Contents

INTRODUCTON

Psychiatry is the medical specialty that deals with the study and treatment of mental illnesses and of other disorders, both behavioural and physical, in which psychological factors are important as causes or clinical features. Modern psychiatry has divided into a number of sub-specialities: Child and Adolescent psychiatry concentrates on disorders in children and adolescents, Forensic psychiatry studies the interaction between psychiatry and the law, Psycho-geriatrics examines the psychiatry of old age, Consultation-liaison psychiatry deals with the interaction between physical and mental disease in the broadest sense and includes psychosomatic medicine and psychological reactions to physical disorders while Social and Community psychiatry is concerned with social determinants of mental illness and with the provision of a co-ordinated programme of mental health to a specified population. Other sub-fields include the addictions, eating disorders and neuro-psychiatry. The area of study of psychiatry thus includes a range of disorders that extends from those for which there are obvious brain abnormalities such as the various dementias through to deviations of personality development.

Over recent years there has been increasing awareness of the prevalence of psychiatric disorders within the community and its contribution to disability and mortality. WHO studies have shown that in 1990 around 11% of the total global burden of human disease was accounted for by mental illness and that this will rise to around 15% by the year 2020. In 1990 it was estimated that five of the ten leading causes of disability were psychiatric conditions – unipolar depression, alcohol misuse, bipolar mood disorder, schizophrenia, and obsessive-compulsive disorders; and mental illnesses were held to account for around 28% of all years lived with disability. Community studies both in New Zealand and overseas have shown that the six month prevalence of mental disorders is around 25% and 8-9% of the population have significant disability due to psychiatric illness. On a more personal level most of us have friends or family who will have received treatment for one of the psychiatric disorders and may also know of someone who tragically, has taken their own life, usually because of untreated or unrecognised psychiatric illness.

The specialist mental health services in any country have limited capacity, and treat only a small proportion of the people with psychiatric disorder. For example, the aim of the New Zealand mental health services is to treat only those 3% of people who have the most severe forms of illness. Most people with mental disorders will therefore present to and be treated by doctors in other branches of the profession, especially General Practitioners. This means all medical practitioners should be able to recognise the manifestations of psychiatric illness, initiate a management plan and to refer appropriately when the condition is outside their level of expertise.

Doctors should also be advocates for those with mental illness, as the stigma that surrounds the conditions may discourage people from seeking treatment. In this regard it should be recognised that Doctors themselves are at risk from mental illness. Alcohol and drug problems, depression and dementia account for a number of the cases considered by the Medical Council. Sensitivity and support for ones colleagues and an awareness of ones own vulnerabilities are important aspects of becoming a professional.

Mental health has been identified as a priority area by government for the development of services and for research. Services are becoming progressively more community based and involve multidisciplinary

teams of professionals of different backgrounds offering a range of interventions from pharmacological management through to group psychotherapy. Consumer groups of patients are carers are becoming vocal advocates for changes to services and for greater recognition of mental health issues. Research ranges across fields as diverse as molecular biology and sociology and conditions are often investigates at a number of different levels. Thus, the investigation of the brain mechanisms underlying the major psychiatric conditions proceeds in parallel with studies of the type and combination of psychotherapeutic intervention best suited for the treatment of the same conditions.

Psychiatry is a complex specialty and may seem bewildering when first encountered. It rewards practitioners who have a high capacity to tolerate uncertainty, a capacity for empathy, an awareness of their interpersonal boundaries, broad intellectual interests and who are appreciative of the range of behaviours and emotions associated with the human condition.

Professor R.R Kydd
Head of Department of Psychological Medicine

Learning Outcomes in Psychiatry:

By the end of the clinical attachment students should be able to:

Domain		Acquisition and Application of Medical Knowledge
	1	Explain the key diagnostic features, aetiology and principles of management of patients with common psychiatric problems. ▪ Explain the concept of psychiatric disorders; ▪ Explain the concept of recovery in mental health; ▪ Describe the principles of basic clinical psychopharmacology; ▪ Describe the principles of psychotherapy and other non-medical interventions in psychiatry.
Domain		**Professional, Clinical and Research Skills**
	2	Evaluate patients presenting with a range of common psychiatric problems. ▪ Perform a formal psychiatric history and mental state examination; ▪ Present the findings of a mental state examination in a logical manner, both written and verbally.
	3	Develop a biopsychosocial management plan. ▪ Formulate a multiaxial diagnosis using DSM IV; ▪ Assess and properly manage safety issues; ▪ Identify the risk issues to be managed and include these in a plan.
	4	Examine the professional issues to work successfully in psychiatry. ▪ Explain the importance and role of good doctor patient relationships; ▪ Show capacity for critical thinking and constructive self-criticism; ▪ Assess the value of a developmental approach to clinical problems.
	5	Explain how and when other health professionals need to contribute to problems resolution for the patient. ▪ Summarise the range and respective responsibilities of other health professionals; ▪ Demonstrate a constructive approach in collaborative working environments.
Domain		**Hauora Maori**
	6	▪ Identify key Maori health issues and explain the approaches to addressing the issues. ▪ Identify the strengths and areas for improvement in both your communication and clinical skills when dealing with Maori patients. ▪ Develop and appropriate management plan for the Maori patient. ▪ Participate in or observe a whanau meeting. ▪
Domain		**Population and Community Based Practice**
	7	Appraise the organisation of health services for patients with psychiatric problems. ▪ Appraise the importance of the family and wider environment on the patient. ▪ Suggest improvements that may lead to better collaboration among mental health agencies.

Clinical Attachment

Your clinical attachment is for a period of 6 weeks.

If you have questions or problems during your attachment, you may contact either
Saira Khan (s.khan@auckland.ac.nz) or
Associate Professor Simon Hatcher (s.hatcher@auckland.ac.nz)

There are coordinators based at each of the DHB's where you will be assigned. These are:

- Central: Dr Tony Fernando
- North and West: TBC
- Mason Clinic: Dr. James Cavney
- South: Dr Simon Bainbridge
- Waikato: Dr Wayne de Beer

Students at Waikato need to contact either Raewyn Wooderson (07) 839 8750 or Wilma Watson (07) 839 8750, Wilma.watson@waikatodhb.health.nz Secretary.

