METRO NORTH

MENTAL HEALTH RESEARCH DIGEST

2017

Integrating RESEARCH and PRACTICE

Cover images by ***Chelsea Johnson***

Chelsea writes: I have always been passionate about art and self-representation … I like that people see, appreciate and enjoy looking at my work. I have battled with mental illness for more than half my life and creating has not only helped brighten my darkest days but it pieces together the puzzle that is my life. Thank you for supporting the journey that so many of us have to endure … in essence life can be awesome; 'keep fighting' is the motto I adopt.

Queensland Government

Public availability Where possible, readers are encouraged to download the report online at:
www.health.qld.gov.au/metronorth/publications

Physical address: Butterfield Street, Herston Qld 4006
Postal address: Post Office, Herston Qld 4029
General phone: (07) 3646 8111
Office hours: 8am to 5pm, Monday to Friday
General e-mail: md16-metronorthhsd@health.qld.gov.au

Interpreter Services Statement

Metro North Hospital and Health Service is committed to providing accessible services to the community from culturally and linguistically diverse backgrounds. If you have difficulty in understanding this Report, please contact us on 07 3646 6102 and we will arrange an interpreter to communicate

Design and typesetting by Eckersley Group,
10 Frawley Avenue, Narangba, Qld 4504

Table of Contents

Metro North Hospital and Health Service

Metro North Hospital and Health Service (MNHHS) is the largest of 16 Hospital and Health Services (HHS) which provide public health services in Queensland. The service provides a comprehensive range of health services to around 1,000,000 residents of a geographically defined catchment extending north of the Brisbane River to Kilcoy and Bribie Island. The 4157square km catchment encompasses inner city, suburban, regional and rural areas; the population is socio-economically and ethnically diverse.

Services including all major health specialties including medicine, surgery, psychiatry, oncology, women's and newborn, and trauma with over 30 subspecialties, are provided across the catchment through five hospitals and many community health centres, residential care facilities and mobile service teams.

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 and further afield. 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 and operational documents articulate commitment to grounding practice in a culture of research education, learning and innovation. MNHHS aspires to being patient centred in research, competitive in national and international research funding and to nurture the next generation of researchers. To enable and support achievement world-class research, the service has invested in establishment of a robust infrastructure including the MNHHS Research Office and Metro North HHS Collaborative for Allied Health Research, Learning and Innovation (CAHRLI).

The MNHHS Research Office

Research is an essential part of the healthcare we provide, and **the Metro North Research Office was established in 2016** to provide strategic direction and support for research across our health service. Through our Metro North Research Strategy 2017-2022, we aim to foster and support new and existing research in the areas of therapeutics, diagnostics and health service improvements that will lead to the delivery of exceptional health outcomes through globally recognised discovery and translation.

The Metro North Research Office is proud to support the annual Research Excellence Awards. The awards represent Metro North's commitment to recognising, acknowledging and celebrating the breadth and depth of research excellence across the HHS, and profiling the valuable contribution that research plays in advancing healthcare for our patients. The annual Snapshot of Research also provides a person-centred overview of the diversity of research programs across Metro North. It shares the stories of research, profiles the research teams leading the advances in healthcare, and collectively acknowledges the continuum of research activity. Importantly, it does not replace, and is in fact complemented by the comprehensive facility and service based annual research reports, such as the Metro North Mental Health Research Review, which brings mental health research into the spotlight and delves in the research outcomes that matter most to Mental Health.

The Metro North Research Office also recognises the value of integrated and consistent research information, management and communication systems, and has published the Metro North Research Policy and Procedures. These documents have been developed collaboratively, with the primary intent to promote consistency in research processes. The Research Policy and ten Procedures provide a framework to promote the responsible and ethical design, conduct and communication of research. We encourage you to read them, to familiarise yourself with the content, and to consider how they will be implemented in your facility or service. These documents can be viewed online on the Metro North Research website https://metronorth.health.qld.gov.au/research/research-policies-procedures

This year, Metro North has also sponsored the inaugural cohort of the Graduate Certificate in Health Services Innovation, a joint partnership with the Australian Centre for Health Services Innovation (AusHSI) and Queensland University of Technology (QUT). The course will support Metro North to increase the capacity of health professionals to implement innovative change in health services, ultimately benefiting our patients and Metro North HHS. We look forward to supporting the first cohort of students through their academic journey, and are excited to see the real-life projects they undertake, designed to innovate and improve health care across the HHS.

Metro North HHS. We look forward to supporting the first cohort of students through their academic journey, and are excited to see the real-life projects they undertake, designed to innovate and improve health care across the HHS.

Metro North Mental Health

Metro North Mental Health (MNMH), a Clinical Directorate formed 1 July 2014, is accountable for provision of mental health services across the MNHHS catchment.

MNMH service employs a balanced model of care encompassing community, inpatient and support services, addressing needs across the lifespan. 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). While the mix and composition of teams varies, the three services encompass 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.

Community services are provided by multi-disciplinary teams based at Brisbane City, Fortitude Valley, Herston, Nundah, Chermside, Pine Rivers, Caboolture and Redcliffe, with outreach services to Kilcoy. Dedicated, specialised teams provide a range of interventions to target groups, including people needing short term intensive care and people with complex needs related to severe and enduring mental illness. 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 334 inpatient beds comprising: 182 acute adult, 12 adolescent, 40 Secure Mental Health Rehabilitation, 60 Community Care, 24 long stay nursing home psycho-geriatric and 16 state-wide alcohol and drug detoxification beds. Admissions to acute care inpatient units are made by consultant psychiatrists at The Royal Brisbane and Women's Hospital, The Prince Charles Hospital and Caboolture Hospital.

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 Queensland Eating Disorders Service and the Alcohol and Drug Service and The Queensland Health Victim Support Service.

MNMH clinical services are supported by two district wide teams: the 'resource team' which provides information and education about mental health issues for clinicians, consumers, carers and the wider community across the HHS and the Recovery and Consumer and Carer Support Service which employs peer workers and promotes and enables the engagement and active participation of consumers and carers at all levels. The Recovery and Consumer and Carer Support Service proactively provides a range of funded and unfunded services, group and programs, employed positions, and consultation activities that support the service in the development, delivery, monitoring and review of clinical and support services.

The service endorses the recovery paradigm and works collaboratively with primary and private health providers and our Non-Government partners to ensure consumers and carers are able to access care appropriate to needs. The service is a leader in clinical care, education and research. Training for all mental health disciplines is a priority.

MNMH has invested substantially over the last decade in human and technological resources, building a robust research infrastructure, expertise and capacity. Research is increasingly integrated in the fabric of services. MNMH supports conjoint clinical academic appointments with various universities, actively encourage and support clinicians to undertake post-graduate study and collaborate effectively with a range of stakeholders, locally, nationally and internationally. Staff across disciplines and service lines are working collaboratively to design and conduct research and support translation of evidence to practice.

Foreword

Associate Professor Brett Emmerson AM (Executive Director Metro North Mental Health) and Professor Michael Breakspear (Chair Metro North Research Collaborative Committee)

We are delighted to present the 5th edition of the annual Metro North Mental Health Research Review. It is our pleasure to celebrate the researchers and clinicians who contribute in so many ways to research and apply evidence to practice, and showcase the wide-ranging research and related activities with the service. As evidenced by the impressive lists of publications and other dissemination activities, 2017 has been another rewarding and productive year.

A/ Prof Brett Emmerson AM
(Executive Director MNMH)

Prof Michael Breakspear
(Chair MNMH Research Collaborative Committee)

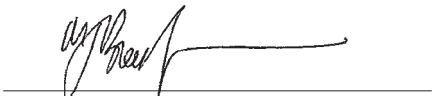
Reflecting the complexity of mental illness and service delivery, research conducted and supported by MNMH is diverse. Our research, encompassing cutting edge computational neuroscience, clinical trials, implementation science and health services and public health research, aligns with the MNHHS Strategy areas of therapeutics, diagnostics and health service improvements. Whatever the phenomena being examined or methods used, the research is designed to make a difference, to improve diagnoses, treatment and services to promote equitable health outcomes for people affected by mental illness.

The quality, scientific merit and relevance of research supported by MNMH is evident in the award of grants and prestigious fellowships, and publications in diverse academic and applied journals. MNMH research is published in top tier journals including Nature, JAMA, The Lancet and British Journal of Psychiatry and journals widely read by practitioners and managers interested in improving services and outcomes. Specific examples of impact include: Consumer-led studies of expectations of clinicians shaping evaluation work of the Royal College of Psychiatrists; extensive study of the mental health of Aboriginal and Torres Strait Islander people in custody underpinning establishment of social/emotional wellbeing programs in correctional centres; translation of a mental health service model –Safewards- in general wards to promote safety; ongoing improvement in management of the physical health of MH patients; enhanced mental health literacy and reduced stigma among health professionals and enhanced workforce capabilities as highly skilled staff are attracted to the research culture. We also note that an innovative study looking at the work lives of administrative and operational staff within MNMH conducted during the year is already supporting organisational development.

At the service level, we have been pleased to observe the development of culture of critical enquiry in which research capabilities and motivation are fostered and opportunities are created for staff to engage as consumers, participants or producers of research. Multiple staff, across disciplines and facilities are enrolled in post-graduate studies, NMMH researchers supervise 31 RHD students, around 70 research/ evaluation projects were being undertaken at different times and grants held totalled more than $35 million. Multiple robust collaborations, with universities across the world, non-government agencies and consumers established by MNMH researchers and clinicians will ensure research within MNMH continues to flourish.

We thank all those who have contributed to this textured representation of research in MNMH and invite you to explore the review, sharing in the experiences of clinicians and researchers who work to improve care provided by MNMH and outcomes for consumers.

Associate Professor Brett Emmerson AM



Professor Michael Breakspear

2017 At a Glance

From the desk of the Principal Research Fellow

Now in my seventh year with MNMH, my work as Principal Research Fellow continues to challenge and motivate me. I am privileged to share professionally in the journeys of people who come to the service and inspired by the tireless commitment of so many people working to deliver the best possible care. I continue to learn as I work with clinicians and researchers to design, implement and report studies.

Research-wise, 2017 has been another busy, rewarding year for MNMH. Staff across the service have been working on a range of projects including formal research, evaluations of current and new practices and audits checking performance against standards; staff have been reviewing literature to develop guidelines for practice and delivering workshops and education sessions to different audiences. This wide-ranging work is united in contributing to the improvement in services, clinical care and outcomes for people affected by mental illness and substance use.

My aim in compiling the content in the following pages is to provide some insight to this work, to mental health care and the experience of those involved. You will find, in addition to the lists grants, conference presentations and publications that are the currency of research, the accounts of people involved in research and evaluation in various ways, and abstracts describing various studies. As you'll see the research and related activities represented in the review use a range of methods to study phenomena of all sorts. I hear regularly that the language of research and mental health can be difficult to negotiate and alienating so we've included a glossary of some of the commonly used 'jargon' (see page N) and provided some other research-relevant bits of information in various places through the review. Thank you for joining us in this celebration of the diverse MNMH community and their work.

Sue Patterson

Glossary

Please note: this glossary has been compiled using information from various sources. The definition and explanations of terms used are general and intended as a guide only. Detailed explanations of each term can be found in relevant literature and other publicly available documents– see for example

- Twycross A & Shorten A(2014)Service evaluation, audit & research:what is the difference? http://ebn.bmj.com/content/17/3/65.info http://guides.mclibrary.duke.edu/c.php?g=158201&p=1036021
- Leech N, Onwuegbuzie A, (2008) A typology of mixed methods research designs, Quality and Quantity, 43, 265-275.
- Bauer M et al (2015) An introduction to implementation science for the non-specialist. BMC Psychology, 3:32 https://doi.org/10.1186/s40359-015-0089-9

Audit: measuring service provided against a predetermined standard. Performance is reviewed to assess the extent what should be done is being done. Ideally audits are undertaken as part of a planned process of quality improvement cycle designed to improve service and outcomes, with the findings of an initial audit used as a baseline against which change is measured.

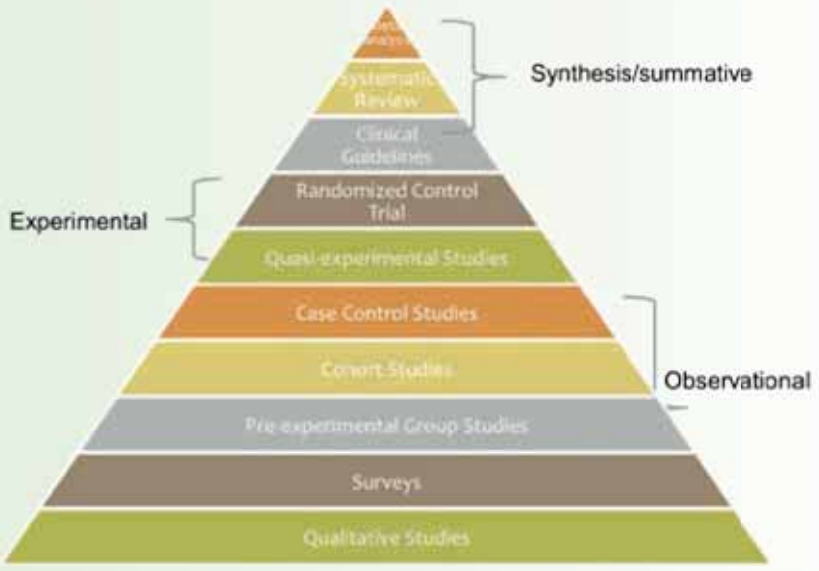
Benchmarking: systematically measuring and comparing the operations and outcomes of an organization, system or process against agreed upon "best-in-class" frame of reference.

Data is a term used in research to describe recorded observations, usually in numeric or textual, form collected to achieve research goals.

Epidemiology: the study of the distribution and determinants of health-related states or events (including disease), and the application of this study to the control of diseases and other health problems.

Evaluation involves collection and analysis of data of various sorts (dependent on aims) to assess how well a service, program, activity or clinical practice is achieving intended aims/objectives. In contrast to research which seeks develop information for use by various stakeholders , evaluations are conducted primarily to define or judging a current service.

Evidence: The term 'evidence' is broadly defined as the available body of facts or information indicating whether a belief or proposition is true or valid. In the context of evidence-based health care the term refers to evidence derived from systematically conducted research, with evidence from different sorts of research accorded different value, dependent on the rigor (precision and control of bias) of the method used. An evidence hierarchy has been developed to support evaluation of the quality of evidence.



Evidence based medicine originally defined as conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients" (Sackett et al., 1996), modified subsequently to incorporate values, patient preferences and clinician 'expertise' in decision making.

Evidence based health care involves application of 'best evidence' to decisions about resource allocation throughout the health care process, to policy, service planning and design, service administration and management, and clinical care. EBHC grew from evidence based medicine

Evidence based practice/Evidence based intervention: practices or treatments shown to be safe and effective (to some degree) through outcome evaluations; considered likely to be effective in changing target behavior/improving outcome in a given condition if implemented with integrity .

Focus group: is a way of collecting quantative data in which a group of 6-12 people are enabled to explore perceptions, opinions, beliefs, and attitudes towards something (e.g. service, product, concept).

Implementation Science developed to facilitate integration of EBPs in routine care, is the study of methods to promote the integration of research findings and other evidence-based practices into routine practice in order to improve the quality and effectiveness of health services and care. Implementation science seeks to understand the behavior of healthcare professionals and other stakeholders as a key variable in the sustainable uptake, adoption, and implementation of evidence-based interventions.

Literature review: An examination of existing research publications on the topic area of a study, undertaken for various reasons: to identify 'gaps' in knowledge and demonstrate the need for further study; to identify or develop theories or models; to analytically summarise what is known about a topic, for example to inform practice development or answer clinical questions. Various types of literature (using different search strategies, data extraction and analysis techniques and methods for write up) are used to address a ranges research questions. When written, a literature review may include researchers' views and observations including reflection on quality of literature.

Meta-Analysis an analysis combining the results of several studies that address a set of related hypotheses.

Methodology is "the description, the explanation and the justification" (Kaplan, 1964) that implementation of the process of scientific inquiry. Methodologies can be dichotomised as quantitative or qualitative with each approach encompassing a plethora of research designs.

Mixed methods research: systematic integration, or "mixing," of quantitative and qualitative methods and data within a single study or program of research.

Qualitative methodologies involves disciplined inquiry that examines people's lives, experiences and behaviours, and the stories and meanings individuals ascribe to them. It can also investigate organisational functioning, relationships between individuals and groups, and social environments. Qualitative research methods produce findings not arrived at by means of statistical procedures or other means of quantification. Qualitative research seeks to answer "why" and "how" questions and develop subjective explanations, typically using textual or observational data that cannot be meaningfully measured mathematically.

