Contents

About Metro North Hospital and Health Service ................................................................. 3
MNHHS Strategic Priorities ................................................................................................. 4
About Metro North Mental Health ....................................................................................... 5
Foreword .............................................................................................................................. 6
At a glance ............................................................................................................................ 7
Metro North Mental Health researchers recognised at Metro North HHS Research Excellence Awards ................................................................................................................. 8
Local study adds to evidence related to Childhood trauma in patients with early psychosis ...
Metro North Mental Health Researcher completes Chairman’s Scholarship ......................... 13
Consumer and carer engagement ....................................................................................... 15
CADENCE – building research capability ............................................................................. 17
How Occupational Therapists can set sail on a research journey? ....................................... 18
Recovery Oriented Care ......................................................................................................... 20
Physical health and mental health ....................................................................................... 22
Nursing Research ................................................................................................................ 25
The Queensland Forensic Mental Health Service ................................................................ 29
On being a clinician researcher ............................................................................................ 31
TPCH Psychology ................................................................................................................ 35
Evaluation: worth the effort? We think so – here’s why! ....................................................... 36
The Valley Mens Group ......................................................................................................... 37
Cannabis and Psychosis ......................................................................................................... 38
MNMH staff enrolled in post graduate study ........................................................................ 42
Supervision of post graduate students by MNMH Staff ......................................................... 43
Dissemination Activities ....................................................................................................... 46
Books .................................................................................................................................. 51
Published Peer Reviewed Abstracts ..................................................................................... 51
Presentations at Conferences, Seminars, Workshops ............................................................. 52
Poster Presentations .............................................................................................................. 56
Research Grants, Awards, & Fellowships ............................................................................ 57
Other dissemination activities ............................................................................................... 59
Interested in research ............................................................................................................ 59
About Metro North Hospital and Health Service

Metro North Hospital and Health Service (MNHHS) is an independent statutory body overseen by a Hospital and Health Board. Encompassing metropolitan, suburban and regional areas over 4157 square kilometres, from inner Brisbane to Redcliffe and Kilcoy, it the largest of 16 Hospital and Health Services in Queensland. Health services for the population of around 900,000 are provided through five hospitals and a range of subacute, post-acute, community based and residential services. MNHHS is unique in that two of its hospitals The Royal Brisbane and Women’s and The Prince Charles Hospitals are tertiary/quaternary referral facilities, providing advanced highly specialist care for people from across the state. Dedicated units provide Public Health and Aboriginal and Torres Strait Islander health services. Oral health and mental health services are governed and provided by district wide directorates.
MNHHS Strategic Priorities: Mental Health, Research and consumer and community engagement

Supporting the mental health needs of our communities is a strategic priority for MNHHS. The HHS has committed to improving the quality of life of people across the lifespan through a range of activities including:

- Working with partners to increase and facilitate access to a broader range of whole of life services
- Integrating inpatient and community alcohol and other drug services with unification of clinical and operational governance structures
- Increasing focus on more innovative and patient centred models of care Developing a centralised mental health triage service to provide a single point of access for consumers, carers, families and the community
- Expanding community based services, particularly in the Redcliffe and Caboolture areas where resourcing is needed to meet growing local demands
- Elevating the focus on physical health, psychological and social wellbeing to support consumers and carers in their recovery journey

MNHHS has also articulated a commitment to embedding research as core business, rigorous evaluation of innovative practices and ongoing quality improvement. Research and evidence based practice are regarded as pivotal to ensuring services are efficient and effective and patient outcomes are optimised. The MNHHS Strategic plan states that the service will enhance its research capability to further strengthen the organisation’s position as a world class provider of healthcare and attract and retain highly competent clinicians and leaders from around the world. The HHS is adopting a multi-faceted approach to enable integration of research in practice. Activities are directed toward streamlining systems and reducing bureaucracy, expanding partnerships with universities and industry investors and development of a learning culture including leadership models. Engagement with consumers, carers and communities is regarded as critical to ensuring activities are appropriately targeted and research is acceptable and relevant.
About Metro North Mental Health

Metro North Mental Health (MNMH) is a Clinical Directorate, providing a single point of accountability for mental health services across MNHHS. MNMH has a budget of $172 million, employs 1040 full time equivalent staff providing a range of assessment and treatment services. With around 3500 people 'open' to the service across the district at any time, around 10,000 individuals access MNMH annually, with staff recording nearly 30,000 occasions of service.

MNMH provides specialist services for people of all ages through a range of interlinked community and inpatient facilities located across the HHS. Assessment and treatment are provided through three area based services: The Inner North Brisbane Mental Health Services (INBMHS), The Prince Charles Hospital Mental Health Service (TPCHMHS) and Redcliffe-Caboolture Mental Health Service (RCMHS). Metro North Mental Health service employs a balanced model of care encompassing community, inpatient and support services. Community services are based at Brisbane City, Fortitude Valley, Herston, Nundah, Chermside, Pine Rivers, Caboolture and Redcliffe, with outreach services to Kilcoy. These services are linked to 330 inpatient beds across the district comprising 179 acute adult, 12 Adolescent, 39 Secure Mental Health Rehabilitation, 60 Community Care, 24 long stay nursing home psycho-geriatric and 16 state-wide alcohol and drug detoxification beds.

Community based services are delivered by multi-disciplinary teams providing services to meet the needs of people who meet eligibility criteria, with access to inpatient care as required. While the mix of teams varies by catchment area, the three services include acute, continuing care and older persons’ teams, and specialist consultation liaison teams which support medical units. INBMHS and TPCHMHS also have Mobile Intensive Rehabilitation Teams and dedicated Early Psychosis Services. Dedicated, specialised teams provide a range of interventions to target groups. A Perinatal Mental Health Team provides services to pregnant women and mothers across the HHS and the Homeless Health Outreach Team delivers care in the community to people who are homeless and experience mental illness. Community services are linked to acute care inpatient units accessed through consultant psychiatrists at The Royal Brisbane and Women’s Hospital, The Prince Charles Hospital and Caboolture Hospital.

MNMH clinical services are supported by a team providing information and education about mental health issues for clinicians, consumers, carers and the wider community across the HHS.

MNHHS also hosts a range of specialist services providing assessment, treatment, education and support to people affected by mental health conditions, health services and partner organisations across Queensland. These services include the Queensland Forensic Mental Health Service, The Eating Disorders Outreach Service and the Alcohol and Drug Service and The Queensland Health Victim Support Service.

The service supports the recovery of people with mental illness through the provision of recovery focussed services and consumer and carer services in collaboration with primary and private health providers and our Non-Government partners.
Foreword

Internationally mental health care is in a state of flux. With finite resources, systems are struggling to manage increasing and dynamic demands and to adapt to changing social circumstances. The need to transform mental healthcare is made particularly urgent in the 21st Century by a confluence of socio-political, economic, technological and demographic factors. Traditional illness-focused models of health care are inadequate, inappropriate and unsustainable in the current context.

A/ Professor Brett Emmerson
(Executive Director Metro North Mental Health)

Professor Michael Breakspear
(Chair Metro North Research Collaborative Committee)

These are exciting and challenging times in which we must critically examine the ways we do business. We must engage meaningfully with partners including other services, our staff, and consumers and carers to coproduce creative solutions to challenges we share. These are times in which the full integration of research and practice is critical to improving the efficiency, effectiveness and experience of services. These are times for harnessing emerging technologies to make the discoveries that will advance diagnosis and treatment, and for bridging translational gaps, systematically embedding evidence based practices in routine care.

As Executive Director of MNMH, and Chairperson of the MNMH Research Collaborative committee we are pleased to present the third Metro North Mental Health Research Review. As you will read research, in its many forms, and evaluation and quality improvement activities are flourishing across MNMH. The impressive list of publications and other dissemination activities attests to the commitment and capacity of MNMH researchers and clinicians to face the challenges of the times. The world-class work described in this review spans the mental health research spectrum encompassing cutting edge computational neuroscience, clinical research, interventional clinical studies and health services and policy research. The accounts of clinician researchers take you behind the scenes, demonstrating that conducting research requires perseverance and negotiation of some challenges. They also demonstrate clearly that successful completion of studies is rewarding, personally and professionally.

The past year has been a brilliant one for research in MNMH on many fronts. We were very fortunate in having some of this work highlighted through success at the Metro North Inaugural Research Awards, bringing home the “Rising Star”, “Healthy Hearts, Healthy Minds” and “Research of the Years” awards. Many congratulations to Dylan Flaws and James Scott. Each of these awards reflects the sustained efforts and inspiration of many teams supporting these researchers, but also supporting all the important research across the Service.

Moving forward there is a pressing need for robust evaluation and review of existing models of service and capacity to meet the ever-changing and complex needs of people accessing mental health services. Research is critical to ensuring that the finite resources available are used creatively to best effect, to improve the outcomes for the communities we serve. We commend this review to you and encourage you to get in touch with any of our research team if you have any questions or ideas.

THANK YOU
Dr Anna Praskova

Dear Anna,

We write to express our thanks personally, and on behalf of the Service, for your important contribution to research at Metro North Mental Health during 2015. We very much appreciated your calm efficiency while you were in the Principal Research Fellow role. Your research expertise and exceptional organisational skills ensured that research continued to flourish.

Sue returned to find her desk clear for the first time in years.

We were very pleased to see your important research recognised in the award of Graduate Student Research Award from the Society for Vocational Psychology. Congratulations, Anna!

We wish you all the best in what we know will be a remarkable career.

With kind regards

Brett Emmerson, Sue Patterson, Michael Breakspear
At a Glance

- $15,000,000 new research funding
- 74 Conference presentations
- 39 postgraduate students
- 87 Peer reviewed publications
- 6 Chapters
- 1 Book

Celebrating Success

[Images of people holding awards]
Metro North Mental Health researchers recognised at Metro North HHS Research Excellence Awards

The inaugural Metro North Research Excellence Awards recognised outstanding achievement in research, in 2015, across all clinical specialties and professions. The Awards attracted 52 high calibre submissions across seven categories. MNMH researchers took out three categories. Dr Dylan Flaws’ ground breaking research into predictive modelling won him the Rising Star, Early Career Researcher, just four years after graduating from medical school. Dylan is a psychiatric registrar at the RBWH. A/Prof James Scott, consultant psychiatrist with the Early Psychosis team won the Promoting Healthy Minds and Bodies category for his work related to the physical and mental health of young Australians. Professor Michael Breakspear who received The Technology and Biotechnology Award for his world-leading research using non-invasive technologies to unravel the mysteries of the brain also took out the Researcher of the Year Award (selected from category winners).

CONGRATULATIONS to Dylan, James and Michael. Read on to learn more about these researchers and their work Dylan Flaws: rising star, early career researcher award.

Just four years after graduating from medical school Dr Dylan Flaws is an internationally respected and influential researcher who has already published 18 papers. In his short research career Dylan has run a multinational validation study, establishing himself as an expert in the field of clinical predictive modelling and decision aids. Among his many accomplishments is the creation of the Emergency Department Acute Chest-pain Score (EDACS), now used throughout New Zealand and in many Australian hospitals, contributing to reduction in waiting times and achievement of NEAT targets.

Dr Dylan Flaws

Dylan’s expertise was recognised in 2015 in the award of a prestigious Department of Health Junior Research Fellowship ($250,000) to support development of a delirium prediction tool. He is also applying his predictive modelling skills to investigation of organic causes in people presenting with a first episode of psychosis and assisting to this project, he has also been assisting senior researchers in ongoing research into diagnostic biomarkers. All this achieved while Dylan maintained a full time workload. Dylan a psychiatric registrar, joined the team at RBWH early in 2016.

90 SECONDS with Dylan

Please tell us about your research in a ‘text message’ (160 characters or less)
I want to predict who is at risk of delirium at presentation, and ideally which deliriums can be prevented. This is based on my chest pain risk stratification research.

What was your greatest research achievement in 2015?
Organising a 2-phase derivation process for developing the delirium prediction score leading to the Junior Research Fellowship and international collaborations.

How do you define success?
I think success is a very relative term; achieving what you set out to do. Walking on the moon, and creating the HPV vaccines were tremendous successes, but it’s important to remember that even putting one foot in front of the other can be a great success, and many of the best things that happen result from failures and successes.

What motivated you to become a researcher?
I was always a curious person. I love the process of finding a problem, thinking of possible solutions and testing them. If you’re right it feels amazing, but even if you’re wrong, you’ve still taken a step towards the right answer. Edison once said “I have not failed I’ve just found 10,000 different ways not to make a light bulb”.

How did you get started?
When I finished my undergrad I had no idea what I wanted to do. I took a job as a research assistant in DEM with Dr Martin Than, and loved it. My first
job was just to call up enrolled patients and ask them follow-up questions. It was through that job that I first got interested in medicine. I was slowly given increasingly challenging tasks, eventually in Singapore collaborating on a multinational chest pain trial.

**What advice would you give to your 25 year old self?**
To be honest it doesn’t feel that long ago! I guess, to be brave enough to ask questions and float ideas. It’s easy to assume that someone else has already tried it, or there’s some obvious reason why your idea won’t work. That assumption only needs to be wrong once to make a big difference.

