POSTER ABSTRACTS

All abstracts presented in this handbook are printed as submitted. Some minor formatting changes may have been made, but the content of each abstract is as per the original submission.
All abstracts received at the time of printing have been included in this handbook. Late submissions, which were received after the time of printing, can be viewed via the speaker section of the Meeting App.
The Poster Abstracts are listed alphabetically by presenting author. Please note that some posters can only be viewed online during the conference.

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INTEGRATED DATA INFRASTRUCTURE (IDI): MENTAL HEALTH RELATED PROJECTS

AIM: To investigate the number of projects that are identified as mental health-related from the IDI "Research using Stats NZ microdata" database.

METHOD: On the 30th September 2019, the "research using Stats NZ microdata" website was accessed. A search for results was performed, with the term 'health' and years 2014-2019 as a filter. Search results webpages were downloaded and the data scraped using a custom python tool with further analysis performed. The project titles were reviewed looking at specific mental-health related terms.

RESULTS: There were 114 entries identified within the health subcategory, with 97 unique projects. From this data set, 15 mental health specific projects were identified. Fifteen projects were identified as specific to mental health. Of these projects thirteen were initiated by Universities, one by KPMG New Zealand, and one from the Health Quality and Safety Commission. From the site, there were only two projects where a participating psychiatrist could be easily identified on the "research using Stats NZ microdata" website. Trends from 2016 – 2018 show an increase in the number of projects initiated, reflecting similar findings across the broader health category.

CONCLUSION: The IDI provides access to linked data that include administrative and survey data from multiple data sets (1,2). Despite restrictions to access this data, trends suggest an increasing appetite within the mental health domain. Psychiatry could gain benefit from an increased presence in this space, with research allowing rich insights through use of the different data collections (2).

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START-UP GUIDE: HOW TO START AND GROW YOUR PRIMARY CARE LIAISON SERVICE

AIM**:** The recent government Mental Health Inquiry and Waitemata District Health Board's (WDHB) Our Health in Mind (OHiM) initiative call for increased mental health support for the Primary Care sector given the increased burden of mental illness on individuals and their supports, and due to the limited resources available within specialist mental health services and Primary Care[1, 2].

WDHB endorsed the provision of enhanced mental health specialist support for Primary Care through the recruitment of a full-time psychiatrist.

METHOD: Under the OHiM initiative, an 0.5FTE psychiatrist was recruited into the position of Primary Care Liaison psychiatrist for West Auckland. This role involved active engagement with Primary Care teams within the West Auckland region and provision of a specialist support package to practices which included consultations with practice team members, offer of teaching and occasional face-to-face patient assessments. The role also involved collaboration with other stakeholders including specialist mental health clinicians and non-government organisations.

The development of the above role involved a systematic approach to engaging with practices. At the outset a clear plan was formulated which considered aspects such as clarifying the type of support the psychiatrist can offer, which practices would be approached, and how initial contact was made.

RESULTS**:** In the first 3 months of the role 15 Primary Care practices were engaged in monthly psychiatrist visits. Enhanced specialist support was well-received by practices across the board.

CONCLUSION**:** Setting up a Primary Care Liaison service requires a well thought out process to allow for successful engagement with Primary Care practices. Successful engagement especially in the initial period is key to effective collaboration between specialist mental health and Primary Care clinicians.

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MINDFULNESS BASED COGNITIVE THERAPY (MBCT) FOR FAMILY DEMENTIA CARERS- A SYSTEMATIC REVIEW

AIM**:** To systematically review the scientific literature for evidence of the effectiveness of Mindfulness Based Cognitive Therapy (MBCT) in reducing carer stress and other secondary outcomes in family carers of people with dementia.

METHOD: A systematic review was performed between June and August 2020. Databases searched included MEDLINE, APA PsycINFO, EMBASE, CINAHL, Scopus, Web of Science, Cochrane Library, AMED, ICTRP, ALOIS and unpublished databases for grey literature. Hand searches of key journals were performed. All kinds of intervention studies were included. Studies were selected, data was extracted and quality assessments were undertaken by 2 independent study reviewers who were blinded using COVIDENCE software. Conflicts were resolved through discussion with a third reviewer. Narrative synthesis will be used to describe quantitative and qualitative findings.

RESULTS**:** 6 studies were found meeting inclusion criteria. We are currently finalizing the results, which will be ready for presentation at the conference.

CONCLUSION**:** MBCT appears to be a potentially effective intervention for family carers but large, high quality, controlled trials in diverse local populations are required to evaluate its effectiveness for a NZ context.

