The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Faculty of Psychiatry of Old Age 2024 Conference

The Art of Ageing

6 – 8 November 2024

Chateau on the Park, Christchurch, NZ

@RANZCP2024

Artwork by: Bronwyn Copeland

Contents

Disclaimer: The information provided in this handbook is for information purposes only and is not intended as an endorsement.

Conference support

The Organising Committee acknowledges the support of

The Selwyn Foundation

Welcome

Dear delegates,

The RANZCP Faculty of Psychiatry of Old Age is pleased to present the 2024 conference, focusing on the theme "The Art of Ageing". The conference will be held over two and a half days at Chateau on the Park in Ōtautahi Christchurch, New Zealand, from Wednesday 6 November to Friday 8 November 2024. The event will commence with a welcome function on the evening of Wednesday 6 November. Prior to this, there will be a trainee education afternoon workshop on Wednesday. The scientific program will run on Thursday and Friday.

Join us for a transformative experience featuring world-renowned old age psychiatrists, Professors Rob Howard and Sube Banerjee, as keynote speakers. Discover the latest advancements in old age psychiatry and connect with peers. The conference will also feature a vibrant mix of art displays and musical performances, celebrating the intersection of creativity and ageing.

Christchurch, set against the backdrop of the majestic Southern Alps and the serene Avon River, offers a perfect blend of urban innovation and natural beauty. The compact city centre makes it easy for delegates to explore the arts scene and beautiful gardens. For those wishing to venture beyond the city, the scenic beauty of Canterbury is just a short trip away. Day trips offer opportunities to experience the dramatic coastlines and charming villages that characterise the region. Additionally, the tranquil hot springs in Hanmer Springs, located approximately 130 kilometres north of Christchurch, provide a relaxing retreat. The natural thermal waters and breathtaking alpine scenery offer the perfect setting to unwind, making for a truly memorable visit.

Associate Professor Gary Cheung
Conference Convenor

Organising Committee

Dr Yoram Barak
Dr Christopher Bloomer
Dr Bronwyn Copeland
Dr Winifred Manning
Dr Anneliese Sayes

Conference management

Katrina Huntington, Conference Coordinator, RANZCP

Program

Wednesday 6 November 2024

11:00-17:00	**Registration open**
12:00-13:00	**Welcome to Country and conference opening** Jellurgal Aboriginal Cultural Centre
	Session Chair: Gary Cheung
13:00-14:00	Managing psychosis in older people more effectively **Professor Rob Howard**
14:00-15:00	Integrated and collaborative care: The importance of psychiatry of old age in the coming years **Associate Professor Ajay Macharouthu**
15:00-15:30	**Afternoon tea**
	Session Chair: Anneliese Sayes
15:30-16:30	Getting your research published **Professor Sube Banerjee**
16:30-17:00	Meeting with SATPOA **Associate Professor Gary Cheung & others**
17:30-19:30	**Welcome reception – Camelot Room**

Program

Thursday 7 November 2024

07:30-17:00	**Registration open**	
07:30-08:30	**Arrival tea and coffee**	
08:30-09:00	**Conference opening and Mihi Whakatau**	
Welcome addresses	**Session Chair: Gary Cheung**	
09:00-09:30	The Hon. Matt Doocey, Minister for Mental Health	
09:30-09:45	Dr Mark Lawrence, RANZCP	
Session 1	**Keynote presentation**	**Session Chair: Mark Lawrence**
09:45-10:35	Why is depression in dementia so difficult to treat and how should we manage it? **Professor Rob Howard**	
10:35-11:00	**Morning tea – Camelot Room**	
Session 2	**Invited presentations**	**Session Chair: Yoram Barak**
11:00-11:40	Changing how we conceptualise personality pathology in clinical practice **Professor Roger Mulder**	
11:40-12:20	The journey of MinDArT: a material and digital drawing programme for people living with neurological conditions and their supporters **Associate Professor Emma Febvre-Richards & Dr Susan Gee**	
12:20-13:00	**Lunch – Camelot Room**	
13:00-15:05	**Session 3a – Free papers** **Session Chair: Adam Sims** **Interface between psychiatric and neurodegenerative disorders**	**Session 3b - Free papers** **Session Chair: Noel Collins** **Improving services and care**
13:00-13:25	Sleep disorder in Alzheimer's dementia: exploring the potential mechanisms- A scoping review **Dr Ayobami Sulayman Yusuff**	Clinical and service design considerations for older adult Hospital in The Home (HiTH) services: Lessons from a Western Australian experience **Dr Chaitra Jose**
13:25-13:50	ECT in the management of treatment-resistant schizophrenia and comorbid Parkinson's disease **Dr Joe Wei**	Covert medication administration – A need for a position statement **A/Professor Ajay V Macharouthu**
13:50-14:15	Mindfulness-based cognitive therapy for family carers of relatives living with dementia: Results of a quasi-experimental feasibility study using mixed methods **Dr Emme Chacko**	Happiness diaries for older adults in an old-age-psychiatry day service **Shilmoni Moktan**
14:15-14:40	Psychological distress, self-reported diagnosis of mental disorders and risk of incident dementia in New Zealand **Dr Etuini Ma'u**	Live well: Enabling positive lifestyle changes during routine clinical care **Dr Carmelo Aquilina**
14:40-15:05	Estimating the impact of risk factor reduction on dementia prevalence in New Zealand **Dr Etuini Ma'u**	The Joint Solutions Project for Young-onset Dementia **Associate Professor Samantha Loi**

Program

Thursday 7 November 2024

15:05-15:25	**Afternoon tea – Camelot Room**	
Session 4	**Award and grant recipient**	**Session Chair: Chris Bloomer**
15:25-15:55	Distinguishing apathy and depression in dementia: A longitudinal study **Dr Michael Connors**	
Session 5	**Keynote presentation**	**Session Chair: Bronwyn Copeland**
15:55-16:45	Time for dementia – Creating a dementia-positive workforce **Professor Sube Banerjee**	
16:45-17:20	**Members forum – Dr David Lie, Chair, FPOA**	
18:30-20:00	**Conference dinner – Mona Vale Homestead** **Dinner speaker: Rachel McAlpine, Freelance journalist and author**	

Friday 8 November 2023

08:30-17:00	**Registration open**	
08:30-09:00	**Arrival tea and coffee**	
Session 6	**Keynote presentation**	**Session Chair: David Lie**
09:00-09:50	The drugs don't work – management of neuropsychiatric symptoms in dementia **Professor Sube Banerjee**	
Session 7	**7 Invited presentation**	
09:50-10:30	Parkinson's update: 10 tips you might find useful **Professor Tim Anderson**	
10:30-11:00	**Morning tea – Camelot Room**	
Session 8	**Invited presentations**	**Session Chair: Alice Law**
11:00-11:40	Understanding patient needs and improving care with big data **Associate Professor Hamish Jamieson**	
11:40-12:20	Chronobiological treatments for mood disorder **Professor Richard Porter**	
12:20-13:00	Elder abuse – Can we do better for our communities? **Associate Professor Yoram Barak**	
13:00-13:45	**Lunch – Camelot Room** **Presentation: Darral Campbell, Dementia Canterbury: Community activity groups for people living with dementia**	
13:45-15:00	**Session 9a – Free papers** **Session Chair: Bronwyn Copeland** **Advanced trainee and Scholarly Project presentations**	**Session 9b – Free papers** **Session Chair: Samantha Loi** **Research updates**

Program

Friday 8 November 2023

13:45-14:05	Dementia with Lewy bodies: A review of disease-modifying therapies for α synucleinopathies **Miss Arzoo Dar**	Testosterone levels and depression in older men **Dr Malcolm Forbes**
14:05-14:25	Singing groups for dementia: A systematic review of qualitative research. **Dr Anneliese Sayes**	Effect of ultra-processed food on depression and mental health in older adults: a target-trial emulation **Mr Belayneh Miteku**
14:25-14:45	A scoping review of the literature comparing the phenomenology of psychotic symptoms experienced by patients aged 65 years and older presenting with delirium and Alzheimer's dementia **Dr Shahzeen Fatima**	Exploring care of persons with dementia and significant violence risk in Victoria: A Delphi study **Dr Zoe Cousins**
14:45-15:05	Bipolar disorder and Lewy body dementia: a relationship and role of lithium in risk reduction **Dr Jasdeep Gill**	Impact of dementia mate ware and equity for Aotearoa (IDEA): A work in progress **Dr Jackie Broadbent**
15:05-15:35	**Afternoon tea – Camelot Room**	
Session 10	**Invited presentation**	**Session Chair: Winnie Manning**
15:35-16:20	Ketamine for treatment-resistant depression and anxiety **Professor Paul Glue**	
Session 11	**Closing and keynote presentation**	**Session Chair: Gary Cheung**
16:20-17:10	How should old age psychiatrists manage the advent of anti-amyloid therapies? **Professor Rob Howard**	
17:10-17:20	**Conference closing / Poroporoaki**	

Keynote speakers

Professor Sube Banerjee

Sube Banerjee is Executive Dean and Professor of Dementia in the Faculty of Health at the University of Plymouth. He trained at St Thomas's, The London School of Hygiene and Tropical Medicine, and the Institute of Psychiatry, King's College London. He served as the UK Department of Health's senior professional advisor on dementia leading the development of its National Dementia Strategy. His research focusses on quality of life and quality of care in dementia and the evaluation of new treatments and services. He works on health services, policy and strategies to improve health for older adults with complex needs and those with dementia. He practices as an old age psychiatrist and has been awarded national and international awards for policy and research in dementia.

Professor Rob Howard

Rob Howard is a professor of old age psychiatry at University College London and honorary consultant psychiatrist at the North London Mental Health Partnership. Through experimental medicine studies and pragmatic clinical trials, he works to understand the basis for symptoms of mental illness and dementia and test potential treatments. Rob has a longstanding interest in education and training in psychiatry and building capacity in our profession and within clinical academia.

Invited speakers

Professor Tim Anderson

Tim Anderson is the Cas Van Der Veer Chair in Parkinson's and Movement Disorders at the Department of Medicine, University of Otago, Christchurch and Clinical Director of the New Zealand Brain Research Institute (NZBRI) in Christchurch. Tim is Co-Director of the Christchurch Dementia Prevention Research clinic. His main clinical interests are in Parkinson's and Huntington's disease, and dementia. Research interests are in biomarkers of cognitive impairment and progression in Parkinson's disease, as well as many other aspects of Parkinson's – advanced brain imaging (MRI and PET), EEG, epidemiology, genetics, behavioural and other non-motor features.