Please remember:

- Dress responsibly; look the part of a respectable medical team
- Ask politely and you are more likely to be rewarded
- Always ask patients whether they are prepared for you to be involved
- Be proactive in asking to sit in during consultations
- Respect patient confidentiality at all times
- Use computer privileges to access information relevant to your case(s) only

Your time in Psychiatry is designed to:-

a. Acquaint you with a variety of psychiatric disorders
b. Accustom you to interviewing patients with psychiatric disorder
c. Teach you to carry out mental status examinations
d. Enable you to watch mental health professionals at work
e. Give you an opportunity to think about the interactions between biological, psychological, social cultural and spiritual influences in the experience of psychiatric illness.

This is a suggested structure for you to follow:

Week 1
Get acclimatised. Introduce yourself to staff, find out the rules and habits that you will need to follow. Talk to 2 or 3 patients every day remembering to introduce yourself clearly, and to ask for permission. Patients may like a chance to talk about the impact of their illness on their family, or the advantages and disadvantages of their medication, or what they think about medical education. In other words, use this week to find your feet and relax. If you feel ready, ask your registrar whether you can spend an **on-call night** working with him/her.

Week 2 and 3

Increase the time spent with patients as you feel able. By the end of the third week you should be able to cover present symptoms, past history, family history and personal history without exhausting either yourself or your patient.

Now that you are more part of your work environment, you should be able to find opportunities to go with members of staff and watch their work often. Wherever possible, discuss cases. You should now be organising your observations into mental state examinations reasonably easily. Arrange 1 night on-call work per week with your registrar. Acute psychiatry is a different world, and you will learn much from it.

PATS

Practice with the Psychiatry Teaching Software.

Start writing your case histories. Follow the template found in the student notes. Ask your consultant and or registrar to critique it.

Discuss with your consultant your performance for the past 2-3 weeks. If you have deficiencies, this is the best time to address it.

Start identifying a topic for your CAT.

Week 4

This is the week to round out your clinical experience – perhaps with a home visit if you have not yet done one, or with taking part in a family meeting. Try to increase your knowledge of multicultural issues this week. Widen your experiences by swapping with a person from another service for a day if possible. Ask permission from the consultants involved before you swap with someone from another service.

Week 5 & 6

Consolidate your experiences in all areas. Complete your logs. Continue to schedule weekly on call experiences. Discuss your CAT with your team.

Log

You are expected to keep a log of your clinical experience. You have been provided with a structured logbook to provide guidance about the types of experience you should have. Please talk to your registrar and consultant about your activities and use the logbook to focus your discussions.

During your clinical attachment, you should aim to see as wide a variety of patients as possible. If you are in a narrowly defined specialty area you should arrange visits to more general units with your colleagues.

Assessment/Course Requirements

Assessment for the psychiatry ward block is based on:-

1. Clinical Supervisor Report which is your consultant's assessment of your ward/unit performance. (See copy at the end of Students Notes).

2. Case History

   You have three case histories to submit.

   They should all be of PASS quality.

   Please look at the guide on "Writing a Case History" found in page 18 of this handbook.

   Each case history should not be more than 2000 words. Anything longer will be returned to you to do again. The reason for the word limit is that it forces you to only include what is important for that particular person.

3. Your CAT should follow the format provided by Professor Rod Jackson. It may consider aetiology, prognosis, diagnosis or treatment. You will present your CAT to your team/consultant. You only hand in the CAT marking sheet to the department. Schedule your CAT presentation weeks before the actual date to make sure your consultant will be present to mark it.

   The CAT marking schedule is found at the end of the Logbook.

4. Logbook – to be handed into the department by **4pm on the last Friday of the run**. It is marked Pass or Fail depending on the number and quality of entries.

   Waikato students must hand in their Logbooks and Case Histories at Waikato on the last day of their run. These will then be sent to School of Medicine, Auckland later by the Secretary at Waikato.

5. Psychiatry Marking

Ward grade	D/P/F
Case Histories	D/P/F
CAT	D/P/F
Logbook	P/F

Students must achieve minimum of pass in all domains to pass the course.

References/Resources

a. Foundations of Clinical Psychiatry. 3rd edition, edited by Bloch & Singh. (2007)
   Easy to read but still a good introduction textbook for students in Psychiatry.

b. Interview Guide for Evaluating DSM-IV Psychiatric Disorders and the Mental Status Examination by Mark Zimmerman
This is a very good basic handbook on how to interview patients with psychiatric symptoms. It is an excellent resource for students who speak English as a second or third language.

c. Kaplan and Sadock's Comprehensive Textbook of Psychiatry by Sadock and Sadock
The classic reference book in Psychiatry. It covers clinical, research as well as theoretical issues in Psychiatry.

d. Introductory Textbook of Psychiatry by Andreasen and Black, 3rd edition. Standard psychiatry text used by US medical students.

e. Psychiatry Assessment and Teaching Software by Dr Tony Fernando
This was released in 2005 to assist students in observing interviews, reporting mental status findings, diagnosis and management. Students are required to practice with this software to ensure that they are familiar with the format of the video exam.

f. University of Tasmania free downloads **http://eprints.utas.edu.au/287/**

g. Psychiatry on-line. This is available through the Philson library database. It is supported by the American Psychiatric Association and provides access to on-line versions of Psychiatry journals, DSM IV and invaluable texts like –

1) Textbook of Psychiatry
2) Textbook of Psychopharmacology

http://www.hsc.wvu.edu/aap/Video/video_page.htm

PROGRAM SCHEDULE FOR 4TH YEAR TEACHING 2011

Block teaching for three days at the beginning of every cycle will be at the Department of Psychological Medicine. There are five Psychiatry cycles during the year, each starting on:

Cycle 1	21 February
Cycle 2	4 April
Cycle 3	13 June
Cycle 4	25 July
Cycle 5	3 October

Students must report to their respective clinical attachments on the following days at 8.30am.