**How do you manage work – life balance?**
Whilst waiting for my GAMSAT results, I started an MSc as a backup plan. I was part way through when I got into medical school. So I’ve had to learn from the start to be efficient with time management, and how to triage my to-do list. I often think of Abraham Lincoln, who once said that “If you have 8 hours to cut down a tree, spend 6 of them sharpening the axe. You can often save a lot of time by stepping back and taking the time to think about how something can be done more efficiently”.

**How can we make mental health research more attractive?**
I think we need to dispel the illusion that research is stale, boring, and all consuming. If people knew how fun, exciting and rewarding research can be without sacrificing the rest of your life, more people would try their hand at it.

**What would your internet search history tell us about you?**
That I’m a tremendous nerd. If I’m not looking up something research related, I’m probably ‘googling’ dungeons & dragons or magic: the gathering. And I play far too much Sid Meier’s Civilization.

**What quality or attribute is essential to being an excellent researcher?**
You need curiosity and patience, and to remember that research is a team sport.

**How does your research contribute to society?**
Prediction of risk allows us to pre-empt disease. Rather than being on the back foot, we can move from damage control to damage prevention.

**What will you be doing three years from now?**
I should be mid-way through my registrar training. I hope to see a completed delirium score in clinical use both locally and nationally, and see patients having better outcomes as a result. I’d then like to look into some other ideas I have about organic screening, and schizophrenia.

**What’s in the future for mental health research?**
The future of mental health research is very exciting. It’s one of the reasons I chose to specialise in psychiatry. One day I hope terms like “schizophrenia”, which describe symptom clusters will be replaced by new definitions, based on the underlying aetiology for these symptoms. This will be the start of a paradigm shift in how we diagnose and treat mental illness. I’d love to see that in my lifetime.
James was awarded the Promoting Health Minds and Bodies Award for his work dedicated to improving the mental health of Australian youth.

He says,

*Mental disorders are by far the largest contributor to the burden of disease in children and youth living in high income countries across the world. In Australia, a national survey examining mental illness in children and adolescents in Australia in 2015 found that 16% of Australian adolescents had suffered from mental illness in the previous 12 months. Sadly, despite advances in treatment, the outcomes for young Australians with severe disorders such as schizophrenia are not good.*

James has been initiating research projects since he commenced working as the consultant psychiatrist at the Early Psychosis Service at the RBWH in 2010. While maintaining a full clinical load, he progressively expanded his research role and collaboratively established a platform to support studies in early psychosis. He now has a central role, as investigator or supervisor, in multiple projects and collaborates with researchers and clinicians from a range of disciplines internationally and locally. He is an expert advisor for the Global Burden of Disease Project on childhood disorders.

James’s research is concerned with preventing the onset of mental disorders, identifying the underlying causes of schizophrenia and improving treatment and outcomes for young people with early psychosis. His work has been nationally and internationally recognised as having the potential to improve the mental health of young people across the world.
Michael undertakes research into the neurobiology of psychiatric disorders, particularly major depression, bipolar disorder, schizophrenia and dementia. His work is grounded in brain network theory, which models the brain as a complex network of regions and their connections - the “google map of the brain”. Michael leads a team of researchers using sophisticated functional and structural brain imaging studies to look at the way different parts of the brain mis-connect in people with mental health disorders, or who are at high risk of future illness. His recent studies have demonstrated brain networks disturbances involving key regions required for decision making and emotional regulation in young people at risk of bipolar disorder.

Michael says “Clinical diagnosis in psychiatry currently rests on subjective clinical assessment in the absence of confirmatory imaging or laboratory based tests. Our research addresses this challenge and aims to provide quantitative information to aid clinicians in diagnosis and management planning. In this way, we hope to help reduce the burden of mental illness on consumers and their carers.”

**Michael explains the work further:**

*What is Systems Neuroscience?*

Systems Neuroscience is an approach to brain sciences that seeks the basic principles of brain organization, dynamics and function across a hierarchy of spatial and temporal scales. It is a rapidly growing field that differs considerably from the traditional reductionist paradigm in neuroscience that addresses sufficient causes for local phenomena.

*What do you and your team do and how?*

The work of our group embodies these principles across three broad domains - empirical, computational and clinical neuroscience. The overarching aim of this work is to contribute towards unifying models of brain architecture, dynamics and cognitive (dys)function.

Empirically, we employ three different technologies - brain imaging (mainly functional), neurophysiology (EEG and EMG) and video-imaging of facial expression and eye movement (a new enterprise). Our computational efforts are primarily grounded in dynamical systems theory and statistical mechanics in order to develop basic models of large-scale neuronal activity. We are also developing a Bayes perspective to understand how the brain performs inference and enacts motor activity. Clinically, we study mood disorders, schizophrenia, dementia and epilepsy.

*What is the purpose of your research?*

The collective research conducted within the Systems Neuroscience Group – QIMR Berghofer enables the integration of advanced multimodal imaging technology with innovative computational modelling, which facilitates translational research in a range of psychiatric and brain disorders. Critically, the current research and subsequent outcomes have numerous direct beneficial implications for the clinical setting. The research aims to provide further understanding of mental health, improves diagnostic accuracy in neuropsychiatric disorders, and provides greater insight into brain dysfunction and how such dysfunctions relates to the emergence of distinct psychiatric and brain disorders. Overall the research expands our knowledge of the functional and structural connectivity of the human brain which provides valuable information regarding potential avenues for clinical diagnosis, treatment and future research.
Local study adds to evidence related to Childhood trauma in patients with early psychosis.

It is generally accepted that childhood trauma can have persistent adverse effects on physical and mental health, social development and wellbeing. While research in the area has been fraught by methodological challenges, evidence of a relationship between childhood trauma and psychosis has been mounting over the last 20 years. A team of researcher led by James Scott investigated this relationship locally, demonstrating that people with early psychosis who experienced trauma during childhood faced higher levels of depression, anxiety and stress. While exposure to childhood trauma appeared to have no impact on an individual's day-to-day functioning at work or socially, the study has important implications for clinical practice. Outcomes will potentially be improved if clinicians sensitively explore experience of trauma in people presenting with early psychosis and work with patients to manage psychological distress as part of holistic care.

Abstract
The prevalence and correlates of childhood trauma in patients with early psychosis.
Michael Duhig, Sue Patterson, Melissa Connell, Sharon Foley, Carina Capra, Frances Dark, Anne Gordon, Saveena Singh, Leanne Hides, John McGrath, James Scott.

OBJECTIVE: To describe the prevalence and demographic, clinical and functional correlates of childhood trauma in patients attending early psychosis clinics.

METHOD: Participants were recruited from outpatients attending four early psychosis services. Exposure to childhood trauma was assessed using the Childhood Trauma Questionnaire (CTQ). Psychopathology was measured using the Positive and Negative Syndrome Scale and the Depression, Anxiety and Stress Scale. Social and vocational functioning and substance use were also assessed.

RESULTS: Over three-quarters of the 100 patients reported exposure to any childhood trauma. Emotional, physical and sexual abuse were reported by 54%, 23% and 28% of patients, respectively, while 49% and 42% of patients reported emotional and physical neglect, respectively. Female participants were significantly more likely to be exposed to emotional and sexual abuse. Exposure to childhood trauma was correlated with positive psychotic symptoms and higher levels of depressive, anxiety and stress symptoms; however, it had no impact on social or vocational functioning or recent substance use.

CONCLUSION: Exposure to childhood trauma was common in patients with early psychosis, and associated with increased symptomatology. Existing recommendations that standard clinical assessment of patients with early psychosis should include inquiry into exposure to childhood trauma are supported.

© The Royal Australian and New Zealand College of Psychiatrists 2015.
Metro North Mental Health Researcher completes Chairman’s Scholarship.

A/Prof Sue Patterson

The Chairman’s Scholarship Program was an initiative of the Board of Metro North Hospital and Health Service (MNHHS). The scholarship program provided funding and support to enable successful candidates to undertake professional development activities such that the candidate experiences diversity of exposure in world leading organisations and contributes to building MNHHS capability and capacity in key business performance areas of governance, quality, safety and risk.

MNHM Principal Research Fellow, A/Prof Sue Patterson was awarded one of two inaugural MNHHS Chairman’s Scholarships, to support development of knowledge and skills related to applying consumer/patient experience to quality improvement, and integration of research and clinical practice. The scholarship was awarded in recognition of her internationally important research into the process of research and substantial contribution to embedding research and consumer participation in MNMH since 2011.

The scholarship enabled Sue to work over the course of 2015 with UK institutions recognised as international leaders in patient centred quality improvement, and engagement in a range of activities relevant to Scholarship goals. She was hosted, while in the UK by

- The Royal College of Psychiatrists, Collegecentre for Quality Improvement (CCQI)
- The Collaboration for Leadership in Applied Health Research and Care for North West London (CLAHRC,NWL) and
- Nuffield Department of Primary Care Health Sciences, Oxford University in conjunction with The Collaboration for Leadership in Applied Health Research and Care, Oxford (CLAHRC, Oxford)

At each organisation Sue worked as a member of teams, in a range of research, evaluation and training projects and participated in strategic and operational meetings.

A range of other ‘activities’ relevant to the goals of the program were facilitated by or conducted in collaboration with these organisations and other academic partners, (notably A/Prof Tim Weaver, Middlesex University), and undertaken independently. Sue attended various public and academic lectures and seminars relevant to Scholarship goals and met with academics, health practitioners, managers and researchers and people representing patients and the public in diverse health service and research activities. Projects with various organisations and collaborators that have particular relevance to MNMH included:

CCQI: Modelling the interface between primary Care and Specialist Mental Health Services: a mixed methods study commissioned by NHS England to support commissioning of primary mental health services. See http://www.rcpsych.ac.uk/pdf/SCN_INTERFACE_STUDY_REPORT.pdf

CCQI: Evaluation of e-Lester: a multiple case study, with mixed methods used to describe process and impact of four pilot programs designed to support improvement in the care provided to people with severe mental illness, specifically in relation to cardiovascular health in NHS Mental Health Trusts. See http://www.rcpsych.ac.uk/pdf/eLester%20final%20report%202016.03.16.pdf

CCQI and The Founders Network (http://foundersnetwork.uk): Enabling Environments: to assess evidence for the impact of enabling environments on organisational and patient outcomes (see pages 39,40); http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/enablingenvironments.aspx)

CLAHRC NWL: Development of a framework to support integration of physical, mental and psychosocial wellbeing in quality improvement activities. for information on CLAHRC NWL ‘systematic approach to quality improvement’ http://clahrncnorthwestlondon.nihr.ac.uk & http://qualitysafety.bmj.com/content/early/2014/10/15/bmjqs-2014-003103.full

CLAHRC Oxford: Development of a standardised approach to monitoring and evaluation of PPI in social care, health, education and research across The Thames Valley and Milton Keynes.
In collaboration with A/Prof Weaver, Modelling the process and impact of service user involvement in mental health services research: Comparative case studies to develop a theory of involvement. This ongoing work is a multinational qualitative study of user involvement in research.

Since her return to MNMH she has been sharing learning from the scholarship in various forums and in the course of her work. She is strongly promoting ‘enabling environments’ and adoption of systematic approaches to quality improvement. Publications arising from Sue’s work are noted in dissemination activities and she’s happy to be contacted to discuss her experiences.

Sue extends sincere thanks to the many organisations and individuals who made the Scholarship possible here at Metro North and in London.
Consumer and carer engagement:

Nothing about us without us.....

Meaningful collaboration between people who use and provide health services is internationally recognised as critical to improvement in the efficiency, effectiveness, experience and outcomes of care. Consistent with this, MNHHS strategic documents articulate a deep level commitment to engagement of consumers, carers and the community, and MNMH promotes and supports involvement of people with experience of mental health problems in the service in various ways.

Collaboration is also recognised as critical to the conduct of research generally and in mental health in particular. Indeed many funding bodies oblige researchers to work in partnership or to collaborate with people potentially affected by the research, to shape decisions about research priorities, policies and practices. Research is to be carried out ‘with’ or ‘by’ stakeholders rather than ‘to’, ‘about’ or ‘for’ them by ‘objective’ researchers. Evidence is building that collaboration can improve the ethics, quality and relevance of research and confer benefits on people involved.

Not all stakeholders and convinced, however. Some researchers have noted that collaboration can be challenging and slow the pace of research, and some reports suggest that a minority of consumers involved in research experience inconvenience, frustration and harm to mental health and wellbeing. Context and individual characteristics and expectations of those involved likely impact the experience and outcomes in complex ways.

Here, Imani Gunasekara who works as a consumer consultant with MNMH describes her experiences.

The Accidental Researcher, collaboration and co-production

My name is Imani. I have been invited to write about my experience as someone who has used mental health services in collaborating with academic researchers to produce a quality improvement project which has been published in an international peer review journal (What Makes an Excellent Mental Health Nurse?), and a research study in progress (What Makes an Excellent Mental Health Doctor?).

I have been a Consumer Consultant, working at the RBWH for almost nine years. My work is broad and varied. It includes developing information brochures and booklets for service users, promoting a consumer perspective in meetings, giving talks and presentations about recovery and the lived experience, organising psycho-education sessions for consumers and carers, participating in quality improvement projects. Collaborating in research has recently been included in my job description.