Associate Professor Yoram Barak

Yoram Barak is an associate professor of psychiatry at the Otago School of Medicine, Dunedin and consultant psychogeriatrician at the SDHB. He is the convenor for fourth-year students for the department of psychological medicine.

Yoram trained in medicine and psychiatry at the Sackler School of Medicine, and in 1993 he became an Israel Medical Scientific Council Specialist in Psychiatry, and in 2004 was awarded a Master in Health Administration from Ben-Gurion University, Beer-Sheva, Israel.

Yoram was the medical director of Israel's inpatient psychiatric services for Holocaust survivors for 25 years. He is past president of the Israeli Association of Old-Age Psychiatry and is the associate editor for Aging Psychiatry of the Frontiers in Psychiatry.

Yoram's research interests include a wide range of psychiatric conditions with special emphasis on old-age psychiatry, dementia prevention and suicide. He has published extensively in these areas and is author or co-author of over 250 peer-reviewed journal articles. His book "Preventing Alzheimer's Disease" has been published in the US.

Associate Professor Emma Febvre-Richards

Emma Febvre-Richards is an artist, and an associate professor at Massey University Wellington. She is passionate about 'drawing is thinking' and its potential for cognitive health.

In 2018, Emma established MeDArT: Science, drawing and technology, to advance dementia research (medartdrawing.com). Most notably of which is MinDArT, an eight-week nature based sensorial material and digital drawing programme. Designed to enhance wellbeing, fine motor skills and communication for people living with dementia and their supporters. In 2024, this has expanded to include a study for stroke survivors in collaboration with The Burwood Academy Christchurch.

Emma has exhibited and published in Asia, Europe and the Pacific (EmmaFebvre-Richards.com), and is a co-founder of Drawing Open: an international drawing research community (drawingopen.com).

Invited speakers

Professor Susan Gee

Susan Gee is the lead researcher of the Psychiatry of Older Age Academic Unit at Health NZ I Te Whatu Ora Waitaha Canterbury. Susan is passionate about dementia mate wareware education, delirium prevention, and person-centred care. She also has roles as liaison officer for the New Zealand Dementia Foundation, and senior researcher with the Burwood Academy Trust.

Professor Paul Glue

Paul Glue is the Hazel Buckland Professor in Psychological Medicine at the Dunedin School of Medicine, University of Otago, New Zealand.

After graduating from Otago Medical School in 1980, Paul received psychiatry training in Auckland and in Oxford, UK, and obtained MRCPsych in 1986. Paul was elected to FRCPsych in 2010. He was involved with translational clinical pharmacology research in the pharmaceutical industry for 18 years. Paul has published over 480 papers and abstracts, has 13 patents and several international research awards and prizes.

Since 2009, Paul has been working as a consultant psychiatrist for the Southern District Health Board, in adult general psychiatry.

Paul has broad research interests, in pharmacology and clinical trials. Current active research interests include use of ketamine and psychedelic-assisted psychotherapy for treatment-resistant depression and anxiety disorders.

Associate Professor Hamish Jamieson

Hamish Jamieson is a geriatrician with Te Whatu Ora, Waitaha, New Zealand. His research interest focusses on understanding the large linked datasets on ageing that are collected in Aotearoa New Zealand as part of routine clinical assessments. This world-leading data provides novel insights into the needs of the older population. Hamish has published over 70 scientific papers covering dementia, carer stress, loneliness, falls and mortality.

Associate Professor Ajay Macharouthu

Ajay Macharouthu currently works as a staff specialist in consultation liaison psychiatry for older persons, and is ECT Director & Director of Training in Psychiatry at the Cairns & Hinterland Hospital & Health Services. Ajay is an adjunct associate professor at James Cook University, Cairns and the Deputy Chair of QDAF (Queensland Dementia Ageing Frailty) Network. Ajay has 27 years of psychiatry experience and is a Fellow of MD Psychiatry, India; MRCPsych, London & CCT in Old Age Psychiatry; FRANZCP, Australia. Ajay was the recipient of the RANZCP award for the Faculty of Psychiatry of Old Age prize for best mental health service improvement in the year 2022.

Ajay is the ex-chair of the Scottish Delirium Association and co-chaired the SIGN 157 Delirium Guideline. He was a research lead and principal investigator for several dementia drug trials and was involved in service development, integration & innovation projects and health policies.

Invited speakers

Professor Roger Mulder

Roger Mulder is professor and former Head of Department of Psychological Medicine, University of Otago, Christchurch. His major research interests are personality disorders, mood disorders, psychiatry and medical disorders, and psychiatric classification. Roger's clinical work is in consultation-liaison psychiatry. Roger has published over 350 articles and book chapters and been cited over 11,500 times. He is Co-Editor in Chief of Personality and Mental Health, Associate Editor of the New Zealand Medical Journal, and Chair of the World Psychiatric Association Personality Disorders Section.

Professor Richard Porter

Richard Porter is professor and Head of the Department of Psychological Medicine, University of Otago, Christchurch, and a consultant psychiatrist in a service for adults with intellectual disability. Richard trained in psychiatry in Newcastle-Upon-Tyne where his clinical training focussed on the treatment of resistant mood disorders. Recently his research has focused on psychological and chronobiological treatments for mood disorders and treatments for neuropsychological impairment in depression and bipolar disorder.

Events in Christchurch have also led to an interest in PTSD and the mental health effects of natural disasters and terrorism. He has published over 250 scientific papers. Richard is an author of the 2020 Royal Australian and New Zealand College of Psychiatrists Mood Disorder Guidelines and Deputy Editor of British Journal of Psychiatry Open.

Dinner speaker

Rachel McAlpine

Rachel McAlpine was born in Fairlie in 1940 and was first published in the Christchurch Press at the age of nine. She has written about 30 books, from poetry to manuals on digital content. For the last ten years all her work has issued a sympathetic challenge to ageism. Last year her play The Secret Lives of Extremely Old People sold out at Circa Theatre, and she hosts a podcast, Learning How To Be Old.

RANZCP Foundation

The RANZCP Foundation is the College charity. Our vision is Transforming mental health care, creating a world of potential. This is achieved through raising funds to support world-class research and the next generation of psychiatrists.

What we do

Your donations help drive new research and support the next generation reach their full potential. Our grant programs include:

- The Beverley Raphael New Investigator Grant for Trainees and Fellows new to research.
- The RANZCP Foundation Early Research Career Grants for Fellows who are new to and pursuing innovative research.
- The RANZCP Foundation Catalyst Grants for researchers at any stage to prepare a pilot or proof of concept.
- Two PhD scholarships – The Foundation Partners Scholarship and the Trisno Family Scholarship - to encourage and support members to pursue PhD research in psychiatry.
- The annual Wānanga for Māori psychiatrists.
- The Barnett Early Parenting Research and Collaboration Grant.
- The gamadji nanggit Scholarship to support the next generation of Aboriginal and Torres Strait Islander psychiatrists.
- The Pat, Toni and Peter Kinsman Research Scholarship for research into postnatal depression.
- The Psychotherapy Research Award for Trainees and recent Fellows.
- The Sved Williams Scholarship for Aboriginal and Torres Strait Islander Perinatal and Infant Mental Health.

Get involved

You can make a difference by joining the Foundation Partners Program (a powerful community of thought leaders leveraging philanthropy to drive change), creating a grant or award in an area you are passionate about, or donating to projects that make a direct impact.

Find out more: **www.ranzcp/Foundation**

Dementia Canterbury

Community activity groups for people living with dementia

Art Appreciation

A great idea for...

Art appreciation can provide stimulation and socialisation for people from all walks of life and abilities. Art offers a powerful mechanism for evoking memories, stimulating emotions, and encouraging people to share their thoughts and ideas in a in a threatening environment. People living with dementia maintain their consistent preferences for particular art styles, and the ability to express their opinions can provide not only a stimulating experience but also a reinforcement of their personal identity.

For example...

Artzheimers meets at the Christchurch Public Art Gallery fortnightly for an hour. An art gallery volunteer guide leads the group to specific pieces of art. While the group sits, the guide tells them about the artist before encouraging discussion and reminiscence.

Running the group involves collaboration between Christchurch Art Gallery and Dementia Canterbury volunteers and staff. Care-partners are welcome to attend but are asked to be silent observers during the discussion.

One of the strengths of Artzheimers is the success of reminiscence and opinion discussions in encouraging people to express themselves. For some it provides a boost to confidence that extends beyond the group.

Making art

A great idea for...

Creating art uses a different part of the brain than the area that controls spoken language, enabling some people a way to express themselves that doesn't rely on words. People who have never considered themselves 'artistic' may discover an outlet with help from art therapists, while past artists can find comfort and meaning in returning to creativity.

For example...

A "creative making" group meets in the purpose-built education workroom at the Christchurch Art Gallery once a month.

The Art Gallery educator introduces the group to a new artist (often a local New Zealand artist that is exhibiting in the Gallery) and gives insight into their history, inspiration and artistic process. The group is then led through a step by step process to create a work of art.

Different techniques and methods are used, such as painting, drawing, collage, screen printing etc. The results are often astounding and all are unique (like their creators), and are taken home with a sense of achievement and pride.

Gee, S., Campbell, D., Toothill, D. (2020) Community Activity Groups for People Living with Dementia: A Guide to Getting Started. Christchurch, NZ: South Island Alliance.

This guide is available to download at:
https://www.sialliance.health.nz/our-priorties/health-of-older-people/useful-resources/

Contact us

- Dementia Canterbury: 03 379 2590
  admin@dementiacanterbury.org.nz
- South Island Alliance: 03 378 6638
  admin.info@siapo.health.nz
- Canterbury District Health Board:
  susan.gee@cdhb.health.nz

Abstracts

Managing psychosis in older people more effectively

Rob HOWARD[1,2]

[1]*University College London*
[2]*North London Mental Health Partnership*

Treating symptoms of psychosis is one of the most satisfying aspects of working with older people. We have effective treatments that can reduce the experience of hallucinations and delusions or at least reduce the salience and intensity of associated feelings and thoughts. I will review the evidence for this in the patients we treat. Use of antipsychotics in older people carries significant risks and we can use an understanding of the pharmacokinetics and pharmacodynamics of antipsychotic drugs to choose optimal dosing and avoid some of the most common adverse events. I will talk about the treatment of patients with late life onset functional psychosis and psychosis in dementia and explain what we know about the therapeutic window for dosing and how it is affected by diagnosis, age and severity of cognitive impairment. I will also talk about clozapine and how important it is that we as old age psychiatrists are confident and supported to use the drug with our patients. Finally, I will talk about the difficulty of treating visual hallucinations and the emerging interest in 5HT3 antagonists to manage this.

