagement.

      See also:

        - Physical Activity – Adults
        - HealthInfo – Keeping Active For Older Adults

    - Offer guidance on diet.

      Dietary advice

      Provide Healthly Eating to Help Reduce the Risk of Dementia. Diets that aim to reduce the occurrence of dementia are likely to help people with dementia. Ensuring adequate nutrition and monitoring weight are important in moderate dementia. Where diabetes and vascular risk factors exist, dietary management is also important.

    - Reduce alcohol.

      Reduce alcohol

      Discuss alcohol intake. Encourage regular or binge drinkers to reduce their intake, and provide patient information, e.g. Alcohol and Older People.

See Alcohol Intervention.

- Maintain a low threshold for treating low or borderline B12 and folate levels.

  B12 and folate

  - If B12 or folate are low, then treat.
  - If B12 or folate are borderline and peripheral neuropathy is present or MCV is increasing, then treat.
  - Beware that folate can suddenly drop once B12 is treated (so monitor or treat both).
  - See B12 Deficiency pathway.
- Manage any cardiovascular risk factors.

  Cardiovascular risk factors

  Cardiovascular risk management may benefit most types of dementia, particularly in the early and middle stages.

  - Consider treating:
    - systemic hypertension (but beware worsening postural hypotension, as mean arterial pressure tends to slowly reduce with dementia progression).
    - hyperlipidaemia.
    - arrhythmias, including atrial fibrillation.
    - risk of cerebral thromboembolism (but beware risk of bleeds).
    - hyperglycaemia (but beware hypoglycaemia).
  - Encourage smoking cessation, as it may be a positive step at all stages of dementia.
- Encourage cognitive stimulation.

  Cognitive stimulation

  The "use it or lose it" principle applies to cognitive abilities in dementia. Engaging in regular social activities is the key intervention.

  - Puzzles are helpful for people who enjoy them.
  - Web-based resources like Lumosity may be helpful, but carry cost.

  Services like Dementia Canterbury offers groups and activities which provide cognitive stimulation with the added benefit of social engagement.

3. All of the above measures are equally beneficial for patients with mild cognitive impairment, or individuals concerned about future risk (e.g. relatives).

4. Arrange practical supports as needed.

Practical supports

- Needs assessment and service co-ordination – in patients with dementia this is via the Older Person's Health Specialist Service (OPHSS) regardless of age
- Carer support – patients with dementia who have associated carer stress have a greater chance of requiring a higher level of care.
- Workplace support, e.g. Workbridge or occupational therapy.
- Home-based occupational therapy or physiotherapy.
- Speech and language assessment if swallowing difficulties with risk of aspiration or choking.
- Falls champion for strength and balance.
- Financial support from WINZ, e.g. Disability Allowance.
- Mobility voucher scheme

See Patients with Complex Long-term Disorders.

5. Manage potential harms that patients with cognitive impairment are at increased risk of.

Potential harms

- Carer fatigue – see Carer Stress.
- Elder abuse – see Elder Abuse and Neglect
- Getting lost – recommend medic alert bracelet or similar identification, or WandaTrak Tracking System.
- Medication risks – consider Medication Management Service to improve adherence.
- Nutrition neglect and weight loss – see Weight and Nutrition in Older Adults.
- Oven or heater hazard – recommend hiring an electrician to install a timer switch.
- Unsafe driving – see Fitness to Drive.
- Unsafe use of weapons if licensed firearm user – see Firearms Licence Notification.

6. Manage co-morbidities proactively.

Co-morbidities

- Patients with dementia are less able to access primary care for other health conditions. Proactively managing developing health conditions can prevent unnecessary morbidity, and may slow unnecessary dementia progression.
- Mitigate sensory impairment early, especially vision and hearing. This can reduce disability and prevent delirium.

7. If possible, carefully withdraw any medication which may worsen cognitive impairment. See Deprescribing and Prescribing in Older Adults pathway.