Cycle 1	24 February
Cycle 2	7 April
Cycle 3	16 June
Cycle 4	28 July
Cycle 5	6 October

TEACHING PROGRAM FOR THE BLOCK TEACHING *

DAY	TIME	TOPIC	PRESENTER
MONDAY	8:00am – 8:30am	Collect materials, sign in/register	
	8:30am – 9:15am	Welcome/Administrative issues	Associate Professor Simon Hatcher
	9:15am – 10:00am	Introduction to Psychiatry	Professor Rob Kydd
	10:00am – 12:00 noon	History Taking & Mental Status	Dr Simon Bainbridge
	12:00 noon - 1:00pm	LUNCH BREAK	
	1:00pm - 2:30pm	Psychosis I	Drs Ian Soosay/Aaron O'Connoll
	2:30pm – 2:45pm	BREAK	
	2:45pm – 5:00pm	Psychosis II	Drs Dmitri Griner/Susan Lane
TUESDAY	8:30am – 10:30am	Anxiety Disorders	Dr Shane White
	10:30am – 10:45am	BREAK	
	10:45am – 12:00pm	Suicide/Deliberate Self Harm	Associate Professor Simon Hatcher
	12:00pm – 1:00pm	LUNCH BREAK	
	1:00pm – 5:00pm	Mood Disorders	Dr James Cavney
WEDNESDAY	9:00am – 12:00 Noon	Old Age/Delirium Dementia	Dr Gary Cheung
	12:00noon – 1:00pm	LUNCH	
	1:00pm - 2:30pm	Science of Happiness	Dr Tony Fernando
	2:30pm – 2:45pm	BREAK	
	2:45pm – 5:00pm	Mindfulness Workshop	Dr Tony Fernando

* Occasionally, there will be minor changes in the schedule. You will be informed of these changes during your orientation.

4th YEAR WORKSHOPS - 2011

During the run there will be workshops for the students in the Department every Thursday afternoon.

Cycle	Date and Time	Topic	Lecturer
One	Thursday 3rd h March 1:00pm – 4:15pm	Child and Adolescent Psychiatry	Dr Louise Webster
	Thursday 10th March 1:00pm – 2:30pm 2:45pm – 4:15pm	Substance Abuse Discussion Group Session	Dr Karla Rix-Trott Professor Rob Kydd Dr Tony Fernando
	Thursday 17th March 1:00pm – 2:30pm 2:45pm – 4:15pm	Psychological Interventions Discussion Group Session	Drs Richard Worrall/ Sarah Preece Professor Rob Kydd Dr Tony Fernando
	Thursday 24th March 1:00pm – 2:30pm 2:45pm – 4:15pm	Biological Treatment Discussion Group Session	Dr Nick Hoeh Professor Rob Kydd Dr Tony Fernando
	Thursday 31st March 1:00pm – 2:30pm 2:45pm – 4:15pm	How to Diagnose and Manage Insomnias Discussion Group Sesison	Dr Tony Fernando Professor Rob Kydd Dr Tony Fernando
Two	Thursday 14th April 1:00pm – 4:15pm	Child and Adolescent Psychiatry	Dr Louise Webster
	Thursday 21st April 1:00pm – 2:30pm 2:45pm – 4:15pm	Substance Abuse Discussion Group Session	Dr Karla Rix-Trott Dr Louise Webster Dr Ian Goodwin

Cycle	Date and Time	Topic	Lecturer
	Thursday 28th April 1:00pm – 2:30pm 2:45pm – 4:15pm	Psychological Interventions Discussion Group Session	Drs Richard Worrall/ Sarah Preece Dr Louise Webster Dr Ian Goodwin
	Thursday 5th May 1:00pm – 2:30pm 2:45pm – 4:15pm	Biological Treatment Discussion Group Session	Dr Nick Hoeh Dr Louise Webster Dr Ian Goodwin
	Thursday 12th May 1:00pm – 2:30pm 2:45pm – 4:15pm	How to Diagnose and Manage Insomnias Discussion Group Session	Dr Tony Fernando Dr Louise Webster Dr Ian Goodwin
Three	Thursday 23rd June 1:00pm – 4:15pm	Child and Adolescent Psychiatry	Dr Louise Webster
	Thursday 30th June 1:00pm – 2:30pm 2:45pm – 4:15pm	Substance Abuse Discussion Group Session	Dr Karla Rix-Trott Dr Tony Fernando Dr Simon Bainbridge
	Thursday 7th July 1:00pm – 2:30pm 2:45pm – 4:15pm	Psychological Interventions Discussion Group Session	Drs Richard Worrall/ Sarah Preece Dr Tony Fernando Dr Simon Bainbridge
	Thursday 14th July 1:00pm – 2:30pm 2:45pm – 4:15pm	Biological Treatment Discussion Group Session	Dr Nick Hoeh Dr Tony Fernando Dr Simon Bainbridge

Cycle	Date and Time	Topic	Lecturer
	Thursday 21st July 1:00pm – 2:30pm 2:45pm – 4:15pm	How to Diagnose and Manage Insomnias Discussion Group Session	Dr Tony Fernando Dr Tony Fernando Dr Simon Bainbridge
Four	Thursday 4th August 1:00pm – 4:15pm	Child and Adolescent Psychiatry	Louise Webster
	Thursday 11th August 1:00pm – 2:30pm 2:45pm – 4:15pm	Substance Abuse Discussion Group Session	Dr Karla Rix-Trott Dr Louise Webster Dr Sai Wong
	Thursday 18th August 1:00pm – 2:30pm 2:45pm – 4:15pm	Psychological Interventions Discussion Group Session	Drs Richard Worrall/ Sarah Preece Dr Louise Webster Dr Sai Wong
	Thursday 25th August 1:00pm – 2:30pm 2:45pm – 4:15pm	Biological Treatment Dr Louise Webster Dr Sai Wong	Nick Hoeh Dr Louise Webster Dr Sai Wong
	Thursday 1st September 1:00pm – 2:30pm 2:45pm – 4:15pm	How to diagnose and Manage Insomnias Discussion Group Session	Dr Tony Fernando Dr Louise Webster Dr Sai Wong
Five	Thursday 13th October 1:00pm – 4:15pm	Child and Adolescent Psychiatry	Dr Louise Webster
	Thursday 20th October 1:00pm – 2:30pm 2:45pm – 4:15pm	Substance Abuse Discussion Group Session	Dr Karla Rix-Trott Professor Rob Kydd Dr Louise Webster

Cycle	Date and Time	Topic	Lecturer
	Thursday 27th October 1:00pm – 2:30pm	Psychological Interventions	Dr Richard Worrall/ Sarah Preece
	2:45pm – 4:15pm	Discussion Group Session	Professor Rob Kydd Dr Louise Webster
	Thursday 3rd November 1:00pm – 2:30pm	Biological Treatment	Dr Nick Hoeh
	2:45pm – 4:15pm	Discussion Group Session	Professor Rob Kydd Dr Louise Webster
	Thursday 10th November 1:00pm – 2:30pm	How to Diagnose and Manage Insomnias	Dr Tony Fernando
	2:45pm – 4:15pm	Discussion Group Session	Professor Rob Kydd Dr Louise Webster

Workshops

1	**Child and Adolescent Session** A case will be presented and an open discussion on Diagnosis and management of a Child and Adolescent patient will ensue.	Dr Louise Webster
2	**Substance Abuse Diagnosis and Management**	Dr Karla Rix Trott
3	**Psychological Interventions**	Dr Richard Worrall Dr Sarah Preece
4	**Biological Treatments**	Dr Nick Hoeh
5	**How to Diagnose and Manage Insomnias**	Dr Tony Fernando

TEACHING PROGRAMME FOR STUDENTS ALLOTED TO WAIKATO

Students who are allotted to Waikato Hospital are expected to report at Waikato on the following days by 8:30am.