The benefits of integration & collaboration of services: Focus on older Australians

Ajay MACHAROUTHU[1,2]

[1]*Cairns & Hinterland Hospital & Health Service*
[2]*James Cook University*

'An integrated older person service within front and back door of the hospital for a seamless patient journey and as well as in the community with the vision of keeping the consumer at home or a homely setting with the help of right staffing with the right skill set at the right place'.

Population projections of Australia suggest a rapid acceleration of over 65 age group in the next decade with more hospital beds occupied by older people. Innovations in service development and provision would be the key and the way forward is delivery of consumer-centred care for the older person with true integration of Old Age Psychiatry and Geriatrics with other stakeholders such as primary care & third (voluntary) sector for a seamless patient journey with better qualitative and quantitative outcomes.

The vision of this model of care is true integration and collaboration between various stakeholders involved in over 65 care within the front & back door of the hospital and as well as in the community. Integrated team within hospital will have a strong proactive presence in emergency department and short stay 'Medical Assessment Unit' for early assessment and management complimented with discharge planning of older persons presenting into the hospital domain. The back-door hospital policy involves inpatient shared care work between the two depts (CL older persons team & Inpatient geriatric team) addressing mental health issues in frail elderly with a view to effective discharge planning.

In addition, this integrated approach is extended to the outpatients in the form of a 'Delirium Clinic', a first in Qld addressing the cognitive and mental health aspects of delirium and have plans in starting an 'Integrated complex MH care needs specialist clinic for Elderly' once I get clinic space & AO input.

Community integration of Old Age Psychiatry & Geriatric teams would liaise with the primary sector and Care homes through a single point of contact thereby minimizing duplication and confusion amongst the stakeholder's referrals. The ethos of this model is to provide comprehensive and holistic care to the older adult in keeping the patient in the community through education and upskilling the community staff strategically.

The service innovation is underpinned with qualitative and quantitative outcomes related to length of stay and bed days saved and as well as reduction of re-admission and representation at ED which will be further evaluated. Mortality rates will be analysed with qualitative evaluation of patient, carer and staff experience. The plan is to commence a period of pilot with the completion of cost-effective analysis.

Overall, I believe that the consumer will benefit with better qualitative and quantitative outcomes with a significant potential for savings for the service by minimizing hospital admissions, supporting primary care in preventing unnecessary admissions and presentations at ED and facilitating early hospital discharges.

Abstracts

Why is depression in dementia so difficult to treat and how should we manage it?

Rob HOWARD[1,2]

[1]*University College London*
[2]*North London Mental Health Partnership*

Major depression affects around 50% of people with dementia caused by Alzheimer's at some point in their illness and around 15% of patients at any time will satisfy diagnostic criteria for this. Depression in dementia reduces functional ability, impacts on quality of life for patients and caregivers and hastens institutionalisation. As psychiatrists, we would like to think we have good tools to manage this. Drug trials have suggested little convincing efficacy beyond the effect of placebo and most psychological therapies (particularly those based in CBT) are reliant on the retention of reasonable memory abilities. It has been suggested that some antidepressant classes might be more likely to be effective than others, but there is no convincing evidence of this yet. There has also been interest in ketamine, although the potential for difficult-to-manage psychiatric side-effects is obvious. We recently looked at 8-session Problem Adaptation Therapy and found that it was welcomed and appreciated by patients and caregivers and led to small improvements in mood although these were not sustained. We plan to look next at a longer and more intensive intervention and to study the effect of combining antidepressant and psychotherapy as would be applied in treatment resistant depression in people who do not have dementia. Our field needs more research into the neurobiology of depression in neurodegeneration and to understand the neurotransmitter pathway dysfunction that underlies the symptoms that we see. I will briefly review current experimental medicine and RCT approaches to this.

Changing how we conceptualise personality pathology in clinical practice

Roger MULDER[1]

[1]*Univeristy of Otago*

A brief overview of the classification of normal and abnormal personality will be presented. A critique of both classifications and their historic lack of compatibility will be discussed. The new ICD-11 classification model will be described, including its relationship to traditional personality disorder categories as well as normal personality measures. The limitations of the current approach to treating personality disorder will be reviewed. Recently developed scales to measure ICD-11 personality disorder severity and the five domains, and their potential utility in clinical populations, will be presented. Finally, tentative recommendations for treatment based on ICD-11 personality disorder severity and maladaptive personality trait domains will be discussed.

The journey of MinDArT: a material and digital drawing programme for people living with neurological conditions and their supporters

Emma FEBRVRE-RICHARDS[1] **& Susan GEE**[2]

[1]*Massey University, Wellington*
[2]*Health NZ I Te Whatu Ora Waitaha Canterbury*

In 2016 Associate Professor Emma Febvre-Richards founded MeDArT, an international collaborative programme to encourage the integration of science, drawing and technology to enrich and enhance dementia mate wareware research. One of the keystone projects in the programme has been the development and evaluation of MinDArT: a material and digital drawing programme for people living with neurological conditions and their supporters that integrates mindfulness techniques with art-making. Between 2023 and 2024, the MindArt team conducted a crossover design study that revealed MinDArT was more effective than a social Memory Café intervention in reducing stress for people living with dementia mate wareware. Associate Professor Emma Febvre-Richards and Dr. Susan Gee will share this voyage and their results with you.

Abstracts

Sleep disorder in Alzheimer's Dementia: Exploring the potential mechanisms- A scoping review

Ayobami Sulayman YUSUFF[1]

[1]University of South Wales, Cardiff, United Kingdom

Background: Alzheimer's Dementia (AD) is the most common type of dementia, with insidious onset and characterized by a progressive impairment of behavioral and cognitive functions including memory, comprehension, language, attention, reasoning, and judgment. Along with progressive cognitive impairment, sleep disorders play a key role in the progression of AD and individuals with AD present with a wide variety of symptoms, including sleep disruption and sleep disorders (SD). Sleep is essential to the brain as it supports learning and memory, regulates synaptic plasticity, and enhances waste clearance from the brain.

Objectives: Despite growing evidence about the link between AD and SD, including its high prevalence, little is known about the potential mechanisms underlying SD in AD. In this review, an understanding of the potential mechanisms is sought, and how they may be of help to clinicians in the management of AD.

Methods: Multiple databases were systematically searched for this project. The keywords for the search criteria in the Boolean operators were words that describe 'Alzheimer AND sleep disorder' including 'neurodegeneration and sleep disturbance'. The search was done up until 9 January 2024.

Findings: 1,511 records were identified in the initial run. 1.2% of the studies met the eligibility criteria. 67% of the included studies explored mechanisms of sleep disorder using molecular tests whilst 33% focused on neuroimaging techniques. Genetics (33%) and AD proteinopathies (33%) were the most common tests recorded and the rest were melatonin disturbance (17%) and others 17% (interleukins and immunohistochemistry).

The results demonstrate:

i. Shared genetic mechanisms underlying development of both conditions;

ii. Disturbance of the glymphatic system through AD proteinopathies' toxicity;

iii. Disruption and dysregulation of the circadian system,

iv. Neuroinflammation;

v. Abnormal functional connectivity between associated and related brain regions and lastly;

vi. Atrophy of multiple brain regions involved in memory and sleep.

Conclusions: This review has identified varying mechanisms and pathophysiology linking AD and SD, it demonstrates the bidirectional and multifaceted relationship between the two. Not only does SD predates development of AD, but its manifestation is also worse in AD, progressing with severity. Thus, sleep might be a promising biomarker for AD, and targeting sleep may be an early potential therapeutic target in the management of AD.

Abstracts

Maintenance unilateral brief ECT in the management of treatment-resistant schizophrenia and comorbid Parkinson's disease

Joe WEI1, Vivek PHUTANE[1,2]

[1]Goulburn Valley Area Mental Health and Wellbeing Service, Shepparton, Australia
[2]University of Melbourne, Melbourne, Australia

The use of electroconvulsive therapy (ECT) has long been established as an effective treatment in treatment-resistant Schizophrenia. Its efficacy in improving both motor and non-motor symptoms of patients with Parkinson's disease have also been more widely studied in recent years. However, the current literature around the use of unilateral brief maintenance ECT (m-ECT) in both of these conditions have been limited.

We report and discuss the case of a 73-year-old gentleman with treatment-resistant Schizophrenia and Parkinson's disease, who received unilateral brief m-ECT for a period of 72 months. Prior to this, he had adequate trials of multiple typical and atypical antipsychotic medications with limited efficacy. He partially responded to Clozapine, but developed myocarditis twice. He was diagnosed with Parkinson's disease after careful evaluation by the neuropsychiatry team. ECT was initially considered primarily for the management of treatment-resistant Schizophrenia, on which he had significant remission observed by his treating team and family. Incidentally, he showed improvements in his motor symptoms of Parkinson's disease after ECT. His improvement was monitored through serial use of Brief Psychiatric Rating Scale (BPRS) and Unified Parkinson's Disease Rating Scale (UPDRS). A significant reduction in the number of inpatient stays, frequency of admissions and improvement to his quality-of-life were observed during m-ECT.

This case shows that unilateral brief m-ECT can be safely considered as a treatment option in treatment-resistant Schizophrenia and comorbid Parkinson's disease. To the best of our knowledge, this is the longest duration of unilateral brief m-ECT in the management of both of these conditions.

Mindfulness-based cognitive therapy for family carers of relatives living with dementia: Results of a quasi-experimental feasibility study using mixed methods

Emme CHACKO[1,2], Frederick SUNDRAM[1,3], Sarah CULLUM[1,4], Gary CHEUNG[1,5]

[1]The University of Auckland, Auckland, New Zealand;
[2]Practice 92, Auckland, New Zealand,
[3]Te Whatu Ora Waitematā Auckland, New Zealand,
[4]Te Whatu Ora Counties Manukau, Auckland, New Zealand,
[5]Te Whatu Ora Te Toka Tumai, Auckland, New Zealand

Background: In New Zealand, the prevalence of dementia will double over the next three decades with massive societal and economic implications. There is a dire need for effective and culturally safe interventions to support carers. Mindfulness-Based Cognitive Therapy (MBCT) was chosen as a potential intervention in the current study due to its robust evidence base in depressive disorder, and cost-effective group delivery mode including online delivery.

Objectives: To test the feasibility of an adapted MBCT programme for family dementia carers in Auckland.