Quantitative methodologies employ techniques that represent phenomena numerically and employ statistical analysis. Quantitative research is designed to answer questions about "how much" and "how often".

Quality Improvement (QI): a "systematic, data-guide d activities designed to bring about immediate improvements in health delivery in particular settings". Improving the quality of care of consumers is a fundamental obligation of health care providers. The QI process is continuous and involves evaluating and learning from experience.

Questionnaire is a survey tool comprising a series of items or questions which can be open-ended (the respondent can formulate his/her own answer), or closed-ended (a number of answer options are given to choose from).

Random Sampling: a process used in research to draw a sample of a population strictly by chance

Research is any attempt to extend the available knowledge by means of a systematically defensible process of enquiry.

Applied research: Research carried out for practical applications and problem-solving functions.

Basic research: Research carried out to discover something simply for the sake of knowledge to improve our understanding of the world, and for academic rather than commercial purposes.

Sample: the population researched in/providing data in a particular study.

Semi-structured interview is a qualitative method of inquiry that combines a planned list of open questions (questions that encourage discussion) with the opportunity for the interviewer to explore particular themes or responses further.

Survey is defined as a research tool used to ask questions to gain specific information about either a specific group or topic. Surveys may be conducted by phone, mail, via the internet, or face to face.

Target population: the population to which findings of 'generalizable' research might apply

Awards and Fellowships

CONGRATULATIONS TO MICHAEL BREAKSPEAR (CLINICAL ACADEMIC PSYCHIATRIST), WARREN WARD (DIRECTOR QUEDS), MICHAEL POWER (DIRECTOR QVSS) AND THE QUEENSLAND FORENSIC MENTAL HEALTH SERVICE

Michael Breakspear: Senior Research Award, Royal Australian and New Zealand College of Psychiatrists

Professor Michael Breakspear received the Royal Australian & New Zealand College of Psychiatrists Senior Research Award in 2017 for his significant contribution to psychiatric research. Michael, who was Metro North's Inaugural Researcher of the Year in 2016, and is Group Leader of the Systems Neuroscience Group at QIMR Berghofer, is known internationally for his ground-breaking research into the application of brain network theory to understand psychiatric disorders. The RANZCP Senior Research Award was established in 1978 to recognise excellence in research in psychiatry in Australia and New Zealand. It is made annually to the Fellows who, in the opinion of the selection panel, have made the most significant contribution to psychiatric research in Australia and New Zealand over the preceding five years.

Warren Ward: Award for Distinguished Achievement in the Field of Eating Disorders, Australia & New Zealand Academy for *Eating Disorders*

Dr Warren Ward received the ANZAED Distinguished Achievement Award in the Field of Eating Disorders in 2017. Warren is Director of the Queensland Eating Disorder Service at the Royal Brisbane and Women's Hospital and Senior Lecturer in the Department of Psychiatry at the University of Queensland. ANZAED recognises Warren's major contribution to service development and clinical treatment of patients with eating disorders in Queensland. He is also recognised for his role in research, and the generous contributions he has made to ANZAED, particularly as Secretary. Achievements under Dr Ward's leadership of EDOS have included opening up generalist medical and psychiatric inpatient beds throughout the state to treat eating disorders, and treatment guidelines endorsed state-wide by psychiatrists, physicians, and general practitioners. Warren has also recently been awarded a prestigious Fellowship with the Academy for Eating Disorders which 'demonstrates that the qualifications of the person honoured have elevated him or her to international recognition as a distinguished contributor to the field of eating disorders'.

Michael Power: Churchill Fellowship

In 2017 Michael Power, Director of the Queensland Health Victim Support Service (QHVSS), Metro North Mental Health, received the Dorothy and Dr Brian Wilson Churchill Fellowship, which supported him in travelling to the United States, Canada, England and The Netherlands in search of innovative ways to assist victims of violence - where the violence has been committed by a person with a mental illness. QHVSS assists victims and their families in cases diverted to the forensic mental health system. (See below)

Forensic Mental Health Service: Gold Award 2017 Australian Crime and Violence Prevention Awards

Queensland Fixated Threat Assessment Centre (QFTAC) is a joint Queensland Police Service and Forensic Mental Health Service early intervention initiative, developed to respond to the risk fixated individuals pose to public office holders, the community and themselves. QFTAC is the first service of its kind in Australia or anywhere outside Europe. It provides risk assessment and intervention for fixated persons, many of whom have untreated or undiagnosed mental disorders. In 2016, the remit of QFTAC expanded to respond to mentally disordered persons in the national security environment who are at risk of committing grievance-fuelled violence.

In 2017 QFTAC was the recipient of a gold award in the Australian Crime and Violence Prevention Awards. These awards recognise and reward good practice in the prevention or reduction of violence and other types of crime in Australia. The awards encourage public initiatives, and assist governments in identifying and developing practical projects which will reduce violence and other types of crime in the community.

Churchill Fellowship

Michael Power, Director, Queensland Health Victim Support Service, Metro North Mental Health, Churchill Fellowship recipient

The Winston Churchill Memorial Trust was established in 1965 after the death of Sir Winston Churchill. The Trust was formed with the principal objective of perpetuating and honouring Sir Winston's memory by the awarding of Memorial Fellowships to be known as 'Churchill Fellowships'. The aim of the Trust is to provide an opportunity for Australians to travel overseas to conduct research in their chosen field that is not readily available in Australia. It also aims to reward proven achievement of talented and deserving Australians with further opportunity in their pursuit of excellence for the enrichment of Australian society.

> "We make a living by what we get, but we make a life by what we give." Sir Winston Churchill

Michael's specific area of interest is the emerging use of restorative justice approaches in mental health and forensic mental health, which has occurred in recent years across the Northern Hemisphere. Restorative justice (also known as restorative justice practice, restorative approaches, community conferencing, victim/offender mediation, victim/offender dialogue, restorative dialogue, circles, and peacemaking circles) has developed overseas as a way of responding to the needs of victims, their families and the people with a serious mental illness who have committed the violence.

In Australia, restorative justice practice is not currently used between victims of violence and people who commit that violence in forensic mental health systems, even though the Australian Mental Health Commission has previously noted that *`good practice can also include restorative justice approaches which focus upon the whole of person needs of the offender as well as the victim. This can help minimise the negative impacts upon mental health, support community re integration and reduce re-offending'* (Australian Mental Health Commission 2013).

Recent application of restorative practices in mental health in Canada, the United States, England and the Netherlands has adapted the extensive knowledge and research from its use in youth justice, schools, adult criminal justice, Indigenous models of peacemaking circles, group conferencing, and models of conflict resolution in the wider community. Restorative practices provide a structured and facilitated opportunity for communication between the victim (and/or their family) and the forensic patient. This can occur directly within a face-to-face meeting (or through a third party or letter) where the patient acknowledges the harm, and takes responsibility for repair and reducing any potential for future harm. This process can be undertaken separately to the Court system, prior to Court, or as an alternative option. While this process may not be suitable for all victims, or all people with a mental illness, it has been shown that when used effectively it can have multiple benefits for victims (including mental health staff who can be victims of violence), families and patients.

Michael spent three days with Dr Sergio Santana (Medical Director) and his multi-disciplinary team at the Forensic and Outpatient Services in Calgary, attending case conferences, family meetings and one-to-one meetings with team members. This innovative Canadian service actively reaches out to family and stranger victims to facilitate understanding about mental illness and support access to treatment for trauma and grief. They seek consent from the patient to share information about their treatment and how the mental illness contributed to the offence. They engage victims on being able to tell their story and raise their concerns directly with the treating team about their safety. This assists victims to understand what has happened and how risks are managed by the treating team.

In England, four forensic mental health services, together with restorative justice practitioners have been developing restorative justice practices responding to patient-to-patient violence, patient-to- staff violence and patient-to-stranger victim violence. Michael visited three of these services, participated in peer review and restorative justice meetings at Hellingly, Broadmoor and Sussex and attended a forum involving these four services and other key stakeholders focussed on the use of restorative approaches in mental health and forensic mental health in England.

Four private and two state-operated secure forensic mental health services in The Netherlands are implementing restorative approaches to facilitating communication between victims in the community and forensic patients. Michael visited the Van Der Hoeven Clinic in Utrecht and the Oostvaarders Clinic at Almere who are implementing restorative approaches to communication between victims and forensic patients. An evaluation has commenced in the four private forensic mental health services of a guideline providing direction for staff facilitating undertaking this work.

Through the opportunity offered by the Churchill Fellowship to spend time with world-class researchers, clinicians, trainers and victims' services, all doing ground-breaking work with restorative justice in the mental health field, Michael has identified the critical elements for the successful provision of restorative justice in forensic mental health in Australia. These elements are documented in his Churchill Fellowship report available at: https://www.churchilltrust.com.au/fellows/detail/4195/Michael+Power

Michael's report includes information gathered from agency visits in New York with services engaging in original and inventive practice around people with a mental illness and their contact with the justice system. The report makes recommendations for Australian states and territories to consider in implementing restorative justice approaches to cases of violence committed by a person with a mental illness, across the criminal justice and forensic mental health systems and within mental health services.

Another focus for Michael's Churchill Fellowship was finding innovative ways to assist families of homicide victims beyond what is currently offered in Australia. As Director of QHVSS for the last five years, assisting families in cases diverted to forensic mental health system, Michael has first-hand experience of the significant needs experienced by victims of serious violence by people with serious mental illness. When Courts decide that the person who committed the violence was of unsound mind at the time of the violence, or they are now unfit for trial, or have diminished responsibility, victims can be extremely distressed, traumatised by the feeling that no-one is being held fully accountable for the violence. When Courts decide that the person who committed the violence is to receive a mental health defence they shift from being an alleged offender to a forensic patient. Confidentiality prohibits victims from understanding why the violence happened and knowing what treatment mental health services are providing to prevent future violence. This impact of this experience is even more profound for family members of homicide victims in cases diverted to the forensic mental health system.

Innovative services are currently underway in England, the United States, Canada, and The Netherlands to respond to families of homicide victims. Highlights include establishing a victim's bureau to respond to media inquiries, systems advocacy within forensic mental health and resources for mental health staff to support implementation of what is known as the 'Duty of Candour' framework in the English National Health Service. Calgary offers hospital based groupwork programs focused on grief and loss. Community based residential programs in England, focused on trauma education; change and establishing 'a new normal' have had positive impacts for families of homicide victims. Michael's Churchill Fellowship considers the applicability of such responses here in Australia and makes recommendations for their implementation.

The opportunity provided by the Churchill Fellowship enabled Michael to meet with key researchers, clinicians, program staff, restorative justice trainers, centres of excellence and victims services across the Northern Hemisphere, to investigate, analyse and report on innovative policy, practice and service responses in this complex area. Michael is committed to promoting these innovative approaches in Australia throughout 2018 and beyond, to reduce the suffering of people impacted by serious violence and those who commit that violence with a serious mental illness. Michael has already presented at the National Victim of Crime Conference in Brisbane August 2017 and conducted a series of presentations to mental health staff, forensic staff and managers and executives in mental health in Queensland with more work to come.

For more information contact Michael Power at Michael.power2@health.qld.gov.au

Older Person's Mental Health

Led by Professor Gerard Byrne, The OPMHS has strong links with the University of Queensland Academic Discipline of Psychiatry and is actively engaged in teaching students of several disciplines (medical, nursing, psychology, occupational therapy, social work). OPMHS personnel are involved in clinical and health services research relevant to mental disorders affecting older people. The program of work encompasses psychotic and mood disorders, particularly anxiety and depression and depression. Work spearheaded by Professor Byrne, including development of an instrument for assessing anxiety in older people is used internationally. OPMHS researchers collaborate widely, with researchers from world leading universities and academics and clinicians from various disciplines within and beyond the RBWH, as well as with several laboratory-based neuroscientists.

Gerard Byrne

As reflected in publications 2017 was a productive and rewarding year for OPMHS researchers, with team members leading the way in development and testing of measures and treatments for anxiety and depression among people diagnosed with Parkinson's.

Australian Psychologist

APS Australian Psychological Society

ORIGINAL ARTICLE

Influences on Psychological Well-Being and Ill-Being in Older Women

Wee Hong Tan, Jeanie Sheffield, Soo Keat Khoo, Gerard Byrne, and Nancy A. Pachana

School of Psychology, University of Queensland

Objectives: To examine factors contributing to psychological well-being and ill-being in older Australian women.
Methods: A multi-variable model examining personality traits, life events, medical diagnoses, and cognitive appraisal was tested on 296 women (mean age = 69.13, standard deviation = 10.20) from the Longitudinal Assessment of Women Study using a cross-sectional design.
Results: Neuroticism, optimism, and extraversion were associated with both well-being and ill-being, but these relationships were partially mediated by cognitive appraisal. The relationship between number of life events and ill-being was fully mediated by cognitive appraisal, while the relationship between number of life events and well-being was partially mediated by cognitive appraisal. The number of medical diagnoses directly predicted well-being.
Conclusions: The supported model suggests that individual and public-health interventions targeting personality traits, cognitive appraisal, and life events might have potential to improve well-being and reduce ill-being as individuals age.

Key words: ageing women; cognitive appraisal; ill-being; life events; personality traits; well-being.

What is already known on this topic

1 The relationship between life events and well-being and ill-being in later life is complex.
2 Personality traits are robust and different traits predict ill-being and well-being.
3 Cognitive appraisal appears to mediate the relationship between personality traits, life events, and well-being in adult populations.

What this paper adds

1 An integrated model of well-being and ill-being in later life combining personality traits, life events, cognitive appraisal, well-being, and ill-being.
2 Common and disparate factors predicting well-being and ill-being in later life.
3 Possible accounts for the complex relationship between life events and well-being and ill-being in later life.

CLINICAL GERONTOLOGIST
2017, VOL. 40, NO. 3, 159–171
http://dx.doi.org/10.1080/07317115.2016.1240131

Routledge
Taylor & Francis Group

ARTICLES

Cognitive Behavior Therapy for Anxiety in Parkinson's Disease: Outcomes for Patients and Caregivers

Nadeeka N. W. Dissanayaka, PhD[a,b], Deidre Pye, BPsychSci (Hons), MPsychClin, MAPS[a], Leander K. Mitchell, BSc (Psych-Hons), DPsych, MAPS[a], Gerard J. Byrne, BSc(Med), MBBS (Hons), PhD, FRANZCP[a,b], John D. O'Sullivan, MBBS (Hons), FRACP, MD[a,b], Rodney Marsh, MBBS, FRANZCP[a,b], and Nancy A. Pachana, PhD, FAPS, FASSA[a]

[a]The University of Queensland, Brisbane, Australia; [b]Royal Brisbane & Women's Hospital, Brisbane, Australia

ABSTRACT

Objective: Anxiety negatively impacts the quality of life of Parkinson's disease (PD) patients and caregivers. Despite high prevalence, there is a paucity of trials investigating effective treatments for anxiety in PD. This uncontrolled study investigated the use of a manualized and tailored Cognitive Behavior Therapy (CBT) for anxiety in PD.

Methods: Participants completed 6 weekly CBT sessions. Pre-, post- and follow-up (3 and 6 months) assessments were made. Change in outcomes were analysed using t-tests and Reliability Change Index. Of 17 PD patients who agreed to CBT, 12 completed the intervention.

Results: This study showed a significant reduction in Hamilton Anxiety Rating Scale scores in PD immediately post CBT ($t(11) = 3.59$, $p < .01$), maintained at 3-month ($t(8) = 2.83$, $p = .02$) and 6-month ($t(7) = 2.07$, $p = .04$) follow-up. A reduction in caregiver burden ($t(11) = 2.68$, $p = .03$) was observed post intervention. Improvements in motor disability ($t(11) = 2.41$, $p = .04$) and cognitive scores ($t(11) = -2.92$, $p = .01$) were also observed post intervention and at follow-up.

Conclusions: Tailored CBT can be used to treat anxiety in PD.

Clinical Implications: This study provides preliminary evidence suggesting that tailored CBT reduces anxiety in PD with persisting benefits, and lowers caregiver burden.

KEYWORDS
Anxiety; caregivers; cognitive behavioral therapy; Parkinson's disease

Forensic Mental Health

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. The Queensland Forensic Mental Health Service (QFMHS) is managed across the State from major groupings based in Brisbane (Metro North and West Moreton) and smaller hubs along the Queensland coast. The integrated services consist of Secure Inpatient Services, Prison Mental Health Services, Court Liaison Services, Community Forensic Outreach Services and Mental Health and Policing Programmes. 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, a Research and Evaluation Manager, and five State-wide positions coordinating Court Liaison Services, Prison Mental Health Services, District Forensic Liaison Network, Indigenous Forensic Mental Health, and the State-wide Community Risk Management program.