Withdraw medications

Medications that are most linked to worsening cognitive impairment are:

- opiates of any kind.
- sedatives of any kind (all benzodiazepines, zopiclone and similar, all sedating antihistamines).
- anticholinergic drugs.

These other medication classes are less strongly linked but can exert a negative effect on cognitive function, at least for some people:

- Pro-dopaminergic drugs including some stimulants and most Parkinson medications
- Most antiepileptic and mood stabilising medications, including lithium
- Most psychotropic medications of any kind

8. If mild-to-moderate dementia, consider whether a cholinesterase inhibitor (ChI) could be beneficial.

    - Trialling a ChI

      Trialling ChIs

      Indications:

        - Alzheimer dementia
        - Dementia with Lewy bodies (or Parkinson disease with dementia)
        - Vascular dementias where there is significant white matter disease rather than pure multi-infarct dementia
        - The evidence supporting benefit for mild-to-moderate dementia is stronger than for moderate-to-severe dementia.

      Contraindications

        - Frontotemporal dementia
        - Pure alcohol-related dementias
        - Dementia secondary to large strokes
        - Mild cognitive impairment (MCI)
        - Concomittant anticholinergic drugs, e.g. oxybutynin, or if the patient is on a medication with a significant anticholinergic side-effect profile, e.g. tricyclic antidepressants:
            - Consider tapering and withdrawing these medicines, as this alone can improve cognition. This should be done before prescribing a cholinesterase inhibitor.
            - Weigh up the clinical indications for the original drug. Consider replacing it with something without an anticholinergic profile.

- Other precautions include a past history of gastric or duodenal ulcer disease, sick sinus syndrome, heart block, recent myocardial infarction, urinary outflow obstruction, and asthma.

Goals of treatment

- Before starting a ChI, discuss clear treatment goals with the patient and family.
- Benefits are likely to be temporary (months to a few years) but ChIs may improve quality of life and enhance general functioning.
- There is no evidence that ChIs modify underlying neurodegenerative processes (disease modification).
- Stabilisation for a period of 6 to 12 months and/or symptomatic improvements occur in up to 50% of patients. It is more likely that symptomatic improvements will be subtle rather than dramatic (although marked benefit can occur).
- The main symptoms that are improved are apathy and impaired spontaneity, and delusions and hallucinations (if present). Cognitive symptoms and some other behavioural and psychological symptoms can also improve.

Donepezil treatment

Donepezil treatment

Donepezil is the primary subsidised ChI medication.

- Before starting:
    - A baseline Mini-Addenbrooke's Cognitive Examination (Mini-ACE) is essential.
    - Cholinesterase inhibitors (ChIs) can worsen pre-existing bradycardia or heart block. If heart rate is less than 60 or there is pre-existing heart disease, an ECG is recommended before treatment, and after achieving target dose.
    - If weight loss would be a significant concern, take a baseline weight.
- Start at 5 mg once daily with a meal (breakfast or evening meal) for 1 month and monitor regularly. Mild transient nausea for the first week after initiation or dose increase is not uncommon. Discuss adherence strategies so that a trial can be monitored adequately.
- Aim to titrate up to 10 mg for greater effectiveness. An adequate trial is 3 months on the highest dose achievable for the patient (5 or 10 mg daily).
- Most people do not experience side-effects if titration is gradual. The more common side effects include:
    - nausea, loss of appetite, weight loss, diarrhoea.
    - syncope.

    - increased urinary frequency or incontinence.
    - increased dreaming or vivid nightmares, fatigue.
    - muscle cramps.
- Assess effectiveness at the end of the trial by:
    - improvement (usually slight) in the Mini-ACE or stabilisation in a previously rapidly declining Mini-ACE.
    - their family's reporting of benefit (more spontaneous, more “themselves”, more active, less apathetic, less delusions or hallucinations if previously present).
    - occasionally, patients themselves experiencing subjectively clearer thinking.