Methods: A quasi-experimental, online intervention study was delivered in 2022, during the pandemic. Methods included quantitative outcome measures (pre-post) as well as in-depth qualitative analysis. The signed rank Wilcoxon test was performed for non-parametric paired outcome measures. A reflexive thematic analysis method was used to analyse and report the qualitative interviews.

Findings: Twelve participants were recruited into a single MBCT carer group with 11 out of 12 completers. Feasibility measures were positive with good satisfaction scores. Quantitative results showed significant improvements in stress, anxiety, burden, wellbeing, self-compassion and trait mindfulness. The primary outcome measure, the Perceived Stress Score showed a significant reduction (T0=19.2, T1= 13.9, p=0.007). Qualitative analysis suggested a journeying metaphor with three themes ("The perfect storm", "The life raft of MBCT" and "Steadying the course"). It has also shown potential for growth of positive emotions, not just the alleviation of distress.

Conclusions: The adapted MBCT protocol was well-received and attended, with promising results for carer stress. Efforts need to be directed at refinements for cultural sub-groups.

Abstracts

Psychological distress, self-reported diagnosis of mental disorders and risk of incident dementia in New Zealand.

Etuini MA'U[1], Naaheed MUKADAM[2], Gill LIVINGSTON[2], Gary CHEUNG[1], Sarah CULLUM[1]

[1]University of Auckland, Auckland, New Zealand
[2]University College London, London, United Kingdom

Background: It is unclear whether psychological distress and mental health disorders increase dementia risk. As there is increasing psychological distress and prevalence of mental health disorders over recent decades both globally and in NZ, it is important to understand their potential implications on dementia risk.

Objectives: This retrospective cohort study aim is to estimate the dementia risk associated with psychological distress and all severities of depression, anxiety, and bipolar disorder and to investigate whether being prescribed medication for these disorders affects this risk.

Methods: The New Zealand Health Survey (NZHS) collects a range of health-related information including psychological distress, and self-reports of ever having been diagnosed by a doctor with depression, anxiety, or bipolar disorder. Linking the NZHS to routinely collected health datasets identified incident cases of dementia. Cox regression models were used to calculate the hazard ratio for dementia for each of the risk factors after adjustment for age and sex.

Findings: All three MH disorders were associated with an increased hazard ratio of dementia, ranging from a 1.31 (95% CI 1.12-1.54) times increase for anxiety to a 2.69 (95% CI 1.87-3.86) times increase for bipolar disorder. Having any one of the mental health diagnoses was associated with a 1.40 (95% CI 1.26-1.57) times increased risk. Psychological distress was associated with a 2.19 (95% CI 1.90-2.51) times hazard of dementia for those scoring over the recommended cut-off for the Kessler K10.

Conclusions: This study demonstrates an increased dementia risk associated with mental disorders and psychological distress in NZ.

Estimating the impact of risk factor reduction on dementia prevalence in New Zealand

Etuini MA'U[1], Naaheed MUKADAM[2], Gill LIVINGSTON[2], Susanne RÖHR[3], Sebastian WALSH[4], Sarah CULLUM[1], Gary CHEUNG[1]

[1]University of Auckland, Auckland, New Zealand
[2]University College London, London, United Kingdom
[3]Massey University, Auckland, New Zealand
[4]University of Cambridge, Cambridge, United Kingdom

Background: While the theoretical prevention potential for dementia in New Zealand (NZ) is high, the assumption of complete risk factor elimination is not realistic. However, even modest reductions in risk factor prevalence will likely have some benefit in reducing dementia prevalence.

Objectives: The aims of this study are to calculate the potential impact fraction (PIF) associated with a 25% reduction in risk factor prevalence and model the impact of a reduction in risk factor prevalence on dementia prevalence projections for NZ and the four largest ethnic groups.

Methods: We calculated the PIF for 12 risk factors using previously published prevalence and relative risk estimates. We developed a Markov model to estimate the projected proportion of dementia prevented following a hypothetical intervention in midlife (age 40-64 years) that proportionally reduced risk factor prevalence by 25%.

Findings: The PIF associated with a 25% reduction in all 12 risk factors would result in a 14.6% (95% CI 7.7-21.1) reduction in dementia prevalence or an estimated 10,166 (95% CI 5396-14378) fewer cases for the total NZ population. Modelling demonstrated accumulating effects over time, from a 1.6% prevalence reduction at 10 years increasing to a 7.0% reduction in dementia prevalence 30 years post intervention. Both PIF and modelled reduction in prevalence projections were higher in Māori and Pacific peoples compared to European and Asian populations.

Conclusions: This study demonstrates that modest risk factor reductions have significant prevention potential and that the projected impact of interventions increase with time but vary by ethnicity.

Abstracts

Clinical and service design considerations for older adult Hospital in the Home (HiTH) services: Lessons from a Western Australian experience.

Chaitra JOSE[1]

[1]Hospital in The Home (HiTH), Lower West Older Adult Mental Health Service (LWOAMHS), Mental Health, Public Health and Dental Services (MHPHDS), North Metropolitan Health Service (NMHS), Perth, Australia.

Background: In Australia, there are few Hospital in The Home (HiTH) mental health services for older adults, relative to youth and adult sectors. Intensive home treatment programs can lead to improved patient satisfaction and outcomes. For this demographic, due to the prevalence of medical comorbidities, frailty, immunosuppression, cognitive impairment and generational attitudes towards mental illness, the risks of hospitalization are potentially accentuated. HiTH can provide an alternative to inpatient care or facilitate early hospital discharge. Careful patient selection and unique service design is necessary to avoid critical incidents and adverse outcomes, that may have been prevented with inpatient care.

Methods: Review of author's experiences as the team psychiatrist for the only HiTH service for older adults in Western Australia from 2022-2024. HiTH is an admitted service with eight beds and a multidisciplinary team including occupational therapist, physiotherapist, social worker and pharmacist.

Conclusions:

1. A range of conditions can be safely treated with HiTH admission including mood disorders, psychotic disorders, eating disorders and dementia.
2. Both voluntary and involuntary treatment can be provided by HiTH.
3. HiTH admission can be utilized to minimize involuntary treatment.
4. Careful risk assessment and patient selection is required – high risk patients can be admitted, provided the risk subtype can be monitored directly or by proxy. Phase of illness, substance misuse, family involvement and capacity are important considerations.
5. Some medical comorbidities preclude safe management in the HiTH setting; particularly if the mental health condition and its treatment directly impacts those.

Covert medication administration – A need for a position statement

AJAY MACHAROUTHU[1,2]

[1]Cairns & Hinterland Hospital & Health Service
[2]James Cook University

Background: The practice of covertly administrating medications to patients likely occurs in various settings which should be viewed from both a legal and ethical lens.

Objectives: Aim is to ensure person centred care and treatment with covert administration of medication which is lawful and ethical with consideration given to promoting patient's welfare with mental health, dignity and respect through patient and carer empowerment and as well as safeguarding the staff involved in patient care.

To ensure and promote person centred care and treatment in adults which is lawful and ethical whilst respecting the rights and freedom of individuals with mental illness, intellectual disability, dementia and other conditions. Be aligned with Principles of Guardianship and Administration Act, 2000, Human Rights Act, 2019 and Principles of Mental Health Act, 2016 and Medicines and Poisons Act, 2019. To provide a care pathway for its use with multidisciplinary team involvement with case examples to support the covert administration in various settings including hospitals, residential aged care facilities and supporting carers at home.

Methods: A multidisciplinary working group was created to provide expertise from a clinical and ethical perspective with clear terms of reference and timelines. The group reports to the Chief Psychiatrist with further liaison with Statewide older persons mental health group in Queensland, QDAF and QPMAC networks.

Findings/Conclusions: Outcomes would be discussed at the time of presentation.

Abstracts

Happiness diaries for older adults in an old-age-psychiatry day service

Dr Shilmoni MOKTAN[1]

[1]*MHSOP*

Background: Positive psychology has seen an intense focus of research and clinical applications in the last decade. Happiness Diaries (HD) have been shown to improve satisfaction with life in very large cohorts of adults. We have initiated a project using HDs for older adults attending a day mental health service.

Aim: To describe a 6 years' experience (2018-2024) using HDs in a cohort of older adults struggling with depression and anxiety.

Methods: Cognitively intact older adults attending the Dunedin Gibson Day Unit Mental Health Service who were struggling with anxiety or depression were presented with an educational session expounding on positive psychology. Following each session a practice demonstration of using the "Three Good Things" HDs was undertaken. Participants were than given an HD and encouraged to use it daily for the 12 weeks course in the day service.

Results: During the study period 103 participants, living independently in the community, mean age 75.6 (range: 65-84), 82 (79%) females received a HD. The great majority completed their daily HD task for the first 2 weeks and then adherence declined sharply. Reasons for discontinuing to practice with the HD were: lack of motivation, boredom and sense of purposelessness. The minority of participants who adhered to the HD instructions reported significant improvement in mood and were still adherent at 36 weeks of follow-up.

Conclusions: The positive psychology HD intervention may be useful for older adults. However, obstacles to adherence need to be examined and overcome.

Live well: Enabling positive lifestyle changes during routine clinical care

Carmelo AQUILINA[1] **and** Lachlan BEST[1]

[1]*Sydney South-West Local Health District, Sydney, NSW, Australia*

Background: Enabling healthy lifestyles should be a core element of all mental health care. Mental Health staff, however, often lack the time, and framework to enable consumers to improve healthy behaviours.

Objectives: To demonstrate the safety, acceptability, and effectiveness of a brief intervention that allows clinicians to help consumers make small, cumulative changes to healthy behaviours as part of routine clinical care.

Methods: Clinicians were trained how to recognise and encourage the different changes of behaviour change from pre-contemplation to action. Consumers were invited to reflect on their own lifestyle and future health goals. Background reading materials and short videos in six languages were developed for consumers to help choose what part of their lifestyle to address. A self-rated health and wellness questionnaire was developed to allow consumers to review their baseline lifestyle and to track progress. Consumers were helped set small sustainable goals using a specific, measurable, achievable, relevant, and time-bound (SMART) goal-setting tool.

Findings: A total of 65 existing consumers of Southwestern Sydney Older People's Mental Health service were registered, of whom 52 completed the trial intervention after 12 weeks. Self-reported outcomes at completion of 12-week reviews included the majority of consumers reporting improvements in wellbeing, goal achievement, and in health and wellbeing scores (HAWQ). No adverse events were reported.