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IMPAIRMENTS IN THEORY OF MIND FOLLOWING TRAUMATIC BRAIN INJURY: A SYSTEMATIC REVIEW

BACKGROUND: Theory of Mind (ToM) enables one to reflect upon the thoughts and emotions of others and oneself. Damage to brain regions can lead to impaired social cognition resulting from ToM deficits. Studies examining ToM in patients with Traumatic Brain Injury (TBI), however, have yielded conflicting findings.

AIM**:** To assess the nature and extent of Theory of Mind (ToM) impairments following Traumatic Brain Injury (TBI).

METHOD: Electronic databases searches included PubMed/MEDLINE, PubMed Central, Scopus, PsychArticles, PsychINFO, Web of Science, ProQuest Central, and Wiley Online Library databases. Only studies conducted on adult patients with TBI compared with healthy controls and published in English in peer-reviewed journals were considered. Reference lists were manually checked for additional studies. 19 studies were identified.

RESULTS**:** Marked moderate-to-severe ToM deficits in adults post-TBI were observed across all severities of injury and chronicity. ToM deficits were documented across tasks and reflected a hierarchy where performance worsened significantly as the tasks progressed in complexity. Additionally, despite supportive factors, certain aspects of ToM impairment, such as ability to detect and interpret non-literal speech and judge appropriateness of context remained affected in the subjects.

CONCLUSION**:** ToM deficits represent a robust finding in adults with TBI. The chronic nature of TBI requires a long-term view, made complicated by the fact that ToM deficits are invisible and difficult to understand. Perceptive-taking deficits faced by TBI sufferers has bio-socio-economic implications. This review also discusses implications for basic and clinical neuropsychology and rehabilitation efforts. Further research is needed, particularly in the form of large, longitudinal studies that mimic day-to-day interactions, to inform and support rehabilitation programs.

REFERENCES:
References available on request. Please contact the author.

DE BEER, Wayne[1]; YONG, Choong-Siew[1]; CHUA, Phyllis[1]; DOTSON, Rhonda[1]; YADAV, Tarun[1]; SUETANI, Shuichi[1]; BACKMAN-HOYLE, De[1]; MCPHERSON, Robert[1]; GARG, Gagan[1]; AUCHINCLOSS, Stephane[1]; STEVENSON, Janine[1]; LYUBOMIRSKY, Anna[2]; HILL, Anita[2]; ORTEGON, Carlos[2]
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RANZCP ANNUAL EDUCATION REPORT 2019 – A SNAPSHOT

AIM**:** The aim of this poster is to present a snapshot of the RANZCP education and training activity and outcomes for the 2019 training year.

METHOD: Data sourced from the College membership database, In Train training management system, My CPD and internal College datasets were analysed.

RESULTS**:** The Committee for Education Evaluation, Monitoring and Reporting (CEEMR) is a committee of the Education Committee charged with the responsibility for monitoring and reporting on educational activity for the RANZCP. Snapshots of activity are published twice annually – a mid-year report of activity in the first six months, and a final report of total activity for the year. Numbers and trends for training intake, demographic trends among trainees, assessment outcomes, and Fellowship will be presented.

CONCLUSION**:** Not applicable

REFERENCES: Not applicable

DE BEER, Wayne[1]; YONG, Choong-Siew[1]; CHUA, Phyllis[1]; DOTSON, Rhonda[1]; YADAV, Tarun[1]; SUETANI, Shuichi[1]; BACKMAN-HOYLE, De[1]; MCPHERSON, Robert[1]; GARG, Gagan[1]; AUCHINCLOSS, Stephane[1]; STEVENSON, Janine[1]; LYUBOMIRSKY, Anna[2]; HILL, Anita[2]; ORTEGON, Carlos[2]
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RANZCP EVALUATION AND MONITORING FRAMEWORK

AIM**:** The aim of this poster is to present the draft Evaluation and Monitoring Framework, outlining what activities are undertaken to monitor various aspects of the Fellowship programme.

METHOD: An evaluation framework was developed based on Kirkpatrick's model of educational evaluation. This model was extended to include attraction to the training program in response to published evidence of an ongoing and persistent predicted shortfall of psychiatrists. The framework outlines key areas for monitoring and includes a range of evaluation questions for consideration, and also outlines key sources of data, both external (such as the Medical Training Survey and Health Workforce Data) and internal.