Cycle 1 - Thursday the 24th of February

Cycle 2 - Thursday the 7th of April

Cycle 3 - Thursday the 16th of June

Cycle 4 - Thursday the 28th of July

Cycle 5 - Thursday the 6th of October

Students will have workshops at Waikato Hospital and will not have to return to Auckland for these.

On arrival the students must report to:

Raewyn Wooderson
Reception Desk
Waikato Academic School
C/O Peter Rothwell Academic Centre
Waikato Hospital

Phone: 07 839 8750

Email: Raewyn.wooderson@waikatodhb.health.nz

Outline of programme:

1 **Thursday of Week One**: Meet with Raewyn Wooderson, Waikato Clinical School, Peter Rothwell Academic Centre (next to the Bryant Education Centre) at 8.30am, followed by meeting with run Co-ordinator, Dr Wayne de Beer, Karen Davies and/or Wilma Watson for orientation to the hospital and the departments. At this meeting you will find out which run you have been allocated and a timetable provided.

2 **Tuesdays:** Each student will rotate through a session of ECT.

3 **Wednesdays**: Departmental Journal Club (venue to be advised) followed by a Child and Adolescent Tutorial. In the afternoon students have self directed learning from 1:30pm to 5:00pm but each student will also rotate through Mental Health Services for Older People.

4 Each student will be allocated **one night on call per week**. The hours are 5:30pm – 10:30pm.

5 There will be teaching Monday, Tuesday, Thursday and Friday afternoons from 3:30pm.

6 The individual teams have their own timetables that each student will be expected to follow. These will be available at the start of each attachment. The teams are:-

Hamilton-Huntly Inpatient Team
Hamilton-Reglan Inpatient Team
Hamilton-Cambridge Inpatient Team
Mental Health Services for the Older Person Team
South Inpatient Team
Hamilton-Huntly OP/CATT Placement

Dr Wayne de Beer (Co-ordinator)
Phone: (07) 834 6902
Fax: (07) 834 3176
Internal extension: 2468
Wayne.debeer@waikatodhb.health.nz

Karen Davies
Secretary Administrator
Waikato Clinical School
Telephone: (07) 839 8750
Fax: (07) 839 8712
Karen.Davies@waikatodhb.health.nz

Wilma Watson
Secretary Administrator
Waikato Clinical School
Telephone: (07) 839 8750
Fax: (07) 839 8712
wilma.watson@waikatodhb.health.nz

WRITING A PSYCHIATRIC CASE HISTORY

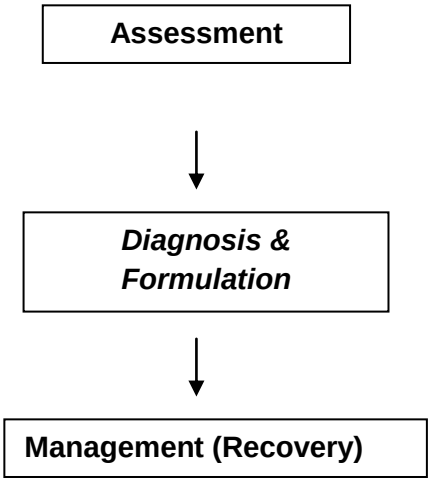
The clinical task and the clinical logic

Consumers or patients come to psychiatric services seeking (or their relatives hope) for some intervention(s) which would improve the way they feel, and/or the way they function. The key to this, and the whole point of the doctor/patient interaction, is to jointly develop a **patient management or recovery plan**.

The development of a comprehensive management plan requires the clinician (in this case student) to gather information (the **assessment**), to bring it together in the (provisional) **diagnosis and formulation**, which in turn will drive the development of the management plan. That management plan can be driven, for example, by the need for more or better information, or by specific therapeutic interventions or by both.

Given the same assessment information, all clinicians should make the same diagnosis and formulation. Such perfection is in practice difficult as the information gathered is rarely identical and the process of selecting the content of the formulation is not perfectly objective. But in all cases, the link from assessment information to diagnosis and formulation should be logical and evident.

The full process of the clinical logic of the clinician/consumer interaction is displayed diagrammatically below. The link between the assessment and the management plan is provided by the diagnosis and formulation.



The diagnosis and formulation should drive the management plan and it should be possible to see a reason for everything which appears in the management plan, in the diagnosis and formulation.

One way of deciding which assessment information goes into the formulation can then be to go through all the assessment information underlining or otherwise extracting everything which will make a difference to the proposed management plan. That material forms the content of the formulation. This

ensures that the formulation content is driven above all by the needs of the management plan, rather than being conceptualised simply as a summary of the assessment.

Reference:

Mellsop G W, Banzato CM (2006) A concise conceptualisation of formulation. Academic Psychiatry, 30:424-5

General Instructions:

Please follow the structure found in the student notes.

Please discuss the case histories with your Consultant or Registrar before submitting it.

The case history should not be longer than 2000 words.

If you have problems with written English, we expect you to seek assistance in your case history. Ask assistance from the Student Learning Centre, friends or classmates. Microsoft word has spell check so please use it**. Poor written English can affect your mark.**

Medical records or clinic files cannot be taken home. **Patients' names, details or other identifying data should not appear in your report. Use pseudonyms or initials**.

Do not "cut and paste" from medical records onto your case histories. It is much better to paraphrase information from medical records rather than copying them verbatim.

Introductory statement

This should be one sentence to orientate the readers to the case and to provide focus for discussion. It proves to the examiners that you are not just presenting facts elicited but that you have the skill to synthesise and make sense of a psychiatric presentation. It should describe what the main clinical issues are in the case – for example "this case is about the management of acute symptoms" or "This case illustrates the problems in preventing relapse of schizophrenia".