My initial introduction to research was through my science degree. After completing my honours project I worked for a year as a laboratory research assistant, developing a tissue culture method. My understanding of research then was constrained by the rigours of “Scientific Method” – impartial research, hypotheses, control groups and randomised control trials. This dry approach is a far cry from the juicy and fascinating qualitative research into the human condition that I have been working on with A/Profs Sue Patterson and James Scott over the past few years.

The catalyst for writing the work underpinning the first paper was my admission to hospital in 2012 with a mental health issue. Admitted first to a public hospital, then transferred to a private hospital I saw stark contrasts between the way consumers were treated in the public and private systems. In particular, I noticed that while some nurses were compassionate and caring, there was sometimes a disdain and lack of respect in the way that others treated patients particularly in the public hospital.

When I was well again and back at work I was curious about the experiences of people hospitalized in our mental health service at the RBWH. I collated and analysed feedback from the suggestion boxes on the wards and found that the experience of care from the nurses was variable. I decided to develop a training package for nurses at the RBWH to assist them to work with people in a way that was person-centred and supported recovery. Because I wanted it to be relevant here at the RBWH and really reflect the views of people admitted to hospital I started talking to people on the wards, asking them what they thought made an excellent mental health nurse and what could be done to improve the practices.
When approaching people I introduced myself as a consumer and assured people that their feedback would be anonymous. I encouraged them to be open and people pulled no punches in expressing what they wanted and didn’t want from an excellent mental health nurse. I wondered whether they would have been so open with someone who wasn’t a consumer, who hadn’t been in a similar position to theirs.

At the time I did not think of this as research and did not plan to publish. I simply wanted to develop some training material grounded in experience. I found the experience both rewarding and challenging but was considering this a one off project. I had no idea where this curiosity would lead.

After developing and delivering the training package, one of my colleagues suggested that other services might be interested and encouraged me to think about publishing. She introduced me to Sue Patterson, a researcher working in the service. Sue and I met and over the course of an hour, she asked me lots of questions about the process that I went through in developing the training package, who was interviewed, how many people were interviewed, how many people declined, how I recorded their feedback. At the end of the conversation Sue said she thought it was a robust piece of work that could be written up as a quality improvement project. She took the lead in arranging the ethical approvals and writing the paper but she consulted with me and the co-authors (Carer Consultant Tracey Rodgers and Carer Tina Pentland) at every stage. The article, “What makes an excellent mental health nurse? A pragmatic inquiry initiated and conducted by people with a lived experience of service use” was published in the International Journal of Mental Health Nursing in 2013.

The second work, a work in progress, is the research project “What Makes an Excellent Mental Health Doctor”. We obtained ethical approval for this research project. There was support at all leadership levels from the Executive Director to the Principal Research Fellow to my direct line manager. I was supported to dedicate a substantial portion of my time to conducting the research work so long as I met the other basic needs of my job. Sue and I worked together to develop the qualitative approach that we used in this research, based on the approach taken in the previous project. The research questions were developed collaboratively. I conducted the interviews with Sue providing guidance and coaching to enable me to delve deeper into the consumers’ responses to questions.

We worked together to analyse the data and make sense of what people were saying to us. An important part of this study was getting feedback from doctors about consumers’ views and expectations – we wanted to understand what the doctors needed to work in the way valued by consumers. Sue has taken the lead in writing the article, in collaboration with Dr James Scott but we always discuss what is to be written and critique it together. The paper reporting the study is soon to be submitted.

Over the course of our working together Sue has since become a colleague, co-researcher and mentor. Professionally we are critical friends and we have developed a personal connection. We bring different perspectives to the study and learn from each other. Sue has supported and challenged me to think about things like subjectivity and impartiality in research and what that means when the purpose of a study is to understand experiences and views. I remember saying to her “what if they think this research is biased because I am a consumer?” And she said “you would have every right to be biased. Any human being has some level of bias. What matters is that you know your own biases”. Sue often seeks my opinion on research and ethical issues and I feel comfortable offering alternative views to hers. We have presented our approach to working together and separately at international conferences.

In conclusion I would urge academic and clinician researchers to consider conducting a collaborative research project with service users. It is not an easy path and positive outcomes are fundamentally dependent on mutual respect. It involves a shift in focus from being experts to becoming partners, supporters, facilitators and mentors. It means acknowledging and respecting the expertise each person contributes. It involves relinquishing control and sharing of power. It may take more time and money but the end product is research gold. Gold that is deeply relevant to consumers, counters stigma, empowers service users and improves services and health outcomes for all people. And that is why collaboration and co-production are the future of mental health research.
CADENCE – building research capability

Building research capability and capacity within mental health services is critically important to generating the evidence needed to improve practice and outcomes. Metro North is pleased to be working with Professor John McGrath to do this.

Cadence by Prof John McGrath

In 2013, the National Health and Medical Research Council awarded John McGrath a prestigious John Cade Fellowship. John Cade was an Australian psychiatrist working at a large mental health hospital in Melbourne. In 1949 he published a landmark paper that reported that lithium was effective for the management of agitated psychosis. Now, lithium is a widely used and effective treatment for mania and for the prevention of relapse in bipolar disorder.

One important component of the John Cade Fellowship relates to building capacity in psychiatric clinical trials. Under the guidance of Associate Professor James Scott, in collaboration with a team of clinicians in south east Queensland, we were proud to launch the first Cadence clinical trial in 2015. The short term goals are to build skills in clinical trials, raise clinical trial ‘literacy’, and to look for more effective treatments for psychosis. The longer term goals are much more ambitious - we believe that clinicians, patients and their caregivers can contribute to the discovery of future treatments. We need to set traps for discovery - and help look for better ways to treat those with psychosis. It is entirely feasible that the ‘next John Cade’ is a staff member at Metro North HHS! We want to encourage clinical teams to contribute to clinical trials (it is important that we find better treatments), and also encourage staff to actively look for better treatments.

In 2016 three clinical trials are underway in Metro North. Cadence BZ is a study examining sodium benzoate (a common food preservative) as adjunctive treatment for those with early psychosis. Cadence M involves the adjunctive treatment with a powerful antioxidant, extracted from the skin of the tropical fruit Mangosteen. Finally, Cadence SCIT builds on the important work of Dr Anne Gordon, Clinical Psychologist at Metro North (see Anne’s story on page N), comparing Social Cognition Interaction Therapy with another type of group therapy. We believe that this type of training can help people manage better in their daily lives.

For more information on Cadence, visit www.cadencetrials.com
Sam Bicker, Professional Lead for occupational therapy reflects on the importance of research for

How Occupational Therapists can set sail on a research journey

Research knowledge, skills and abilities are essential, not just desirable, competencies that all occupational therapists need to attain, develop and apply to their practice. The trajectory of a career pathway that includes research for an OT is often a unique journey, it may involve personal interest or a vision that they are striving towards, but whatever their motivation, OT’s need to be supported on this journey to help encourage a culture of research within the discipline.

Here at the RBWH MNHHS mental health service the OT cohort are working hard to develop a pathway to help support this development. There is currently a successful journal club that occurs on a monthly basis where OT’s digest research and complete reflection tools to demonstrate their linking of these theories, concepts or findings of studies into practice. The reflection involves a robust review of the article to help support and build confidence in understanding research and remain familiar with specific research terminology.

We are actively working hard to provide quality assurance activities through working towards evaluating specific programs OT’s are facilitating to demonstrate the provision of these services have a positive outcome for consumers, and can be translated into functional change within the consumers lives, ultimately improving their quality of life. Although this process is in its infancy the OT’s are working towards making this a standard approach to all service provision they are involved in, with a vision to publish these findings within relevant journals.

As the professional lead for OT within MH at RBWH I remain passionate that if viewed as part of professional practice research skills can and will be developed. By actively promoting research within mental health OT’s there will be a natural movement towards OT’s learning more about research within the entire organisation, increasing their confidence in talking about research, develop their understanding of the research process and ultimately become an active part of the research community.
Please tell us about your research in a ‘text message’  
(160 characters or less)
Inflammation impairs cognitive refinement in early psychosis. I use MRI to study how brain networks become faulty when inflammation occurs.

How do you manage work – life balance?
Not very well. I suspect I have more to learn. However, I prioritise my family first (partner and pet doggie), my work and research second and then everything else third.

What is one thing the Executive should do to build research capacity?
Metro-North Mental Health is already emerging as a veritable bastion of research, as evidenced by its recent successes at the Research Excellence Awards 2016. This would not have been possible had it not been for the leadership shown by the Executive in promoting a research culture. If this disposition is maintained Brisbane will soon match the institutional research capacity in mental health seen in Melbourne and Sydney.

What was your/the service’s greatest research achievement in 2015?
Establishment of the Cadence Trials across Metro-North and Metro-South. Finally, our service has established a research infrastructure for RCTs. This was a vital step to improving research capacity in mental health seen in Melbourne and Sydney.

What do you define success in relation to research?
Success in research is derived from its personal meaning. If you can get out of bed in the morning eager to take on your research work, despite the seemingly insurmountable obstacles and endless tasks that need to be met, you will know what you are doing is worthwhile.

What motivated you to become a clinician/researcher?
Once I realised that research could truly inform your clinical practice on a level that engaged your personal interests it was very easy to dive in.

What advice would you give to a clinician thinking about undertaking a PhD?
Make sure you find mentors/supervisors who not only encourage you but who also share cautionary tales of undertaking a PhD. There is wisdom in the struggles of those who came before you.

What qualities or attribute are essential to being an excellent researcher?
Indefatigability.

Qualitative or quantitative? – Why?
This question is loaded. But my research interest favours quantitative research.

What is the greatest challenge to integration of research in practice?
In Mental Health the challenge lies in the nature of the unequal relationship we have with our patients. An alliance is needed to engage the consumer as often we call on them to participate in research that may not directly benefit them.

What’s in the future for mental health research?
Translational research working in both directions from bench to bedside; meeting in the middle!
Recovery oriented care

Organisation and delivery of care in Metro North Mental Health, as in all Australian public mental health services, is governed by Federal and State legislation and guided by multiple policies; the National Standards for Mental Health Services which set out principles for care, provide a framework to support continuous quality improvement. Collectively these documents oblige services to enact least restrictive practices and to adopt a ‘recovery approach’.

The ‘recovery approach’ to which MMHS aspires is grounded in the view that serious mental illnesses are not ‘irremediably incapacitating’. Instead people who have experiences defined medically as mental illness are understood as able to live full, satisfying lives, integrated with and contributing to society. This intensely personal recovery, conceptualised as a ‘journey’ is often contrasted with ‘clinical recovery’ defined as an endpoint, achieved when resolution of symptoms enables return to pre-morbid functioning. In locating ownership of the process of recovery in the person affected, this recovery is also differentiated from ‘rehabilitation’ a professionally driven approach to mental health service provision (Anthony, 1993)

Adoption of the recovery approach requires substantial shifts in philosophies and structures of care, predicated on shifting the balance of power from clinicians to people who use services. Recognition of people diagnosed with mental illness as experts in their experience and recovery requires fundamental changes in assumptions, practices and anticipated outcomes of services established within the biomedical tradition.

With embedding the required shifts proving challenging internationally researchers and clinicians are working to develop ways to make services more ‘recovery oriented’.

Lucianne Palmquist, a psychologist at Redcliffe Caboolture child and youth mental health services is undertaking research designed to support application of recovery principles to services for adolescents.
Lucianne Palmquist, mother, wife, daughter, PhD candidate and practicing psychologist.

Works as a psychologist with Child and Youth Mental Health Service 2-3 days per week. Studying a PhD in clinical psychology at Griffith University 3 days per week. Course work, placements and thesis. Expected completion mid-2018.

Study title:
A grounded theory explanation of Adolescent ‘Recovery’: CYMHS consumer perspectives.

Why? Australian mental health policies endorse a recovery-oriented approach to service provision across the life span. These policies are grounded in research conducted primarily with adults, suggesting that ‘recovery’ is best understood as a process of improving sense of wellbeing while living with mental health challenges (‘personal/social recovery’) rather than an event involving symptom remission or cure (‘clinical recovery’). The limited research conducted examining recovery in young people, however suggests their experiences and perspectives may differ from adults in some important ways. It is therefore unclear whether adult-oriented recovery principles provide the appropriate grounding for services supporting young people whose mental health concerns often relate to their particular stage(s) of development. We need more information to promote design and delivery of services that are acceptable and effective.

How? I’m using a qualitative approach called grounded theory. Grounded theory methodology is designed to support development of a theory that conceptually explains, at a broad a process or phenomenon. Grounded theory, like experimental research is grounded in the view that scientific theories explain observations but in contrast grounded theories are inductively derived from the study of the phenomenon it represents.

The aim of my study is to develop an understanding of recovery from mental health problems from the perspective of young people aged 12 to 17 years. Drawing on interviews with around 30 young people involved with Child and Youth Mental Health Services in three sites including Redcliffe-Caboolture CYMHS, I will model the process of transition into and through services. I will also explore young people’s expectations of recovery are, and what stands out to them as being helpful or challenging in their journey.

I’ve now interviewed around 15 young people who’ve described a range of experiences. While each story is unique there are common concerns and patterns in the journey into and through mental health services. I have been inspired by the tenacity, honesty and resilience of the young people I’ve interviewed and have been personally moved by their stories.

What will happen to my findings? I will write the study up for my PhD thesis, share findings with people who have supported the study and with services. I will also write papers and make presentations at conferences. I hope that my findings helpful in shaping policy, service development and intervention approaches that are pertinent to young people.