RESULTS**:** The Committee for Education Evaluation, Monitoring and Reporting (CEEMR) is a committee of the Education Committee charged with the responsibility for monitoring and reporting on educational activity for the RANZCP. Accreditation as a provider of specialist training and professional development in psychiatry by the Australian Medical Council (AMC) and the Medical Council of New Zealand (MCNZ) includes Standard Six – Monitoring and Evaluation. In 2019 the CEEMR developed a draft Evaluation and Monitoring Framework. The draft evaluation framework provides a basis for a comprehensive and structured monitoring of key areas of the Fellowship program, and will contribute to ongoing quality assurance.

CONCLUSION**:** Not applicable

REFERENCES: Not applicable

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THE BALINT GROUP- REFLECTIVE PRACTICE FOR PSYCHIATRISTS?

AIM**:** Introduction of the Balint - Reflective Practice Group model and applications in psychiatric practice and in psychotherapy teaching.

METHOD: Presentation of the Balint Group Model and its history, personal experiences as a group-member and group-leader of Balint Groups in New Zealand and UK, feedback psychiatry registrars of experiences with the Balint Group in the context of teaching psychodynamic psychotherapy for psychiatry registrars in Auckland, New Zealand.

RESULTS**:** Summary of predominantly positive questionnaire-feedback by psychiatric registrars and personal reflections on benefits of Balint – Reflective Practice Group work.

CONCLUSION**:** Balint - Reflective Practice Groups enhance psychotherapeutic insight for psychiatrists and psychiatry registrars and reduce professional isolation.

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Nash D Balint Group Process, An introduction to Balint Group Work, Balint Society of Australia & New Zealand.

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AN OPEN-LABEL NEUROIMAGING STUDY OF REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (RTMS) FOR TREATMENT-RESISTANT DEPRESSION IN THE NEW ZEALAND HEALTHCARE CONTEXT

AIM**:** Major depressive disorder (MDD) poses a significant and growing burden on the New Zealand population. It is a leading cause of disability, and resistance to currently offered treatments is common. Repetitive transcranial magnetic stimulation (rTMS) is a treatment offered internationally demonstrating good efficacy and few reports of side effects. This study aimed to investigate the effectiveness and acceptability of offering rTMS as a treatment for MDD in the setting of New Zealand health care systems. Additionally, magnetic resonance spectroscopy was used to investigate the effects of rTMS on levels of gamma-aminobutyric acid (GABA) and the combined resonance of glutamate/glutamine (Glx).

METHOD: This was a naturalistic, open label, pilot study in which patients with moderate to severe treatment-resistant MDD were treated with a course of daily rTMS (10 Hz) over the left dorsolateral prefrontal cortex for four weeks (20 sessions). Primary endpoint was response to treatment, stratified into non-responder, partial responder, or responder based on the Montgomery–Åsberg Depression Rating Scale (MADRS) at the end of treatment compared to baseline (<25 % reduction, 25-50 % reduction, and >50 % reduction respectively). Neuroimaging was conducted prior to and following treatment.

RESULTS**:** Forty-four participants completed the full course of treatment (21 female, mean age 46.0 y). Nineteen participants were classified as responders, eight as partial responders, and seventeen as non-responders. Of the responders eleven were in remission at the end of treatment. Minimal side effects were reported. rTMS was found to increase levels of Glx in the brain ($p = 0.046$), however this difference was not found to correlate with antidepressant response.

CONCLUSION**:** rTMS was successfully administered and effective in treatment resistant MDD. The treatment was accessible and well tolerated by the majority of the study participants and should be made available to MDD patients in New Zealand as a treatment option.

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IATROGENIC HELP OR HARM? A STUDY OF CAUSATION IN PATIENTS WITH OPIOID USE DISORDERS

Opioid users have a high risk of tolerance and dependence and also likely to suffer from withdrawal symptoms when reducing their intake, thus it is vital to treat and manage patients' addictions. The purpose of this study is to assess the demographics of those receiving treatment and evaluate the causation of their opioid addiction – specifically whether the patient was initially clinically prescribed an opioid or sourced their opioids illicitly. Patient data was obtained using Waikato Hospital ICT services. The Intake Assessment was analysed for each patient to see their reason for joining the service. This was recorded under 1 of 3 categories: prescribed an opioid, over-the-counter abuse, or illicit use. Data was collected for all 348 patients currently enrolled in the OST program. The OST population was 22% Māori, which is higher than the national population of 15%. 62.6% of patients became dependent after starting opioids illicitly. 20.4% of patients were prescribed an opioid by either their GP or in hospital which then led them to becoming dependent. 3.2% sourced their opioids from legally available over-the-counter drugs. There has also been a significant increase in the number of patients who attribute their addiction to a prescribed opioid, with an increase from 6.7% in 1998-2008 to 26.2% in 2008-2018. This needs to be controlled at a national level – by tighter controls of pharmaceutical companies – and at a local level – by training clinicians on the opioid prescription guidelines. The Māori population is overrepresented and prevention strategies should be tailored to this in the future.