Discontinuing donepezil

- If donepezil is not tolerated, or ineffective, it should be withdrawn. (At least half of all trials will be unsuccessful.) Unless absolutely intolerable, withdraw donepezil by reducing to 5 mg for at least 2 weeks, then ceasing.

Alternative ChIs

- The strongest indication for trialling an alternative ChI is if donepezil was not tolerated, less so if it was simply ineffective or if a beneficial effect faded.
- If intolerable nausea and vomiting with donepezil, rivastigmine patches are fully subsidised.

  Rivastigmine

    - Rivastigmine is available in capsule and transdermal patches.
    - The patches are subsidised if intolerable nausea and vomiting with donepezil. A special authority is required.
    - Capsules are not subsidised.
    - Generally, the patches have less GI side-effects than donepezil but can cause contact rashes.
    - The patch is just as effective as capsules but is better tolerated.
    - Initial dose:
        - Capsules: 1.5 mg twice a day with food, increasing by 1.5 mg per dose monthly, up to a maximum of 6 mg twice a day.
        - Patches: 4.6 mg daily for a month, then increasing up to a maximum of 9.5 mg per day.
    - Consider for a full 3-month trial.
- Otherwise, consider a trial of patient-funded rivastigmine capsules or galantamine tablets.

Galantamine

- Galantamine is not subsidised.
- The initial dose is 8 mg once daily for 4 weeks and then increased to 16 mg once daily.
- The most common side-effects are nausea and vomiting.

Rivastigmine

- Rivastigmine is available in capsule and transdermal patches.
- The patches are subsidised if intolerable nausea and vomiting with donepezil. A special authority is required.
- Capsules are not subsidised.
- Generally, the patches have less GI side-effects than donepezil but can cause contact rashes.
- The patch is just as effective as capsules but is better tolerated.
- Initial dose:
    - Capsules: 1.5 mg twice a day with food, increasing by 1.5 mg per dose monthly, up to a maximum of 6 mg twice a day.
    - Patches: 4.6 mg daily for a month, then increasing up to a maximum of 9.5 mg per day.
- Consider for a full 3-month trial.

- Shop around – prices vary from $140 per month to twice that amount. Consider applying for funding using the Disability Allowance through WINZ if donepezil is not tolerated or ineffective.

- Stopping a ChI after long-term use.

Stopping ChIs after long-term use

- Fully involve the family and caregivers in this decision, particularly the patient's activated enduring power of attorney (EPA).
- In time, the beneficial effects of the ChI will appear to fade or a particular treatment end-point may have been met, e.g. transition from home to residential care. There is no way of determining in advance whether the ChI remains effective at this point other than trialling a slow withdrawal.
- If discontinuation is agreed to, choose a time when there are no other significant factors affecting cognitive function. For example, if the agreement is for discontinuation after a move into care, wait until the person is settled into care before discontinuing.
- To discontinue, reduce the ChI to low dose for 1 month, then cease. Monitor closely.

- If there is a significant deterioration in the patient due to reduction or discontinuation then restore to the former dose within 2 weeks. If deterioration occurs but restarting is delayed beyond 2 weeks, restoring pre-discontinuation functioning may not occur.

9. Do future planning:
    - Consider a delirium management plan.
    - Discuss legal and end-of-life considerations early, before cognitive changes make this impossible.

    Legal and end of life considerations

    - Encourage setting up Enduring Power of Attorney, and creating a will.
    - Start discussions on Advance Care Planning regarding:
        - aged residential care
        - resuscitation

          Resuscitation

          - See Canterbury DHB – Making Resuscitation Decisions – Information for Doctors
          - Give the patient Canterbury DHB – Deciding about Resuscitation – Information for Patients, Family / Whānau
        - attitudes to limiting future medical interventions
        - dying with dementia.
    - Monitor for deteriorating decision-making capacity. See the Mental Capacity pathway for guidance.