On balancing her many roles while managing research, Lucianne says...

With valued support at family, educational and professional levels, balancing my various roles has been challenging but never overwhelming. What has also helped in those moments of questioning why I started and whether I’ll ever finish the research, is my interest in giving young people a voice in regard to processes that directly affect them, where sometimes they may be overlooked.
Physical health and mental health

Whereas life expectancy generally has increased steadily over the past century, rising from around 56 in 1900 to over 80 in 2005, no such gains have occurred among people with severe mental illness (SMI). Indeed with life expectancy of people with SMI reduced by around 20% (13-32years) disparity has increased. While suicide accounts for around 30% of excess mortality, the majority is caused by a range of treatable physical illnesses including metabolic and cardiovascular diseases. With the overarching aim of improving outcomes, policies and guidelines oblige mental health services and psychiatrists to monitor cardio-metabolic health of patients and intervene as appropriate.

Improving the physical health of people who access MNMH services has been a priority– clinically and for research and evaluation - since 2011. The service has employed multiple strategies to promote adherence to therapeutic guidelines, improving rates metabolic monitoring and follow up of abnormalities and enhancing consumer access to health promoting interventions. Alongside, and to inform quality improvement activities the service is conducting a program of research related to the provision of physical health care within specialist mental health services. Four components of the ongoing research undertaken during 2015 are described below.

Psychiatrists’ follow up of metabolic abnormalities and influences on practice

Mixed methods (an audit of clinical records and interviews with psychiatrists) were used to describe psychiatrists’ follow up of identified metabolic risk and influences on practice. This study showed that follow-up in routine practice was variable (with given doctors usually responding in the same way for all their patients) but more likely when four or more metabolic abnormalities were detected.

Psychiatrists generally endorsed therapeutic guidelines requiring monitoring and follow up but were often ambivalent about responsibility of mental health services generally and psychiatrists in particular. Practice was influenced by professional norms, resource constraints and perceived skills as well as patient factors. Therapeutic optimism (believing that treatment could work), desire to be a ‘good doctor’ and flexible practice were associated with consistent, comprehensive follow-up. The paper reporting the study was published in the BJPsych Bulletin early 2016 see DOI: 10.1192/pb.bp.114.049379

Attending to physical health in mental health services: Consumers’ experiences and expectations

Ongoing debate about resourcing and responsibilities of mental health services in relation to physical health has to date been dominated by clinicians who have identified disinterest among patients as influencing practice. Seeking to balance discussion, we posed the question ‘what do patients experience and expect of mental health services in relation to their physical health?’ To answer it, we interviewed 40 consumers recruited from inpatient and community settings across MNMH early in 2015. With few regarding themselves as healthy, participants were commonly concerned about side effects of medication, weight and fitness but rarely mentioned tobacco smoking. Participants’ accounts indicated substantial variability in attention to physical health within mental health services. While some participants reported comprehensive care many said they did not know why various assessments were conducted and some reported being denied support to manage physical side effects of medication. Although participants in this study wanted to improve their health and health-related quality of life, they acknowledged that their motivation and ability to do so fluctuated with mental health. Under these circumstances, they expected clinicians to work proactively, especially when symptoms compromised capacity for self-care, and mental health services to provide or enable access to health-promoting interventions.

Conducted with funding support from the Caboolture Hospital Innovation and Research Program, the study was presented at three conferences and has been published in Health and Social Care in the Community. See DOI: 10.1111/hsc.12349. See poster on page 24 and Sarah Young’s account of her work on the study on page 31.

Homeless Health: Taking Metabolic Monitoring to the Street

Changing clinical practice is notoriously difficult but evaluations have shown that various interventions, including introduction of specialist positions, scheduling monitoring at service rather than individual level, and formalisation of service policy and procedures can improve rates of monitoring, identification, and follow up of cardiovascular risk factors among patients who attend clinics. Evidence is limited, however, in relation to care for more marginalised populations, such as people who experience homelessness and may avoid services.
As part of ongoing service development, The MNMH Homeless Health Outreach Team (HHOT) implemented a multi-faceted quality improvement initiative designed to improve rates of metabolic monitoring among people receiving support from the team. Central to the initiative was provision of a portable metabolic monitoring kit that enabled clinicians to undertake monitoring ‘on the street’ and in other public spaces where they usually provide services.

An observational study, involving collection and analysis of data from service documents and team members was conducted to describe

1. the design and implementation of HOTMM
2. outcome (rates of monitoring and follow up of abnormalities) and mechanisms by which outcomes were achieved
3. the metabolic health of a group of people who are homeless and experience SMI

The study showed that the initiative was associated with substantial, sustained improvement in metabolic monitoring with all assessments completed for around half, and some for nearly 90% of eligible patients six and 12 months after implementation. It also demonstrated the importance understanding the identified ‘problem’ fully and of shaping interventions to suit the context to success. A paper reporting the study is in preparation.

The roles of Psychologists in physical health

With the majority of literature related to physical health care in mental health services focused on medical and nursing staff, little is known about the practice and views of allied health professionals. Reasoning that psychologists’ knowledge and skills could place them well to support people to engage in health promoting behaviour we set out to explore their practice and views.

The study involved interviewing 29 psychologists working in different clinical/non-clinical roles within the service about current practices, factors influencing practice, and potential roles for psychologists in attending to the physical health needs of people accessing services. Interviews were recorded and transcribed verbatim for analysis using the Framework approach. Participants reported varying practices ranging along a spectrum from ‘nothing at all’ with physical health considered out of scope of psychologists or mental health services, through responding to requests from consumers, to proactive integration of physical and mental health in assessments and care planning.

Psychologists generally agreed that psychological interventions could add value to services and interventions targeting physical health. They noted however, that use of discipline specific interventions (e.g. provision of motivational interviewing and psychotherapy) was currently constrained by case management roles and resource limitations. Consensus among psychologists was that increased role clarity and delineation would enhance the contributions each discipline could make to provision of holistic care. The findings and implications are explored further in a paper soon to be submitted for publication. See Natalie Avery’s story on page 31.

For more information about any of these studies or other research related to physical health care within mental health services, please contact Sue Patterson on susan.patterson@health.qld.gov.au.
Physical health care in mental health services: The experiences and expectations of consumers

Sarah Young, Anna Praskova, & Sue Patterson

Metro North Mental Health

THE PHYSICAL HEALTH OF PEOPLE WITH SEVERE MENTAL ILLNESS

Lifespan curtailed by 13 to 32 years

60% OF PREMATURE MORTALITY DUE TO PHYSICAL ILLNESS

Compared to the general population people with SMI are:

TWICE as likely to be obese

3x more likely to have diabetes

70% of people with SMI smoke tobacco

Causation is complex

Antipsychotic medications cause metabolic dysfunction and weight gain

Barriers to health care access and suboptimal care

Cardiovascular disease:
Leading cause of premature death in people with SMI

Identification of the most at-risk Australians and targeted interventions for them should be a priority

We know about the guidelines

But we have limited time and have to prioritise mental health; we can’t do it all!

Patients aren’t interested or motivated

BUT, Nobody asked me!

RESEARCH: practice is variable internationally, typically suboptimal

WHY?

Therapeutic guidelines:
Don’t just screen, intervene

• You weigh and measure us but don’t tell us why or what you find. Please feedback results and tell us what they mean

• Motivation to attend to physical health is affected by mental health; sometimes just getting by is all we can do

• We do care about our physical health, we just don’t know how to change

• We need you to be assertive and proactive, especially when we’re unwell

• Support access to structured physical activity and provide information about healthy eating and refer for specialist help when needed

• Make hospital healthier (food is stodgy and we can’t exercise)

• We need you to be assertive and proactive, especially when we’re unwell

• Support access to structured physical activity and provide information about healthy eating and refer for specialist help when needed

• Make hospital healthier (food is stodgy and we can’t exercise)

• We need you to be assertive and proactive, especially when we’re unwell

• Support access to structured physical activity and provide information about healthy eating and refer for specialist help when needed

• Make hospital healthier (food is stodgy and we can’t exercise)

HELP us HELP OURSELVES

You can’t compartmentalise a person; how you’re feeling physically affects your mental health and vice versa. A more holistic approach is going to help people’s mental health too

The 40 Participants (including 23 men) were

21 to 80 years old mean 47 years

Service users for 2 weeks to 46 years (90% at least 12 months)

Half live with chronic illness or injury

SELECTED REFERENCES


Nursing Research
by Niall Higgins Senior Research Fellow

NURSING RESEARCH

Academic and industry partnerships continue to be an important focus for the nursing profession within Metro North Mental Health. The Nursing Research Office, Metro North Mental Health is actively involved in departmental, interdepartmental and multi-site collaborative research projects. Under the directorship of Clinical Associate Professor Lisa Fawcett and the four Nursing Directors across Metro North Mental Health, together with the Nurse Researcher, the Nursing Research office manages all aspects of nursing research related to mental health. Dr Niall Higgins is a Senior Research Fellow in a conjoint position between Metro North Mental Health and Queensland University of Technology, School of Nursing. In his role he aims to not only support nursing research across Metro North Mental Health as its capacity grows but also help develop the academic partnership with the School of Nursing at Queensland University of Technology. For example, the Safewards model of mental health nursing is currently being integrated into the undergraduate curriculum of the School of Nursing at Queensland University of Technology and is also the focus of work conducted for Metro North Mental Health Nursing Research.

Registered Nurses are required by the Australian College of Mental Health Nurses (ACMHN) to complete a postgraduate mental health qualification at Graduate Diploma or Master Degree level in fulfilment of their specialty credentialing assessment requirements. Registered Nurses are encouraged to initiate or become involved in existing departmental projects, providing an environment for junior nurses to develop key research skills for their future careers. The Nursing Research Office also receives enquiries from nursing students and non-nursing staff who wish to be involved in research activities. Nursing research pursuits in 2015 have publications in peer reviewed journals, along with presentations at local and international mental health nursing conferences, by all levels of nursing staff including Nurse Educators and ward staff. The future of nursing research in Metro North Mental Health is positive, with continuing growth in research involvement.

The Nursing Research Office has a range of active service-based research programs. One such nursing research project this year was initiated by the nursing leadership group shown in the main photo. They conducted an extensive literature search and following ethical approval conducted an audit on the topic of managing aggression during psychiatric hospitalisation. This is frequent, problematic, and a major challenge for nurses and mental health services more generally. Additional nursing research conducted at Metro North Mental Health found that the continuing need to focus on good communication and teamwork is integral to contemporary management of aggressive behaviour (Fawcett, 2015). Details of the work and other nursing research described below for this year is linked from the names in brackets to the references section at the back of this review.

Violence towards health-care workers, especially in areas such as mental health, has become increasingly common, with nursing staff suggesting that a fear of violence from their patients may affect the quality of care they provide. Following from this, the nursing research team decided to implement the Safewards program, developed by Professor Len Bowers, Kings College London. The nursing leadership team followed the recommended evaluation approach with the added view to understand how this would be translated to the context of mental health nursing practice in their wards (Dart, 2015). Their work was presented at the ACMHN annual conference. Throughout the Safewards project,
several one day training events were conducted for staff to receive education support (Higgins, 2015). Additional supervision was provided at unit level to support the program, and the majority of components of the program were successfully implemented. Consumer Consultants, who have a lived experience with mental health issues participated in ward meetings and activities where appropriate. Carer Consultants also attended regular meetings to represent Carer views. The introduction of the Safewards program has become a positive group activity. It appears to engage consumers with a positive experience and staff are beginning to notice small changes to their language during interactions with consumers (Hiscox, 2015). The contribution to research from nursing education and clinicians in the ward areas include education, training and support to assist nurses to develop and maintain therapeutic relationships within inpatient mental health units in Metro North HHS (Hatch, 2015).

Support from Nurse Educators at Royal Brisbane Hospital, The Prince Charles Hospital and Caboolture Hospital has also helped with new graduates entering the mental health nursing workforce. The results of a survey identified what students felt helpful and interesting on their mental health placement (Dalton, 2015). It was encouraging to see how ‘beneficial’ the students see the mental health placement and that the stigma surrounding the consumers and staff is greatly reduced. Feedback indicated that some wished to commence a career in mental health nursing, stating their experience has ‘completely changed my mind about mental health’. The integration of nursing research and education of nurses has helped highlight what the learning needs are for clinicians and informed undergraduate curriculum and ward based education needs. Ongoing initiatives, such as the Medication Safety Committee has facilitated nursing research outcomes this year (Collyer, 2015). The success of the committee in its organisational structure and role has become recognised by the RBWH with several other service lines utilising its model and Terms of Reference. An additional separate novel approach was developed by the nursing education team to give students an opportunity to develop skills, in addition to a greater exposure to the specialty of mental health, beyond the 2 or 3 weeks normally included in their degree (Hall, 2015). The outcomes of this evaluation work continue to attract and retain new nursing graduates into the specialty of mental health. The combined efforts of Nursing Research and Nursing Education is challenging, but vital to the sustainability and productivity of the workforce.

Nursing workforce

Recruiting, retaining and supporting a highly skilled nursing workforce is vital to the efficient delivery of mental health care and optimising outcomes, particularly in inpatient units. This is challenging however with attitudes and confidence of students recognised as a barrier to recruitment.