In 2017, research operations at QFMHS rapidly expanded with the appointment of two fixed term project managers for the research informed implementation focused project Partners in Prevention: Understanding and Enhancing First Responses to Suicide Crisis Situations. In addition, two research scientists were appointed to the Queensland Forensic Mental Health Group, a new research group at Queensland Centre for Mental Health Research (located in West Moreton HHS). These positions are co-located within QFMHS at Biala. The QFMHS-QCMHR collaboration has been further strengthened through the creation of several affiliate Principal Researcher positions for QFMHS staff.

Research in 2017 has focused on:

- The interfaces between police, ambulance and mental health services
- Understanding and enhancing first responses to suicide crisis situations
- National benchmarking of Forensic Mental Health Services
- Retrospective chart audit of fitness for trial and fitness for interview of people found to be of unsound mind
- The use of interactive technology in custodial settings for the delivery of culturally appropriate social and emotional wellbeing programs to Indigenous Queenslanders
- Enhancing partnerships with other government departments and the tertiary education sector to improve mental health outcomes.

QFMHS research informs 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 high impact publications, seminars and presentations.

FIONA DAVIDSON, RESEARCH AND EVALUATION COORDINATOR, QUEENSLAND FORENSIC MENTAL HEALTH SERVICE; SENIOR RESEARCH SCIENTIST, QUEENSLAND CENTRE FOR MENTAL HEALTH RESEARCH; NHMRC CENTRE FOR RESEARCH EXCELLENCE IN OFFENDER HEALTH.

Fiona Davidson

Fiona Davidson is a credentialed mental health nurse who has worked in the mental health sector for over twenty years. 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 coordinated state based mental health benchmarking projects and has been involved in national forensic mental health benchmarking.

Her role with Metro North Mental Health 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 more recently established services such as the Police Communications Centre Mental Health Liaison Service.

"There is a growing research and evaluation agenda in Forensic Mental Health 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 emergency services hold great promise in benefiting clinicians, first responders, 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 and the title of her study is, "Australian Mental Health Court Liaison Services: variation and common ground, performance measurement and evaluation."

Key performance indicators for Australian mental health court liaison services

Australasian Psychiatry
2017, Vol 25(6) 609–613

DOI: 10.1177/1039856217711052
journals.sagepub.com/home/apy
SAGE

Fiona Davidson University of Queensland, Brisbane, QLD, and; Queensland Forensic Mental Health Service, Brisbane, QLD, and; NHMRC Centre of Research Excellence in Offender Health, University of New South Wales, Sydney, NSW, Australia

Ed Heffernan University of Queensland, Brisbane, QLD, and; Queensland Forensic Mental Health Service, Brisbane, QLD, and; NHMRC Centre of Research Excellence in Offender Health, University of New South Wales, Sydney, NSW, Australia

David Greenberg NHMRC Centre of Research Excellence in Offender Health, University of New South Wales, Sydney, NSW, and; Justice and Forensic Mental Health Network, State-wide Clinical Court Liaison Service, Sydney, NSW, Australia

Tony Butler NHMRC Centre of Research Excellence in Offender Health, University of New South Wales, Sydney, NSW, Australia

Philip Burgess University of Queensland, Brisbane, QLD, Australia

Abstract

Objectives: The aim of this paper is to describe the development and technical specifications of a framework and national key performance indicators (KPIs) for Australian mental health Court Liaison Services (CLSs) by the National Mental Health Court Liaison Performance Working Group (Working Group).

Methods: Representatives from each Australian State and Territory were invited to form a Working Group. Through a series of national workshops and meetings, a framework and set of performance indicators were developed using a review of literature and expert opinion.

Results: A total of six KPIs for CLSs have been identified and a set of technical specifications have been formed.

Conclusions: This paper describes the process and outcomes of a national collaboration to develop a framework and KPIs. The measures have been developed to support future benchmarking activities and to assist services to identify best practice in this area of mental health service delivery.

Mental Health and Criminal Charges: Variation in Diversion Pathways in Australia

Fiona Davidson[a,b,c], Edward Heffernan[a,b,c], David Greenberg[a,d,e], Rhondda Waterworth[c] and Philip Burgess[b]

[a]NHMRC Centre of Research Excellence in Offender Health, Kirby Institute, University of New South Wales, Australia; [b]School of Public Health, University of Queensland, Brisbane, Australia; [c]Queensland Forensic Mental Health Service, Brisbane, Australia; [d]School of Psychiatry, University of New South Wales, Sydney, Australia; [e]New South Wales State-wide Community and Court Liaison Service, Justice and Forensic Mental Health Network, Sydney, Australia

Mental health and criminal justice legislation must provide the appropriate mechanisms for ensuring the assessment and care of mentally ill individuals. It must also balance the right to justice of these individuals with the rights of the community. In Australia, each jurisdiction has its own legislative provisions related to mental health, criminal legislation and sentencing, with variation in the mental health diversion options that are available. This article uses a national survey of court liaison services and mental health courts in Australia and a review of the relevant legislative frameworks to compare jurisdictional approaches to mental health diversion. Despite calls from the National Mental Health Commission for consistency, the Australian approach to the provision of mental health services to people in the criminal justice system is heterogeneous and piecemeal. Variation in the diversion pathways available to individuals with mental illness exists across Australia. The presence of problem-solving courts in some, but not all, jurisdictions results in differences in access to legal and treatment options.

Key words: court diversion; court liaison; fitness to plead; mental health defence; mental health legislation; problem-solving court.

ABSTRACT

Abstract Forensic mental health services in Australia have developed in response to the high rates of mental illness among offenders. Of particular concern is the disproportionate rate of people with serious mental illness in custodial settings. In response to this, court based approaches have emerged in Australian as a key component of the forensic mental health sector. The types of court based mental health service delivery differ across jurisdictions in Australia and are generally formed in response to the relevant legislation regarding mental disorder and criminal charges.

Two types of court based mental health approaches exist in Australia, Court Liaison Services and Problem Solving Mental Health Courts. Court Liaison Services (CLS) provide assessment and recommendations to the court for individuals who have been charged with an offence at the pre-trial stage and then establish mental health treatment via referral to local service providers. Mental health problem solving courts provide an additional approach in some Australian States.

Court Liaison Services (CLS's) can provide early identification of mental illness in those who have been charged with a criminal offence. Where legislation permits, court liaison services can initiate diversion from the criminal justice system to mental health services for individuals with mental disorder. Australian CLS's in each jurisdiction have formed in isolation, with little opportunity for collaboration, limited guidelines for what might represent good practice and with no well-defined approach for performance measurement.

Overall, this body of work examines Australian mental health Court Liaison Services. These services may be considered from a variety of perspectives including policy related to court based diversion, legislative provisions relevant to this type of mental health service, structural aspects of services, performance measurement and the evaluation of service outcomes. Variation and common ground in the area of court liaison service provision throughout Australia will be identified and critically appraised.

Occupational Therapy and Research in Mental Health

FROM OCCUPATIONAL THERAPY PROFESSIONAL LEAD, SAMANTHA BICKER

I am really pleased to see the work of occupational therapists highlighted in the MNMH Research Digest. In the context of ongoing changes in the landscape of mental health care occupational therapy (OT) continues to be a dynamic and responsive profession, particularly in the area of research. Research knowledge, skills and abilities are essential not just desirable competencies that occupational therapists need to attain, develop and apply in their practice; however this is much harder to achieve in every day practice when there are competing demands. Within Metro North Mental Health there is support to assist occupational therapists to aspire to these competencies, through proactive means. Within RBWH mental health OT these competencies are grown from entry to the service with clinicians being involved in the evaluation of clinical programs / interventions to support ongoing quality improvement while there are multiple forums to enable the critical appraisal of research outputs. The OT service continues to aspire to develop budding researchers who will produce innovative research in the field of OT and mental health. The need for the profession to robustly demonstrate clinically cost effective services that make a difference to health care is a priority. The OT service is driven to build capacity in this area to support with producing the ever-growing evidence base that underpins OT practice. Over the last 12 months the service has produced a range of research outputs, some of which are described in this review. You will read about a falls prevention program delivered in community and inpatient settings, implementation of a student resourced sensory clinic, evaluations of an occupational therapy assessment clinic and community group, education provided to health professionals about sensory approaches and how children's stories featuring monsters can manage childhood fears and promote empowerment.

The service would like to thank clinicians in the studies for their commitment and hard work within this arena, and for overcoming the barriers and challenges to research engagement when working within front line positions providing healthcare to consumers. These research outputs will hopefully inspire others to pick up the challenge and demonstrate the positive outcomes that can be achieved for consumers when utilising occupational therapy within mental health recovery. We hope it provides you with insight into the world of OT and contributions in MH and all who participated.

What is Occupational Therapy?

The term "occupation" has various meanings, dependent on circumstance. In health care the term refers to practical and purposeful activities that enable people to live independently and contribute to a sense of identity and connectedness to community.

Occupational Therapy (OT) is grounded in the belief engaging in meaningful occupations is fundamental to health, wellbeing and quality of life. OT is concerned with promoting health and wellbeing through occupation. The primary goal of occupational therapy interventions is to enable people to participate in activities of everyday life. Occupational therapists work to achieve this by working with people and communities to enhance their ability to engage in the occupations by modifying the occupation or the environment to better support their occupational engagement.

OT can be useful across the lifespan, in various health care domains including mental health.

Effective provision of occupational therapy, like any therapy is dependent on tailoring and targeting interventions to an individual's need and goals. Planning intervention is in turn dependent on a comprehensive assessment of needs and circumstances, encompassing barriers to occupation and personal circumstances. Assessment supports formulation of a patient's strengths and limitations leading to identification of goals and treatment recommendations (Creek 2014). A comprehensive OT assessment involves collecting and organizing information about the person from a variety of sources in order to identify the challenges they are experiencing, and thus plan interventions effectively. A wide range of assessment methods and tools including observation, interviews, and questionnaires are utilised. While some of these methods are widely used by other professionals, those that are more specific to OT focus on function and involve activity or occupations such as functional analysis, performance scales and projective methods. Within an assessment occupational therapists will use a variety of standardized and non-standardized assessments as appropriate to the circumstances (Creek 2014). In order to effectively complete robust and complex assessments occupational therapists will additionally liaise with various stakeholders, and assess the individual's capabilities within a range of environments and across occupational forms. Such comprehensive assessments can take a number of days to complete.

Despite the robust evidence base for the effectiveness of various occupational therapy interventions, and potential value of a full occupational therapy assessment and targeted interventions for people with SMI, access to OT is often restricted in public mental health services. Occupational therapists working in these services are commonly employed in generic roles as care coordinators / case managers. In these roles, occupational therapists have limited capacity to undertake comprehensive assessments and deliver discipline specific interventions, impacting on care available to patients and negatively affecting the clinician's work experience (Culverhouse and Bibby 2008).

Occupational Therapy in Mental Health

OT is particularly useful in promoting recovery of people experiencing mental illness because symptoms often impair a person's ability to take part in meaningful occupation - education, play, leisure, work, social activity and perform the activities of daily living that are central to social participation. In the mental health context, Occupational therapy involves the provision of a range of interventions to promote independence and enable people to overcome barriers preventing them from doing activities that matter to them, and ultimately form an adaptive occupational identity.

Some of these include:

- Evaluating and adapting the environment at home, work, school etc., to promote an individual's optimal functioning
- Working with clients to develop leisure or vocational interests and pursuits
- Conducting functional assessments to assist in job and accommodation placements
- Facilitating the development of skills needed for independent living such as using community resources, managing one's home, managing time, managing medication, and being safe at home and in the community
- Developing independence in activities of daily living (e.g., hygiene and grooming)
- Providing education to address self-awareness, interpersonal and social skills, stress management, and role development
- Providing evaluation and treatment for individuals with sensory processing difficulties (see sensory modulation)
- Focusing on remotivation and reablement to enhance occupational engagement.

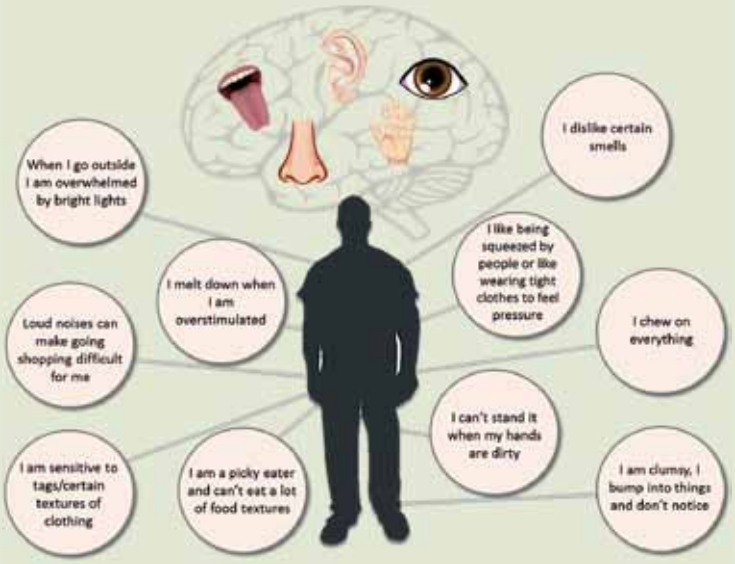
Sensory Modulation is a key occupational therapy intervention delivered to consumers in mental health settings

Sensory Modulation describes the way our bodies regulate and organise the information we are constantly receiving from the environment. The five 'main' senses include touch, sight, hearing, taste, and smell. We also have three'hidden' senses – proprioception (body awareness), vestibular (movement and balance), and interoception (perceiving our internal state of being – cisceral). Sensory modulation involves adapting the degree, intensity and nature of responses we have to sensory input in order to achieve an optimal level of functioning. An individual's capacity to modulate this input impacts on experience, behaviour and ability to adapt to challenges in everyday life. Generally, sensory modulation occurs outside awareness as people go about their day to day activities. Attention is typically paid when stimulation is 'too much' or 'too little' and if modulation strategies are inadequate, distress may result.

With a growing evidence base, the application of sensory modulation interventions in mental health settings is expanding on an international level. Sensory 'interventions' can be described as a range of therapeutic strategies which have been shown to provide comfort and relief from distress by supporting a person's ability to self-regulate emotions in more adaptive and effective ways. They can also help to enhance occupational performance and functioning in daily living activities. Mental health clinicians working with consumers may also adopt a 'sensory approach' employing a sensory lens when undertaking assessment, case formulation and planning care.

Sensory modulation is a recovery focused approach which aims to support consumers in the development of individualised and effective self-management strategies. The National Mental Health Recovery Framework recommends that Mental Health Clinicians use approaches to support self-management including sensory modulation strategies to manage distress and arousal levels. 2017 MNMH research highlights in the area of sensory modulation included the completion of a quality review of a student resourced sensory clinic, evaluation of sensory interventions in mixed mental health settings at TPCH and development and evaluation of sensory training packages for staff.

How might sensory processing difficulties be experienced?



Note: sensory processing is an umbrella term encompassing 3 areas: sensory modulation, sensory discrimination, sensory motor based disorders

ESTABLISHMENT OF AN OCCUPATIONAL THERAPY ASSESSMENT CLINIC IN METRO NORTH MENTAL HEALTH: EVALUATING PROCESS AND IMPACT

Geogie Griffin

Georgia Griffin is an occupational therapist working within the mental health service with adolescents admitted to hospital. Georgia recently joined A/Prof Sue Patterson and occupational therapy professional lead Sam Bicker in evaluating the MNMH OT Assessment Clinic.

Describe your experience working in research

As a new graduate fresh from university, I was apprehensive but excited when the opportunity presented itself to get involved in a research evaluation of the OT assessment clinic. This research project happened to fit in perfectly with my time spent working in a clinical role as a mental health clinician on the adolescent inpatient ward. Being an occupational therapist myself, but not having any had any exposure to the assessment clinic, I was well placed to work on the evaluation.

I quickly realised that few new graduates would be offered the chance to experience both clinical and non-clinical work so early in their career. This project provided a setting which would further develop my undergraduate research skills. I have gained experience in interviewing study participants, data collection and analysis and report preparation. Through completing stakeholder interviews, I got the opportunity to meet and learn from various clinicians within the service and familiarise myself within the wider structure of MNMH outside of my own ward.