Examples of introductory statements: - "This case illustrates the complexity of diagnosis in a person with a first presentation of psychotic symptoms", "This case illustrates the clinical and ethical dilemmas of managing a woman with ongoing suicidal behaviour", This case illustrates the importance of a comprehensive psychosocial rehabilitation assessment and strong treatment alliance in a man with a twenty year history of schizophrenia". These statements should be based on what you believe to be the crux of the issue. If safety concerns are present it is important to highlight this for example "This case illustrates the importance of managing suicide risk in an elderly man with an agitated depression."

Demography

Again one or two sentences – you must put age, gender, occupation and ethnicity. Do not guess clients race or cultural affiliation ask this. You cannot practice psychiatry without understanding how the

illness impacts on the individual's cultural world view or what it would mean to them about themselves or what the implications are for treatment alliance.
In demography you may also wish to put number of children or living circumstances for example "Mr Pearce is a sixty year old Caucasian widower who is a retired bus driver and lives with his only daughter"' "Mr Toto is a thirty year old Maori who lives with his wife and two year old son. He is a civil engineer." Immediately with a demographic statement the readers start to form a picture of the person as an individual.

Presenting complaint

This is a brief description of the reason and context that you are seeing the person in for example "Mr Smith was referred to the liaison psychiatry service yesterday by the inpatient cardiology team who were concerned about his bizarre behaviour"

History of presenting complaint-

This is a description of the **current complaints/ signs/ symptoms** that the person has.
You are **narrating a story** here. Stories often have a beginning, middle and an end. Coherent stories have flow, a clear time line or chronology of events.
It is very important that you attempt to answer the question- **"Why now?"**
Mental and behavioural symptoms should be described in detail. This requires detailed elaboration often using the persons own words and supported by a relevant functional enquiry. Quote the patient but in a selective way so that information is going to support your mental state and diagnosis and be consistent with the theme of the case e.g. "John describes both male and female voices talking about him. They say insulting statements such as "He has a hideous nose, no wonder everybody thinks he's a freak". With an important piece of history like this you must tag on relative negatives e.g "the voices do not tell or command John to do anything."

It would be helpful if the **identified mental/ behavioural symptoms** (ie low mood, rapid speech, suicidal thoughts) are **qualified in terms of a) onset b) duration c) precipitating or mitigating factors d) severity**. For example, "Chris has had on and off thoughts of ending his life for about 2 yrs now. It started after he separated from his partner. He noticed that everytime he drinks alcohol, for the next 48 hours, these suicidal thoughts increase. On the other hand, when he spends time with his kids, the thoughts seem to melt away."
If you have someone with psychotic symptoms you must present a relevant functional enquiry e.g look for common delusions such as persecutory, mind reading and delusions of reference. In history of presenting complaint this section should be detailed and must include the patients **attribution** of their experiences for example "John believes the voices come from the devil as a result of a voodoo curse put on him by his neighbours." Attribution should also cover cultural understanding of illness.
History of presenting complaint must also include **impact** of illness on functioning, for example "Because of John's voices, he has left home in fear and is now homeless. He has also dropped out of his Unitec course and has no contact with either family or friends." This impact statement shows the examiner that you are familiar with the concepts of disability and handicap. A common criticism is that Doctors can elicit symptoms but make no sense of them in terms of the individual's life experiences.

Key areas to ask about include activities of daily living, social functioning and effects on cognitive tasks such as concentration and learning.
Another key area is **coping -** how does the individual cope with their experiences – later it can be discussed in the formulation whether this is protective or not e.g " Jack copes with the voices by drinking alcohol which he feels reduces their intensity" e.g "Jane copes with her feelings of being unreal by ringing her mother. If her mother is not available she cuts her wrist with a scalpel which she says helps her feel focused."

Current medication/ interventions, duration of treatment, efficacy and side effects should be documented.

Current neurovegetative signs and symptoms have to be included. These are sleep, energy, concentration, ability to experience pleasure, appetite and libido.

A common problem that medical students experience is how to write up the history of presenting complaint in the person seen in a community mental health setting. The key is to start with their current well being not when they were referred several years ago. The details of referral several years ago are part of the person's past psychiatric history.

One of the most common mistakes students make is lack of elaboration of signs and symptoms.
They simply report a symptom/ sign/ event without proper elucidation or enquiry. Examples:
"Maria felt quite bad that she overdosed and was then hospitalised. " End of paragraph.
With this report, any inquisitive student will ask details about the following:

1) Why was she feeling bad? How long has this been going on? Any specific triggers? How frequent is this? Is this a recurring pattern?
2) Overdosed with what? Has she done this before? Is this a recurring pattern? Was there someone present when she did this? Was it impulsive or was it planned? Did she do it in a place where she can be found easily or did she hide herself to prevent rescue?
3) How did she end up in the hospital? Did she actually call 111 or she called her partner/ family? Was she found unconscious? What's her attitude about being in the hospital?

As you can see from this example, **simply reporting events is not enough** when one writes the History of Presenting Complaint. You are reporting in detail the background story behind the signs/ symptoms which inform the subsequent management plan. For example the amount of planning that Maria made for her overdose will determine some aspects of the management plan.

Remember also to include important negatives that are relevant to the main issue. For example if the issue is around diagnostic uncertainty in someone who is psychotic include the absence of thought disorder as this is important in deciding whether it may be due to schizophrenia.

Past psychiatric history

If this is extensive, summarise the pertinent points. Exact dates are less important but treatments

received, responses and serious events leading to hospital are. If no past attempts at harming self or others say this. If there are, detail it e.g "John has had at least ten hospitalisations over the last six years with what sounds like an exacerbation of his schizophrenia. On one occasion he had a serious suicide attempt where he jumped in front of a car and fractured his hip in response to command hallucinations. He tells me he has been on a number of medications including chlorpromazine, haloperidol, pimozide and an injectable antipsychotic. He also describes frequent side effects such as tremor, impotence and akathisia. He does not believe that the medicine treats his voices, only dampens them down".

By presenting past psychiatric history in this way you have directed the key issues that you can raise both in formulation and management namely treatment resistant psychotic symptoms and forming a therapeutic alliance with a disengaged high risk patient with revolving door admissions. It is important for the management plan to know what the key issues are, what has worked, what hasn't worked and *why* things have or haven't worked in the past.

Forensic history

Useful to put here as it may relate to past psychiatric history for example "Janet has had one arrest for dangerous driving when she was manic." Always mention even if negative "There is no forensic history."