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RANZCP'S PRACTICE, POLICY AND PARTNERSHIPS COMMITTEE: HOW, WHAT AND WHY?

AIM: The RANZCP Practice, Policy and Partnerships Committee, and its six constituent committees are responsible for delivering on priorities in the College's Strategic Plan to improve the mental health of the community, particularly as they relate to the practice, professional roles and the profession of psychiatry. All committees include members of the community who have lived experience of mental illness, who provide their perspectives, knowledge and experience. This session will explain how these committees work, what they have achieved for members and the community, and what they are working on next.

METHOD: The Practice, Policy and Partnerships Committee (PPPC) is chaired by a Board Director and oversees six committees: Committee for Professional Practice; Committee for Evidence-Based Practice; Committee for Research; Te Kaunihera; Committee for Aboriginal and Torres Strait Islander Mental Health; and the Community Collaboration Committee. These Committees encompass professional and clinical psychiatry practice, research, and collaboration with community members including Māori and Aboriginal and Torres Strait Islander peoples.

Each committee has a work plan with a schedule of delivery. In addition, throughout the year, many inquiries and consultations, being undertaken by government and other organisations, are referred to the committees to inform the College's submission.
Achieving input and consensus from across the membership and College committees can be challenging, however is crucial to the success of this work. To achieve this involves reviewing the evidence and developing and agreeing the College's views and recommendations for action on all aspects of mental health, the mental health system and the broader determinants.
The PPPC, supported by the College's PPP Department, works in close collaboration with its constituent committees, Faculties, Sections, Networks, Branches, Tu Te Akaaka Roa and other committees.

RESULTS: Discussion of examples of the Committees' work will highlight the importance of working relationships between Members and staff, formed over years and ever evolving. The discussion will also highlight the importance of the College's valuable partnerships with community members who have lived experience.

CONCLUSION: As the peak body representing psychiatrists in New Zealand and Australia, the RANZCP is proactive in developing its own policies and guidelines as well as aiming to proactively inform and influence the mental health policies of governments and other key stakeholders. Key to the success of this work is engagement with the College membership and the wider community.

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CHANGING STAFF ATTITUDES TO TELE-PSYCHIATRY IN RESPONSE TO COVID-19

OBJECTIVE: The COVID-19 pandemic resulted in significant changes to psychiatric practice in order to comply and assist with the international public health response. This resulted in rapid and en-masse adoption of remote working practices inclusive of telephony and tele-psychiatry. We sought to monitor the changes in the staff perception of these technologies over this period.

METHOD: Data was collected via an electronically questionnaire circulated to all Mental Health workers working within one New Zealand Health Board. This was circulated at beginning of COVID-19 Level 4, and again at the step down to Level 2.

RESULTS: We found that whilst the confidence of and acceptability to staff increased perceived patient acceptability decreased.

CONCLUSIONS: This further supports the growing body of evidence supporting tele-psychiatry as a viable alternative to face-to-face meetings, but simultaneously highlights the need for more study into patient attitudes, patient perspectives, and patient side barriers to these emergent technologies and means of working.

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USING TELEHEALTH DURING A PANDEMIC TO INFORM NEW MODELS OF CARE

AIM**:** Lessons from working in COVID-19 situations were sought by the Ministry of Health - especially in relation to the telehealth service. In response Tu Te Akaaka Roa collected data from the New Zealand members to understand the impact of the pandemic on front-line psychiatry services, the work environment, and people living with mental health or addiction issues.

Prior to COVID-19, mental health and addiction services were already experiencing pressure due to increases in people accessing services. During the lockdown psychiatric care was predominately delivered via telehealth services sometimes presenting barriers to both consumers and psychiatrists. This poster describes some of the challenges and opportunities arising from the pandemic.

METHOD: This is a qualitative study based on feedback, from New Zealand members and committees, detailing experiences of what worked well during the COVID-19 pandemic, where improvements could be made, and how specific populations with mental health/ addiction issues were managed during the pandemic. Tu Te Akaaka Roa's four policy platforms were used to analyse the results.

RESULTS**:** Lessons, ideas and the use of telehealth had a positive impact on care e.g. reducing the number of DNAs (Did not attend). The pandemic was challenging for some, such as those who were disorientated due to their clinical situation or cognitive awareness. Front-line staff highlighted the importance of adequate training, being well equipped and supported to deliver telehealth services.