It has been has been an invaluable experience working alongside Sue and Sam. This evaluation has been a great eye opener into the world of research and I look forward to being a part of any future projects that come my way.

Tell us about the evaluation of the OT Assessment Clinic

The evaluation aimed to develop a contextualised account of the process and impact of the establishment of a specialist OT assessment clinic within the service over 2017. The OT Assessment clinic was piloted in January 2017 as a means of enabling improvement in core mental health services within existing resources. The OT Assessment Clinic was conducted one day a week, staffed by OTs within the MNMH occupational therapy team on a rotational basis. The primary target groups for the clinic are the consumers within the inpatient and community mental health services that have been identified as requiring a review of their functional capacity to support future recovery orientated planning. Referrals are generated through the existing teams using a specific occupational therapy referral form.

It was proposed that through implementing the OT Assessment Clinic, consumers, particularly inpatients would have better access to discipline specific treatment and that the clinicians would be able to provide this service in a more timely and streamlined fashion. It was also proposed that OT students be involved in completing assessments within the clinic under direct supervision of appropriately qualified OTs. Through utilising the students during their placements, (3x placements each year) the OT clinic would be able to complete more assessments and the students would be provided with a range of clinical experience in delivering assessments.

Because this was a pilot and ongoing support depended on the clinic achieving its objectives, evaluation of the pilot program was important to ensuring the efficient allocation of resources and to continuous improvement of the service. Given the widespread and widely acknowledged difficulties embedding evidence-based practices in mental health services, understanding the implementation is critical to further program development, efficient resource allocation and optimising patient outcomes. Lessons from this evaluation may also inform implementation of other interventions and roll out to other settings.

Findings from the evaluation

The evaluation demonstrated that an OT assessment clinic can be established and operate successfully within a public mental health setting through redistribution of resources. Stakeholders reported high levels of satisfaction with the service provided noting that the clinic enabled timely access to necessary assessments. OTs valued the opportunity to work within the clinic, providing discipline specific services. While acknowledging some impact on routine duties and work load, they observed that working in the clinic with a range of consumers enabled maintenance and development of discipline specific skills and promoted knowledge of the profession.

What did you achieve in 2017 and where to next?

- *Evaluation report complied for MNMH executive*
- *Continuation of the assessment clinic within the MNMHS in 2018*
- *Journal article to be finalised and submitted to Australian Occupational Therapy Journal in 2018*

OCCUPATIONAL THERAPY STUDENT RESOURCED SENSORY CLINIC WITHIN CHERMSIDE COMMUNITY MENTAL HEALTH SERVICE: A QUALITY REVIEW OF THE EXPERIENCE OF PARTICIPATION.

QUALITY REVIEW TEAM: Anneliese Russell, Debbie Bicknell and Chris Herd

GOALS AND OBJECTIVES: The clinic provides an in-depth sensory modulation service delivered by occupational therapy students receiving supervision on placement.

The primary objective is to describe the experience of participation by consumers in the clinic's individual and/or group program, and the acceptability of the sensory interventions to clients of the Chermside Community Mental Health Team.

METHOD: This is a quality review action project that involves the collection of qualitative data to address the objectives set out above. Consumer feedback forms are completed as well as engagement and liaison with other stakeholders such as discussions with multidisciplinary staff and students on the Chermside Community Mental Health Team to obtain their perspectives and recommendations.

EVALUATION: The objectives as stated are met using data collected from participants and records of practice. Acceptability and experience of participation is assessed using:

- Attendance log
- Self-report participant questionnaires with feedback questions
- Completion of Personal Safety Plans and development of individual sensory kits.
- Mental health clinician evaluation surveys

EXPECTED OUTCOMES: Following collection of data, recommendations will be reviewed as part of a 12-month summary report, thus influencing ongoing implementation and future provision of student resourced sensory clinics within other community mental health settings in The Prince Charles Hospital Mental Health Service.

Sensory Clinic: Pilot - Nov & Dec 2017

We were excited to pilot the first student-resourced Sensory Clinic at Chermside Community Health in late 2017 (26 October – 1 December). This has been the result of 18 months of careful planning and preparation, including key project work from undergraduate OT students during their 2016/17 placements in Metro North Mental Health services (under the guidance and supervision of local occupational therapy staff). The clinic ran for six weeks, and was attended by a total of eight consumers of the adult mental health service. Attendance varied for the duration of the clinic. Four sessions went ahead as planned, with an average of five regular attendees. The clinic was offered as either a group or individual session each week, depending on resources and client need.

Sensory Clinic: 2017 Feedback & 2018 Planning

At the end of every weekly session, each attendee was asked to complete a feedback form to detail their experience of the clinic for that week. Most consumers agreed to do so, although some did decline due to literacy level, poor eyesight or choice. In the end, we received 19 correctly completed feedback forms over the course of the clinic.

The vast majority of consumer feedback about the clinic has been positive. In 95% of the feedback responses received, consumers reported feeling better after attending the session. Most attendees (88% of responses received) said they learnt something about themselves and in 94% of the feedback, consumers said they would recommend sensory sessions to a friend. In 100% of the responses received, attendees said that they will use sensory approaches to make themselves feel better in future.

Student feedback on participation in both the Sensory Clinic development project and clinic facilitation has also been positive. Students reported enjoying the variety and diversity of the clinic project development and facilitation as a component of their placement experience – with 100% of students who provided written feedback in 2017 recommending the placement.

It has been wonderful to see all the hard work and planning for the Chermside Student Resourced Sensory Clinic come to fruition this year. Following our initial successful pilot with the Chermside team, it is our hope to continue to build on and improve the clinic heading in to 2018 with an expansion in referrals now being accepted from all 3 community mental health teams. The above preliminary results have provided a tantalising snapshot of the potential for this clinic moving forward. Over time, and once we have had a chance to run and complete more clinics, we hope to be able to share more substantial evaluation and quality review data.

This would not have been possible without the University of QLD OT students who worked on this project. The project team wishes to acknowledge (L-R in photo over page): Jessica Collins; Nadi Han; Brooke Tunks; Laura McCarthy; Jessica Fleming; Caitlin Page; Francesca Harris; in addition to Alice Ryan, Sophie Blakely, Rebecca McGory and Chris O'Dowd (not photographed).

Our thanks and appreciation to all!

EVALUATION OF A CONSUMER CENTRED DAILY RESIDENT MEETING AT COMMUNITY CARE UNIT - RBWH.

Lauren Ives is an Occupational Therapist working in Somerset Villas Community Care Unit (CCU). Lauren presented her evaluation of a consumer centred daily resident meeting at CCU at the Occupational Therapy Mental Health Forum 2017 in Sydney.

Background: The daily community meeting has been significantly transformed during the past 12 months. It was originally delivered by members of staff. Through initial feedback from consumers, the meeting became consumer centred and consumer led. The purpose of this study was to evaluate consumers' perceptions regarding how well the community meeting is currently run, how motivated individuals are to attend the meeting, and what changes individuals would like to enhance current meeting.

Method: Two quantitative & three qualitative questions were asked within a questionnaire to understand each consumer's perspective. All consumers were invited to contribute. Consumers could keep their response anonymous. Outcome measures included consumers perceptions regarding how well the revised community meeting is run, how motivated individuals are to attend, and what changes individuals would like to occur to enhance the meeting.

Discussion/outcomes: The results indicate that the consumers are motivated to attend and the meeting provides meaning, purpose and routine to their day. At RBWH, the occupation focused Model of Human Occupation or (MOHO) is our primary OT model of practice. Using this model within our OT lens, the results indicate that the meeting is now an Activity of Daily Living that consumers perceive as valuable, meaningful, important to them and they enjoy it. The qualitative feedback indicates that each individual's sense of capacity and self-efficacy is improving. They feel confident in using their abilities.

Furthermore, the consumers identified that facilitating the meeting provides a positive, consistent and familiar daily routine, and they value their chosen roles. By doing this, they are developing their occupational identity.

The consumers' subjective perception and the therapist's objective evaluation demonstrates that the consumers have the mental and physical capacity to facilitate their own meeting. They are building on their occupational competence.

Through the therapeutic milieu developed, familiar and consistent daily routine, the qualitative feedback indicates that consumers perceive that the environment facilitates their performance.

Conclusion: Using the recovery framework and through the dynamic and reciprocal interaction between the MOHO elements, feedback from consumers indicates that the consumer led meeting is enhancing their occupational engagement - to become adaptive occupational beings. This is an example of how occupational therapy is enabling individuals with their recovery journey.

Stepping On:

Building Confidence and Reducing Falls

A Combined Inpatient/Community Based Program for Consumers of the Older Person's Mental Health Service

Eleanor Vallelonga and Hayley Barnett Royal Brisbane and Women's Hospital

Falls are the most common cause of non-fatal injuries and hospital admissions for trauma in adults aged 65+. 1 in 3 adults aged 65+ report falling at least once per year (Clemson et al., 2004). Falls are a major contributor to immobility, premature nursing home placement and long-term care (Letts et al., 2010) and have a significant psychological impact on the person and their family/carers. Without preventative strategies, the burden on health services from fall-related injuries will continue to increase with the ageing population (65+).

What is the Stepping On Group Program?

Stepping On is an evidence-based, falls prevention group program designed for adults aged 65+ who have experienced a fall or are concerned about falling.

Stepping On is a seven week program, developed by Occupational Therapists that aims to address the major risk factors for falls and support older adults to improve their self-efficacy, explore different coping strategies and encourage behavioural change to reduce their risk of falls.

Scientific research and evaluation of the Stepping On Program has reported a 31% reduction in participant falls (Clemson et al., 2004).

Group Objectives:

To explore the effectiveness of an exercise and education based falls prevention group program for consumers over 65 years with severe and enduring mental health concerns across two domains:

1. To reduce falls and fear of falling
2. Improving quality of life and daily functioning for consumers

Design

The Stepping On program incorporates exercise and education. It uses a set of 6 practical exercises specifically designed to improve strength and balance and covers a range of falls education topics including home and environmental hazards, vision, medications, community safety, bone health and footwear.

Eligibility Criteria

Group participants were screened as part of the recruitment process. Inclusion criteria included:

- Inpatient/community consumers of the Older Persons Mental Health Service (OPMHS), Royal Brisbane and Women's Hospital
- 65 years and older
- History of falls or fear of falling

The program follows a closed group format, in which participants attend a 2 hour session each week for a period of 7 weeks. There is also a post-completion phone call or home visit and a two month booster session.

Evaluation

Pre and post outcome measures are undertaken to measure participant's progress. Evaluations are completed in week 1 and week 7 of the program.

Pre- and post outcome measures include:

- TUG (Timed-up-and-go) test
- NTS (The near tandem stand)
- STS (Sit to stand test)
- FES-I (Falls Efficacy Scale International)
- WEMWBS (Warwick-Edinburgh Mental Well-being Scale) 7 or 14 question version

Participants are also asked to complete a written outcome survey as part of these sessions.

Consumer Feedback :

"I haven't had a fall since engaging in the course. I have developed mindfulness and believe it has potentially saved my life"
- Karen

"it made me feel better about myself"
-Dan

"I learnt things that will be beneficial to me"
-Sue

Group Implementation

In July 2016, two Occupational Therapists, Amelia Grimmer and Eleanor Vallelonga from the Royal Brisbane and Women's Hospital (RBWH) Older Person's Mental Health Service (OPMHS), completed the Stepping On 'Train the Trainer' course. This was the first ever training to be delivered in Queensland. Falls were identified as an increasing problem in the OPMHS population. The Stepping On program was identified as part of a quality improvement project within the service as a positive way to actively meet Standard 10 from the EQUIPP National Health Care Standards and reduce falls in the OPMHS population.

The first pilot of the 7-week group program was run by Amelia and Eleanor at the RBWH Mental Health Centre in October 2016, followed by the 2 month booster session. The trial group consisted of four participants, a mix of both inpatient and community consumers. Participant feedback and pre and post outcome measures showed an overall increase in strength and balance, and reduced fear of falling.

The second pilot of the program commenced in July 2017 and was run by OPMHS Occupational Therapists, Eleanor Vallelonga and Hayley Barnett. Results of the second pilot showed an increase in awareness and education on falls prevention principles. Group participants reported a significant increase in confidence to be on their feet and improved strength and balance following completion of the 7 weeks. 100% of participants continued to complete their exercises at home following the completion of the program. Participants reported benefits from engaging in a supportive, social setting and an overall improvement in their well-being surrounding their ability to cope with challenging functional tasks at home and in the community.

Future Directions

Following on from the successful completion of two programs, it is anticipated that the Stepping On program will continue to be run annually for OPMHS consumers, with the view to expand the program to the adult mental health population in the future. This RBWH Mental Health Occupational Therapy initiative, alongside multiple student projects, is expected to result in completion of a second literature review and collection of all outcome measures to date for the purpose of generating ongoing research.

It is hoped that Stepping On will continue to be integrated into the Mental Health Service RBWH as evidence-based, best practice for working towards the prevention of falls and result in improved function, health and well-being for older adult consumers.

References

Clemson L, Cumming RG, Kending H, Swann M, Heard R, Taylor K. The Effectiveness of a Community-Based Program for Reducing the Incidence of Falls in the Elderly: A Randomized Trial. Journal of the American Geriatrics Society. 2004 Sept;52(9):1487-1494.

Gillespie LD, Robertson MC, Gillespie WJ, Lamb SE, Gates S, Cumming RG, Rowe BH. Interventions for preventing falls in older people living in the community (Review). Cochrane Database Syst Rev. [Internet]. 2012 [cited 2016 Mar 24];Issue 9. Art. NO.: CD007146. DOI: 10.1002/14651858.CD007146.pub3

Letts, L., Moreland, J., Richardson, J., Coman, L., Edwards, M., Ginis, K. M., Wilkins, S. and Wishart, L. (2010), The physical environment as a fall risk factor in older adults: Systematic review and meta-analysis of cross-sectional and cohort studies. Australian Occupational Therapy Journal, 57: 51–64. doi:10.1111/j.1440-1630.2009.00787.x

Queensland Health. National Safety and Quality Health Service Standards [internet]. [updated 2016;cited 2016 Apr 8]. Available from: http://qheps.health.qld.gov.au/psu/safetyandquality/ standards /default.htm

Queensland Government

FALLS PREVENTION

Falls are the most common cause of non-fatal injuries and hospital admissions for trauma in adults aged 65+. 1 in 3 adults aged 65+ reports falling at least once per year. Falls are a major contributor to immobility, premature nursing home placement and long-term care and have a significant psychological impact on the person and their family/carers. Falls risk is significant concern in inpatient mental health settings as well as in the community, particularly in the older adult population. Inpatients with a mental illness are at a high risk of falling both in the acute phase of their illness and when they improve and become more independent with their activities of daily living. Treatments for some consumers may include the use of high dose anti-psychotic medications, sedatives, and/or electroconvulsive therapy (ECT) to treat mental illness which is all associated with increased falls risk. Without preventative strategies, the burden on health services from fall-related injuries will continue to increase with the ageing population.

Stepping On: Building Confidence and Reducing Falls

A Combined Inpatient/Community Based Program for Consumers of the Older Person's Mental Health Service

Hayley Barnett, Amelia Grimmer & Eleanor Vallelonga, occupational therapists working at RBWH, are working to promote falls prevention through delivery of a combined inpatient/community based program for consumers of the Older Person's Mental Health Service (OPMHS)

Stepping On is an evidence-based falls prevention group program designed for adults aged 65+ who have experienced a fall or are concerned about falling. Stepping On is a seven week program, developed by occupational therapists that aims to address the major risk factors for falls and support older adults to improve their self-efficacy, explore different coping strategies and encourage behavioural change to reduce their risk of falls. The Stepping On program incorporates exercise and a range of falls education topics including home and environmental hazards, vision, medications, community safety, bone health and footwear. Scientific research and evaluation of the

Stepping On Program has reported a 31% reduction in participant. Research also showed that participant's self-efficacy surrounding their ability to cope with challenging functional tasks at home and in the community also improved significantly.

The first trial of a combined inpatient/community based program for consumers of the OPMHS was run by two occupational therapists in October 2016. A second pilot program was completed in November 2017.

The Stepping On program was identified as part of a quality improvement project within the service as a positive way to actively meet Standard 10 from the EQUIPP National Health Care Standards and reduce falls in the OPMHS population. The poster outlines the Stepping On program and outcomes following the first trial implementation, which was presented at the Tri- Nations Falls Forum in September 2017 by Eleanor Vallelonga and Hayley Barnett.