Substance abuse history

Need to not only quantify amounts of substances but show the distinction between abuse and dependency by relevant positives and negatives. If the case is clearly a substance abuse one, the substance abuse history should be presented in history of presenting complaint. For example "Jean drinks two bottles of wine a night. She has at least five episodes of blackouts in the last year and two DIC charges. In the last week she has started to have shaking hands in the morning which go when she takes 5mg of diazepam prescribed by her GP for anxiety. Last year she went to one AA meeting after an ultimatum from her partner but has had no help since."

Common omission by students: after detailing a significant substance abuse/ dependence, they forget to include it in their multiaxial diagnosis. Remember, it is part of Axis 1 disorders.

Family Psychiatric History

Not just psychiatric diagnosis and treatment but ask about family suicides and substance abuse. For example Alcoholic parents are relevant for a risk of alcoholism in children but also vulnerability to personality or mood problems in children because of attachment experiences. This section can not only relate to genetic risk in formulation but also the meaning of the illness to the individual.

Medical History

You may wish to put this heading higher in your presentation e g if doing an elderly/ delirious patient. The order of the headings can be flexible but each must be clearly articulated. Use common sense to

the most relevant parts, for example don't write in detail on an appendectomy that is likely to be of no relevance. However, a diagnosis of diabetes in a woman with an eating disorder is highly relevant and would require detailed discussion.
Key points are physical illness and their treatment either presenting as a mental illness or increasing risk for a mental illness for example post CVA depression or the impact of a chronic illness on an individual's personality development and mental well being for example major importance if you get a young person who has had a chronic severe physical illness throughout of their life. Clearly a psychogeriatric or consult liaison case requires detailed consideration of medical history.

Developmental and Social history

Key areas need to be covered but again select information that is relevant to the overall presentation. *****PLEASE BE VERY SENSITIVE ASKING THESE QUESTIONS***.**

This should cover **family composition**, **what was childhood like, schooling, friendships. Major events** like death of family member can be included. An example of the above is "John is the oldest of three sons. He describes a chaotic and traumatic family life where he often witnessed his father assaulting his mother. Frequently John and his brothers would be taken from the house by different extended family members. He had been to ten different schools by the age of fourteen and had difficulty forming friends and learning to read to write. He frequently got into trouble with the teachers and was expelled at fourteen for assaulting a teacher." This type of history is relevant to management as it predicts how people relate to others as adults including care givers.

History of abuse or trauma (emotional/ sexual/ physical) should be included. This also includes **bullying**. Patient's perspective on how it has affected him/her can be helpful. *****PLEASE DO NOT ASK QUESTIONS ABOUT SEXUAL ABUSE WITHOUT DISCUSSING IT FIRST WITH YOUR CONSULTANT*****

You also need to give a **vocational and relationship history**. E.g. Ann has worked for ten years as a teller in the bank. She married her first boyfriend at the age of nineteen but describes the marriage as "loveless". She finds she has little in common with her husband and has never enjoyed sex as she finds it "dirty". Her husband is 10yrs older and tends to be controlling. They have no children and Ann has little social contact outside the fundamentalist church she attends weekly." The relevance to management here is that one of the main impacts of an illness is on work and returning to work is often an important management goal.

Hobbies and religion are good things to present here as both are related to recovery.

Who is the **current circle of support** for this patient? Any partner? Close relatives and friends? Children?

Current source of income? Financial situation? Is the patient on the benefit? How is the patient's housing situation?

Premorbid personality

Don't leave this out because it's difficult. You get major clues from how people cope or appraise illness, forensic history, relationship and work history. Also from your observations in interviewing people e g the style of communication of someone who is histrionic and flamboyant or with the over inclusive obsessional person who makes you particularly irate in a setting which is time limited. Generally not good to label as "disorder" unless very clearly able to defend the case as such e g you may get a woman with borderline disorder. Better to say "Sam has features (traits) of an obsessional personality. He describes a need for orderliness and perfection and control over a number of situations. Sometimes it also helps if you ask the patient (and or family) how the patient was as a person prior to the onset of illness. Psychologists have identified 5 personality factors. Openess to experience, conscientiousness, extro (tendency to be sociable, active and willingness to take risks), agreeableness (ability to relate – trust, tenderness …….) and neuroticism (emotional stability, tendency to anxiety). Asking questions about these may help build up a picture of the person.

Physical examination

Generally brief and *tailored* – in psycho-geriatric cases may need more detail e g detailing physical findings of Parkinsons. In eating disorders you will fail if you don't have weight+height for BMI and look for features of anorexia or bulimia. In some one with a primary substance abuse diagnosis look for this eg stigmata of alcoholism. In someone on long term anti-psychotics do an AIMS in someone on lithum look for tremor/hypothyroidism.

"On physical examination Jane had a BMI of 16 her skin was dry and showed lanugo. Her teeth were chipped with dark staining. On cardiovascular examination she was bradycardic with a pulse of 48/minute regular. Her BP was 110/60 and her heart sounds were dual with no murmurs. Her temperature was 36.5C. No further abnormalities were detected on a brief examination."

If there are grossly abnormal physical findings, you need to talk about how that was assessed and managed in the appropriate parts of the Case History.

Mental state examination

This is the art and science of psychiatry. It must be organised, detailed and consistent with what has been presented. Use the phenomenological terms and be sure you can justify and define them. Do not leave out a section you cannot say "cognition was not assessed" unless you have an exceptionally good reason such as the patient walked out of the room.

Please refer to the teaching software (PATS) for practice in reporting MSE.

Appearance, behaviour, eye contact and rapport

Paint a picture of the person in front of you – its good psychiatry and it makes it interesting to listen to eg "Paul was dressed in unevenly buttoned hospital pyjamas with a ripped denim jacket on top. During

the interview he remained curled into the corner of the couch and avoided eye contact. Rapport was difficult to establish as he seemed frightened both of being in hospital and the experiences he was going through." Comment on the quality of the rapport, don't just say good or bad, elaborate on it. Describing why rapport was bad doesn't mean that you are necessarily a bad Dr rather that you are a reflective Dr with a conception about dynamics. DO NOT BLAME THE PATIENT OR MAKE DEROGATORY REMARKS ABOUT THEIR APPEARANCE.

Orientation/Cognition

Present a MMSE with frontal lobe extensions. If there are no abnormalities this can be done quickly e.g. "No abnormalities were detected on a Folstein Mini Mental State Examination or on tests of frontal lobe function." If there are any cognitive abnormalities this is always relevant and you have to say what tests were abnormal.