CONCLUSION**:** The fast pace of the COVID-19 situation provided opportunities to work differently. Responses required solutions to be developed within teams, utilising existing resources, improving collaboration, and continuous planning in a high trust situation to meet individual needs. Our findings suggest that lessons could inform future models of care.

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DIAGNOSTIC ACCURACY OF THE 10/66 DEMENTIA ASSESSMENT PROTOCOL IN MĀORI, FIJIAN-INDIAN, SAMOAN AND TONGAN ELDERS WITH MEMORY PROBLEMS LIVING IN SOUTH AUCKLAND, NEW ZEALAND

AIM**:** New Zealand (NZ) is recognized officially as a bicultural country comprised of NZ Europeans and Indigenous Māori (1). It is also one of the most multicultural countries in the world, which brings challenges if we aim to conduct a dementia prevalence study that is representative of the whole of NZ population. The 10/66 dementia assessment tool was developed for use in non-English speaking communities in order to accurately measure the prevalence of dementia (2). It is a language-fair, scientifically rigorous questionnaire used in epidemiological studies of dementia (3). It has been translated and adapted into a language fair instrument for use with Māori, Fijian-Indian, Samoan and Tongan elders living in New Zealand.

METHOD: The translated and adapted 10/66 instrument versions were administered in the selected ethnicities. The results of the 10/66 dementia assessment are been tested in older people with and without dementia who have received a clinical diagnosis (gold standard) assessment in a local memory service in South Auckland. Each ethnic group included 15 subjects with dementia and 15 subjects without dementia

RESULTS**:** Data are still being collected and analyzed. The preliminary results for the Fijian-Indian group showed that the 10/66 dementia assessment has a sensitivity and specificity above 90% (ROC ≥ 0.85). Along with three other Fijian Indian participants, Māori, Tongan, and Samoan data are still being collected and analyzed.

CONCLUSION**:** We will test the diagnostic accuracy of the 10/66 dementia assessment protocol by using a scientifically rigorous method in an inter-ethnic community that includes Māori, Fijian-Indian, Samoan and Tongan elders living in NZ. Preliminary results in the Fijian Indian group suggest the 10/66 diagnosis is a reliable tool for the diagnosis of dementia in the community. If appropriate, this instrument can later be used in a population-based study to calculate the prevalence of dementia in NZ.

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SUPPORTING MEMBER WELLBEING DURING COVID-19

AIM: Last year, the Membership Engagement Committee (MEC) led an update to the College's approach to addressing welfare and improving the wellbeing of members. A new Member Wellbeing Subcommittee was integrated into the MEC itself, recognising and putting wellbeing upfront as a key ongoing membership focus. COVID-19 has only increased the need for appropriate and effective member wellbeing supports. This poster presentation informs New Zealand members about the wellbeing resources and services available for them.

METHOD: The Member Wellbeing Subcommittee has supported the College to help implement several projects aimed at better meeting the wellbeing needs and expectations of members, particularly during COVID-19.

RESULTS: The impacts of COVID-19 have been experienced by all members bi-nationally in different ways both professionally and personally.

The College has recognised and responded to the elevated wellbeing and welfare needs of its members, as well as other doctors and medical students. The high-level objectives of the response so far have included to:

- encourage members to access the College supports already available to them;
- reduce feelings of professional isolation, particularly for rural and private practice members;
- provide new opportunities for members to share information and give advice to each other;
- create new avenues for members to expand their peer support networks;
- share constructive advice for members working in less familiar environments and health services;
- offer diverse wellbeing content members can engage with in ways that suits them; and
- aggregate relevant doctor wellbeing information from external sources.

New and existing wellbeing supports and services available to members will be profiled in this poster presentation.

CONCLUSION: The Member Wellbeing Subcommittee will continue to expand the range of wellbeing services and supports for members. Every member is encouraged to use or refer a colleague to these resources to help improve the wellbeing of ourselves, and each other.

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THE RANZCP FOUNDATION: TRANSFORMING MENTAL HEALTH CARE, CREATING A WORLD OF POTENTIAL

AIM: Eighteen months on from its official launch, the RANZCP Foundation has established its role within the College to raise funds that support initiatives in research, clinical work and collaborative projects to improve the mental health of Australian, New Zealand and neighbouring region communities. This poster presentation provides an update to New Zealand members on the recent achievements and developments of the RANZCP Foundation.

METHOD: The Foundation is overseen by a senior advisory committee responsible for developing and implementing strategic goals that include communicating the value of psychiatry to health policy leaders, forming new external partnerships, raising funds, as well as supporting new and existing grant recipients.