Conclusions: Clinicians have a framework to introduce lifestyle issues to be part of any mental health discussion. When consumers are ready to change, Live Well provides a feasible structure to encourage small, sustainable improvements in consumer lifestyle and, over time, improve health and wellbeing.

Abstracts

The joint solutions project for young-onset dementia

Samantha LOI [1,2], Clare BEARD[3], Priscilla TJOKROWIJITO[1], Monica CATIONS[3], Nathan D'CUNHA[4], Jade CARTWRIGHT[5], Adrienne WITHAL[6], N MOYLAN[7], D STANGE[8]

[1]Neuropsychiatry Centre, Royal Melbourne Hospital, Victoria, Australia
[2]Department of Psychiatry, University of Melbourne, Victoria, Australia
[3]College of Education, Psychology and Social Work, Flinders University, South Australia, Australia
[4]Faculty of Health, University of Canberra, ACT, Australia
[5]College of Health and Medicine, University of Tasmania, Hobart, Australia
[6]University of New South Wales, New South Wales, Australia
[7]Brightwater Care Group, Perth, Western Australia, Australia
[8]Wesley College, Victoria, Australia

Background: Young-onset dementia represents 5-10% of all dementias, has a heterogeneous range of aetiologies affecting people of middle age with significant psychosocial impacts on the individual and their families. In Australia, diagnostic delay is the norm rather than the exclusion and post-diagnostic care is fragmented, poorly coordinated with difficulty in accessing age-appropriate services including the National Disability Insurance Scheme.

Objectives: The Joint Solutions Project is commissioned by the Australian Government aimed at mapping the Australian service system for people with young-onset dementia, investigating, gaps, barriers and positives.

Methods: Quantitative surveys were distributed nationally to consumer, clinical and service providers. Qualitative data was gathered from remotely conducted stakeholder focus groups. Findings and Conclusions Both data sets revealed a convoluted system with inconsistent approaches to care and services for people with young-onset dementia and their families. These results will contribute a lived experience perspective to inform a national pathway care.

Distinguishing apathy and depression in dementia: A longitudinal study

Michael H. CONNORS[1], Armando TEIXEIRA-PINTO[2], David AMES[3,4], Michael WOODWARD[5], and Henry BRODATY[1]

[1]Centre for Healthy Brain Ageing, Discipline of Psychiatry and Mental Health, UNSW Sydney, Sydney, Australia
[2]School of Public Health, The University of Sydney, Sydney, Australia
[3]National Ageing Research Institute, Melbourne, Australia
[4]University of Melbourne Academic Unit for Psychiatry of Old Age, Melbourne, Australia
[5]Austin Hospital, Heidelberg, Australia

Background: Apathy is a common symptom in dementia, though can be difficult to distinguish from depression due to shared features and frequent co-occurrence. As such, a significant limitation of much previous research on apathy is the failure to control for depression.

Objectives: The current study sought to address this by examining the trajectory and clinical correlates of apathy after controlling for depression.

Methods: Seven-hundred-and-seventy-nine patients with dementia were recruited from nine memory clinics around Australia. Measures of dementia severity, cognition, functional ability, neuropsychiatric symptoms, caregiver burden, and medication use were completed at baseline and at regular intervals over a three year period. Driving and institutionalisation data were obtained throughout the study. Mortality data were obtained from state registries eight years after baseline.

Results: Of 662 patients with completed measures of neuropsychiatric symptoms, 342 (51.7%) had apathy and 332 (50.2%) had depression at baseline, while 212 (32.0%) had both. Whereas apathy increased over time, depression remained relatively stable. Apathy, but not depression, was associated with greater dementia severity, poorer cognition and function, driving cessation, and mortality. Both apathy and depression were associated with greater neuropsychiatric symptoms, psychosis, caregiver burden, and institutionalisation.

Conclusions: Apathy increases over the course of dementia and is associated with worse clinical outcomes independent of depression. Distinguishing apathy and depression appears important given their different implications for prognosis and management.

Abstracts

Time for dementia – Creating a dementia-positive workforce

Sube BANERJEE[1]

[1]*University of Plymouth*

The delivery of healthcare to people with dementia is widely recognised as being sub-optimal and a lack of understanding about dementia in the workforce is seen as a contributing factor. The increasing numbers of people with dementia, driven by population ageing, demand a future healthcare workforce with the necessary knowledge, positive attitudes, and skills to deliver effective assessment and support to those living with the condition. To date, dementia education for undergraduate healthcare students has generally failed to meet this aspiration. With its reliance on didactic teaching and emphasis on acute episodes of care, there is a need for undergraduate teaching to adapt to produce a future multiprofessional workforce able to rise to the complex challenges of ageing and dementia for both generalists and specialists.

One programme that seeks to address is Time for Dementia (TFD). In TFD students are introduced to a family with dementia in their first or second year of training. Pairs of students then visit that family for at least two hours every 3–4 months for two years, learning from them, discussing the experiences of the family and developing a relationship with them. The purpose of TFD is that, through this interaction, the students build an understanding of dementia, ageing, the role of family carers in long term care and the response of health and social care systems to their problems. TFD is delivered as a mandatory component of the curriculum. This means that the whole year participates, not just those with an interest in dementia. It was also explicitly developed to be delivered to all healthcare student groups, not just medical students.

In this session we will discuss data from the programme of mixed methods research carried out with over 7,000 students and 4,000 families in the UK. Findings include: (i) significant improvements in attitudes and knowledge about dementia compared to students not taking part; (ii) increased numbers of visits associated with greater improvements in student knowledge and attitudes towards dementia; (iii) students feeling the impact of the programme lies in real-life learning and relationships with families; (iv) promoting a person-centred approach to dementia care, enhancing social comfort in interactions; (v) a key motivation for families to take part is altruism and wanting to improve the healthcare workforce; and (vi) families expressing high satisfaction and valuing their participation. The programme's model could be applied to training for other long-term conditions.

The drugs don't work – management of neuropsychiatric symptoms in dementia

Sube BANERJEE[1]

[1]*University of Plymouth*

Depression, agitation, and other neuropsychiatric symptoms (NPS) are a common challenge for people with dementia with profound negative impacts for them and their family carers. Non-drug care is first-line treatment, but evidence on medication use evidence is sparse, other than for antipsychotics in agitation which have significant harms. Antidepressants have increasingly been used as treatments for depression in dementia and as alternatives to antipsychotics in agitation, but with little evidence to support their use. Here we will review the status of NPS as a treatment target and the effectiveness of drug treatments using data from the SYMBAD and SADD RCTs. The concept of NPS in dementia being a complex problem requiring the skills of secondary mental health care and a multifaceted personalised approach will be explored. The limitations of seeking simple answers (such as medication) for a complex problem (NPS in dementia) will be discussed.

Abstracts

Parkinson's update: 10 tips you might find useful

Tim ANDERSON[1,2]

[1]Department of Medicine, University of Otago, Christchurch
[2]New Zealand Brain Research Institute (NZBRI)

Parkinson's disease (PD) is the fastest growing neurological disorder and as such has been termed a "pandemic", with numbers in Aotearoa NZ set to double in the next 20 years. Peak incidence and prevalence has shifted to be in the early 80's and, given that over 50% develop dementia (PDD), input from old age psychiatrists is likely to be increasingly required.

The lecture aims to provide an update on the epidemiology, genetics, neuropathology and neuroimaging of PD and PDD, provide tips on the prodromal and clinical diagnosis of PD and its differential, and outline an emerging diagnostic tool, the seeding amplification assay. Treatment options and complications (e.g. ICDS) particularly relevant to psychiatrists will also be discussed, including the management of psychosis and cognitive impairment. An argument for greater use of clozapine, and therefore sanction by psychiatrics, will be presented.

Understanding patient needs and improving care with big data

Hamish JAMIESON[1]

[1]Te Whatu Ora, Waitaha, New Zealand

We are entering a world where large datasets are going to help guide service provision. New Zealand has mandated a standardised assessment for older people requiring home services or are in a rest home. Over 120,000 of these standardised assessments are collected annually. The dataset, with now over 1,000,000 assessments which have been linked to hospital admission data (including ICD codes), prescribing data and mortality.

The presentation covers interesting and relevant findings from this big dataset including predictors of entering rest homes, mortality predictors and ethnic differences in outcomes.

Chronobiological treatments for mood disorder

Professor Richard Porter[1]

[1]University of Otago

All processes in the body occur in a cyclical rhythm, governed at a cellular level by gene transcription and at a higher level by light and social cues. Alterations in this circadian rhythm are potentially important in all mental health conditions, perhaps particularly mood disorders. Chronobiological treatments such as bright light or evening blue light blocking, particularly for bipolar disorder, have increasing evidence for effectiveness. Other simple and low risk chronobiological strategies may help sleep. This presentation will review and discuss this evidence particularly with reference to older people.

Abstracts

Elder Abuse – Can we do better for our communities?

Yoram BARAK[1]

[1]*The University of Otago*

Elder abuse (EA) has devastating and costly effects on the victim and society, yet often goes unidentified or unreported. Health care professionals are in a unique position to identify and intervene in elder abuse as they may be the only contact an elderly adult has outside of their home. There is agreement in the published literature that the issue of EA globally is not receiving attention adequate for the scale and severity of the problem. Globally, one in six people aged 60 years and older experience EA in the community annually, with potentially severe physical and mental health, financial, and social consequences.

While the development of high-quality screening tools may improve the identification of EA, providers need to be willing to use these tools in their practice. The interRAI is a collaborative network of researchers and practitioners in over 35 countries committed to improving care for persons who are disabled or medically complex.

Research by our group has shown that the interRAI-HC is neither sufficiently sensitive nor specific to detect suspicion of EA, capturing only 3% from a population of increased frailty and thus at higher risk of abuse. Analysis of nine years of interRAI-HC data encompassing 186,713 individual assessments from an Aotearoa New Zealand cohort identified that through altering the criteria for suspicion of EA, capture rates of at-risk individuals could be more than doubled from 2.5% to 5.9%. We propose that via adapting the interRAI-HC criteria to include the "unable to determine" whether abuse occurred (UDA) category, identification of EA victims could be substantially improved, facilitating enhanced protection of this vulnerable population.

Dementia with Lewy bodies: a review of disease-modifying therapies for α synucleinopathies

Arzoo DAR[1]**,** Tim GREEN[1]

[1]Hull York Medical School, York, United Kingdom

Background: Neurodegenerative disease prevalence is high in the elderly, as aged brains accumulate molecular and cellular damage. Protein misfolding and aggregation are pathological processes underlying neurodegeneration. Dementia with Lewy bodies (DLB) is characterised by Lewy bodies (LB) deposits, predominantly compromised of misfolded ā-synuclein protein. Disease modifying therapy (DMT) targets underlying protein misfolding and promotes LB clearance.