"Mrs Jones scored 27/30 on a Folstein Mini State Examination. She made two errors on testing of attention and concentration and scored two out of three on short term memory testing at five minutes. On frontal lobe testing she displayed several deficits. She perseverated on copying alternative patterns of w's and m's. She perseverated on alternative tapping testing and had a reduced verbal fluency only naming 8 words beginning with'a' in one minute with two repetitions.

Her new word learning was impaired only recalling two out of four word pairs after two attempts and her ability to describe similarities between an orange and a banana was impaired after saying they were both fruit she was unable to generate further ideas. On proverb interpretation she was concrete to both simple and easy proverbs. When asked a meaning of "two many cooks spoil the broth" she told me she had a small kitchen where not many people would fit in."

Speech

Comment on rate, rhythm, volume and intonation

Thought form

Is the thought form logical, irrational, loose?
Giving examples helps

Thought content

Comment on delusions, ruminations, obsessions or overvalued ideas if they are present. Describe what is the person actually saying to you, what is important e.g "Tom spoke in a self deprecatory manner outlining his many failures although this was neither delusional nor ruminatory in nature."

Be very clear on accurate terminology regarding delusions – especially highlight threat/control/passivity as very relevant for dangerousness.

SUICIDE/HOMICIDE (safety risks) can be included here. Sometimes, it is a separate category in itself at the end.

Perception

Illusions, hallucinations, also know rarer ones and comment if present. Always discuss command hallucinations in detail.

Mood

"Objectively" (or from your assessment) - patient is apathetic, euthymic, dysphoric, despondent, depressed elevated, angry fearful etc
You can also ask mood directly – and quoting the patient's response (subjective) "Mark says he is feeling grumpy."

Affect

Be clear that this is a different concept to mood – discuss range, reactivity, mobility, intensity and congruence.

Insight

This has several parts

1. Does the person think that something different is going on i.e. they see the symptoms as different to usual self?
2. Do they see symptoms as illness?
3. Do they see symptoms as part of mental illness?
4. What is their attitude to help seeking/treatment?
5. Do they see impact of illness?
6. In people with personality disorders concept of psychological insight important.

Always relate insight to the appropriate other part of the MSE ie is it the person's mood, psychosis or cognition for example that makes insight less than full. It is inadequate to say "insight is impaired" "insight is partial" without adequate exploration of the components insight.

Judgement

How does all the mental state you have presented impact on decision making regarding action. Clearly key ones = suicide, risk to others and ability to self care. Again don't make global statements without discussion – not adequate to say "judgement is impaired" without saying why and how.

A helpful mnemonic is **BOATPIS**

B- Behaviour/ appearance/ physical findings

O- Orientation and cognitive functioning
A- Affect and Mood
T- Talk or Speech, Thought Form and Thought Content
P- Perceptions
I- Insight and Judgment
S- Safety risks to self, others; Self cares

Formulation

A formulation is more than a summary. It is your opportunity to define how you understand why this person is presenting with this disorder and at this time. As medical students the key aspects to appreciate is that a formulation contains three core parts.

1. DSM IV

A formulation using the 5 Axis system. This should be included in the write up as part of the student's diagnostic formulation.

2. a) Descriptive

A formulation starts with a brief statement about the case. This should link to your introductory statement.

For example "Mr Jones has had multiple admissions for treatment refractory schizophrenia and has significant disability and a range of rehabilitation needs"

b) Explanatory

The models of understanding discussed in the explanatory aspect of the formulation can vary according to the individual's presentation and the field of interest of the psychiatrist. In general a biopsychosocial framework is the most appropriate one for a medical student to use. How does the biology of the individual relate to their psychological and social world? Even in a "very biological" condition such as Alzheimer's Dementia the person's psychological coping style and family structure and support create a unique aspect to understanding the situation.

The developmental stage of the individual is a key aspect of the explanatory component of a formulation. For example what is the difference between a person developing schizophrenia at age 14yr compared with age 30yr? Clearly there is a marked difference. The fourteen-year-old will have a significant disruption to the tasks associated with that age – education, peer relationships, becoming aware of their sexuality. The tasks for a thirty-year-old that would be disrupted by the illness would be consistent with developmental areas such as employment and developing or sustaining a family network of their own.

c) Prognosis

This is not a statement merely relating to a statistical likelihood of a cure. A prognostic statement needs to include factors related to the individual, both protective and risk related. It also needs to

consider factors that may relate to the ease or difficulty of forming a therapeutic alliance. For example: "Although I have emphasised the need for adequate antidepressant therapy a key issue remains the ability for health services to engage with this man in a culturally appropriate manner as his religious beliefs leave him with fear regarding taking medication"

MANAGEMENT PLAN COMPONENTS

Please refer to PATS (Psychiatry Teaching Software) on how to report management plans.

1. Safety

What are the current safety concerns? Priority lies with immediate risk to self from suicidality or diminished self cares and risk to others. Be aware of risk factors e.g. age, gender, substance abuse and of course significant past events and personality style. An accurate and thorough mental state examination will identify features which specifically increase risk e.g command hallucinations, delusions of threat/control, an irritable and elevated mood or suicidal ideation. Long term risk relates to ongoing factors either in the individual's mental state or environment.

Psychiatry has moved away from predicting dangerousness to *managing risk.* Strategies for managing risk include engagement with the individual, frequency of contact and education around early warning signs for illness relapse. Increase in nursing and medical supervision, respite admissions and or acute in-patient hospitalisations are options in managing unwell and unsafe patients. On some occasions the mental health act may be required to ensure appropriate medication use or inpatient care at times of acute crisis. An active plan to address substance abuse issues may be part of managing safety as may attention to environmental stress such as housing stability.

2. Clarifying diagnosis and differential diagnosis

Is it clear what the individual's diagnosis is? It is surprising how many consumers are treated within the system for years with an unclear or inconsistent diagnosis. Too often diagnoses like schizo-affective disorder are used in a loose and meaningless way to justify unfortunate poly-pharmacy. Management addressing differential diagnosis includes reviewing old notes both psychiatric and medical, obtaining a thorough longitudinal history from the individual and meeting with family members for clarification

3 Cultural issues

The individual and family's cultural identification must be established on first contact. This is so the family and individual can have access to culturally appropriate support and the staff can receive advice on how to work with the consumer and appreciate their world view. It is essential to utilise the interpreting service when the consumer requests this or when English is not their first language.

4 Biological Management

a) Pertinent diagnostic tests and examinations

Consideration of the physical health of the individual is essential. This is because physical conditions may present with an altered mental state for example delirium. Another important reason is because of the possible medication interactions with pre-existing medicines taken for a physical condition. It is important to establish baseline blood tests prior to prescribing many medications e.g. renal function and thyroid function prior to lithium.