MICHELLE TAYLOR IS AN OCCUPATIONAL THERAPIST WITH EXTENSIVE EXPERIENCE IN THE AREA OF SENSORY MODULATION. WE SPOKE WITH HER ABOUT HER CURRENT ROLE AND EXPERIENCES WITH RESEARCH.

Michelle Taylor

IWhat's your professional background?

I'm an Occupational Therapist and have worked for over 25 years in the areas of drug and alcohol and mental health - in Brisbane and around England and Scotland. Lots of my working life has been with Metro North – my first role was at HADS (Hospital Alcohol and Drug Service), then the Mental Health Adolescent Unit and Community Mental Health teams. More recently I've held roles as Professional Leader for Occupational Therapy, Clinical Educator and Dual Diagnosis Co-ordinator.

Tell us a bit about yourself

I'm the mother of three girls and our family lived in Portugal on a small island called Madeira when they were younger. I write fiction and poetry when I have time and enjoy using creative writing to support wellbeing, especially when combined with yoga! I completed a Master of Arts Research looking at the role of scary children's stories to empower young people (see text box)

What is your current role?

I seem to keep returning to Metro North – my current role is Advanced Clinical Educator with the Insight team at Biala. I help develop and deliver alcohol and other drug training, education and resources to support workers and services across Queensland. As the Occupational Therapist in the team I'm excited about continuing to explore sensory approaches, occupational approaches and trauma informed care and practice for people with alcohol and drug problems.

Please tell us about your research

Sensory modulation and sensory approaches have been recognised internationally as alternatives to seclusion and restraint. They offer ways for people to self-regulate and reduce distress by using sensory modalities and sensory-motor input. While these approaches are increasingly being adopted across mental health and alcohol and other drug settings, workplace cultures and a lack of accessible training can be barriers to implementation. Our research explored the effectiveness of a custom-designed self-paced e-learning training package on sensory approaches in mental health. Workers across Queensland could access this training on The Learning Centre's website. Real and perceived levels of knowledge, perceived levels of confidence and attitudes to using this approach showed significant improvements between pre- and post-training. The findings suggest this is an effective and accessible way to train health professionals, with some participants suggesting face- to- face training in addition to this initial package would further enhance their practice. It's the first time an e-learning package on sensory approaches has been evaluated and there is another project to follow that investigates whether these initial gains in knowledge, attitudes and confidence are retained over time and translate in to practice.

What has your role been?

My role was to offer clinical expertise - so contributing to the development and review of the training package, along with questionnaires to measure changes in attitudes, confidence and knowledge pre- and post-training.

Who else has been involved?

Pam Meredith and Harriet Yeates from the School of Health and Rehabilitation Sciences, University of Queensland; Amanda Greaves from MNMH; Maddy Slattery from the School of Human Services and Social Work, Griffith University; Michelle Charters and Melissa Hill from The Learning Centre. The training package was developed by The Learning Centre with Sue Holley, and with input from the Mental Health Sensory Approaches Clinical Collaborative in Queensland.

How does research fit with your job?

In most of my roles research hasn't been a high priority so I carved out little bits of time after I'd done my other work. I'm glad I did because I've learnt a great deal and it's led to the opportunity in my current role to do research in the alcohol and other drug area. Along with the University of Queensland and Hot House Youth Alcohol and Other Drug team we're exploring the Sensory Profiles of young people accessing the service.

What challenges have you encountered and how did you overcome them?

I've always been interested in asking questions and looking at ways to improve what we're doing. But I had no interest in writing up large literature reviews or crunching data, or applying for ethics! Nor did I have time. The only way we've been able to do these projects has been by slowly gathering together a group of people with common interests but different skills and resources. The plus side after you've found that cohort of professionals is sharing the workload and learning together.

What advice would you give a colleague thinking about undertaking some research?

You can't do it all yourself. You don't have the time, the skills or the energy. Start talking to others who are interested in the same things as you. Once you have a team then you need backers. Explain to managers and academics what the current evidence is and why your project is important. For us it was improving worker's capacity to deliver new interventions, which should lead to better outcomes for our clients, with the added benefit of better partnerships.

International Journal of Mental Health Nursing

International Journal of Mental Health Nursing (2018) 27, 106–115 doi: 10.1111/inm.12299

ORIGINAL ARTICLE

Preparing mental health professionals for new directions in mental health practice: Evaluating the sensory approaches e-learning training package

Pamela Meredith,[1] Harriet Yeates,[1] Amanda Greaves,[2] Michelle Taylor,[2] Maddy Slattery,[3] Michelle Charters[4] and Melissa Hill[4]

[1]School of Health and Rehabilitation Sciences, The University of Queensland, St Lucia, [2]Metro North Hospital and Health Service, Herston, [3]School of Human Services and Social Work, Logan, Griffith University, Nathan, and [4]The Queensland Centre for Mental Health Learning, Brisbane, Queensland, Australia

ABSTRACT: *The application of sensory modulation approaches in mental health settings is growing in recognition internationally. However, a number of barriers have been identified as limiting the implementation of the approach, including workplace culture and a lack of accessible and effective sensory approaches training. The aim of this project was to investigate the efficacy of providing this training through a custom-designed e-learning package. Participants in the present study were predominately nurses and occupational therapists working in mental health settings in Queensland, Australia. Data were collected from 121 participants using an online survey. Significant improvements were found between pre- and post-training in participants' real and perceived levels of knowledge, their perceived levels of confidence, and their attitudes towards using sensory modulation approaches in mental health settings. The findings of the study suggest that the custom-designed sensory approaches e-learning package is an effective, accessible, acceptable, and usable method to train health professionals in sensory modulation approaches. As this study is the first to analyse the efficacy of an e-learning sensory approaches package, the results are considered preliminary, and further investigation is required.*

KEY WORDS: *e-learning, health professional, mental health, sensory approach, sensory modulation.*

THE ROLE OF CHILDREN'S STORIES FEATURING MONSTERS IN MANAGING CHILDHOOD FEARS AND PROMOTING EMPOWERMENT.

Michelle Taylor

Children's fascination with monsters is a normal part of childhood development. Children's literature reflects this with a wealth of stories featuring monsters, ranging from fairy tales to picture books to books for independent readers. These stories can raise concerns from educators, parents and other sections of the community such as political and religious institutions on the basis that they could be disturbing or harmful to children. In contrast, there is evidence to indicate the potential for managing fears and enhancing feelings of empowerment in children through the reading of stories featuring monsters. A reappraisal of these stories from a predominantly therapeutic perspective reveals that they may act as agents of positive change in six ways – catharsis, naming, taming, integration, transformation and moral empowerment. Two of these functions, transformation and moral empowerment, are examined further in three case studies of stories for the older reader that feature monsters, Wolf Brother by Michelle Paver, Monster Blood Tattoo, Book One: Foundling by D.M. Cornish and my manuscript, 'The Monster Chronicles'. The insights from this research have been used to inform the writing and editing of 'The Monster Chronicles' and inherent to that, my goal of creating a children's story featuring monsters that is sensitive to children's fears and their desire for empowerment.

GROUNDED THEORY OF ADOLESCENT 'RECOVERY': ADOLESCENT CYMHS CONSUMERS' PERSPECTIVES.

Lucianne Palmquist a psychologist with Child and Youth Mental Health Services at RedCab speaks with us about her research into adolescent 'recovery'. Lucianne is completing a PhD through Griffith University. Her thesis (due early 218) is grounded in a qualitative study of 'recovery' from mental illness among young people aged 12-17years. It involves in-depth qualitative interviews with young people at two times during their transition through CYMHS. Lucianne is supervised by Prof Analise O'Donovon, A/Prof Graham Bradley and A/Prof Sue Patterson.

Tell us about your research

In Australia, approximately half of adolescents experiencing diagnosable mental health conditions do not access professional support. Research indicates multiple personal, social and structural barriers to accessing relevant services, and upon access, engagement can be tenuous. While some research has focused on factors associated with access and, to a lesser extent, engagement and service satisfaction, the views of adolescent consumers of specialist services are underrepresented in research pertaining to their journey toward recovery.

Through sequential interviews, this largely qualitative study explores adolescent consumers' perspectives on the processes involved in their journeys into and through specialist mental health care from initial recognition of disturbances. In particular, it focuses on identification of primary concerns within the journey, how they are negotiated, with whom (if anyone) and outcomes of their decisions.

This research aims to develop a comprehensive explanatory model of adolescent consumers' 'recovery' processes, with the overarching purpose of improving clinical and organisational practice.

Tell us about what this research means for Metro North, our patients and the community?

In line with MNMHS recovery-oriented policy, the voice of local adolescent consumers are being sought to inform the ongoing improvement and development of services. The research is being conducted within the Metro North HHS, Metro South HHS and CHQ HHS. Thirteen participants have been recruited from Metro North Child/Youth Mental Health Services (CYMHS) and six from Metro South and CHQ. Their stories and concerns are locally applicable, and applicable to other CYMHS.

Outcomes of this research highlight issues relevant to the spectrum of informal supports and formal services within the community, inter-agency and inter-sectoral collaboration, early intervention initiatives, acute and ongoing care.

Why is this important?

This research identifies, at each stage of their journey, how adolescents negotiate the mental health difficulties they experience, how they navigate access to support, and their experiences and expectations of service accessibility, relevance, acceptability and effectiveness.

Early data analysis indicates that adolescents' journey into specialist services is frequently lengthy and fraught with challenges. Their access to specialist support often occurs only after all other known viable options have been explored and exhausted, or when thoughts of suicide have become a prominent feature of their experience. This means that when they access specialist services, they may have guarded expectations of services, are often in a critical state, highly defended and in survival mode.

To prevent loss of life and to aid in the promotion of recovery, specialist services must reflect on organisational and clinical processes from the perspective of primary stakeholders of the service – consumers. Comprehensive understanding of consumers' experiences and expectations will inform policy, organisational and clinical practice for CYMHS. Specific areas of concern or need will be highlighted, and recommendations will be made for quality improvement initiatives.

What is next?

- *Analysis is ongoing.*
- *A comprehensive model of adolescent recovery will be developed.*
- *Results will be written and disseminated along with recommendations relevant to local and similar communities and health services.*

ABSTRACT

Protocol: A grounded theory of 'recovery'—perspectives of adolescent users of mental health services

Lucianne Palmquist, Sue Patterson, Analise O'Donovan, Graham Bradley

Introduction Policies internationally endorse the recovery paradigm as the appropriate foundation for youth mental health services. However, given that this paradigm is grounded in the views of adults with severe mental illness, applicability to youth services and relevance to young people is uncertain, particularly as little is known about young people's views. A comprehensive understanding of the experiences and expectations of young people is critical to developing youth mental health services that are acceptable, accessible, effective and relevant.

Aim To inform development of policy and youth services, the study described in this protocol aims to develop a comprehensive account of the experiences and expectations of 12–17 year olds as they encounter mental disorders and transition through specialist mental health services. Data will be analysed to model recovery from the adolescents' perspective.

Method and analysis This grounded theory study will use quantitative and qualitative data collected in interviews with 12–17 year olds engaged with specialist Child/Youth Mental Health Service in Queensland, Australia. Interviews will explore adolescents' expectations and experiences of mental disorder, and of services, as they transition through specialist mental health services, including the meaning of their experiences and ideas of 'recovery' and how their experiences and expectations are shaped. Data collection and analysis will use grounded theory methods.

Ethics and dissemination Adolescents' experiences will be presented as a mid-range theory. The research will provide tangible recommendations for youth-focused mental health policy and practice. Findings will be disseminated within academic literature and beyond to participants, health professionals, mental health advocacy groups and policy and decision makers via publications, research summaries, conferences and workshops targeting different audiences. Ethical and research governance approvals have been obtained from relevant Human Research Ethics committees and all sites involved.

EVALUATION OF THE SCIT PROGRAM RUN IN THE SMHRU

Emma Simpson

Emma Simpson

Emma Simpson is a clinical psychologist working in the Secure Mental Health Rehabilitation Unit located at Caboolture hospital. Emma has worked across various mental health settings over the past 10 years and has a passion for working with people experiencing severe and complex mental health issues. As a Scientist-Practitioner, Emma values the importance of evaluating the acceptability and clinical effectiveness of psychosocial evidence-based interventions in this unique setting, to contribute to quality improvement of mental health service delivery and the broader 'practice-based evidence' literature.

In schizophrenia, the ability to adaptively infer the thoughts and feelings of others (i.e., social cognition) is strongly associated with community functioning. Social Cognition and Interaction Training (SCIT) is a group based treatment aimed at improving social cognition in schizophrenia.

The acceptability and feasibility of Social Cognition Interaction Training (SCIT) was explored in the clinical context of the Secure Mental Health Rehabilitation Unit (SMHRU) at the Caboolture hospital. SCIT is a 16-20 session manualised group-based intervention with demonstrated efficacy in improving the quality of social functioning and connectivity through addressing biased cognitive processes characteristic of individuals living with psychotic illness. On a real-world level, SCIT has been shown to demonstrate strong engagement with consumers receiving treatment for schizophrenia on an outpatient basis, as evidenced by high retention and attendance rates, positive feedback and a trend towards improvement in life skills from pre to post intervention (Gordon et al. 2017).

The SMHRU is an extended care inpatient facility providing intensive rehabilitation to consumers with severe and complex mental health and social needs. The SMHRU environment presents unique challenges for the effective delivery of psychosocial interventions given issues relating to mental health act status and illness severity. SCIT was implemented at the SMHRU for the first time in the latter half of 2017, in the format of weekly 45 minute sessions over a 20 week period, facilitated by two clinical psychologists trained in the provision of SCIT. There was strong fidelity to the manualised protocol, however the content was protracted over some sessions in the early phase, 'Introduction and Emotions,' due to the neurocognitive challenges experienced by the consumers of the SMHRU population.

Five consumers completed the SCIT program. Objective measurement of those psychological constructs thought to the be improved by SCIT was obtained, such as social and emotion perception, theory of mind and hostile attributional bias, however the sample size was much too small for any meaningful pre and post intervention change to be detected. As a result of being involved in SCIT, participants reported to be seeking greater understanding of other people's behaviour in social situations as well as wanting to better understand and improve attributional bias tendencies. Participants also reported wanting more meaningful social engagement generally in their lives.

Upon completion of SCIT, Research Fellow Sue Patterson conducted individual semi-structured interviews with the participants for the purpose of eliciting feedback about the perceived usefulness of the program. In regards to group processes, participants reported that the small closed group format was beneficial to ensure individual 'in-session' attention, promoting safe self-disclosure and minimising fear of judgement, while enabling everyone to "get to know each other." One participant stated, "we mostly get on well, we have to because we live together, you get to know people pretty well here." Two participants identified that the inequitable contribution of members at times was a reminder of the expected participation format of the SMHRU recovery program, and that the changeability in consumers' levels of mental health wellness affected the group cohesion on occasions. The interviews revealed varied impact as a result of group participation, ranging from minimal "not much will change for me," to profound, "changed everything, I thought I was very good at reading people but I was proved wrong."

The qualitative evaluation revealed that SCIT was generally well accepted by the 5 participants who completed the program. From a facilitator perspective, it has been shown that SCIT can be feasibly delivered in a unique clinical setting such as SMHRU. For therapeutic group-based interventions at SMHRU to be successful, it is important to be dynamic and flexible with program delivery considering highly fluctuating levels of wellness, symptom severity, neurocognitive impairment and often low motivation to participate in formal treatment activities. Facilitators need to be prepared to augment session length depending on individual abilities and group dynamics on the day, ensure consolidation of new learning though the repetition of content, and to offer small incentives to promote motivation to participate. In addition to a stated willingness to commit to a longer-term treatment program, when selecting consumers for participation, facilitators need to carefully consider the cognitive ability and neuropsychological functioning of each participant so as to ensure inclusion of those who will benefit most from the intervention.

A consideration for future SCIT groups at SMHRU, one participant made a valuable comment, "groups were for learning, but my individual therapy sessions supported constructive application of learning to practical and personal situations." Given the rehabilitative focus of the SMHRU, there could be scope to incorporate a more formalised adjunct component to the manualised protocol, of regular individual sessions aimed at assertive follow up of SCIT homework tasks and promoting the generalisation of new skills to consumer real-life circumstances.

Bullying and its Harmful Effects on Mental Health

James Scott Consultant Psychiatrist and Conjoint Associate Professor, UQ Centre for Clinical Research and MNMH RBWH

James is a child and adolescent psychiatrist working clinically at the RBWH and in private practice. He holds conjoint appointments with the University of QLD. James has extensive clinical and research experience and has published widely in the areas of child and adolescent mental health and early psychosis. James is interested in bullying and the devastating effect it has on mental health.