Motivated by literature and her own experiences guiding nursing students on mental health placements, Johanna Dalton Nurse Educator at the RBWH set out to help students feel more confident working with people on mental health wards. She presented her work at The Australian College of Mental Health Nursing 41st International Mental Health Nursing Conference – ‘Mental Health Nurses: shifting culture, leading change’

Successful strategies for building student confidence in mental health care

There is much evidence highlighting the lack of understanding and even fear that undergraduate students voice in regard to mental health nursing. Reports have found that students have minimal understanding of the role and functions of a mental health nurse. During my professional career, I have witnessed students crying out of fear before they even get to the ward. This paper addresses the approaches taken to assist undergraduate students to build confidence when caring for consumers of mental health services and debunk some of the associated stigma that surrounds this specialty. The aim of this paper is to describe the results of a survey that supports the steps that we take to reduce the stigma of mental health and mental health nursing during student clinical placement.

Generally, students are in their second year of undergraduate nursing and the placements are 2 weeks in length. A pre- and post survey was conducted between March 2012 and November 2014 with undergraduate student nurse respondents from seven Australian universities that were on clinical placement rotation within Royal Brisbane and Women’s Hospital. Approximately 90% of all students reported their overall experience as either Excellent or Good. Prior to placement, 60% of students felt ‘not (confident) at all’ or ‘mostly not at all’ in completing a Mental Status Examination.

Significantly, after placement, this confidence increased to at least 96% (‘completely confident’ or ‘mostly confident’).
The survey identifies what students felt helpful and interesting on their mental health placement. It is encouraging to see how ‘beneficial’ the students see the mental health placement and that the stigma surrounding the consumers and staff is greatly reduced and in some cases appears to be completely removed – particularly their perceptions about Electro Convulsive Therapy. Feedback indicates that some wish to commence a career in mental health nursing, stating their experience has ‘completely changed my mind about mental health’.

The survey is ongoing and is routinely delivered by the Nurse Educators and Clinical Facilitators. The data gathered help highlight and ensure positive learning experiences continue for future undergraduate nursing students undertaking mental health clinical placements.
Introduction
Medication Safety has been listed as Number 4 of the “National Safety and Quality Standards”, an it is every clinicians concern to act and practice in a safe manner. In 2010 Metro North Mental Health RBWH initiated a multidisciplinary Medication Safety Committee with representatives from Nursing, Pharmacy and Medicine. What grew out of a working party set up to examine issues with the prescribing of Clozapine, involved into a committee that is responsible for the monitoring of all aspects of medication safety for the Mental Health service line here at the RBWH. It was the first Queensland public hospital committee of its kind that was specific to Mental Health.

Method
The Committee was setup to monitor issues of medication safety and reporting mechanisms. Chaired by a Mental Health Nurse Educator, its primary role is to examine incidents reporting mechanisms to assist in the identification of the major cause of errors and how these errors could be mitigated. A range of disparate legacy and mandatory reporting systems were consolidated with traditional communication patterns that were often hit and miss with regard to the type of information relayed and to whom it was intended for.

Results
The committee has played a major role in policy development and procedural clarification for this hospital and many of its recommendations have been adopted by other HHS’ in Queensland. The current system of reporting now highlight errors related to documentation and prescribing practices to other relevant committees and contributes to other professional reporting bodies.

The committee has created an awareness amongst clinicians of the importance with “safety” around all aspects of the process of medication administration concern for all clinical professionals.

Conclusion
The success of the committee in it organisational structure and role has become recognised by the RBWH with several other service lines utilising its model and Terms of Reference. Our experience has shown that there is a need for an active medication safety committee that is specifically tailored to the specialty of Mental Health.
The Queensland Forensic Mental Health Service

Queensland Health is the major provider of mental health services to people with a mental illness who are involved with, or at risk of entering, the criminal justice system. These services are provided across the age spectrum. The Queensland Forensic Mental Health Service comprises an integrated system of services consisting of large multi-disciplinary teams based in Brisbane (Metro North and West Moreton), Townsville and Cairns, coordinating with smaller forensic teams and mental health services across the state. The integrated forensic programs include Secure Inpatient Services, Prison Mental Health Services, Court Liaison Services, and Community Forensic Outreach Services. The State-wide component of the service is led by the Director and Operations Manager, Queensland Forensic Mental Health Service (based in the Metro North HHS) with the support of the Service Managers, Clinical Directors, and five State-wide positions coordinating Court Liaison Services, Prison Mental Health Services, District Forensic Liaison Network, Indigenous FMH, and the State-wide Community Risk Management program.

QFMHS has an active research and evaluation program with studies designed to inform service design and delivery and, ultimately, improves the experience of forensic consumers and other stakeholders. The service prioritises the sharing of research findings with stakeholders and the wider community through publications, seminars and presentations.

Research in 2015 focussed on:

- The interface between police and mental health services
- Post traumatic stress disorder in Aboriginal and Torres Strait Islander women in custody
- Benchmarking with Forensic Mental Health Services in other states and territories
- The use of interactive technology in custodial settings for the delivery of social and emotional wellbeing programs
- Enhancing partnerships with other government departments and the tertiary education sector to improve mental health outcomes

Ensuring research conducted by the service is acceptable and relevant to stakeholders, particularly participants is a high priority for the service. Reflecting the service commitment to ‘cultural safety’ members of the communities involved commonly work along-side QFMHS researchers or as part of QFMHS research teams. (see Heffernan et al Enhancing research quality through cultural competence: a case study in Queensland prisons. 10.1177/1039856215609763

Researcher Profile

Fiona Davidson is a mental health nurse who is employed part-time as the Research and Evaluation Coordinator for the Queensland Forensic Mental Health Service.

She has qualifications in nursing, mental health and social science, and has experience in mental health & alcohol and drug clinical and policy settings. Fiona has previously been managed state based mental health benchmarking projects and has been involved in national forensic mental health benchmarking projects. Her role is to foster research opportunities within the service and take a supporting role in research and evaluation projects across the range of the components that form the Forensic Mental Health Service. These include Prison Mental Health, Court Liaison, Community Forensic Outreach, Inpatient Services and new services such as the Police Communications Centre Mental Health Liaison Service.

“It's an exciting time to be involved in research at the Forensic Mental Health Service. There is a growing research and evaluation agenda at the moment with a broad variety of projects taking place. We are lucky to have many clinicians with strong research interests and skills that are committed to improving the mental health and wellbeing of people with mental illness that are involved with the criminal justice system. New areas of inquiry such as the interface between the mental health system and police hold great promise in benefiting clinicians, police, consumers, carers and the community.”

Fiona is also a PhD student with the School of Population Health, University of Queensland and the NHMRC Centre for Research Excellence in Offender Health. Her current research is in the area of court based approaches to mental health diversion in Australia.
Abstract

**Harassment, stalking, threats and attacks targeting New Zealand politicians: A mental health issue.**


**OBJECTIVE:** Due to the nature of their work, politicians are at greater risk of stalking, harassment and attack than the general population. The small, but significantly elevated risk of violence to politicians is predominantly due not to organised terrorism or politically motivated extremists but to fixated individuals with untreated serious mental disorders, usually psychosis. Our objective was to ascertain the frequency, nature and effects of unwanted harassment of politicians in New Zealand and the possible role of mental illness in this harassment.

**METHOD:** New Zealand Members of Parliament were surveyed, with an 84% response rate (n = 102). Quantitative and qualitative data were collected on Parliamentarians’ experiences of harassment and stalking.

**RESULTS:** Eighty-seven percent of politicians reported unwanted harassment ranging from disturbing communications to physical violence, with most experiencing harassment in multiple modalities and on multiple occasions. Cyberstalking and other forms of online harassment were common, and politicians felt they (and their families) had become more exposed as a result of the Internet. Half of MPs had been personally approached by their harassers, 48% had been directly threatened and 15% had been attacked. Some of these incidents were serious, involving weapons such as guns, Molotov cocktails and blunt instruments. One in three politicians had been targeted at their homes. Respondents believed the majority of those responsible for the harassment exhibited signs of mental illness.

**CONCLUSION:** The harassment of politicians in New Zealand is common and concerning. Many of those responsible were thought to be mentally ill by their victims. This harassment has significant psychosocial costs for both the victim and the perpetrator and represents an opportunity for mental health intervention.

© The Royal Australian and New Zealand College of Psychiatrists 2015.

Abstract

**Enhancing research quality through cultural competence: a case study in Queensland prisons.**

Edward Heffeman, Kimina Andersen and Stuart Kinner. Australasian Psychiatry 23(6), 654–657. 10.1177/1039856215609763

**OBJECTIVE:** To describe the processes undertaken to maximise cultural competence in a complex research project and illustrate how this enhanced the quality of the research and impact of the research outcomes.

**METHOD:** An epidemiological survey of the mental health of Indigenous people in custody in Queensland was conducted using culturally informed research processes.

**Results:** The research process that enhanced cultural competence is described. The research outcomes were positive in terms of participant and community experiences, participation rates, publications and other research outputs, capacity building and translation of research findings.

**CONCLUSION:** This paper describes in practical terms how to conduct culturally informed research and how this approach enhanced the scientific rigour of a complex Indigenous health research project. Indigenous health research should be conducted using a culturally competent method.

© The Royal Australian and New Zealand College of Psychiatrists 2015.
On being a clinician researcher

Here four clinicians share their different experiences of conducting research in conjunction with clinical roles.

Sarah Young, clinical psychologist and researcher.

I am a clinical psychologist with experience in a range of settings including inpatient and community mental health units. I am interested in understanding patient treatment experiences in order to guide future service delivery both clinically and organisationally. During 2015 I worked half time as a clinician researcher as part of the “Let’s Get Physical” initiative. I was also working as a psychologist in an inpatient. My research role involved me co-ordinating a small team of allied health professionals to explore consumers’ experiences regarding their physical health management through Metro North Mental Health Services. Our aim was to hear from consumers to understand how their physical health needs could be better met.

This was my first experience of running a research project and I was pleased to be actively involved in all aspects of the process. The hands on approach helped me learn the practicalities of all of the steps involved in getting a project up and running through to submitting the results for publication. Given I had not conducted research since completing my doctoral thesis in 2013; I was keen to be involved, particularly as the project used a qualitative approach, which was new to me.

The topic was of particular interest to me as it linked in with my clinical practice as a psychologist working with mental health patients, and I was excited knowing that the findings were going to be used to influence service development discussions. I found it rewarding to be on the ground conducting the consumer interviews and then carefully conveying their stories to represent their voice in the formal write up.

The prospect of being responsible for managing a team and keeping to strict deadlines was slightly daunting but I was fortunate to work with a dedicated team who helped make my job a lot easier with their clear communication and proactive approach.

I am so thankful to have been involved in this project and it has certainly solidified my appreciation of the importance of clinical research. I think it was particularly rewarding as I could see that the findings were directly relevant for health services. Probably the most challenging aspect of the project was the write up and allowing ample time for multiple draft revisions.

There were many positive aspects but one thing that stands out was the joy of speaking to consumers and hearing their stories and passion regarding the topic of their physical health. I was pleasantly surprised that consumers were really keen to discuss their experiences and they were equally as pleased that their comments were going to have an influence on service development.

I encourage others to volunteer for research opportunities; it can be extremely rewarding. Working with consumers provided an added insight into patient experiences and expectations that is often not fully captured in clinical practice, where we can often be focused on our own, discipline specific interventions. When working in research I think communication is key, as well as an ability to juggle responsibilities. I was unsure as to whether I would entertain research again following my postgraduate training, however I am so glad that I did as it helped me appreciate the value of research in having the potential to meaningfully impact on clinical practice.
Natalie Avery, primary care liaison officer, TPCH MHS completed a qualitative study for her masters’ thesis while working full time.

In early 2015, I started a qualitative research project in Metro North Mental Health, specifically exploring the role of psychologists regarding physical health needs of severe mental illness. My research was part of a mixed methods study related to the role of specialist mental health services in attending to physical health of Mental Health consumers. Aiming to describe psychologists’ views about responsibility for physical health care, current and potential practice and influences on practice, I interviewed 29 psychologists working across Metro North Mental Health. The research formed the basis of my dissertation for a Masters in Clinical Psychology. The outcomes of this study, as well as the process of interviewing psychologists and analysing the data, have direct relevance to my substantive role within the service (Primary Care Liaison Officer – MNMH, TPCH). As part of this role, I am involved in a number of service initiatives which aim to promote the awareness of the physical health needs of people with severe mental illness, and to facilitate access to services and interventions to enhance physical health outcomes for our client group.

I found the process of conducting research in my workplace, while also continuing to work full-time and study part-time, both challenging and rewarding. One of the main benefits to conducting research in the workplace is the relevance of the outcomes to my practice and professional development - this helped keep me motivated along the way! MNMH was very supportive of the project, allowing psychologists to take part in work time and Sue Patterson, my supervisor helped keep the project on track. My colleagues have also been very supportive, interested in hearing about the study (and participating!).