Aims & hypothesis: To review international trials investigating DMT in DLB.

Methods: Two international registries (ClinicalTrials.gov; EU clinical trials register) were consulted to identify agents being tested in completed, ongoing and recruiting trials. Both databases were searched by disease "Lewy body dementia" or "LBD" or "alpha-synuclein pathology" and study type "interventional" for phase 1-3 trials.

Results: 11 trials were reviewed. 10 out of 11 trials were in phase 2 and one in phase 1. Tyrosine-kinase inhibitors and ā GCase chaperones were the main agents investigated. Primary outcome measures were "safety/tolerability of agent", "changes in cognitive function or serum/CSF ā synuclein". Phase 1 nilotinib trials demonstrated increased mini-mental state examination scores at 6 months1. Slight reduction in CSF/plasma ā synuclein was observed. Bosutinib versus placebo trials showed no significant difference in cognitive function2. Ambroxol trials remained in the recruiting stage but have proven drug tolerability.

Conclusions: Current understanding of protein misfolding suggests that disease-modifying monotherapy may be insufficient in mixed pathology. DMTs have limited use as most patients are diagnosed with advanced DLB. Sensitive diagnostic biomarkers with high specificity are required for accurate DLB diagnosis in prodromal phase, for successful protein misfolding reversal with DMT.

References:

1. Pagan, Fernando, et al. "Nilotinib Effects in Parkinson'S Disease and Dementia with Lewy Bodies." Journal of Parkinson's Disease, vol. 6, no. 3, 2016, pp. 503-517, https://doi.org/10.3233/JPD-160867. Accessed 27 Jun. 2024.

2. Pagan, Fernando L., et al. "Safety, Target Engagement, and Biomarker Effects of Bosutinib in Dementia with Lewy Bodies." Alzheimer's & Dementia : Translational Research & Clinical Interventions, vol. 8, no. 1, 2022, https://doi.org/10.1002/trc2.12296. Accessed 28 Jun. 2024.

Abstracts

Singing groups for dementia: A systematic review of qualitative research

Anneliese SAYES[1]

[1]*Te Toka Tumai, Auckland, New Zealand*

Background: Worldwide, dementia is highly prevalent, causing significant personal and carer distress, reduced wellbeing, and quality of life, along with behavioural, psychological, and cognitive symptoms. Music-based interventions are social programs that can meet the complex needs and address social factors for people living with dementia.

Objectives: This study aimed to identify key features in delivering group singing interventions, explore their effects from the perspectives of dementia patients and their carers, and examine the feasibility of these interventions.

Methods: A systematic review of qualitative literature was conducted using electronic databases with the terms (Dementia OR Alzheimer's) AND (Group singing OR choir). Data were analysed thematically, and quality was assessed using the Mixed Method Appraisal Tool version 18.

Findings: Six studies were included. Key features of delivering group singing interventions included engagement of the person with dementia, choice of music, facilitator factors, and creation of a safe environment. For patients, positive impacts on mood, cognitive stimulation, reminiscence, new relationships, and identity, hope, and personal growth were noted. For the dyad, themes included the impact of dementia on the relationship, lasting benefits, and the effect of group singing on the relationship. For carers, support, identity, and positive impacts on mood were highlighted. Only three studies considered feasibility

Conclusion: Group singing interventions show promise in addressing the complex needs of dementia patients, positively impacting their mood, cognitive function, relationships, and overall well-being, as well as providing support and benefits for carers. However, further research is needed to fully understand the feasibility of these interventions.

A scoping review of the literature comparing the phenomenology of psychotic symptoms experienced by patients aged 65 years and older presenting with delirium and Alzheimer's dementia

S FATIMA[1]**,** A TEODORCZUK[1], S PARKER[1]

[1]*The Prince Charles Hospital Brisbane Australia*

Background: Distinguishing delirium from Alzheimer's dementia in older patients is a challenge in clinical practice. There is limited literature that compares the phenomenology of psychotic symptoms in these conditions.

Objectives: This scoping literature review compared the phenomenology of delusions and hallucinations experienced by patients aged 65 and older presenting with delirium and Alzheimer's dementia.

Methods: A scoping review was completed following the modified six-step framework. The search strategy was implemented across Medline, CINAHL, APA Psychinfo, Embase and Cochrane Central Register of Controlled Trials databases. A narrative synthesis was completed, and quantitative comparisons were made between weighted average score for the frequency of psychotic symptoms in Alzheimer's dementia and the single study identified considering this in a delirium sample.

Findings: Twenty-four articles were included in the narrative synthesis. Hallucinations are more common in patients with delirium than those with Alzheimer's dementia (50.x% v 10.2%, p<.000). Visual (p<.000) and auditory (p<.009) were the only hallucinations where comparisons significantly differed.

Similarly, the prevalence of delusions in delirium where relevant data was available was significantly higher than for Alzheimer's dementia studies (40.9% v 21.7%, p<.000). In delirium, visual hallucinations were the most common type reported in 50% of the patients. Paranoid delusions and delusional misidentifications occurred frequently in Alzheimer's dementia (1.6% and 11.7% respectively).

Conclusions: There is limited literature considering the phenomenology of delusions and hallucinations in the context of delirium. The literature suggests both these psychotic symptoms are more common in delirium than Alzheimer's dementia. Future research is required to explore this further.

Abstracts

Bipolar disorder and Lewy body dementia: a relationship and role of lithium in risk reduction

Jasdeep GILL[1]

[1]*Fremantle Hospital, Perth, Australia*

I present the case of a 68-year-old lady with young-onset bipolar disorder (BD) and Lewy body dementia (LBD) presenting with upper limb stiffness, passage phenomenon, and feeling of presence, the latter two being a form of visual hallucinations referred to as minor phenomena.

Discussion: Determining the aetiology of Parkinsonism in BD can be challenging. While one reason is side effects of neuroleptics, in older adults with BD, motor, autonomic and cognitive disturbances may be secondary to LBD. Research suggests that patients with young-onset BD have increased risk of cognitive impairment later in life, with some also presenting with Parkinsonism, visual hallucinations, cognitive fluctuations, and REM-sleep behaviour disorder (1). The pathophysiological relationship between BD and LBD can be explained by the dopamine dysregulation hypothesis: that recurrent mood states cause dopaminergic system abnormalities, resulting in Parkinson's-related diseases (2).

Lithium is neuroprotective and effective in preventing relapse in BD. It may also reduce the risk of neurodegenerative diseases, including that of LBD, irrespective of its mood-stabilising properties (3).

References:

1. Khosravi M. Lewy body dementia in an elderly patient with bipolar disorder: challenges and treatment options. Bipolar Disord. 2021 Nov;23(7):736-9. doi:10.1111/bdi.13079.

2. Dols A, Lemstra AW. Parkinsonism and bipolar disorder. Bipolar Disord. 2020;22:413–5. doi:10.1111/bdi.12888.

3. Nakamura S, Sugawara H, Asada R, Hatanaka A, Hori H. Bipolar disorder and Lewy body dementia: case report and literature review. Front Psychiatry. 2024;15:1409027. doi:10.3389/fpsyt.2024.1409027.

Abstracts

Testosterone levels and depression in older men

Malcolm FORBES[1], Cammie TRAN[2], Mohammadreza MOHEBBIi[1], Michael BERK[1], Robyn WOODS[2], John MCNEILI[2]

[1]Deakin University, The Institute for Mental and Physical Health and Clinical Translation (IMPACT), School of Medicine, Geelong, Victoria, Australia
[2]School of Public Health and Preventive Medicine, Monash University, Melbourne, Victoria, Australia

Rationale: I'm a consultant old age psychiatrist with an interest in late-life depression. This is the first of two abstract submissions for oral presentations. If only one presentation can be given, I would prefer this paper be accepted over the anaemia and depression paper.

Our findings are pertinent to the theme of the Faculty of Psychiatry of Old Age 2024 Conference, "The Art of Ageing." As the conference focuses on advancements in old age psychiatry and improving mental health care for older adults, our research provides critical insights into the hormonal influences on mental health. There has been a growing interest in this area over the past decade and the use of testosterone supplementation usage is rising among older men. Understanding the relationship between testosterone levels and depression can inform better diagnostic and therapeutic strategies for managing depression in older men, aligning with the conference's goal to enhance the mental health and well-being of the ageing population.

Background: The relationship between testosterone levels and depressive symptoms in older men remains unclear.

Objectives: This study aims to examine the association between testosterone levels and depressive symptoms in older men. Specifically, it investigates whether low testosterone levels are associated with a higher incidence of depression and whether changes in testosterone levels over time predict depressive symptoms.

Methods: We analysed baseline and follow-up data from Australian and US male participants in the ASPREE (ASPirin in Reducing Events in the Elderly) trial and the ASPREE-XT (extension) study. Testosterone levels were measured at baseline and year 3, and depressive symptoms were assessed using the CES-D-10 scale. Cox proportional hazards regression models were used to analyse the association between testosterone levels and depressive symptoms, adjusting for confounders such as age, smoking status, education level, BMI, living status, medical comorbidities, and cognitive function. Patients with baseline depression or taking antidepressants at baseline were excluded.

Results: Of the 16,703 Australian ASPREE participants eligible for clinical biochemistry collection, 7,524 were male. After excluding those receiving contraindicated medications, including androgen supplements or anti-androgen therapies, along with those with a history of prostate cancer, there were 4,107 men included in the primary analysis. The median age was 73.8 years and participants were followed-up for a median of 8.4 years (IQR 2.2 years). Neither baseline testosterone concentrations nor change in testosterone level over time predicted incident depression, after adjusting for potential confounders.

Conclusion: Low testosterone levels are not associated with incident depression. Testosterone levels are unlikely to play a significant role in the aetiology of late-life depression in some men.

Abstracts

Effect of ultra-processed food on depression and mental health in community-dwelling older adults: A target trial emulation

Belayneh Mengist MITEKU[1], Mojtaba Lotfaliany[1], Julie A. Pasco[1], Bruno Agustini[1], Michael Berk[1], Malcolm Forbes[1], Mohammadreza Mohebbi[2]

[1]Deakin University, the Institute for Mental and Physical Health and Clinical Translation (IMPACT), School of Medicine, Geelong, Victoria, Australia
[2]Biostatistics Unit, Faculty of Health, Deakin University, Geelong, Victoria, Australia

Background: The effect of UPF on depressive and mental health symptoms in older adults is uncertain.