10. Manage any behavioural and psychological symptoms (BPSD).

11. If mild cognitive impairment (MCI), monitor yearly.

    Monitor MCI yearly

    - Involve family and carers in consultation.
    - Determine if the family and patient have concerns about any progressive cognitive impairment.
    - If there is progressive impairment, assess as above.
    - Do not prescribe cholinesterase inhibitors for MCI.

12. Consider requesting cognitive impairment specialised assessment if:
    - uncertainty about diagnosis.
    - high risks, or behavioural, psychological, or social difficulties that cannot be managed without specialist support.
    - prominent psychiatric features.

- younger than 65 years and:
    - symptoms are impacting daily functioning (work, home life), or
    - prominent neurological signs are present.
- the patient requires needs assessment for home or carer supports, or residential care.

Request

- Community support:
    - At the earliest opportunity, refer all patients and their carers to Dementia Canterbury via ERMS: Support Services > Dementia Support Service Referral.
    - Include triage information for dementia support service referral.

      Triage information for dementia support service referral
        - Confirmation of dementia diagnosis including type, and other relevant diagnoses
        - Issues for patient e.g., education, isolation
        - Issues for carers e.g., education, support
        - Risks to patient or carers
        - Support person contact details and Enduring Power of Attorney (EPA) status
- Request cognitive impairment specialised assessment if:
    - uncertainty about diagnosis.
    - high risks, or behavioural, psychological, or social difficulties that cannot be managed without specialist support.
    - prominent psychiatric features.
    - younger than 65 years and:
        - symptoms are impacting daily functioning (work, home life), or
        - prominent neurological signs are present.
    - the patient requires needs assessment for home or carer supports, or residential care.
- If unsure whether a community CT head would aid diagnosis and management, seek written advice.
- For allied health support depending on functional need, request:
    - occupational therapy through:

    - home occupational therapy assessment
    - work assessment and rehabilitation service
- physiotherapy assessment
- falls risk assessment
- Medication Management Service
- speech and language assessment

Sources of Support and Advocacy

Consumer family-whānau information – Specialist Mental Health Service

Listed below are some of the services available for self-referral with little or no cost. Pamphlets and resources on a number of services are also available in reception and waiting areas.

298 Youth Health Provides medical and social services for those aged 10-25 year olds.	Ph. (03) 943 9298 298 Bealey Ave, Christchurch Email admin@298.org.nz www.298.org.nz
Christchurch Resettlement Services Supports people from refugee and migrant backgrounds living in Christchurch.	Phone (03) 335 0311 Email admin@crs.org.nz www.crs.org.nz
Etu Pasifika Provides a range of services to support Pasifika young people and adults with a lived experience of mental health issues and their families.	Ph. (03) 365 1002 Email info@etupasifika.co.nz
Mental Health Advocacy and Peer Support (MHAPS) Assist people who experience mental distress, mental illness and/or substance addiction. They offer Peer Support, Peer Advocacy, groups, education and other programmes.	Phone (03) 365 9479 Text: 022 370 8055 Rural Phone 0800 437 324 Email: reception@mhaps.org.nz 357 Madras St, Christchurch
Purapura Whetu Trust A kaupapa Māori health and social services provider helping adults, youth, children and their whānau. Providing counselling, advocacy, group therapy programmes, education and mentoring.	Phone (03) 3798001 Email office@pw.maori.nz Level 1, 166 St Asaph St, Christchurch,8011 www.pw.maori.nz
Reframe Wānanga 14-25 years Provides workshops co-delivered by facilitators with personal experience of mental health recovery and facilitators with a professional background.	Ph. (03) 338 6390 Email rw@stepstone.org.nz
Addiction Support Services	
Alcohol & Other Drug (AoD) Central Coordination Service A coordination and information service for people with alcohol and drug issues. The service links people to the appropriate AoD treatment providers in Christchurch.	Phone (03) 3384437 Email chchaod@odysseychch.org.nz
Problem Gambling Foundation Free and confidential counselling services for individuals and family-whānau affected by problem gambling. Also run a support group for family-whānau.	Phone 0800 664 262 or Asian Family Hotline 0800 862 342 Mapu Maia 0800 21 21 22 (Pasifika) www.pgf.nz
Family-Whānau Support Services	
Yellow Brick Road (formally Supporting Families NZ) Support for family-whānau and those close to a person with a mental illness. This includes support for children and youth.	Phone (03) 3669 284 or 0800 87 66 82 www.yellowbrickroad.org.nz