One of the main challenges of conducting research has been managing competing demands of my role, as well as additional study commitments outside of work. I was very fortunate to have support of my line manager, given the relevance of the findings to my role and priorities of the service to improve health outcomes of consumers. I was able to schedule interviews with participants within work hours, either at their workplace or by telephone – which also made it a lot easier for participants to fit this in with their existing demands. I was able to balance this with my workload, by attending some after-hours meetings and work groups for other projects I was involved in, and by planning ahead in advance any deadlines I had coming up. By collecting data within work hours where possible, I had more time outside of work to focus on transcribing and analysing data. As I was completing the research component of my Masters part-time over two years, I had a longer period of time to gradually collect data, and discuss the findings (and any challenges) with Sue as they emerged.

I then used the break between university semesters over Summer 2015/2016 to focus on piecing together the findings and drafting the write up. I submitted my thesis early in 2016 and am writing up a paper for publication. I have begun sharing the findings with colleagues and services across Metro North, and hope to disseminate them more widely to other Mental Health Services, and possibly present at conferences or other forums.

I would suggest to other staff members who are interested in undertaking research in their workplace, to get in touch with the Research Fellows to discuss their ideas, and seek input and advice regarding research design. They can also help navigate the ethics approval processes required, and provide practical suggestions and advice for implementing research. If you are undertaking further studies, or thinking of conducting research to complete postgraduate qualifications, they can also provide advice/support to assist in matching university requirements to the requirements (and practicalities of the research) in your workplace.

Since starting my own research project, I have had the opportunity to assist others in developing research ideas, and have also been involved in a number of collaborative projects with other partner organisations interested in improving physical health outcomes of consumers, as part of my role. I have also made a number of really useful contacts – both for future research, and projects regarding physical health needs of people with severe mental illness.
needed to be addressed and problem-solved. All in all, Reminders to participants to attend each session, and groups and ensuring high retention rates throughout.

and my clinical practice) was to co-facilitate the SCIT participating. Another part of conducting the research about the study and what would be required of them if before enrolling, and who wanted further information clients who wanted more information about the group as well as advertising flyers for clients. I also contacted them with written information about SCIT and the study, all clinical staff using various means, such as providing and continue to try and promote the program among the program and research. I had to persist in my efforts meetings to encourage clinicians to refer consumers to of six groups entailed attending many clinical team time consuming. Getting enough people to run a total program was challenging and required a lot of energy and enthusiasm, but was well worth the effort. I am continuing my involvement this part of the research involved lots of persuasion on my part! It also involved me working out of usual hours to make it all possible.

The effectiveness of the SCIT program was assessed by comparing its effect between two groups (control vs intervention) at two time points. Post-treatment assessments were conducted immediately following completion of each group program, and, again, four months after participating in the SCIT. 2015 was an important year for me requiring data collection, analysis and interpretation to be completed. Data collected from SCIT participants showed that most rated the program very good to excellent and said that they would recommend it to a friend. Participants reported using the skills they acquired at SCIT on an every-day-basis, and pursuing new activities or friendships. Comparing outcome measures between Improvement in quality of life across different psycho-social domains and a reduction in hostility bias for people in the SCIT group. What was very encouraging was that folk kept coming along– this says to me that they were finding session rewarding and getting something out of the program.

Earlier this year I submitted my research dissertation reporting the study and was very pleased that it passed. I am now moving on to writing up the findings for publication in a peer-reviewed journal, and, thus, contribute to current SCIT literature. I am grateful to Metro North and Griffith University and the several highly experienced research colleagues at the RBWH who guided and encouraged me over the three years of running the SCIT groups and the study. They helped keep me motivated and helped me with clinical and research issues.

Wherever possible I would recommend clinicians being involved in research in their clinic setting, including helping others carry out their research, as it’s a great way to learn, and importantly helps clients access better clinical treatment and care. Getting SCIT off the ground and delivering the program as well as doing my research required a lot of energy and enthusiasm, but was well worth the effort. I am continuing my involvement with research, working with a team of researchers and clinicians on a large randomised controlled study of SCIT for people with psychosis or schizophrenia.
Qualification as a psychiatrist involves an extensive program of education and clinical training. To achieve the competencies required for Fellowship of the Australia and New Zealand College of Psychiatrists, trainees must generally complete a Scholarly Project involving novel research. Project topics and methods can be selected by the trainee to suit their research interests but must enable them to demonstrate they are able to

- Critically evaluate academic material pertaining to psychiatry or mental health in a broad sense
- Demonstrate knowledge of research methodologies
- Generate research of peer-review quality.

Just dipping my toe in Psychiatric research field, I am pleased to share with you my experience of embarking on a scholarly project and to describe the current progress of our research project, Clinical Audit of Lithium Monitoring and Therapy (CALiMiTy). This is mainly to explain some of the real life challenges we have managed so far. First I am grateful to the Royal Australiana and New Zealand College of Psychiatrists for including the “scholarly project” component in the training program. This gives budding psychiatrists an invaluable opportunity to be more focused on evidence based medicine and to develop research skills. I think this will strongly help bridge the gap between evidence based knowledge and practical clinical care.

It has been a great privilege to work at Caboolture Hospital Mental Health Service under the present and previous clinical leaderships, which have been giving a tremendous motivation to enhance local research enthusiasm. Having an experienced and erudite squad of researchers with scholarly insight around has made me always feel rewarded and comfortable beginning out as a researcher. My clinical lead Dr. George Bruxner and service researcher Sue Patterson have been providing superlative mentorship and support in initiating this audit and it has been a great honour to work with these research experts.

From the time first research seeds implanted in our minds, identifying the research topic was the most tedious and testing period to be honest. We had numerous brainstorming sessions for over two months to narrow down a research topic. We all experienced many forms of formal thought disorder during this time ranging from thought block, poverty of thought, tangentiality, circumstantiality, over-inclusive thinking to grandiose flight of ideas. We helped each other by supportive psychotherapy and constantly reminding ourselves about the capacity and resources we have and can access. (Fortunately none of us required any PRN Olanzapine).

Over and over we, George, Sue and I asked ourselves “Do we need to reinvent the wheel again... and again... and ?” And let’s not forget Sue’s famous “So what?” questions, which guided us, reminding us that our study should matter and preferably be clinically relevant. For example, when discussing doing an audit on seclusion patterns, “So what” and ‘Why?’ questions couldn’t reveal any rationale even if we discover “the highest seclusion rates are reported in young males with mental illness and illicit substance use”. Being friendly critics to each other’s suggestions, we rejected zillions of topics before agreeing on CALiMiTy, a study of the management of Lithium in routine psychiatric practice in Australia.

While this has been studied in the UK and the USA, demonstrating that practice does not always accord with guidelines, literature told us not much about practice here. Understanding what happens now is the first step to improving practice. Our aim is to promote safe and effective use of this highly efficacious medication for Bipolar affective Disorder and Mania locally and further afield.
TPCH Psychology
by Lee Beames, Director Psychology

A team of psychologists researchers from MNMH and Queensland University have been examining the translation of a well-established psychotherapy for schizophrenia (Cognitive Behaviour Therapy for Psychosis (CBTp) into an Health Mental Health adult service. The research has additionally examined the acceptability and outcomes of individual therapy vs group therapy. The research was completed in December, 2015 with a paper submitted for publication.

Participants who engaged in individual and group CBTp experienced a reduction in the severity of hallucinations and delusions with no clear difference between individual versus group therapy. Attendance was higher in the individual therapy. Subjective reports indicated the therapy was acceptable to all participants despite concerns about disclosure in the group participants.

The research team conclude: the results of this pilot study provide preliminary evidence that CBTp may be a feasible and effective intervention to include in Australian public mental health services but that consideration needs to be given to who would best suit individual versus group therapy. Larger trials are now required to provide further evidence for and guidance of how best to translate CBTp protocols to Australian mental health services.
Evaluation: worth the effort? We think so – here’s why!

- What gets measured gets done
- If you don’t measure results, you can’t tell success from failure
- If you can’t see success, you can’t reward it
- If you can’t reward success, you’re probably rewarding failure
- If you can’t see success, you can’t learn from it
- If you can’t recognise failure, you can’t correct it
- If you can demonstrate results, you can win support!


Evaluation needn’t be complex and should fit the philosophy and purpose of the intervention. Evaluation should be designed to enable you to answer questions that matter to you and those who might be supporting or using your service or intervention or attending your event. Evaluations, should ideally be designed in conjunction with the intervention (service, treatment, event or program) being evaluated and be relevant and acceptable to those who will be asked to participate.

As described by evaluation theorist, Donald Kirkpatrick evaluations can be designed to measure reactions (what the participant thought and felt), learning (change in attitude, knowledge or capability), behaviour (change in implementation/application of learning) and results (the effects of behaviour change – e.g. on patient experience of care). Evaluations can also assess process factors – related to the implementation of the intervention and cost. As the science of evaluation has developed, increasing emphasis has been placed on understanding the process, experience and outcomes of an intervention of any kind in context.

see http://www.kirkpatrickpartners.com/OurPhilosophy/TheKirkpatrickModel

The Metro North Mental Health Research Fellows can assist you to plan and conduct an evaluation of your service or intervention, whether old or new! Contact Sue on Susan.Patterson@health.qld.gov.au
The Valley Mens Group
Andrew Cummins

The Men’s Group was sponsored by the Police Citizens Youth Club and run by Tiger (Community Elder), Shelton (Police Liaison Officer) and Andrew (Homeless Health Outreach Team).

The group was first developed through discussion when doing outreach within the Fortitude Valley whilst on Patrol with community Elders, Shelton PLO, Elwyn from 139 Club and Andrew from HHOT. It was seen as a need to start group for men to attend and have a place where they can talk about core issues as men and give an opportunity to be able to look at these issues that men are facing in their current situations in today’s society.

Art Work was used to show what the Men’s Group is about and show how attending the Men’s Group can enable opportunity to yarn about their current issues. The art work shows men coming from their current situation to yarn as equals.

The first group held created 12 core discussion points, core issues on what the men within the group would like to talk about.

At each Men’s Group, one core issue would be discussed and each core issue had 3 talking points created. From the talking points conversation would develop for all the men to converse about their current situations, what they have gone through and how they were coping with these issues. This enables more talking points to flow from this yarning group at each session.

The group created acceptance for everyone attending without being judged. It allowed men the opportunity to talk about their issues, ability to express themselves, learn about services and created ability to enable awareness to accept support. With having the Men’s Group at the HHOT office enabled a positive acceptance to the service, the building and created community awareness and acceptance. It enables Indigenous men who are clients to Mental Health to engage with Indigenous community without being judged or shamed to talk about issues and concerns.

It assisted the Senior Health Worker to network with various services and get known within the indigenous community and to promote the HHOT service. By just doing the promotion of the Mens Group enabled community awareness and interest of various services of HHOT and how our service works within an holistic approach.

Outcomes from the Men’s Group.

The Men’s Group has seen various guys come and go forward who have attended this group. Participants have discussed various issues and concerns and been able to vent and managed their current issues.

Men have completed their rehab and gone back to family and found accommodation whilst attending the group. Men have talked about what they have done to get to where they are.

This has supported other men with seeing what they have to do to get to where they want to be.
Cannabis and Psychosis

The connection between cannabis use and psychosis has long intrigued researchers and clinicians. The difficulties in working clinically with young people who smoked cannabis prompted Shane Rebgetz, clinical psychologist at Redcliffe-Caboolture Child and Youth Mental Health services to study this area.

An observation that Shane had made was that a group of people presenting with cannabis use and psychosis ceased or reduced their use without formal treatment (‘Natural Recovery’).

This phenomenon motivated Shane to attempt to capture and understand the motivating factors associated with this population’s natural quit attempts with the view of integrating the findings into clinical practice. His studies in the area form the basis of his PhD thesis scheduled for submission (fingers crossed, says Shane) Sept 2016.

Abstract

Natural Recovery From Cannabis Use in People With Psychosis: A Qualitative Study
Shane Rebgetz, Leanne Hides, David Kavanagh and Anand Choudhary
Journal of Dual Diagnosis. 201511179-83. doi: 0.1080/15504263.2015.1100472.

OBJECTIVE: There is rapidly growing evidence of natural recovery from cannabis use in people with psychosis, but little is known about how it occurs. This qualitative study explores what factors influence the decision to cease cannabis use, maintain cessation, and prevent relapse. METHOD: Ten people with early psychosis and lifetime cannabis misuse, who had been abstinent for at least a month, were recruited from public adult mental health services. These six men and four women participated in a semi-structured qualitative interview assessing reasons for addressing cannabis use, effective change strategies, lapse contexts, and methods used to regain control. Interpretative phenomenological analysis was used to identify themes in their responses.

RESULTS: Participants had a mean age of 23 years (SD = 3.7), started using cannabis at age 13.7 (SD = 1.6), began daily use at 17 (SD = 3.1), and had abstained from cannabis for 7.9 months (SD = 5.4). Awareness of the negative impact of substance use across multiple domains and the presence of social support for cannabis cessation were seen as vital to sustained success, as was utilization of a combination of coping strategies. The ability to address pressure from substance-using peers was commonly mentioned.

CONCLUSION: Maximally effective treatment may need to focus on eliciting a range of benefits of cessation and control strategies and on maximizing both support for change and resistance to peer pressure. Further research might focus on comparing perceived effective strategies between individuals who obtain sustained cessation versus those who relapse.