Bullying is a serious public health issue. It is now clear that it is causatively associated with increased risk of depression, self-harm and suicide. In schools, it can be reduced through a combination of universal preventative strategies and targeted interventions. James became interested in this area of research in 2012 after seeing the harm so many adolescents and young adults experienced as a result of bullying. In collaboration with Hannah Thomas and others he, conducted epidemiological studies to show the health and social harm that results from bullying. Hannah then led the development of a scale to measure traditional and cyberbullying in adolescents. Measurement of the behaviour enables evaluation of interventions to address bullying. James has been invited by Premier Annastacia Palaszczuk to be a member of the Queensland Anti-Cyberbullying taskforce which will provide the Queensland Government with detailed advice and coordination on tackling cyberbullying. This exemplifies the power of research to translate observations from the clinic to influence public policy throughout the state of Queensland.

See http://statements.qld.gov.au/Statement/2018/2/19/membership-and-terms-of-reference-for-queensland-anticyberbullying-task-force for more information about the Queensland Anti-Cyberbullying Task Force.

Social Psychiatry and Psychiatric Epidemiology
https://doi.org/10.1007/s00127-017-1462-1

INVITED REVIEWS

CrossMark

Why do children and adolescents bully their peers? A critical review of key theoretical frameworks

Hannah J. Thomas[1,2] · Jason P. Connor[3,4] · James G. Scott[1,2,5]

Received: 20 July 2017 / Accepted: 12 November 2017

Abstract
Bullying is a significant public health problem for children and adolescents worldwide. Evidence suggests that both being bullied (bullying victimisation) and bullying others (bullying perpetration) are associated with concurrent and future mental health problems. The onset and course of bullying perpetration are influenced by individual as well as systemic factors. Identifying effective solutions to address bullying requires a fundamental understanding of why it occurs. Drawing from multi-disciplinary domains, this review provides a summary and synthesis of the key theoretical frameworks applied to understanding and intervening on the issue of bullying. A number of explanatory models have been used to elucidate the dynamics of bullying, and broadly these correspond with either system (e.g., social-ecological, family systems, peer-group socialisation) or individual-level (e.g., developmental psychopathology, genetic, resource control, social-cognitive) frameworks. Each theory adds a unique perspective; however, no single framework comprehensively explains why bullying occurs. This review demonstrates that the integration of theoretical perspectives achieves a more nuanced understanding of bullying which is necessary for strengthening evidence-based interventions. Future progress requires researchers to integrate both the systems and individual-level theoretical frameworks to further improve current interventions. More effective intervention across different systems as well as tailoring interventions to the specific needs of the individuals directly involved in bullying will reduce exposure to a key risk factor for mental health problems.

Prevalence and correlates of bullying victimisation and perpetration in a nationally representative sample of Australian youth

Australian & New Zealand Journal of Psychiatry
2017, Vol. 51(9) 909–920
DOI: 10.1177/0004867417707819

Hannah J Thomas[1,2], Jason P Connor[3,4], David M Lawrence[5], Jennifer M Hafekost[6], Stephen R Zubrick[5,6] and James G Scott[1,7]

Abstract

Objective: Bullying prevalence studies are limited by varied measurement methods and a lack of representative samples. This study estimated the national prevalence of bullying victimisation, perpetration and combined victim-perpetration experiences in a representative population-based sample of Australian youth. The relationships between the three types of bullying involvement with a range of mental health symptoms and diagnoses were also examined.

Methods: A randomly selected nationally representative sample aged 11–17 years (N = 2967, M_{age} = 14.6 years; 51.6% male) completed the youth component of the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing (Young Minds Matter). Parents or carers also completed a structured face-to-face interview that asked questions about a single randomly selected child in the household. The youth survey comprised self-reported bullying victimisation and perpetration (Olweus Bully–Victim Questionnaire–adapted), psychological distress (K10), emotional and behavioural problems (Strengths and Difficulties Questionnaire), as well as self-harm, suicide attempts and substance use. Modules from the Diagnostic Interview Schedule for Children Version IV were administered to all youth and parents to assess for mental disorder diagnoses (major depressive disorder, any anxiety disorder and any externalising disorder [attention-deficit hyperactivity disorder, oppositional defiant disorder and conduct disorder]).

Results: The 12-month prevalence of bullying victimisation was 13.3%, perpetration 1.6% and victim-perpetration 1.9%. Logistic regression models showed all forms of involvement in bullying were associated with increased risk of psychological distress, emotional and behavioural problems, substance use, self-harm and attempted suicide. Victimisation and victim-perpetration were associated with youth-reported major depressive disorder. There were also significant associations between bullying involvement and parent-reported diagnoses of major depressive disorder, any anxiety disorder and any externalising disorder.

Conclusion: Bullying continues to be frequently experienced by Australian adolescents. The current findings showed that involvement in any bullying behaviour was associated with increased risk of concurrent mental health problems. This evidence can be used to inform decisions concerning the allocation of resources to address this important health issue.

AGGRESSIVE BEHAVIOR
Volume 43, pages 352–363 (2017)

Two Sides to the Story: Adolescent and Parent Views on Harmful Intention in Defining School Bullying

Hannah J. Thomas[1]*, Jason P. Connor[2,3], Chantelle M. Baguley[4], and James G. Scott[1,5]

[1]*The University of Queensland, University of Queensland Centre for Clinical Research, Herston, Queensland, Australia*
[2]*Discipline of Psychiatry, School of Medicine, The University of Queensland, Herston, Queensland, Australia*
[3]*Centre for Youth Substance Abuse Research, The University of Queensland, Herston, Queensland, Australia*
[4]*School of Psychology, The University of Queensland, St Lucia, Queensland, Australia*
[5]*Metro North Mental Health, Royal Brisbane and Women's Hospital, Herston, Queensland, Australia*

Bullying is defined as *repeated negative actions* involving a *power differential*, and *intention to harm*. There is limited research on harmful intention as a definitional component. This study explored the role of the perpetrator's harmful intention and the target's *perception* of harmful intention. Some 209 students (M = 14.5 years; 66.5% female) and 447 parents (M = 46.4 years; 86.4% female) were randomly assigned in an online survey. Participants assessed the likelihood of bullying in five hypothetical scenarios (physical, verbal, rumor, exclusion, and cyber) across five intention conditions, that also involved repetition and a power differential. The five intention conditions were: 1) harm intended by perpetrator (I) and perceived as intended to harm by target (I) [II condition]; 2) harm not intended by perpetrator (N) but perceived as intended to harm by target (I) [NI condition]; 3) harm intended by perpetrator (I) but not perceived as intended to harm by target (N) [IN condition]; 4) harm not intended by perpetrator (N) and not perceived as intended to harm by target N [NN condition]; and 5) a control which did not state any actual or perceived harmful intention [C condition]. For students and parents, the perpetrator's harmful intention and the target's perception of harmful intention were important when considering whether a peer interaction constituted bullying. These findings confirm the applicability of the three-part definition of bullying, and highlight the importance of assessing these two dimensions of harmful intention when determining whether a problematic peer interaction should be regarded as bullying.
Aggr. Behav. 43:352–363, 2017. **© 2016 Wiley Periodicals, Inc.**

SOCIAL WORK AND RESEARCH: FAMILY INCLUSIVE PRACTICE

Working with family and supporters is an essential part of a comprehensive response to working with people experiencing mental health problems and entrenched family difficulties. Research shows that working in an open, respectful and collaborative fashion with consumers, families and carers is likely to promote and enhance recovery. Developing these trusting relationships puts health care providers in a better position to assist families and supporters in overcoming crises and problems and often means time efficiencies in the long term, however it does not always fit with traditional models of practice. Social workers as a discipline recognise the role family inclusive practice has to play in improving the quality of care provided to consumers.

Family Inclusive Month at Caboolture Hospital - A Social Work Research Informed Activity.
The month of September 2017 saw 310 staff from Caboolture Hospital and Redcliffe Caboolture Mental Health Service attend 16 diverse presentations themed at celebrating and promoting the important role that Families and Carers play in their loved ones recovery and how we as Health Professionals can facilitate this important relationship.

Research heavily informed the organising of this event and the development of each of the presentations. The Redcliffe Caboolture Social Work group had previously undertaken a scoping exercise to identify how we as a service are doing in terms of best practice in including families and also identifying barriers to family inclusive practice. What we discovered was supported by our subsequent review of both Australian and International research. As social workers we knew that we needed to view this issue from a systemic perspective and ensure that the various barriers which were individually, familial, societal, cultural, gendered and organisationally driven were captured and addressed throughout the month.

Our research identified a number of barriers including

- *Myths around confidentiality;*
- *Low confidence levels in staff in their skill levels to support distressed/complex families;*
- *Family perceptions of disrespect and holding a devalued role by professionals;*
- *Stigma and discrimination;*
- *Perceived lack of time and organisational support for health professionals to work with families.(to name a few)*

These barriers informed the practical topics chosen for workshops held across the month- including a popular Panel discussion with key MDT staff stakeholders *"Privacy and confidentiality: What you can you say to families"*. Other topics such as *'Having Difficult conversations with Families'*; *"How can I strengthen families in my busy day to day work'* ; *"Working collaboratively with parents whose kids are in care'*; *"Mindfulness tools for managing carer distress"*; *"Understanding Mother Guilt'*; *"Forgotten Fathers"* and *"Engaging Pacifica families"*.

In a spirit of collaboration and inclusivity, carer representatives also facilitated presentations adding their unique and valuable perspectives to aid improved understanding. 10 local NGO partners were also invited to showcase the services they specifically offer families and carers to improve referral pathways for our families.

Each of the presenters (clinicians with expertise and passion in their field) utilised research to inform their workshops and we discovered a particularly strong emphasis on trauma informed practice and compassionate health care weaving throughout the month.

We utilised simple evaluations and found that 89.6% of participants rated that they were likely or very likely to use the information in the sessions in their future clinical work with families. This demonstrated to us we got the topics right and were positively chipping away at making our service more inclusive to families!

CLINICIAN RESEARCHER PROFILE

Michelle Carter-Mangan

Michelle Carter-Mangan is a social worker at RedCab working in the Transitional Care Team. Michelle describes her current research contributions towards evidence informed practice.

When I commenced my Bachelor of Social Work, I did so with the intention of working in the Domestic Violence sector. Like far too many others, my life had been personally touched by domestic violence which fed my motivation to work proactively towards safer outcomes for victims. In some respects, this didn't necessarily eventuate in that I have never worked specifically for a Domestic Violence organisation or agency. My work has never solely focused on domestic violence. However, having worked across multiple sectors including Youth Work, Child Protection, Family Support, Alcohol and Other Drugs and Mental Health, what I can say is that domestic violence is pervasive and delivering interventions intervening has consistently been part of the work I do regardless of my client group.

I am currently a Discharge Facilitator with the Transitional Care Team in Mental Health and regularly support consumers admitted to the Mental Health Unit many of who are either being abused in some way or are perpetrating abuse against others.

Over the last few years, we have seen a shift in the way we as a community respond to domestic violence. Historically it's been a bit of a taboo subject, kept behind closed doors. While we've seen a gradual shift, for some clinicians there remains some hesitation in screening for and intervening in domestic violence. I wanted to contribute to change around this barrier and so last year I completed a Postgraduate Certificate in Domestic Violence. As part of the course requirements, I was tasked with completing a research project in which I critically examined the way we respond to domestic violence within the acute inpatient mental health setting. The next component of the assessment was to then draft a professional plan to respond appropriately.

During my study, it became very clear that there is a strong association between exposure to traumatic experiences and mental illness. That is not to say that all people who have a mental illness have a trauma history, or everyone who has experienced a psychological injury go on to develop a pervasive mental illness however the evidence is clear in that there exists a complex interplay in the relationship between abuse and mental illness such that one can be precipitant, contribute to and exacerbate the other. Many victims of domestic violence develop significant and enduring mental illness as a result of the abuse they have experienced (Golding 1999, Cascardi and O'Leary 1992). A trauma history can increase the person's vulnerabilities to mental illness which can then lead to further abuse, perpetuating the illness even in cases where domestic violence was not the predisposing cause. Typically, mental illness is perceived in the medical setting as a disease of the brain that can be corrected and rectified, often through medication or targeted behavioural therapies that focus on the individual's symptoms rather than taking into account the wider psychosocial factors that may have impacted on the person's mental health. The evidence suggests current clinical approach in mental health settings can fail to acknowledge and address the role trauma plays in impairing mental wellbeing. Trauma-informed practice can bring an alternative, more holistic perspective that recognises the intersections between abuse and mental illness (McDonald 2005).

Through my research, I identified some challenges for our service, and problem solved ways to address those challenges. It was clear that our biggest issue was our lack of routine screening tools and practices. The barriers to routine screening have been identified as time pressures, high case loads, lack of confidence in clinicians in knowing how to screen and what to do with disclosures when they are made and/or the victims inability to disclose violence, whether through reluctance, fear or not recognising that what they were experiencing is domestic violence. Sometimes indications of domestic violence can be missed when heard in a context-specific way as mental health clinicians are trained to screen for symptoms of illness. Clinicians may presume that the disclosure is part of an underlying delusional persecutory disorder and may disbelieve reports of domestic victimisation.

It is suggested that screening for background trauma would help identify underlying contributing factors when people present for treatment for mental health conditions, including screening for any historic abuse, current or potential abuse and future risk of harm. When abuse has been identified, trauma-informed responses should focus on empowering victims towards safety and social, emotional and cultural connection to facilitate and promote recovery (Davis et al 2001).

The next step to screening is knowing what to do when domestic violence has been identified. Supporting staff to access training is important to allow them to develop the skills, confidence and knowledge to respond appropriately.

Mental health clinicians are well placed to reduce harm as a result of domestic violence through early identification, first-line responses, safety and risk assessments as well as provide timely perpetrator interventions but they must have access to adequate tools, resources and training to ensure responses promote safety and wellbeing (Spangaro 2017).

Prescribing Medications to Pregnant Women with a Mental Illness – Common Practice and Gauging Clinicians Perceptions of Fetal Risk

S. WILLIAMS[1], E. BALLARD[2], G. BRUXNER[3], A. KOTHARI[3]

1) Gold Coast University Hospital, Southport, Australia; summer.williams@health.qld.gov.au
2) QIMR Berghofer Brisbane, Brisbane, Australia
3) Redcliffe Hospital, Redcliffe Australia

Queensland Government

THE UNIVERSITY OF QUEENSLAND AUSTRALIA

Introduction:

Depression and anxiety are common disorders and can complicate any pregnancy. Inadequate treatment is associated with risk of morbidity and even mortality. Women's adherence to psychotropic medication is fraught with controversy and fear fetal harm – many seek guidance outside the orthodox medical realm[1]. Clinicians' perception of teratogenicity of antidepressants (AD) and anxiolytics (AX) may impact patient decision-making[2]. Australian clinician perception of teratogenicity impacts counseling and care of this vulnerable group and is largely unexplored[3].

Hypothesis: There exists a difference in the perception of risk of teratogenicity of AD and AX medications, by differing clinicians, namely Obstetricians (O&G) and General Practitioners (GP).

Methods:

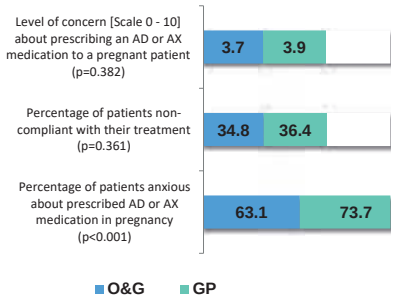
A nation-wide cross sectional observational survey using a 10 minute anonymous questionnaire was conducted in March 2017 using Survey Monkey. 34 questions surveyed clinician attitudes about AD and AX prescription, patient medication counseling, perceptions of patient concerns and the stakeholders who influenced a pregnant women's decision making.

Clinician demographics, basic knowledge and perception of teratogenicity, and prescribing practice, confidence and adequacy of training was surveyed. 5409 clinicians from Australia and NZ (fellows, trainees and GP diplomates) from RANZCOG database were invited. 545 (10.1%) valid responses were submitted for analysis.

Results:

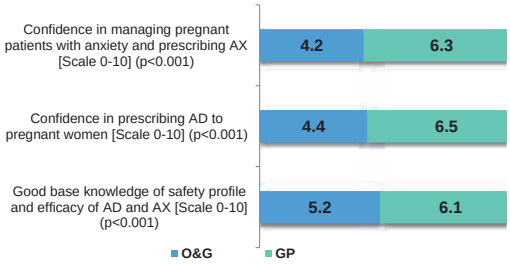
The studies findings are compelling. Only small differences in **demographics** were noted between the two groups. A more significant proportion of O&Gs were in full time public work, with less having attained a fellowship, than their GP counterparts. Respondents did not report a particular **interest** in mental health disorders in pregnancy (only 36.7%) nor were involved in research (3.1%) or trainee education on medication prescription in pregnancy (15.3%).