Family Drug Support Aotearoa (FDSA) Assists familes and whānau to deal with alcohol and other drug misuse in a way that strengthens relationships and achieves positive outcomes	Phone (03) 218 740 Support 0800 337 877 Email: office@fds.org.nz www.fds.org.nz
Helplines	
1737 – Need to talk? A 24/7 free phone number for mental health and addiction support. Free call or text anytime for support.	Call or text 1737 free from a mobile or landline www.1737.org.nz
Alcohol and Drug Helpline Phone helpline for anyone concerned with their own or someone else's alcohol or other drug use.	Phone 0800 787 797 www.alcoholdrughelp.org.nz
Warmline Canterbury A phone line peer support service for people experiencing mental illness living in Canterbury or the West Coast.	Phone 379 8415 (1pm-midnight) or 0800 89 WARM (0800 899 276)
Lifeline Aotearoa provides phone counselling and support for anyone needing help. Services include: • **Lifeline Helpline** Free and confidential counselling and support. • **Kidsline** Free service for children and youth up to 18 years of age. Phone calls between 4-9pm on weekdays can access a Buddy. • **Youthline** A phone, text, webchat or email based counselling service for youth. • **0508 Tautoko** for suicide crisis support. Also supporting family-whānau and friends of a person in crisis.	www.lifeline.org.nz **Lifeline** - 0800 543 354 24hrs/7days **Kidsline** - 0800 54 37 54 24hrs/7days **Youthline** – 0800 37 633 or free text 234 **Tautoko** - 0508 828 865
Rainbow Youth Online support chat available for people aged 13-27 years old looking for guidance, support, or advice around sexuality, gender identity, and intersex status. Also available for family-whānau and those who are supporting them.	www.ry.org.nz/what-we-do/support 2-4pm, Monday-Friday
Outline A helpline for people who are questioning their sexuality or gender identity, LGBTIQA+/rainbow people, their friends, family-whānau and colleagues.	0800 OUTLINE - 0800 688 5463 6pm-9pm every evening www.outline.org.nz

For more information about:

- Mental health services directory go to MHERC www.mherc.org.nz/directory
- Hospital and specialist services, go to www.cdhb.health.nz
- Your health and medication, go to www.healthinfo.org.nz

APPENDIX 6

Canterbury District Health Board
Te Poari Hauora ō Waitaha
Specialist Mental Health Service

Office of the Director of Area Mental Health Services
Telephone DDI 03-339-1136
Facsimile external 03-339-1143
damhsoffice@cdhb.health.nz

Voluntary admission of a person subject to section 29 Compulsory Community Treatment Order

Mental Health (Compulsory Assessment and Treatment) Act 1992

To:

Patients name:
Date of birth:
NHI:

You have agreed to become a Voluntary Inpatient for a period of no more than 14 Days

Your rights:
You have agreed to come into hospital as a voluntary patient, it is important that you have the same rights as any other voluntary patient on this ward. One of these rights is that you may leave at your request at any time. However it is important also to bear in mind that you have come into hospital because you agreed with your doctor and nurse that hospital was necessary. For that reason, if you then feel differently about being in hospital or circumstances have changed, it is important to discuss this with your primary nurse. If you do leave hospital it is also very important that arrangements have been properly made for your continuing care after being in hospital.

It is important that you are aware that your Sec 29 Compulsory Community Treatment Order remains in place during this admission.

Consent/acceptance:

Patient/Welfare Guardian's name: _____

Signature: _____ **Date:** _____

Clinicians name: _____

Clinicians designation: _____

Clinicians signature: _____ **Date:** _____