RESULTS: Key developments and achievements of the Foundation include:

Supporting eight College trainees and Fellows to undertake new research projects in psychiatry.
Developed our new vision and mission statement to guide the Foundation's work.
Adopting a new 5-year fundraising strategy to ensure a sustainable future for the Foundation.
Implementing a new online donation option for all members to use.
Receiving strong support from the College membership through an uplift in donations received.
Updating our website with new profiles of grant recipients and their projects.
Identifying prospective partners for the Foundation for collaborative projects.

Case studies from Foundation grant recipients will be profiled through this poster.

CONCLUSION: We now face a world of unprecedented challenges and the role of psychiatry in response will be vital. As the Foundation now enters the next phase of its development, all College members are encouraged to help realise psychiatry's potential and to give back to our community.

The Foundation is a fresh avenue for us to now drive this ambition.

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PRELIMINARY RESULTS OF THE NORTHLAND DHB PRIMARY CARE LIAISON PROGRAM A COLLABORATIVE SERVICE DESIGN

AIM**:** The NDHB initiated a Primary Care Liaison Program to provide specialist support directly to GPs. The protocol used a population based, collaborative program design methodology to test various modes of clinician to clinician interaction and their effects on patient care.

METHOD: The collaborative process started with a series of Focus Group Discussions with the Whangarei GPs. Based on the results of the FGD's, the NDHB Primary Care Liaison Program implemented the following interventions : Short Term Specialist Support Program; Online consults where GPs refer and discuss cases using an electronic referral system; Telephone consults; and Face to face consults where GP's assess patients in tandem with the PCL psychiatrist .

RESULTS**:** This is a preliminary report on the Northland experience. Of the interventions, the Short Term Specialist Support Program and the electronic referral system yielded the most positive results. None of the 71 in specialist support were referred back to MHS. The electronic referral system provided timely clinical exchange between the psychiatrist and the GP. At the time the pilot concluded, no measures have been implemented for the telephone and tandem assessment interventions.

CONCLUSION**:** PCL interventions, while patient centered, need active GP support. Collaboration from program inception to implementation are crucial elements of program success. Within the DHB, a clear triage system and electronic media are key inputs.

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A CASE OF PRE-MENSTRUAL PSYCHOSIS WITH CATATONIC SYMPTOMS

This case report discusses the case of a 28-year-old woman, with a history of Premenstrual Dysphoric Disorder, who presented with polymorphic psychosis, with multiple catatonic features. This developed rapidly one week prior to menstruation. This was her first episode of psychosis and there was no history of catatonia and no family history of mental health disorders.
She was treated with lorazepam and olanzapine as an inpatient and her psychotic symptoms resolved rapidly, upon menstruation. She was subsequently treated in the community and continues to do well without antipsychotic therapy. Her Premenstrual Dysphoric Disorder is being well managed by luteal-phase fluoxetine.

Not recognized in either ICD or DSM criteria, menstrual psychosis is nonetheless well described in the literature. Because of its rarity, and the lack of recognized diagnostic criteria, it is difficult to assess it's prevalence. However, several cases have been reported worldwide. Menstrual psychosis with catatonia appears to be an extremely rare condition, with only a handful of cases reported internationally[1,2,3,4]. As such, its pathology and most appropriate treatment is not well described.
The pathophysiology of (pre)menstrual psychosis is unclear, with evidence suggesting it may be related to anovulatory cycles[5], oestrogen regulation of dopamine transmission[6], or caused by inflammation seen in the luteal phase of the menstrual cycle[7]

CONCLUSION**:** This case highlights the challenges of treating conditions with no clearly defined guidelines of their management. This should highlight the need for psychiatrists to familiarize themselves with diagnoses outside the margins of ICD and DSM, such as menstrual psychosis.

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AUDIT; THE EFFECT OF BENZODIAZEPINES AND ANTIEPILEPTIC MEDICATION ON THE SEIZURE THRESHOLD OF PATIENT'S UNDERGOING ELECTROCONVULSANT THERAPY

AIM**:** It is known that certain medications prescribed frequently in Mental Health Units such as anti-epileptics and benzodiazepines interact with Electro Convulsant Therapy (ECT) by increasing the seizure threshold (ST), and may inversely affect the efficacy of ECT treatment(1). This audit examined the use of benzodiazepines (BZP) and anti-epileptics (AED) in patients undergoing ECT over a 24 month period and examined the effect these agents had on the ST at the first, sixth and final treatment.