In certain populations, a comprehensive physical examination and investigation is particularly important as in potentially life threatening conditions such as anorexia nervosa. It is important to remember that consumers with schizophrenia have poorer general physical health than the general population and often do not access General Practitioners. A physical examination on someone prescribed anti psychotic medication must include an examination for tardive dyskinesia and extrapyramidal side effects.

b) Medication

The other major component of biological management is medication. What does the evidence tell us about which medications are effective for someone with this condition? Clearly the attitude of the consumer and their family to medication is important. A discussion of the advantages and disadvantages of medication and possible side effects is obligatory in good management. It is also important to discuss the dosing regime, the expected time for effect, the need for any special monitoring and practical issues such as what to do if a dose is missed. There should also be a statement on how often the person will be reviewed. Written information sheets in the appropriate language are important. Directing patients to websites which detail medication side effects can be helpful (www.medsafe.govt.nz).

5 Psychological management

Psycho-education (discussing what the individual's condition is and potential treatment strategies) and exploring the patients coping style and aggravating stressors are components of general psychological management. Additionally specific psychological therapy may be indicated such as cognitive behavioural therapy for depression or a number of anxiety disorders. Psychological management may include special assessments such as neuropsychological testing. As with all management, psychological strategies should be a planned intervention with specific goals and outcomes to be evaluated.

6 Social and Family issues

A major criticism of mental health services has been the lack of communication with family members. Family members are not only a valuable source of information but are often a major support in the individual's recovery process. Families may experience their own stress from seeing a member unwell and community organisations such as the "Supporting Families" can be invaluable. Family support groups from the CMHC's and inpatient units are also useful resources. Specific interventions involving the family such as Integrated Mental Health Care or Family therapy may be indicated. The individual's

family or major social support person should be involved in developing a wellness plan with early warning signs and contact numbers.

Social issues often relate to housing, money, education and employment. There is clear evidence that for people with ongoing mental illness the quality of their housing relates to their ability to maintain wellness in the community. Hopefully as a service we can move past the language of "placement "to working together with the consumer to find a stable home. Assessment of living skills may alert the team to specific needs for the individual for example budgeting or cooking. Management of employment issues may range from providing a letter to employers supporting a gradual return to the workplace to a referral to specialist agencies.

7 Rehabilitation Management

This is of more relevance to consumers with the more severe and enduring mental disorders. Rehabilitation is not concentrating solely on symptoms but rather looks at the impact of the illness on the individual's ability to function within and as part of the community. Establishing goals with the individual and their family and looking at the steps needed to achieve these are important. A rehabilitation plan identifies areas for skill retrieval, skill development and community integration.

8 Reflections

In asking the students to write case histories, we do not just expect them to be "scribes". We encourage **critical thinking and reflection**. In this section of the Case History, we want you to reflect on what you have learnt from this case. For example this may include the impact it has had on you, whether the patient's needs were met, the feedback from the Confidential Feedback Questionnaire (below) or any important treatment or ethical dilemmas that arose.

9 Confidential Feedback Questionnaire

For each case history we would like you to submit a completed confidential feedback questionnaire from the patient. Please photocopy the questionnaire on page 29, check with the patient's doctor it is ok for the patient to complete the questionnaire and then ask the patient to complete it. When it is complete attach it to the case history when you submit it. This does not count as part of the 2000 word limit.

Confidential Feedback Questionnaire for completion by patient

Indicate how much you agree with the statements on the left side of the page by placing a tick in the relevant box

This doctor/student	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Unable to Assess
1. explained his role and purpose of the assessment						
2. listened to me						
3. treated me with respect						
4. showed interest in my problems						
5. asked appropriate questions about my problem(s)						
6. asked about details of personal life when appropriate						
7. seemed to understand my problems						
8. allowed me to refer to all my important issues						
9. answered my questions well						
10. showed compassion						
11. explained my illness or concern to me clearly						
12. respected my privacy and personal values						
13. performed an appropriate examination of my memory and concentration						
14. communicated well with me						
15. talked about my future care and what might happen next						
16. I would be happy to see this doctor/student again						

Child and Adolescent Psychiatry experience for 4th Year Medical Students

Welcome to Child and Adolescent Psychiatry!

As child psychiatric disorders are common (around 17% prevalence), under-recognised and under-treated we would like to ensure that you leave 4th year with an understanding of how to assess mental health problems in children and adolescents within a family context, a knowledge of common child and adolescent psychiatric illnesses and how to manage them.

We have a limited time to achieve these aims and unfortunately the child and adolescent services are too under-resourced to provide a worthwhile clinical experience, although we hope this will change in the next few years. We have organised the teaching in child and adolescent psychiatry to optimise the resources we have available but welcome feedbacks and suggestions, we are always keen to do better!

OUTLINE OF TEACHING IN CHILD PSYCHIATRY

There are two components of the Child Psychiatry teaching.

1 Assessment – These sessions are on Thursdays

Dates

Thursday 3rd March - 1:00pm – 4:30pm
Thursday 14th April - 1:00pm – 4:30pm
Thursday 23rd June - 1.00pm – 4.30pm
Thursday 4th August - 1:00pm – 4:30pm
Thursday 13th October - 1:00pm – 4:30pm

Timetable

a) Lecture – 1:00pm – 2:30pm
b) Video Session – 2:45pm – 4:30pm

At the end of this you will have enough information to fill in your logbook entry for child and adolescent psychiatry.

2 **Overview of Disorders and the Management**

Campus Block Teaching will be on the following days:

Tuesday 13 September
11:00am – 1:00pm
2:00pm – 4:00pm

Thursday 15 September
8:30am – 10:30am

READING ESSENTIAL

In response to student feedback in the past we have organised videos and vignettes to demonstrate different disorders in the campus block teaching. To get the most out of this you need to know the disorders beforehand. So please could you read the following which is available as a desk copy in the library.

Management of Mental Disorders WHO

Vol 2 Chapter 8 – Child & Adolescent Disorders

Vol 2 Chapter 5 – Schizophrenia

Vol 1 Chapter 3 – Mood Disorders

Chapter 4 – Anxiety and Somatoform Disorders

Child Psychiatry will be included in the end of year exam.

If you have any questions regarding the time table contact Saira Khan and about the teaching, exams you could contact Dr Louise Webster: LouiseW@adhb.govt.nz