© The Royal Australian and New Zealand College of Psychiatrists 2015.
Ten evidence based reasons for embedding health care in values-based enabling environments

Human beings are inherently social: they need honest, positive connections with others to survive and thrive in the workplace. Enabling Environments (EEs) are workplaces which can demonstrate ‘relational excellence’ and can be expected to confer the following benefits:

1. **EEs improve quality of care and thus measurable patient outcomes**
   - Patient and doctors’ satisfaction are positively correlated (Haas et al 2000)
   - Physicians’ job satisfaction positively influences patients’ adherence to treatment and self-management of chronic illness (Di Matteo et al 1993)
   - Doctors are more empathic when personally well (Shanafelt et al 2005)
   - Job satisfaction and employee wellbeing are associated with work performance, productivity, and hence the quality of healthcare (Lundstrom et al 2002)

2. **EEs promote wellbeing of patients, optimising conditions for recovery**
   - Engagement is “A positive attitude held by the employee towards the organisation and its values. An engaged employee is aware of business context, and works with colleagues to improve performance within the job for the benefit of the organisation. The organisation must work to develop and nurture engagement, which requires a two-way relationship between employer and employee.” (Robinson et al 2004)
   - There is a strong body of evidence that demonstrates the importance of employee engagement in healthcare. It is linked not just to employee wellbeing, but also to patient satisfaction and clinical outcomes. Employee engagement is therefore vital to high quality care in the NHS.

3. **EEs enhance workforce engagement**
   - Recognition and legitimization of virtuous behaviours (such as courageous or compassionate acts), creates virtuous cycles; virtuousness becomes self-reinforcing and fosters resilience (Cameron et al 2004)
   - Enablement is contagious: exposure to positive behaviours evokes positive emotions leading to replication and hence improvement in organisational performance (Seligman, 2002)
   - Turnover is lower where environments facilitate work engagement and meaningful involvement of staff in decision-making processes (Rondeau & Wagar, 2012)

4. **EEs reduce staff sick leave**
   - Engaged staff have lower levels of absence and less frequently turn up for work unwell and unable to work productively (West and Davidson 2012)
   - Better staff experiences (particularly those associated with better well-being and job design, and more positive attitudes about the organisation generally are associated with lower levels of absenteeism (Powell et al 2014)

5. **EEs are good for the organisation’s bottom line**
   - Greater social capital is associated with increased cooperation, employee commitment and reduced costs.
   - Employees translate positive experiences into relationship with service users; customer satisfaction is related to the subjective wellbeing of employees (Johnson & Gustafsson, 200)
   - Staff turnover is lower where employees are engaged (West & Davidson 2012)
   - Enhancing mutual support among nurses promotes healthy environments and potentially increases retention and work satisfaction (Medland et al)

6. **EEs support positive mood; positive mood promotes more flexible problem solving, robust decision making and enhanced analytic precision**
   - Interviews with CEOs and senior leaders of 35 U.S. health services known for their patient experience improvement initiatives linked compassionate care to lower staff turnover, higher retention, recruitment of more highly qualified staff, and reduced costs from shorter lengths of stay, lower rates of rehospitalisation, better health outcomes, and fewer costly procedures. [http://www.theschwartzcenter.org/media/Building-Compassion-into-the-Bottom-Line.pdf](http://www.theschwartzcenter.org/media/Building-Compassion-into-the-Bottom-Line.pdf)

7. **EEs reduce the risk of adverse outcomes**
   - Work stress reduces standards of patient care and increases mistakes (Firth-Cozens & Greenhalgh, 1997)
   - Dissatisfied doctors have riskier prescribing profiles, less adherent patients and less satisfied patients (Williams & Skinner, 2003)
8. EEs are good for the organisation’s reputation

- Positive workplaces give rise to more unsolicited compliments from patients and families (Machin et al 2010).

9. EEs nurture the collaborative ethos that is fundamental to effective teamwork

- Delivery of health care is complex and fundamentally dependent on the collaboration of workers from a range of backgrounds. The quality of teamwork and communication predicts patient safety (see Manser 2009)
- Poor team work is associated with an increased risk of complications and death among surgical patients (Mazzocco et al 2009)
- Co-worker support correlates with patient experience (Maben et al 2012)

10. Enabled, healthy workers are more productive workers and are better at handling adversity.

- Organisations that work with their staff to provide healthy and safe work combined with a caring environment perform better, and, importantly, by promoting the health of their workers rather than risking damage, they deliver reliably. (RCP, 2012).
- The quality of care provided is predicted by the engagement of healthcare workers, as well as by the support they receive from others (colleagues, supervisors and the organisation more widely) (DoH, 2009)
- A study involving multiple-case studies in the NHS found a relationship between staff wellbeing and various dimensions of staff-reported patient care performance and patient-reported experiences. (Maben et al 2012)

The fact that job satisfaction, organisational commitment, turnover intentions, and physical and mental wellbeing of employees are predictors of key organisational outcomes such as effectiveness, productivity and innovation means there are multiple reasons to encourage such positive employee attitudes. This applies even more so in health services, where the attitudes of employees are likely to directly affect the quality of the patient experience. (West & Dawson, 2012 p. 5)

References


For further information please contact Sue Patterson, Principal Research Fellow Mental Health MNHHS, 3646 1153. http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqipprojects/enablingenvironments.aspx
The role of geometry in determining the connectome's network properties

James A. Roberts1, Alistair Perry1,2,3, Anton R. Lord1,4, Gloria Roberts1,5, Philip B. Mitchell3,5, Robert E. Smith6, Fernando Calamante1,7,8, Michael Breakspear1,9

1 Systems Neuroscience Group, QIMR Berghofer Medical Research Institute, Australia; 2 Centre for Healthy Brain Ageing (CHeBA), School of Psychiatry, University of New South Wales, Australia; 3 School of Psychiatry, University of New South Wales, Australia; 4 Leibniz Institute for Neurobiology, Magdeburg, Germany; 5 Black Dog Institute, Prince of Wales Hospital, Australia; 6 The Florey Institute of Neuroscience and Mental Health, Australia; 7 Department of Medicine, Austin Health and Northern Health, University of Melbourne, Australia; 8 Florey Department of Neuroscience and Mental Health, University of Melbourne, Australia; 9 Metro North Mental Health Service, Royal Brisbane and Women’s Hospital, Australia.

Corresponding author: Michael Breakspear
michael.breakspear@qimr.berghofer.edu.au

Introduction

The human connectome is a topologically complex, spatially embedded network. While its topological properties have been richly characterized, the constraints imposed by its spatial embedding are poorly understood. Indeed network analyses are typically performed at an abstract level that ignores the role of physical locations and fiber lengths.

Recent studies have begun to emphasize the importance of spatial embedding [1,2]. Here, we show that important high-level topological properties of the human connectome are largely inherited from low-level properties conferred by its spatial geometry, while other properties have crucial additional topology beyond that of the brain’s geometry.

Data Acquisition and Tractography

Diffusion MRI scans were recorded from 75 healthy subjects on a Philips 3T Achieva Quasar Dual MRI scanner: single-shot EPI sequence (TR = 7767 ms, TE = 68 ms), 32 gradient directions (b = 1000 s/mm²), reconstructed to yield 1 mm × 1 mm × 2.5 mm voxels.

Using probabilistic tractography, we derived estimates of whole brain structural connectivity. The fiber orientation distribution (FOD) within each voxel was estimated using MRtrix by performing constrained spherical deconvolution. Our connectivity matrices were reconstructed from densely seeded tractography (100x10⁶ streamlines/subject) and parcellated into a relatively fine representation of 513 uniformly sized cortical and subcortical regions.

Spatial properties

To measure connection lengths we calculated both the Euclidean distances and the curved fiber tract lengths:

Fiber length vs
Euclidean distance
Black: intrahemispheric
Blue: interhemispheric

The connectome is fully described by two matrices:

Weighted connectivity
Distance matrix

The connectome's network properties

We developed an algorithm for constructing reference graphs that preserve low-level features of the spatial embedding but lack any additional topology. This enables identification of topological properties of empirical networks that cannot be attributed solely to the underlying geometry.

Geometric surrogates

Preserves weight distribution, but alters node strength distribution
→ can stop here or obtain original strength distribution by slightly modifying the weight distribution

Both options for preserving strength distribution:
original sequence (W_original) or random sequence (W_random).

Geometric surrogates preserve cloud and some fine details:

Distance-preserving randomized graphs exhibit only slightly decreased clustering, and essentially preserve modularity. These features are thus largely determined by the geometry.

Rich club

Identifying the strongest 75 nodes reveals key differences between the brain and surrogate networks:

If geometry solely determined the rich club, all the rich nodes would lie in a ‘ball’ near the center of the brain.

Preserving the original strength sequence yields increased interhemispheric connectivity, particularly feeder connections between rich and non-rich nodes.

Fiber lengths within the rich club are longer than predicted by geometry. Usual geometry-ignoring random networks have a higher wiring cost than the brain, but geometric surrogates have lower cost – thus inter-hub wiring cost cannot have been the dominant consideration governing brain evolution, extra wiring has been traded for increased utility.

Consistency

Out data set of 75 subjects also enables analysis of the consistency of connectivity across subjects. We find that indeed the strongest edges are the most consistent (justifying weight-based thresholding), but plotting vs fiber length shows that it is in fact edges that are strong for their length that are most consistent.

Conclusions

Randomized surrogates that preserve spatial geometry enable us to answer questions of whether specific network properties emerge simply from spatial constraints or whether they result from higher-order concerns.

We speculate that during evolution, a rich central core of nodes was forced to expand and split peripherally, much like the growth of cities that form dense but distributed cores.

References


Fiber length slightly slower than nodes decrease as a function of fiber length slightly slower than exponentially.

Black: intrahemispheric
Blue: interhemispheric
Red circles: homologous L-R
Black line: cubic fit over red circle

Randomized surrogate networks are widely used to determine whether a network feature is “expected” from simple assumptions. Typical randomization algorithms do not take spatial properties into account:

Potential for new thresholding methods that include both consistency and spatial properties.

Rich club by node degree
Gray lines: ensemble of geometric surrogates, each normalized to their own degree-preserving surrogates

Rich club by node strength
Blue: Data
Green: Geometric surrogate W(sp)
Red: Shuffled surrogate W(shuff)

Rich club by strength-sequence preserving
Blue: Data
Green: Strength-sequence preserving W
Red: Random rewiring W

Poisson
W
Geometric
W
Shuffled
W
Random rewiring
W

Mean clustering coefficient. Blue: Data. W
Yellow: Strength-preserving W
Green: Strength-sequence preserving W
Red: Random rewiring W

The rich club effect persists when measured against geometric surrogates (cf. [2]).

Out data set of 75 subjects also enables analysis of the consistency of connectivity across subjects. We find that indeed the strongest edges are the most consistent (justifying weight-based thresholding), but plotting vs fiber length shows that it is in fact edges that are strong for their length that are most consistent.

Out data set of 75 subjects also enables analysis of the consistency of connectivity across subjects. We find that indeed the strongest edges are the most consistent (justifying weight-based thresholding), but plotting vs fiber length shows that it is in fact edges that are strong for their length that are most consistent.

Out data set of 75 subjects also enables analysis of the consistency of connectivity across subjects. We find that indeed the strongest edges are the most consistent (justifying weight-based thresholding), but plotting vs fiber length shows that it is in fact edges that are strong for their length that are most consistent.

Out data set of 75 subjects also enables analysis of the consistency of connectivity across subjects. We find that indeed the strongest edges are the most consistent (justifying weight-based thresholding), but plotting vs fiber length shows that it is in fact edges that are strong for their length that are most consistent.

Out data set of 75 subjects also enables analysis of the consistency of connectivity across subjects. We find that indeed the strongest edges are the most consistent (justifying weight-based thresholding), but plotting vs fiber length shows that it is in fact edges that are strong for their length that are most consistent.

Out data set of 75 subjects also enables analysis of the consistency of connectivity across subjects. We find that indeed the strongest edges are the most consistent (justifying weight-based thresholding), but plotting vs fiber length shows that it is in fact edges that are strong for their length that are most consistent.

Out data set of 75 subjects also enables analysis of the consistency of connectivity across subjects. We find that indeed the strongest edges are the most consistent (justifying weight-based thresholding), but plotting vs fiber length shows that it is in fact edges that are strong for their length that are most consistent.

Out data set of 75 subjects also enables analysis of the consistency of connectivity across subjects. We find that indeed the strongest edges are the most consistent (justifying weight-based thresholding), but plotting vs fiber length shows that it is in fact edges that are strong for their length that are most consistent.

Out data set of 75 subjects also enables analysis of the consistency of connectivity across subjects. We find that indeed the strongest edges are the most consistent (justifying weight-based thresholding), but plotting vs fiber length shows that it is in fact edges that are strong for their length that are most consistent.

Out data set of 75 subjects also enables analysis of the consistency of connectivity across subjects. We find that indeed the strongest edges are the most consistent (justifying weight-based thresholding), but plotting vs fiber length shows that it is in fact edges that are strong for their length that are most consistent.