Objective: To investigate the effect of UPF on depression and mental health in community-dwelling older adults.

Methods: A pragmatic target trial was designed and emulated using the ASPirin in Reducing Events in the Elderly longitudinal data. Participants were community-dwelling older adults (>70 years) in Australia followed for a median of 5.8 years. We emulated the protocol of a two-arm pragmatic RCT using level of UPF consumption as the intervention (≥4 servings of UPF). Diet was assessed using a mail-based diet screening questionnaire and food processing level was classified based on the NOVA classification. Depression defined as a score of ≥8 on the Center for Epidemiological Studies Depression 10-item scale, and general mental health, defined by the mental component of the SF-12. We applied inverse probability treatment weighting to balance potential confounders. Marginal structural models were employed to estimate the population-level average causal effect of intervention using generalized estimated equations.

Result: A total of 11,192 participants (3,415 intervention and 7,777 controls) were included. High UPF consumption at time zero was linked with an increased risk of depression at follow-ups (RR: 1.17; 95%CI: 1.09-1.24). The finding was consistent with sensitivity analyses, after excluding participants on antidepressants at time zero (RR: 1.18; (1.09-1.26)). Consumption of UPF also adversely affected the SF-12 mental component (mean difference: -0.58; (-0.83- -0.33).

Conclusion: A higher level of UPF consumption increased the risk of depression and adversely affected mental health among older adults, suggesting a possible causal relationship.

Exploring care of persons with dementia and significant violence risk in Victoria: A Delphi study

Zoe COUSINS 1,2, Sam PANG[1,2], Thomas REGO[2,3,4]

[1]Victorian Institute of Forensic Mental Health, Melbourne, Australia (Forensicare)
[2]Department of Psychiatry, The University of Melbourne, Melbourne, Australia
[3]Northern Health, Melbourne, Australia
[4]The Royal Melbourne Hospital, Melbourne, Australia

Background: It is expected that over the next 40 years, the Australian population aged over 65 years will double, and over 85 years will increase threefold (1). This expanded aging population will likely mean increased persons living with dementia, of which a small proportion of will experience a significant risk of violence. This sub-population is heterogeneous, with complex ethical, legal, and medical issues. Currently, in Victoria, there is no specific service designed to meet the needs of this group, with limited specific research into their care needs.

Objectives: This study aimed to explore the current service landscape for persons with dementia and significant violence risk in Victoria through a small group of medical practitioners with expertise in dementia, aged psychiatry, and forensic psychiatry.

Methods: A modified two-phase Delphi study was used to interview 12 medical practitioners with backgrounds including Forensic Psychiatry, Psychiatry of Old Age, General Practice, and Geriatric Medicine.

Findings: The research identified five key recommendations to enhance service provision for this population in Victoria, including recommendations for specific care pathways, service agreements, physical environment considerations, educational needs, and consideration of a specialised service.

Conclusions: To the author's knowledge, this is the first study to specifically examine the care available for persons with dementia and significant violence risk in Australia. Whilst this population is small; it is evidently a population with scope for improved care and service provision, particularly as this population is likely to expand.

References: 1. Commonwealth of Australia. Intergenerational Report 2023. Australia, Treasury T; 2023.

Abstracts

Impact of Dementia mate wareware and Equity for Aotearoa (IDEA): A work in progress

Jackie BROADBENT[1], Sarah CULLUM[2], Gary CHEUNG[2], Xiaojing (Sharon) WU[2], Rita KRISHNAMURTHI[3], Susan YATES[2], Lynette TIPPETT[4], Ngaire KERSE[2]

[1]Health NZ Te Whatu Ora- Canterbury Waitaha, Christchurch NZ
[2]Department of Psychological Medicine, School of Medicine, University of Auckland, NZ
[3]National Institute for Stroke & Applied Neurosciences, Auckland University of Technology, NZ
[4]School of Psychology, University of Auckland, NZ
[5]Department General Practice and Primary Health Care, School of Population Health, University of Auckland, NZ

Background: The population with dementia in New Zealand is approximately 70,000 and is projected to triple in 30 years. However, the true prevalence of dementia in New Zealand is unknown, as estimates are extrapolated from overseas data.

Objectives of IDEA study: The IDEA programme will establish the true prevalence of dementia in New Zealand's Pākehā, Chinese and Indian populations, to enable equity analyses with Māori and Pacific populations, and then co-design fit-for-purpose services for these populations.

Methods: Methods are based on a previous feasibility study,1 selecting geographical meshblocks in urban and rural areas of Auckland and Christchurch with high proportions of older Indian and Chinese residents in addition to Pākehā. Multiethnic interviewers with appropriate language fluency door-knock in the selected meshblocks, completing door-step cognitive screening, and recruit a random sample of 65+ year olds for a full interview using the 10/66 dementia protocol.

Findings: This presentation will describe the first 6 months of the project, including experiences of the door-knocking team, progress on recruitment, and initial indications of dementia prevalence in ethnic groups. While final results will not be available, background methods and progress will be informative and stimulate debate.

Conclusions: This significant study is essential for New Zealand health service planning. An accurate and nuanced understanding of populations living with dementia is crucial to optimize the brain health of older people and their families/whānau in the future.

1 Martinez-Ruiz, A., Yates, S., Cheung, G., Dudley, M., Krishnamurthi, R., ... & Rivera Rodriguez, C, & Cullum, S. (2024). Living with Dementia in Aotearoa (LiDiA): A Feasibility Study for a Dementia Prevalence Study in Māori and Non-Māori Living in New Zealand. Dementia, 23(3), 343-365.

Ketamine for treatment-resistant depression and anxiety

Paul GLUE[1]

[1]Dunedin School of Medicine, University of Otago, New Zealand

Over the past 20 years ketamine has been identified as a highly effective antidepressant medication, with a much faster onset of activity compared with conventional antidepressants. Most clinical trial data are from non-elderly adults, but there are two promising trial results in elderly depressed patients. More recent research has identified a much broader spectrum of activity across all internalizing disorders (anxiety, PTSD, OCD), and suggests that ketamine may be working via a more fundamental neural mechanism than conventional antidepressants. If given by injection or intranasal routes, ketamine has strong side effects (e.g. dissociation, sedation) and needs to be given in a clinic. Alternative routes of administration may make it easier to dose patients at home.

Abstracts

How should old age psychiatrists manage the advent of anti-amyloid therapies?

Rob HOWARD[1,2]

[1]*University College London*
[2]*North London Mental Health Partnership*

The arrival of anti-amyloid drugs that can effectively clear amyloid from the brain of people with Alzheimer's disease and whose use has been associated with small reductions in cognitive and functional deterioration at the very earliest symptomatic stages has been a once in a generation event for us. As the dust settles from scientific and marketing presentation of the trials and consideration by licensing authorities and bodies who consider cost-effectiveness within public health systems, this is a good time to reflect on how the patients and families we see and the systems we work within can be best served.

The international regulatory environment is still considering how to receive these drugs. For lecanemab, the European Medicines Agency considered that any treatment benefits were outweighed by the risks of ARIA and the National Institute for Health and Care Excellence decided that small and uncertain benefits did not justify drug costs plus costs involved in delivery, safety monitoring and assessing when to stop. These decisions were controversial and illustrate how marginal and unclear the benefits, risks and costs are.

Our patients, their families and many of our colleagues will have heard things about the efficacy of these treatments that are not true. A good starting point for us would be to ensure that we have understood and can communicate exactly what the data show these drugs can do. We should all take the time to familiarise ourselves with the pivotal phase 3 trials of both lecanemab and donanemab and be able to critically appraise what the data mean for treated patients. In particular, we should understand the limitations of claims for percentage disease slowing, months of time saved and long-term benefits with treatment.

Poster

Retinal inner nuclear layer thickness may be a non-invasive diagnostic tool for cognitive impairment in mouse models of natural ageing.

Jack Jonathan MARAN[1], Moradeke M. ADESINA[2], Colin R. GREEN[2], Andrea KWAKOWSKY[3,4,5], Odunayo MUGISHO[1,2]

[1]Buchanan Ocular Therapeutics Unit, Department of Ophthalmology, New Zealand National Eye Centre, University of Auckland, Auckland, New Zealand.
[2]Department of Ophthalmology, New Zealand National Eye Centre, University of Auckland, Auckland, New Zealand.
[3]Centre for Brain Research, University of Auckland, Auckland, New Zealand.
[4]Department of Anatomy and Medical Imaging, University of Auckland, Auckland, New Zealand.
[5]Pharmacology and Therapeutics, School of Medicine, Galway Neuroscience Centre, National University of Ireland Galway, Galway, Ireland.

Background and Objectives: Major neurocognitive disorder (NCD) affects over 55 million people worldwide and is characterized by cognitive impairment (CI). However, the early diagnosis of NCD poses numerous challenges due to insidious symptoms and limited objectivity during clinical investigation. This study aimed to develop a non-invasive diagnostic test for CI based on retinal thickness measurements explored in a mouse model of natural ageing.

Methods: Discrimination indices (a surrogate measure of cognitive impairment in mice) and retinal layer thickness of healthy C57BL/6J mice were quantified repeatedly while mice aged through a novel object recognition test (NORT) and ocular coherence tomography (OCT), respectively. The relationship between retinal layer thickness and discrimination indices was examined with multiple linear regression. Subsequently, a diagnostic test was generated by transforming data into rolling monthly averages and categorizing mice into those with and without CI and those with a high or low decline in retinal layer thickness, based on criteria from the Diagnostic and statistical manual of mental disorders 5th ed. (DSM-V),

Findings: Only retinal inner nuclear layer thickness had a statistically significant relationship with discrimination indices ($p = 0.0123$). Furthermore, our diagnostic test revealed that the change in inner nuclear layer thickness was 85.71% sensitive and 100% specific for diagnosing CI, with a positive predictive value of 100% ($p = 0.0099$).

Conclusions: Changes in retinal inner nuclear layer thickness over time may assist in the early diagnosis of CI in NCD. However, further investigation and validation in comorbid mice and humans is warranted prior to clinical application.

Social functions

Welcome reception

Date: Wednesday 6 November 2024

Time: 17:30-19:30

Venue: Camelot Room

Cost: Included in conference registration

Dress code: Smart casual

Canapés and drinks will be served.