There was no statistically significant difference between O&G and GPs in self reported **perception** of concern at prescribing AD or AX medications in pregnancy (with scores 3.7 and 3.9 respectively) and both perceived similar rates of patient noncompliance with prescribed medications. See Figure 1.

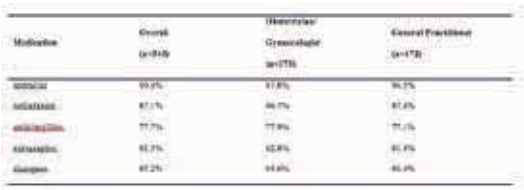


There were several ways in which O&Gs and GPs **prescribing practice** differed. Though both infrequently counseled patients on medications with use of written information (10.5%), over 50% GPs spent 15 minutes counseling patients, whereas O&G typically spent less than 5minutes. Interestingly, 84.8% GPs initiated AD and AX medications compared with only 52% O&G. Troubleshooting patient dosing concerns and cessation requests also revealed O&G relied heavily on their psychiatric colleagues (48.8%), but GPs much less so (5.3%).

Levels of concern about medication prescription was equal, however GPs admitted to higher levels of **confidence** in prescribing AD and AX than O&G (see Figure 2) and more confidence in knowledge of current recommendations and safety profiles (57.6% vs 44.2% respectively)



Knowledge of AD and AX medications was similar between both groups, however, of concern is that up to 22.3% respondents incorrectly ascribed teratogenicity to a well-known AD or AX (see Figure 3).



GP's more often (56.1%) felt they'd had **training adequacy** for confident AD and AX prescribing than O&G (29.0%). Both groups strongly supported increased training (71%) over improved technological aids or apps to improve patient counseling.

Conclusion:

Mental health disorders exert considerable impact on maternal health and decision making, and clinician competence in robust counseling is vital. This survey revealed a superior GP confidence in discussing and prescribing AD and AX medication to pregnant women than that of O&G. A need for improved training has also been strongly highlighted.

References: 1 Cantillino A et al. Use of psychotropic medications during pregnancy: perception of teratogenic risk among physicians in two Latin American countries. Revista Brasileira de Psiquiatria 2014: **36**: 106-110
2 Csajka C, Jaquet A, Winterfeld U, Meyer Y, Einarson A, Panchaud A. Risk perception by healthcare professionals related to drug use during pregnancy: a Swiss survey. Swiss Med Wkly 2014: **144** w13936.
3. Polifka J, Faustman E, Neil N. Weighing the risk and the benefits: A call for the empirical assessment of perceived teratogenic risk. Reproductive Toxicology 1997 (**11**) (**4**): 633-640 ,

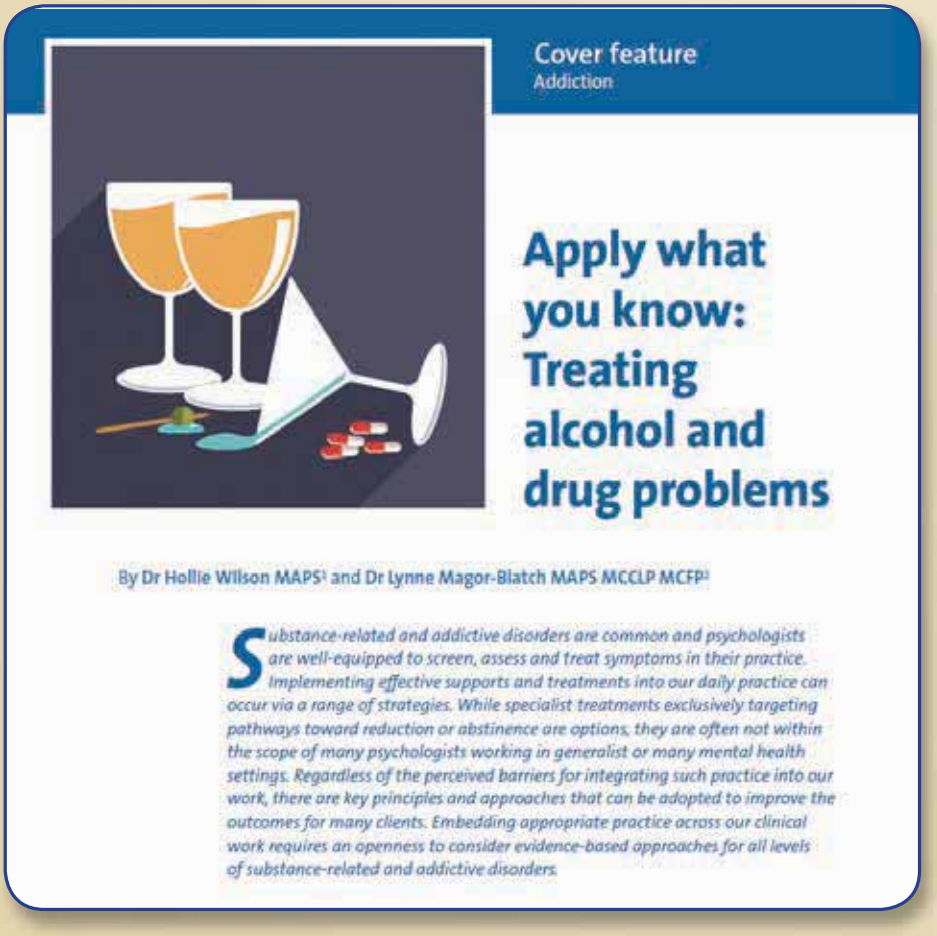
RESEARCHER PROFILE

Dr Hollie Wilson

Dr Hollie Wilson is the Allied Health Manager of Alcohol and Drug Information Service (ADIS), which provides 24/7 counselling, information and referral services throughout Queensland to anyone experiencing issues with alcohol or other drug use, family members, and health professionals. Hollie provides operational and strategic oversight to the service, which is delivered by counsellors on a rotating shift roster, servicing the following phone lines: ADIS, alcohol and drug clinical advisory (ADCAS), clean needle helpline, and the national alcohol and drug hotline. Hollie is a psychologist with a significant breadth of experience spanning 12 years in the specialist AOD field in rural, regional and metropolitan settings, in client-facing, academic research, lecturing, and management settings. She holds a concurrent vising fellowship with the Queensland University of Technology Faculty of Health where she has coordinated and lectured in advanced addiction units, supervised student projects, held a postdoctoral research fellowship with the Centre for Children's Health Research and is a current representative on the QUT Health Academic Board. Hollie also chairs the national Psychology & Substance Use interest group of the Australian Psychological Society, where she has also provided expert review to the literature regarding evidence-based interventions for substance use. Hollie has extensive publications in the field including 21 as first author, and has been a named investigator in six research project grants, including three as chief investigator.

We spoke with Hollie about her research interests and experiences

Managing ADIS within the Alcohol and Drug Service, Metro North Mental Health, has enabled me to collaborate on and undertake various research projects. My current research interests include alcohol and other drug service program evaluations, utilising and linking secondary data sources to enhance treatment outcomes and inform service enhancements, and developing and evaluating digital (app and online) behaviour change interventions for substance use disorders. At present, my main research projects involve the ADIS call database, and I am currently supervising two QUT honours students undertaking projects around drug trends utilising this data. Supported by senior management, have been involved in other various (clinician led) research teams within the service, including evaluating our group model entry to treatment program (Getting Ready for Change) and assessing the sensory profiles of youth seeking alcohol and other drug treatment.



Cover feature
Addiction

Apply what you know: Treating alcohol and drug problems

By Dr Hollie Wilson MAPS[1] and Dr Lynne Magor-Blatch MAPS MCCLP MCFP[1]

Substance-related and addictive disorders are common and psychologists are well-equipped to screen, assess and treat symptoms in their practice. Implementing effective supports and treatments into our daily practice can occur via a range of strategies. While specialist treatments exclusively targeting pathways toward reduction or abstinence are options, they are often not within the scope of many psychologists working in generalist or many mental health settings. Regardless of the perceived barriers for integrating such practice into our work, there are key principles and approaches that can be adopted to improve the outcomes for many clients. Embedding appropriate practice across our clinical work requires an openness to consider evidence-based approaches for all levels of substance-related and addictive disorders.

I like that research can generate new knowledge to inform service direction and policy decision making. I also like seeing new researchers develop and take on the scientist-practitioner perspective to their clinical practice and growing their confidence in pursing their ideas. The main challenge of research in our service is that there is no resourcing for it (we don't have a research manager/coordinator/liaison or team within ADS). This ultimately results in what clinicians know will be a significant (and often confusing) administrative load that unfortunately makes them hesitant to pursue their ideas.

MENTAL HEALTH

SUBSTANCE USE

Men are 2x as likely as women to have substance abuse disorders.

3/4 of people with alcohol and substance use problems may have a mental illness.

25% **of people with anxiety disorders, affective disorders and substance use disorders also have another mental disorder.**

About **5%** **of Australians** will experience substance abuse disorders in any 12-month period.

Nearly **13%** of people aged 16-24 have a substance use disorder

Two Thirds of psychiatric in-patients may have a current or previous drug use problem.

As many as **90%** of men diagnosed with schizophrenia may have a substance use problem.

Substance use disorders are more common in young men (16%) than women (10%)

"Medication safety- More than calculations: Implementation of a Mental health safety Awareness tool" "Salutem medication"

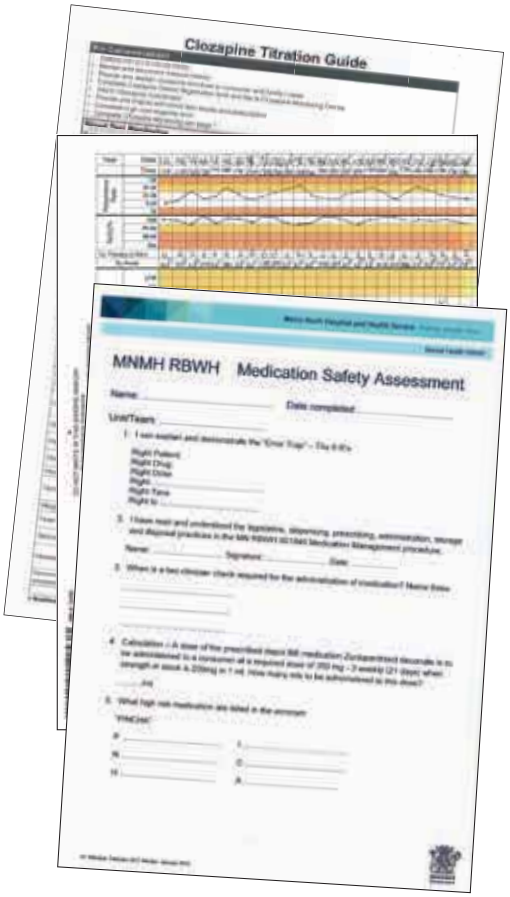
Bruce Collyer, Diane Burrows, Karen Davies and Rama Jyothi Chelemashetty
Metro North Mental Health RBWH

Introduction

Medication administration is an integral part of nursing practice with public expectations of safe standards of practice according to World Health Organisation, National Safety and Quality Standard [4], Nursing and Midwifery Board of Australia and state and local procedures. In recent years many Mental health treatment facilities have implemented assessment tools which have been used to assess psychopharmacological and safe clinical practice for Mental health Nurses. Both inpatient and community environments have assessment tools that are based on mathematical calculations. We believe that medication safety is inherent with psychomotor and cognitive process associated with medication administration and requires more than just a mathematical skill.

Aim

To create a greater awareness of medication safety so that it becomes part of routine practice for Mental Health Nurses.



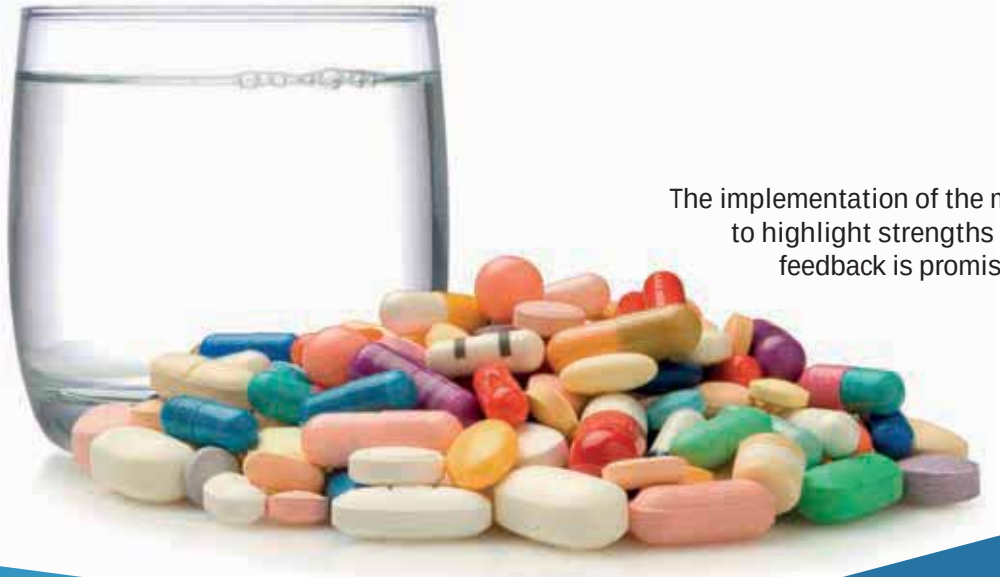
Method

A medication safety Awareness tool was developed that incorporates self-report items on medication management, policy, legislation, clinical practice and safety as well as some discipline specific calculations. The format was deliberately chosen to acknowledge current assessment procedures as well as literature based evidence. Questions have been derived from past known clinical incidents and recommendations from reporting systems.

Results

The paper based assessment tool consists of 15 items that were designed to cover a range of safety questions and a similar number related to knowledge of policy and procedure as well as two based on calculations. The calculations returned 100% success, as expected from current hospital requirements and there appeared to be a reasonable level of understanding of hospital and practice. The only shortfall was noted in the safety related questions.

Two out of the five safety items were poorly answered and displayed a distinct lack of understanding of the frequency and indications for performing physical observations. The questions posed were directly related to the common practice of administering medications that have a sedative effect



Conclusion

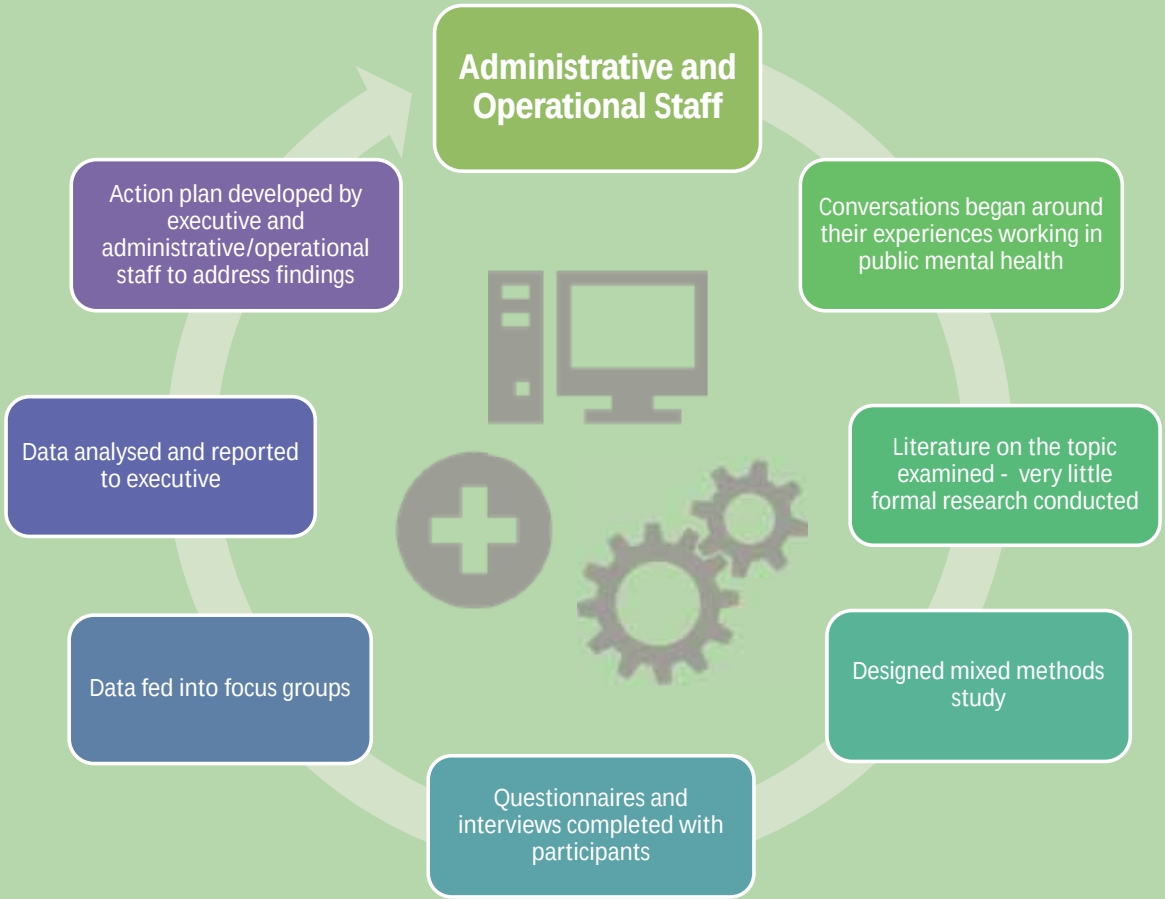
The implementation of the medication safety awareness tool appears to highlight strengths in skill, knowledge and practice. Informal feedback is promising as the concept promotes professional development and reflective practice.