METHOD: Patients who received ECT within the Henry Bennet Centre between January 2018 and December 2019 and met our inclusion criteria were examined. Ethical Approval was received from Waikato Health Research and Ethics Committee in February 2020. Information was gathered from Patient's online medical notes. Clinical data was anonymously compiled on an excel sheet designed for this study, and compared against recently published guidelines by the RANZCP(2). Statistics were analyzed using SPSS version 25. The associations of ST and increase in ST with the use of ST increasing drugs were assessed using Chi-square test and logistic regression analysis.

RESULTS**:** 48 patients were included in this study. 24% of this cohort were concurrently prescribed a seizure threshold increasing medication.
Statistical analysis showed association between initial ST and AED; *Post hoc* adjusted residuals for AED (with or without BZP) were negative and statistically significant ($P < 0.006$, the Bonferroni corrected *P* value). The results were similar for increase in ST over the course of ECT. Sex, diagnosis, or use of benzodiazepines (BZPs) had no effect on ST or its increase.

CONCLUSION**:** Improvements can be made in our centre in mitigating AED/BZP administration prior to ECT. Large doses of antiepileptics were associated with higher initial ST with stronger shifts in ST during the course of treatment. Benzodiazepines had a mild effect on initial ST which wasn't deemed to be statistically significant.

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PREDICTORS OF SUPER-RESPONSE TO ANTIPSYCHOTICS IN SCHIZOPHRENIA: A LITERATURE REVIEW

AIM: Response to antipsychotics is defined variably as a 20-50% reduction in PANSS/BPRS across schizophrenia populations (First Episode Schizophrenia, chronic, treatment-resistant). A subset of responders showed super-response (>50% reduction in PANSS) and this could determine predictors of treatment continuation, remission, recovery, and long-term outcome; though, this is debatable. Super-responders are highly likely to achieve recovery by gaining employment, living independently, and maintaining adequate social relationships. We aimed at identifying predictors of super-response, that would help in understanding modifiable factors and prognosticators.

METHOD: A systematic literature search in PubMed using MeSH-terms “Schizophrenia”, “Antipsychotic” and “Response” was made. Studies were identified, describing predictors of >50% response to AP.

RESULTS: The super-response rate varied from 5% to 56% across studies. Studies were heterogeneous concerning the schizophrenia stage, duration of treatment, time to response, sustenance of improvement, and antipsychotic type (mostly atypicals). Super-responders were mostly in the second decade of life, females, non-smokers, students/academicians, and, in a stable relationship; family history of schizophrenia, affective symptoms, and capacity for age-appropriate romantic relationships predicted super-response in early-onset schizophrenia. Individuals who were well-adjusted pre-morbidly, had severe baseline positive/negative symptoms, but, with better insight and presenting with shorter duration of untreated psychosis and good adherence to prior antipsychotic trials had super-response. Dramatic-responders (defined as >70% response to antipsychotics) were likely to be young, female, and Hispanic with higher baseline illness severity.
Biological markers like an absence of EEG dysrhythmias and higher glutathione in the Dorsal Anterior Cingulate Cortex were some of the predictors of super-response. Patients with intact presynaptic dopamine capacity and synaptic hyperdopaminergic state at baseline were more likely to be super-responders.

CONCLUSION: Treated early and optimally, “super-responders” are likely to have lower morbidity with better outcome. Further systematic research is required on predictive biomarkers for “super-responders”.

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EFFICACY OF LAI (LONG ACTING INJECTABLE) ANTIPSYCHOTIC MEDICATION IN REDUCING HOSPITAL LENGTH OF STAY IN A COMMUNITY MENTAL HEALTH TEAM IN AUCKLAND

AIM: Pilot study to check on the efficacy of long-acting injectable antipsychotic medication (LAI) in preventing hospital admission in clients in a Community Mental Health Team in Auckland.

METHOD: A small retrospective observational study of treatment as usual. All clients allocated to me on LAI and with data available (10 clients) An additional 10 clients on LAI allocated to other doctors, matched by age, gender and current type of LAI medication. Admission bed nights in psychiatric inpatient units in Auckland pre-and post-client receiving any LAI for the first time were measured in a mirror image design. After getting the post-LAI data, the bed nights for any admission after a LAI was first initiated were subtracted if the client had been off a LAI for more than 3 months prior to that admission.

CONCLUSION: For all 20 clients, total bed nights were 1216 pre-LAI and 393 post-LAI (while still on LAI). Therefore, an average of 61 bed nights before the LAI was initiated. This was reduced to an average of 20 bed nights on LAI. Mean bed nights were 36 pre-LAI and 0 on LAI. Total hospital admissions were similarly decreased. In spite of limitations, the number of hospital bed nights and hospital admissions was markedly decreased after initiation of LAI antipsychotics, particularly if the client remained on LAI antipsychotic. Limitations included the small number of clients and other confounding factors such as respite/ step-down care, periods of more intensive community care and substance abuse. This was a group of clients with significant suffering and severity of illness.