Out data set of 75 subjects also enables analysis of the consistency of connectivity across subjects. We find that indeed the strongest edges are the most consistent (justifying weight-based thresholding), but plotting vs fiber length shows that it is in fact edges that are strong for their length that are most consistent.
## MNMNH staff enrolled in post graduate study

### Graduate Certificate in Health (Mental Health)

<table>
<thead>
<tr>
<th>Name</th>
<th>University</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ryan Zeppa-Cohen, INBMH CMHT</td>
<td>Graduate Cert Health (Mental Health) University of Southern Queensland</td>
</tr>
<tr>
<td>Tara Lane, Nurse HHOT</td>
<td>Grad Cert Suicide Prevention Studies, Griffith University</td>
</tr>
</tbody>
</table>

### Grad Dip Nursing; Master of Mental Health Nursing

<table>
<thead>
<tr>
<th>Name</th>
<th>University</th>
</tr>
</thead>
<tbody>
<tr>
<td>Korpo Joanna Galakpai, RBWH</td>
<td>Central Queensland University</td>
</tr>
<tr>
<td>Jannette Newell, Nurse Educator RBWH</td>
<td>University of Southern Queensland</td>
</tr>
<tr>
<td>Maria Padilla Luque, INBMH CMHT</td>
<td>Central Queensland University</td>
</tr>
<tr>
<td>Natalie Allen, INBMH CMHT</td>
<td>Central Queensland University</td>
</tr>
<tr>
<td>Jasmin Hunter TPCH CCU</td>
<td>University of Newcastle</td>
</tr>
<tr>
<td>Matene Ackfun, TPCH inpatient unit</td>
<td>University of Southern Queensland</td>
</tr>
<tr>
<td>Sharen Duncan, Pine Rivers CMHT</td>
<td>University of Sunshine Coast</td>
</tr>
<tr>
<td>Benjamin Roper, Red/Cab SMHRU</td>
<td>University of Newcastle</td>
</tr>
<tr>
<td>Natasha Sutton, MNMH-Red Cab CCCU</td>
<td>Australian Catholic University</td>
</tr>
<tr>
<td>Rebecca Ashby, MNMH-TPCH Acute Care Team</td>
<td>University of Newcastle</td>
</tr>
<tr>
<td>Hannah Morecroft, MNMH-TPCH</td>
<td></td>
</tr>
<tr>
<td>Jessy M Ngoma, MNMH-RBWH</td>
<td>University of Newcastle</td>
</tr>
</tbody>
</table>

### Masters Degrees

<table>
<thead>
<tr>
<th>Name</th>
<th>University</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annette Vasey</td>
<td>M Mental Health Family Therapy The University of Queensland</td>
</tr>
<tr>
<td>Amy Strong, Nursing TPCH CMHT</td>
<td>M Counselling, University of Sunshine Coast</td>
</tr>
<tr>
<td>Jessica Waine, Occupational Therapy HHOT</td>
<td>M Mental Health Practice, Griffith University</td>
</tr>
<tr>
<td>Emma Ashe, Social Work RBWH CMHT</td>
<td>M Counselling, Queensland University of Technology Use of constructive therapies such as narrative therapy with mental health consumers.</td>
</tr>
<tr>
<td>Kylie Garrick, Director Allied Health, MNMH</td>
<td>M Psychology (organisational) Griffith University The Employee Experience of Peer Support in a Mental Health Context.</td>
</tr>
<tr>
<td>Natalie Avery, Psychology, MNMH-TPCH</td>
<td>M Psychology (clinical) Charles Sturt University The role of psychologists in addressing physical health needs of people with Severe Mental Illness</td>
</tr>
<tr>
<td>Patricia Bicevskis, TPCH Secure Mental Health Rehab Unit</td>
<td>M Forensic Mental Health, Griffith University</td>
</tr>
</tbody>
</table>

### Doctor of Psychology (Clinical)

<table>
<thead>
<tr>
<th>Name</th>
<th>University</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anne Gordon, Psychology INBMHS</td>
<td>Griffith University A randomised wait-list control community study of Social Cognition and Interaction Training (SCIT) for people with schizophrenia</td>
</tr>
<tr>
<td>Annette Vasey, Psychologist, CFOS</td>
<td>Annette Vasey, Psychologist, CFOS</td>
</tr>
</tbody>
</table>
# PhD

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiona Davidson</td>
<td>The University of Queensland</td>
<td>A comparison of court liaison and court diversion services throughout Australia for people with mental disorders.</td>
</tr>
<tr>
<td>Shane Rebgetz</td>
<td>Queensland University of Technology</td>
<td>‘Natural Recovery of Cannabis Use and Psychosis’ yes Adam</td>
</tr>
<tr>
<td>Ed Hefferman, Director</td>
<td>The University of Queensland</td>
<td>Mental health of Aboriginal and Torres Strait Islander people in custody.</td>
</tr>
<tr>
<td>Melanie Mitchell</td>
<td>The Queensland University of Technology</td>
<td>Precursors to violence in people with a mental illness who threaten violence.</td>
</tr>
<tr>
<td>Lucianne Palmquist</td>
<td>Griffith University</td>
<td>Recovery in young people using CYMHS.</td>
</tr>
<tr>
<td>Elke Perdacher, Co-ordinator</td>
<td>The University of Queensland</td>
<td>Utility of the Android tablet PC app. adaptation of the AIMHi Stay Strong Plan with Aboriginal and Torres Strait Islander women in custody.</td>
</tr>
<tr>
<td>Bjorn Burgher</td>
<td>The University of Queensland</td>
<td>Microglial activation in early onset psychotic disorders.</td>
</tr>
<tr>
<td>Dylan Flaws</td>
<td>Decision aid derivation methods for the Acute Coronary Syndrome Pathway</td>
<td>u</td>
</tr>
</tbody>
</table>

# Professional Doctorate

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kimina Andersen</td>
<td>University of New South Wales</td>
<td>Forensic Mental Health and Aboriginal and Torres Strait Islander people</td>
</tr>
</tbody>
</table>

## Supervision of post graduate students by MNMH Staff

### Sue Patterson

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natalie Avery</td>
<td>Charles Sturt University</td>
<td>The role of psychologists in addressing physical health needs of people with Severe Mental Illness accessing public Mental Health Services</td>
</tr>
<tr>
<td>Lucianne Palmquist</td>
<td>Griffith University</td>
<td>A grounded theory explanation of Adolescent ‘Recovery’: CYMHS consumer perspectives.</td>
</tr>
<tr>
<td>Lucien Lloyd-West</td>
<td>Griffith University</td>
<td>Optimising the efficiency of groups in mental health care</td>
</tr>
</tbody>
</table>
### Supervision of post graduate students by MNMH Staff

#### Ed Heffernan

**Fiona Davidson, University of Queensland**

A comparison of court liaison and court diversion services throughout Australia for people with mental disorders.

#### Niall Higgins

**Peter Carr**  
**Co-Supervisors: Profs Claire Rickard & Marie Cooke**

Griffith University  
Risk Factors for peripheral intravenous cannula insertion failure in the Emergency Department: The VADER Study

#### Michael Breakspear

**Matt Hyett, University of New South Wales**

Attention and inference in melancholic depression  
PhD conferred 2015

**Kartik Iyer, The University of Queensland**

Novel methods for predicting outcome in neonates from electroencephalographic recordings. PhD conferred 2015

**Anton Lord, The University of Queensland**

Biometric markers for affective disorders  
PhD conferred 2015

**Phil Mosley, The University of Queensland**

University of Queensland  
Neurobiology of impulsivity in Parkinson’s Disease

**Matt Aburn, The University of Queensland**

Computational neuroscience

**Justin Chapman, The University of Queensland**

Physical activity in mental illness

**Jonathon Robinson, Queensland University of Technology**

Predictive coding errors in schizophrenia

**Megan Campbell, The University Of Queensland**

Functional anatomy of human mirror system

**Saurabh Sonkusare, The University of Queensland**

Interoception in depression

#### Mark Daglish, Jason Connor & Matt Gullo

**Bonnie Law**

PhD / MBBS UQ, Interactions between mood, stress & alcohol dependence

#### James Scott

**Carina Capra, PhD, Queensland University of Technology**

Measuring, understanding and reducing psychotic-like experiences (PLEs) in young people (2011-2015)

**Holly Erskine, The University of Queensland**

The epidemiology of conduct disorder and implications for interventions (2013-2016)

**Natalie Mills, The University of Queensland**

The role of cytokines in depression and cognition in adolescents

**Hannah Thomas, The University of Queensland**

Beyond the classroom and into the cyber world, next generation research into adolescent bullying

**Thy Meddick, The University of Queensland**

Exploring family mental health as predictors of children’s education and vocational outcomes across the lifespan

**Rebecca Banney, The University of Queensland**

Specific language impairment across the lifespan: A retrospective and prospective study
<table>
<thead>
<tr>
<th>Name</th>
<th>Institution</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suichi Suetani, The University of Queensland</td>
<td></td>
<td>Physical activity and people with psychosis</td>
</tr>
<tr>
<td>B Burgher, The University of Queensland</td>
<td></td>
<td>Microglial activation in early onset psychotic disorders</td>
</tr>
<tr>
<td><strong>Gerard Byrne</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ji Hyun (Julia) Yang, The University of Queensland</td>
<td></td>
<td>Mindfulness and cognitive training in Parkinson’s disease</td>
</tr>
<tr>
<td>Ellizabeth Ness McVie, The University of Queensland</td>
<td></td>
<td>An analysis of the decisions of the Queensland Mental Health Court</td>
</tr>
<tr>
<td>Beyon Miloyan, The University of Queensland</td>
<td></td>
<td>Epidemiology of anxiety in later life</td>
</tr>
<tr>
<td>Jenifer Anne Murphy, The University of Queensland</td>
<td></td>
<td>Treatment-resistant depression</td>
</tr>
<tr>
<td>Natalie Therese Mills, The University of Queensland</td>
<td></td>
<td>Genetics of cytokine activity in children and adolescents</td>
</tr>
<tr>
<td>Crystal Higgs, The University of Queensland</td>
<td></td>
<td>TBC</td>
</tr>
<tr>
<td>Lucianne Palmquist, Psychologist, Red/Cab CYMHS</td>
<td>Griffith University</td>
<td>Recovery in young people using CYMHS.</td>
</tr>
<tr>
<td>Elke Perdacher, Co-ordinator Post Grad Program Qld Forensic Mental Health Service</td>
<td>The University of Queensland</td>
<td>Utility of the Android tablet PC app. adaptation of the AIMHi Stay Strong Plan with Aboriginal and Torres Strait Islander women in custody.</td>
</tr>
<tr>
<td>Bjorn Burgher, Psychiatric Registrar</td>
<td>The University of Queensland</td>
<td>Microglial activation in early onset psychotic disorders</td>
</tr>
<tr>
<td>Dylan Flaws, Psychiatric Registrar MNMH-TPCH</td>
<td>The University of Queensland</td>
<td>Decision aid derivation methods for the Acute Coronary Syndrome Pathway</td>
</tr>
</tbody>
</table>
Dissemination activities

Peer Review Publications


Books


Book chapters


Published peer reviewed abstracts


Presentations at Conferences, Seminars, Workshops


41. Scott J (2015) Auto immune encephalitis. Lecture at the Lady Cilento Children's Hospital, Brisbane

42. Scott J (2015) Clinical Trials in Early Psychosis. Lecture at Metro South Mental Health Grand Rounds, Brisbane (1/6/15),


47. Scott J (2015) Preventing Mental Disorders in Children and Adolescents. Invited Presentation to the Queensland Mental Health and Drug Advisory Council, Brisbane (19/10/15)


54. Sonkusare S (2015) Probing the brain body interaction underlying natural emotional experience. 7th QIMR Berghofer Biennial Student Retreat, O'Reilly Rainforest Retreat, Australia. 17–18 September 2015 (Breakspear M)


63. Ward W (2016) Reconfiguring general health services to meet the needs of adults with anorexia nervosa. The 3rd Eating Disorders and Obesity Conference, Gold Coast. (Keynote Address)


**Poster Presentations**


Research Grants, Awards, & Fellowships


11. Davidson F, A comparison of court liaison and court diversion services throughout Australia for people with mental disorders, NHMRC CRE PhD scholarship in Offender Health, $100,000 (2014-2016)


16. Fleming C, Improving the service response to families affected by eating disorders. Collaborative for Allied Health Research, Learning and Innovation (CAHRLI) MNHHS, Pre-PhD Scholarship funding for 26 research days backfilled at current level (2015-2016).

17. Gollo L, From brain maps to mechanisms: Modelling the pathophysiology of dementia, NHMRC Dementia Fellowship (ECF level) ID: 1110975, $604,512.97 (1 Jan 2016 to 31 Dec 2019).

18. Greer J, Mowry B, & Scott J, Investigating the aetiopathogenic role of autoantibodies against the M1 muscarinic acetylcholine receptor in patients with first episode of schizophrenia, NHMRC Project grant, $830,986.


25. Scott JG, Best Clinical, Education or Health Services Oral Presentation at the 24th Annual RBWH Health Care Symposium, October 2015.

26. Scott JG, National Health and Medical Research Council Clinical Practitioner Fellowship.

Other dissemination activities

**Catalyst:**  

**EurekAlert:**  

**UQ News:**  

---

**Interested in research?**

If you are interested in learning more about research at Metro North Mental Health, taking part in a study, undertaking research within the service or have ideas for research we’d like to hear from you.

Our aim is to make research relevant to the community.

Please contact Sue Patterson on susan.patterson@health.qld.gov.au or 36461153