Conference dinner

Date: Thursday 7 November 2024

Time: 18:00-21:30

Venue: Mona Vale Homestead and Restaurant, 40 Mona Vale Avenue, Fendalton, Christchurch

Cost: $175, pre-registration required

Dress code: Smart casual

General Information

Enquiries

Please speak to staff at the registration desk if you require any assistance. The registration desk will be open during the following times

Wednesday 6 November 2024	11:00 – 17:00
Thursday 7 November 2024	07:30 – 17:00
Friday 8 November 2024	08:30 – 17:00

Name badges

You will be provided with a name badge at the registration desk upon arrival at the conference. Please wear this badge for the duration of the conference, including during social functions.

Certificates of attendance

Certificates of attendance will be emailed to all delegates after the conference.

Continuing Professional Development

In accordance with the RANZCP CPD Program Guide, credit for participation in this educational activity may be categorised under Section 4: Self-guided learning.

Wi-Fi

Complimentary Wi-Fi is available at the conference venue.
Login: CONFDTCHCH
Password: CONFDTCHCH

Refreshments & dietary requirements

A light working lunch and afternoon tea will be provided on Wednesday. Morning tea, lunch and afternoon tea will be provided on Thursday and Friday. If you have notified the organisers of any dietary requirements you have, please make yourself known to a venue staff member at catering times.

Electronic devices

Please ensure your electronic devices (mobile phone, laptop, iPad etc.) are in silent mode or switched off during conference sessions.

Special requirements

Every effort has been made to ensure that delegates with special requirements are catered for. To assist us with ensuring your attendance at the conference is a pleasant and comfortable one, please advise staff at the registration desk of any special requirements you have.

Standards of conduct

Attendees of RANZCP events and meetings are expected to be considerate, respectful and collaborative, and be mindful of their surroundings and of other participants at all times. The RANZCP has a zero-tolerance approach to any form of discrimination or harassment, including but not limited to sexual harassment.

All participants in RANZCP events and meetings should:

- engage in conduct that is respectful of difference and does not discriminate
- take reasonable precautions for their own health and safety, and that of other staff or guests
- not engage in behaviour that may be reasonably perceived as harassing, intimidating, overbearing, bullying or physically or emotionally threatening, and
- refrain from any conduct which could adversely affect professional performance or the safety and well-being of themselves or others, including alcohol or substance abuse or misuse.

COVID Safety

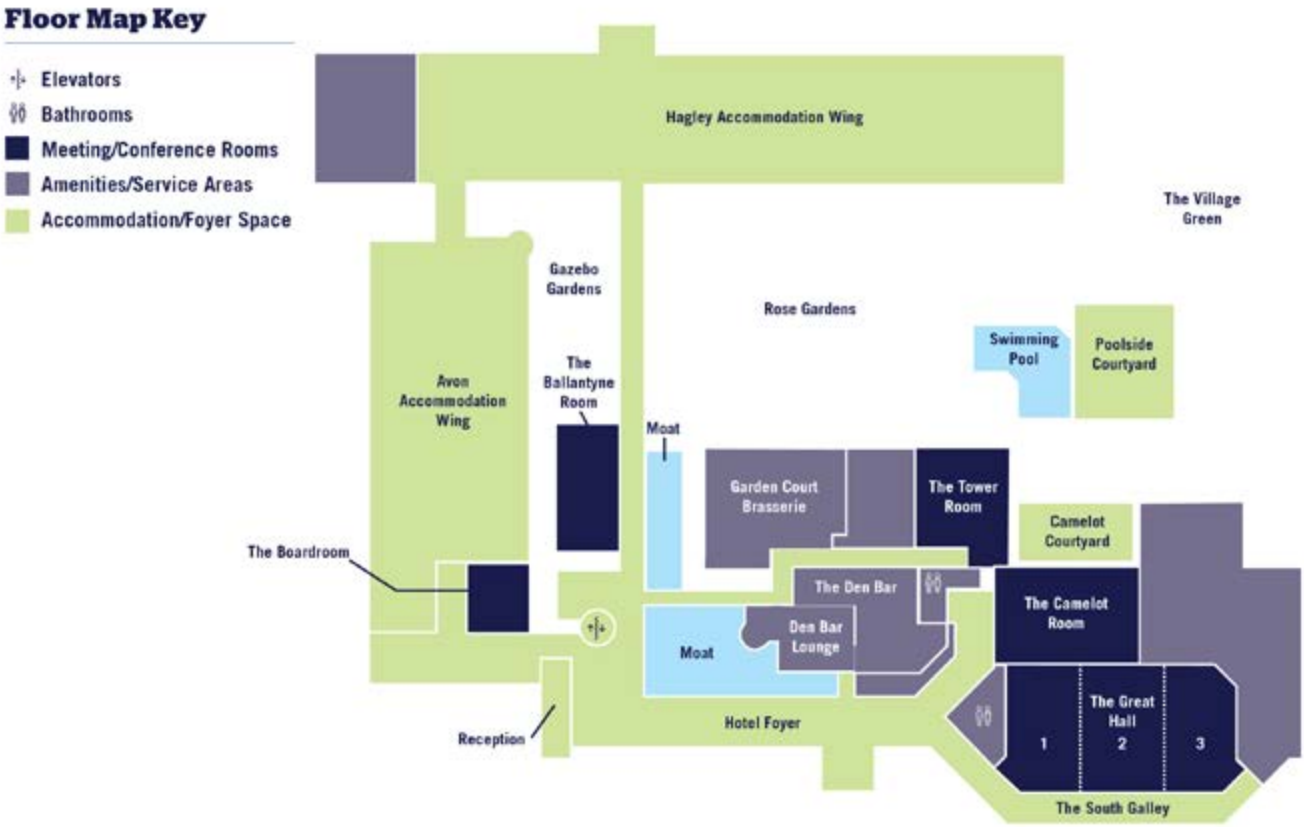
The health and safety of conference attendees is our highest priority. All attendees are expected to take personal responsibility for their safety during the event by practicing good hygiene; cleaning hands frequently with soap and water or hand sanitiser; and maintaining appropriate social distancing where possible. Face masks are an important and simple measure that can be taken to help prevent the transmission of COVID-19 and other airborne diseases. We encourage all delegates to bring and wear their own mask if they feel comfortable doing so.

Please do not attend the conference if you are feeling unwell or have tested positive for COVID-19 in the immediate lead-up to the conference. If you become COVID positive during the conference, please do not attend and let us know via email to events@ranzcp.org.

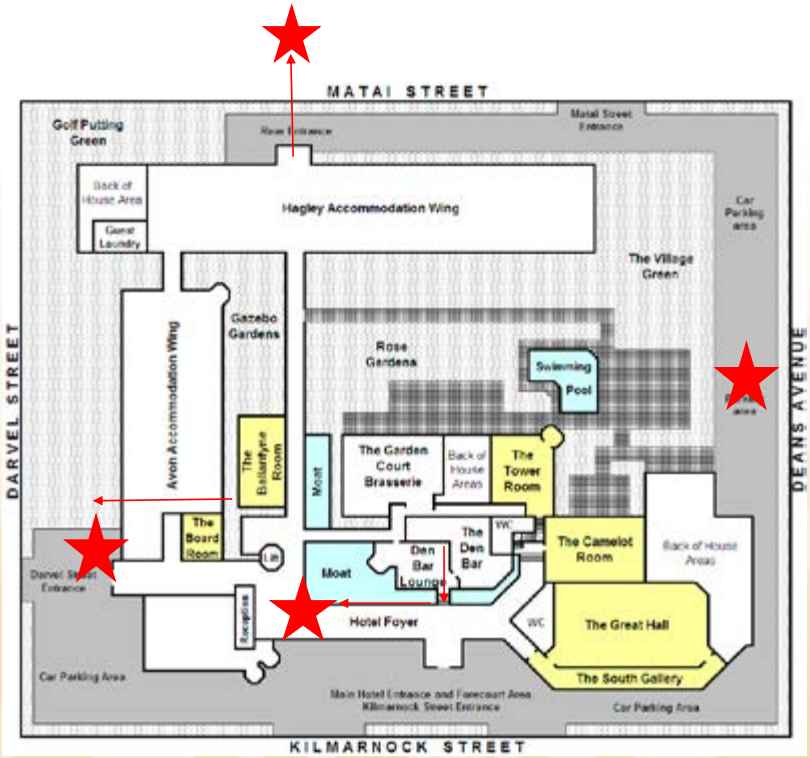
Photography

Photographs may be taken during sessions and in breaks for use on social media. If you do not wish for your image to appear in any published photographs, please email events@ranzcp.org.

Venue and map



Emergency evacuation procedure



Emergency evacuation procedure

IN THE EVENT OF AN EARTHQUAKE

- Move away from windows and any equipment or furniture which may be dangerous if it falls
- Stand in a doorway or beside a solid object, or crouch under a table, and hold on until the shaking stops
- Remain in the building - do not go outside unless directed to by a hotel staff member
- If directed outside, follow standard evacuation procedures

STANDARD EVACUATION PROCEDURES

Upon hearing the continuous sounding of the fire alarms:

- Leave the building immediately via the nearest emergency exits which are clearly marked
- Walk in an orderly fashion – Remain calm – DO NOT RUN
- Do not use the elevators
- Do not stop to take personal belongings with you
- Keep together with the people around you
- Once you have left the building, do not return
- Make your way to the designated meeting point
- At the designated meeting point keep your group together
- Event organiser to advise a hotel staff member of the group's safe arrival

IF A FIRE IS DISCOVERED

- Raise the alarm by operating the closest fire alarm (located next to all emergency exits)
- Call the Fire Brigade by dialling 111 and alert a staff member to the emergency
- Follow the standard evacuation procedure

DESIGNATED MEETING POINTS

- The designated meeting point in an emergency is the carpark in the hotel grounds, on the Corner of Darvel Street and Kilmarnock Avenue – please refer to the hotel map.

Upcoming RANZCP conferences

Keep up to date with all the upcoming RANZCP conferences and events at https://www.ranzcp.org/events-learning.

November 2024

Faculty of Psychotherapy 2024 Virtual Conference
23 November 2024
Online

May 2025

RANZCP 2025 Congress
4 - 8 May 2025
Gold Coast, Qld, Australia

March 2025

Section of Child and Adolescent Forensic Psychiatry 2025 Conference
20-22 March 2025
Wellington, New Zealand

June 2025

Faculty of Consultation-Liaison Psychiatry 2025 Conference
12-14 June 2025
Noosa, Qld, Australia

Faculty of Psychiatry of Old Age
2025 Conference

The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Journey to the West: Discourse and discovery in old age psychiatry

12–14 November 2025

Esplanade Hotel Fremantle/*Waylyup*