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INTERVIEWING THE INTERVIEWERS: EXPERIENCES OF MULTI-CULTURAL DEMENTIA RESEARCH

AIM: The Living with Dementia in Aotearoa (LiDiA) Research Group has recently completed validity studies on the translation and adaption of the 10/66 diagnostic assessment for dementia in the major ethnic groups in New Zealand, and are in the process of completing a prevalence feasibility study in two areas of South Auckland. Interviews as part of this study are being conducted by bilingual, bicultural interviewers representing the major ethnic groups in New Zealand (Māori, Samoan, Tongan, Indian/Fijian Indian, Chinese, and New Zealand European). The aim is to investigate interviewer experiences of conducting semi-structured interviews using the 10/66 diagnostic assessment for dementia.

METHOD: Interviews are currently being conducted with the LiDiA interviewers on their experiences, including on the translation and adaptation of the 10/66 diagnostic assessment, training process, experiences of interviewing, and cultural issues.

RESULTS: Preliminary results indicate that there are cultural differences in how best to engage participants and the ways in which certain topics are broached (e.g. suicidal ideation), and that interviewers may need extra support on how to manage concerns regarding cultural safety. Interviews that have been conducted and analysed will be discussed.

CONCLUSION: Little information is available on the prevalence of dementia in New Zealand, and current estimates do not account for inter-ethnic differences. The studies that are currently being conducted by the LiDiA Research Group hope to provide a clearer understanding of the prevalence of dementia in the major ethnic groups, as well as how dementia is perceived and understood. Interviewer experiences will inform a future fully powered culturally sensitive dementia prevalence study.

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ADVERSE EFFECTS IN VIRTUAL AND AUGMENTED REALITY STUDIES: A SYSTEMATIC REVIEW

AIM: The use of Virtual Reality (VR) and Augmented Reality (AR) is an emerging field in psychiatry. Several studies have demonstrated how these technologies compare to standard therapies, and the additional benefits from increased control over variables. However, the side effect profile of using this technology remains relatively unknown. The main objective of this review is to examine existing literature on the adverse effects of using VR or AR technology in the field of mental health.

METHOD: A systematic literature search was conducted on various databases and evaluated via PRISMA guidelines to examine side effects from using VR or AR technology in the management of mental health disorders

RESULTS: Adverse effects of these new treatment modalities are rarely reported in studies conducted thus far, and most make no mention whatsoever of adverse effects. The few reported adverse events were compared to those reported in non-mental health VR and AR in other, mainly recreational, settings.

CONCLUSION: Based on available evidence, most of VR/AR in mental health have failed to consider or measure adverse effects associated with the technology. We hypothesize that dropout rates in VR trials may indicate that such effects are not rare and may be serious.

It is recommended that future trials carefully evaluate potential medical and psychological side effects and that a standard is developed for reporting events associated with VR and AR, including reasons for dropout.

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WHERE HAS ALL THE FLOUR GONE? AN ANALYSIS OF CONSUMER PURCHASING OF FLOUR PRODUCTS DURING THE COVID-19 PANDEMIC

AIM**:** In December 2019, a new coronavirus (*SARS*-CoV-2) was reported in Wuhan, China. On 25 March 2020 a state of emergency was declared in New Zealand and the country would be in lockdown for a minimum of 4 weeks. Media reported shelves being emptied of various products, including flour. Our aim was to study the demand in NZ and to consider possible reasons for observed changes.

METHOD: A comprehensive literature search was undertaken as a student research elective during lockdown. Sales data were obtained from New Zealand's largest grocery distributor, Foodstuffs, including flour, in store baking, and proprietary bread sales leading up to and during the COVID-19 lockdown (and for same period in 2019).

RESULTS**:** An Increase of approximately 136% in sales of flour occurred during the week preceding lockdown. Bread sales peaked at the same time. In-store baking sales peaked on the 22 March followed by a rapid decline.

CONCLUSION**:** Consistent with international evidence, people in NZ engaged in a form of panic buying during the lockdown pandemic. Panic buying is likely fuelled by stress and previous research suggests it is driven by self-preservation. Public and social media function as an amplifier of this stress and, as a result, a similar trend in consumer purchasing has occurred globally. A different degree of response has been observed in different supermarket chains, suggesting that changes in consumer purchasing are greater in certain populations. The data also indicate a global *interest* in baking, however, whether the flour was used remains unclear.

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