Clinical Multimedia_17 0715_ss

Work Engagement and Wellbeing of Administrative and Operational Staff in Mental Health WHONCS

Efficient delivery of quality healthcare is fundamentally dependent on the concerted, complementary contributions of a vast, variously-skilled workforce. Employee engagement in work, motivation and health and wellbeing impact organisational performance: unhealthy and disengaged employees are less productive with higher rates of absence and turnover than counterparts whose emotional/cognitive engagement in work promote discretionary effort. Work environments (physical and psychosocial), resources and demands directly impact and influence employee health, engagement and stress levels Recognition of the complex relationships between work environments, employee health and engagement has supported substantial investment in efforts to improve conditions and work-lives of health professionals. Scant attention has been paid, however to operational/non-clinical staff who perform diverse functions essential to organisational performance, delivery of health care and patient outcomes. Workplaces should be psychologically and physically safe and promote engagement and health but knowing 'what matters' to staff is critical to the development of enabling environments that promote sustainable engagement and optimise individual and organisational outcomes.

A team from MNMH are running a mixed methods study looking into the experience of work, health and well-being of non-clinical staff working in mental health settings across the service. The study began at Recliffe-Caboolture where the research cycle has been completed with findings leading to development of systems and processes to enable operational and administrative staff to access a range of training, education and psychosocial support relevant to their roles. Here members of the study team (Sue Patterson, Stephanie Donovan and Jordan Duncan), a participant and the Operations Director (Mary Watt) tell the story of the study.



JORDAN DUNCAN SENIOR ADMIN WHONCS

A chance phone call from Sue Patterson seeking Administration Support sparked my interest in research and resulted in my research journey. This journey involved many challenging obstacles and required me to think critically and outside the box. Remaining objective and removing personal motivations and emotions was challenging. I had to continue to remind myself to separate my research involvement from my 'general duties' as the Senior Administration Officer in order to mitigate potential conflicts of interest.

One of the biggest challenges faced in this project was non-clinical staff participation and perceptions around confidentiality with individuals believing the organisation had the ability to act like 'big brother' and have some secret way of identifying who said what. There was a fear factor in relation to consequences for negative feedback. In the end participation was peer driven as trust was obtained from positive interview experiences with Stephanie and also continued information sharing. Eventually as a research team we gained momentum and a real interest in the project amongst the non-clinical staff was developed which was pivotal to the success of the project here in Redcliffe Caboolture

Overall the WHONCS study was a really positive experience for me both personally and professionally. Professionally it was a great opportunity to be part of research and have a voice in changing the way we do things in Mental Health. Personally my desire to be involved was from a genuine care for the people I work with. I look forward to continuing to work with the Redcliffe Caboolture Executive Management Team on the action plan derived from this research project.

SUE DESCRIBES THE ORIGINS OF THE STUDY

The idea for the WHONCS study grew from various conversations with operational and administrative staff in various health care settings within MNMH. While staff often reporting 'enjoying' their work, they also disclosed distressing experiences (including finding patients hanging, witnessing self-harming, being verbally abused and threatened, being 'with' patients experiencing extreme emotions and observing critically injured patients) and feeling forgotten and neglected by the organisation. They spoke of providing emotional and practical support to patients and developing a 'bond' with some. Disturbingly staff spoke also of feeling inadequately prepared to respond in some circumstances and struggling to manage the emotional labour involved in their jobs. Administrative staff spoke of frustration arising when they were unable to influence work practices and of struggles balancing the demands of work with family life, particularly when they questioned job security. Staff also spoke of increasing workloads and potential risk to service delivery and safety.

A quick scan of the literature demonstrated that while very little formal research had been conducted, with non-clinical staff described by one researcher as the 'forgotten workforce', that operational staff elsewhere reported being unable to do a proper job because of "impossible" workloads.

I spoke about the idea of researching the topic with people who'd shared experiences and with colleagues including senior administrative staff. They were supportive so I began reading literature around the experience of work, and learned about the links between the wellbeing of staff, 'engagement in work' and organisational outcomes. I learned about the reciprocal relationships between work environments, employee health and work engagement and organisational outcomes - that staff who are not engaged in their work are more likely to take extended sick leave than counterparts who are, and that engaged staff deliver better quality work. I spoke with Exec Director Brett Emmerson who generously supported the study and worked with Jordan Duncan, Senior Administrator at RedCab to design a study.

COMMENTS FROM STUDY PARTICIPANTS

On risk…*"It's scary. You have to be on your game. We tried to close the fire doors to clean a section, thinking we were safe and relaxed our muscles and then we found out that we weren't safe anyway because the door could still open. You have to stay on guard"*

On their career…*"I have no plans on leaving and intend to work here for the rest of my working life. Because there are so many different areas."*

On feeling safe… *"I guess it's knowing the people I'm working with every day and trusting them. I know they're there and they'll always be there to protect me, and it goes both ways."*

On support from other staff… *"When things go wrong, they blame us. Instead of saying mistakes happen, it's chastising. We are human error too. We can't fix everything." "Had to work to get accepted"*

On their role… *"We are their eyes when we go on the floors of the ward. We inform nurses of clients' behaviours"*

CLINICAL PSYCHOLOGIST STEPHANIE DONOVAN, DESCRIBES HER EXPERIENCE ASSISTING IN RESEARCHING THE WELLBEING AND WORK LIVES OF NON-CLINICAL MENTAL HEALTH STAFF.

Stephanie Donovan

As an early career clinical psychologist with experience in a range of settings in various clinical roles, I found myself looking for something different. I was working casually as a psychologist within Metro North when the Director of Psychology asked whether I'd be interested in a research role. I spoke with Sue who explained that she was looking for someone to work on a study designed to understand the experience of work for non-clinical staff. Having completed my masters in a similar area, I was interested so, in addition to my part time private practice, I joined the research team, two days a week.

My role involved finalising the survey questionnaire, interviewing staff , analysing data and academic writing.

This required me to adapt my interviewing skills from a therapist providing treatment to a research investigator collecting data. Moreover, I had to bring to the table my analytical skills, proficiency with SPSS, and written communication skills.

In interviewing participants for the project questions about work, work life balance and health often led to disclosure of sensitive personal information.

Many of the people I interviewed said 'no-one has ever asked or cared about my work or experiences before'

For the purpose of this particular project my clinical skills were advantageous for building rapport and trust, and empathically navigating participant's distress in describing encounters of negative influences of their working lives. Further to this, my clinical skill set assisted me in the management of caution/apprehension staff displayed around participation in the research project. It was not uncommon for staff to raise concerns about confidentiality and the potential impact of their participation on employment/relationships with managers and the organisation. In the context of these concerns, being an unknown "outsider" of the hospital health service also proved favourable.

The success of recruiting participants was enhanced by endorsement of the study from management personnel and peers. Proactive facilitation by managers/supervisors to inform staff of the research study and allocate time for participation for those staff who expressed interest in the research increased engagement, reports suggest so too did staff (admin and operational) who acted as pseudo champions. Unexpectedly, peers provided encouragement to each other to participate, seemingly motivated by an opportunity to be 'heard and understood'.

Mixing "being a therapist" with a research role created variety in my working life and brought with it a positive sense of balance. However the research role served up some challenges. Writing academically, focussing in on a computer screen with Sue racking our brains in synchrony to construct sentences for a paper stretched my brain, though simultaneously was rewarding to collaborate on a piece of work. Promoting awareness and understanding of the study prompted me to step outside of my comfort zone; not surprisingly marketing is not my forte, currently anyway.

Overall, the more prominent memory that I have taken away from my time on the research project would be sitting together with the small research team analysing and conceptualising themes in interview data, feeling satisfaction when reaching a shared clarity and understanding of the data. I have come to appreciate the sense of connection experienced in collaborating with a small team to carry out the research project, and would recommend it to clinicians who may be seeking variety in their working life.

CHRISTINA WALKER, AN OPERATIONAL SERVICES OFFICER AT CABOOLTURE WAS ONE OF THE STAFF INVOLVED IN THE CONVERSATIONS THAT LED TO THE STUDY.

Christina Walker

A day in the life of an operational services officer:

First thing in the morning you do a rubbish run, collecting rubbish from kitchen and dining room is the first thing and I say good morning, just breezily and have small talk with the clients and then go through the wards emptying bins. If nurses want you to collect equipment or medicines, they'll ring you up – I carry a (mobile) phone, take specimens to the labs, take people for xrays, run stuff between wards, just whatever needs to happen to keep things moving. I clean bedrooms, clean beds. We have a large turnover of clients, average around 8 discharges a day, so after discharges cleaning everything then, the wardrobe, toilets, beds, I'm one person on the ward from 6am til 2.30 some days. Three days a week, I have someone help me otherwise I work by myself and looking after nurses, if they need help getting a patient out of bed, we can do that…. jack of all trades.

Like most of those who took part in the study, Christina says she works mostly for financial reasons but really enjoys her job. She has been exposed to a range of unpleasant experiences including seeing two deaths and been assaulted 'on the job' but has also had some very rewarding experiences and feels valued -

"One lady brought her children into the ward to meet me on a work day because she said I made her time on the ward a lot happier"

We asked her about her experiences watching the idea for the study grow and then taking part…

From my experience, it's the first time in 25 years of employment with QH, I have ever been asked to participate in discussing a work environment that affects me. I feel good, I do really feel good because being surrounded by educated people with degrees and whatever you feel as if you're a non-entity so when people with more knowledge than you ask how things operate in your field it is quite an honour. See, normally an uneducated person would not be asked their opinions about how things should be run because they have more educated people to say what has been done so being asked was really important.

I was interviewed by Steph. I was very apprehensive to start with because, her being a psychologist, I had not had any experience with the mental health people. I don't talk to psychologists or psychiatrists and when you think about going one on one, it might be that they're sizing you up so I was wary at the start about what was involved but it felt more like two people just having a chat. I didn't feel as though she was pumping me or analysing me. I didn't know how what I had to say would be received… but it was received quite positively. I haven't seen any changes yet but I hope to. One day while the study was going on, I was in the tea room and introduced myself to Brett (the Executive Director) before then I didn't know who he was until Sue told me, we don't get to talk to the executive. I knew he was as doctor of some sort or an executive because of the way he was dressed so I just introduced myself and said I must thank you for supporting the study so that we could contribute…

A WORD FROM MARY WATT OPERATIONS DIRECTOR, METRO NORTH MENTAL HEALTH – REDCLIFFE CABOOLTURE

Mary Watt

We are committed to the health, safety and wellbeing of all staff working in the service. We understand and are aware on a daily basis of how demanding our work is in mental health services. So when we were approached about this research, looking into wellbeing of non-clinical staff we immediately wanted to be a part of it. We were really excited and grateful to be involved throughout this research, from the beginning to where we are now.

This research is important as it highlighted a number of factors that impact on Administration Officers (AO) and Operational Support Officers (OSO) that we would not have necessarily thought of. Although we were not overly surprised by the results, it has put a spotlight these staff members and forced us to look at how the organisation can support to improve the worklives of this very important, and sometimes forgotten (as the research highlighted), workforce.

The research resulted in a great opportunity to have a conversation with the AOs and OSOs we would not have ordinarily had. The research created an opportunity to have an open dialogue, and because of this we are now doing something about it. We agreed there is a need to look at things differently. We have had the pleasure to engage with the AOs and OSOs further with the research creating a platform for us to engage. Now we are working with them to design solutions to provide more support to them. Had the research not been conducted, we would not have had the conversation, as we would not have known about it.

What is so important about this process is that not only did we commit to the research from the beginning, we are actioning the research outcomes. Often overlooked is closing the loop to follow through - 'This is what you told us, and this is what we are doing about it.'

We are excited to see where this takes us, we are committed to addressing the issues and are excited to work with the AO and OSO team to continually discuss, listen and design solutions that works for them and the organisation. We hope this research has provided an opportunity for ongoing dialogue to promote continuous improvement. Research was the vehicle for telling us we need to do things differently.

The Australasian College of Health Service Management (ACHSM),

Health Management Internship Program.

Mary Watt, Operations Director at Redcliffe Caboolture Mental Health is a psychologist who has worked in mental health for more than a decade. She worked as a clinician and team manager and in a range of project roles before being appointed as Director in 2017. Mary is committed to ensuring services proactively meet the needs of local communities. Mary has recently completed a master's degree in Health Administration as part of a management leadership program supported by Metro North HHS. Here she describes her experiences.

In late 2015, an email was sent across the health service seeking applicants for the ACHSM Health Management Internship Program. There were 4 identified places for the 2016 intake. As soon as I saw this email, I applied, not knowing exactly what I was signing myself up for. I had applied (unsuccessfully) for a number of leadership programs over the years and saw this as an opportunity to develop my understanding of leadership, particularly in the health care context and build skills. At the time I was working as the Team Leader for the Redcliffe Adult Mental Health Team and Transitional Care Team, I really loved my job and wanted to be a better leader.

The internship had 3 distinct components:

- the academic component involving completion of a Master in Health Administration with Latrobe University. \
- the professional development program
- the workplace component involving exposure to a range of workplace experiences through placements in different sections of the HHS.

The internship was extremely demanding. Over the 2 years (working 7 days a week to keep up) I was assessed on a range of capabilities including, but not limited to: Organisational leadership; Personal leadership; Strategic planning; Problem solving and decision Making; Change management; Communication skills; Relationship management; Professionalism; Business skills; Financial management; Human resources; Corporate governance; Information management; and Risk management

As part of the internship, I was required to design and implement practice research to gain practical experience, applying analytical and problem solving strategies to health care using an action learning framework. Study and assessments around this focussed on project management, planning and evaluation.

I commenced the research 2017, as I was new in the role as Operations Director I decided to focus on the Redcliffe Caboolture mental health service and local catchment needs. I wanted to improve my understanding of the needs of consumers who access the service and the knowledge of the catchment needs population. My study was grounded in the detailed analysis of data routinely collected by the mental health service such as: characteristics of the people accessing the service; key performance indicators already reported detailing activity and outcomes measures for inpatient and community services. After describing the people presenting to the service, I comparted this with the community profile. The comparison demonstrated that the mix of people presenting to the mental health service is consistent with population profiles.

Although my training as a psychologist had involved formal study of research methods, I found this project really daunting. It provided me with valuable insights regarding the challenges completing ethics processes and research within a health setting.

It is well known that the quality of management and leadership in the health services has a substantial and tangible effect on consumer outcomes and experiences, healthcare costs and the satisfaction of the health workforce. I believe leadership programs, ongoing professional development and using evidence informed practice is integral in creating, developing and supporting the leaders and managers of the health services to ensure high quality systems. I am grateful that I had this opportunity from Metro North, within 2 years I managed to complete the internship, Master's degree, professional development program but most importantly I landed my dream job as the Operations Director. It is a privilege to be in this position. I am keen to continue the continuum of research to increase the capacity of staff to implement change in the service to improve how we do things for the consumers and family that require our service and staffing working in our service.

Physical Health and Mental Health

Severe mental illness

The terms 'mental illness' or 'mental disorder' encompasses a diverse range of conditions characterised by disturbances in thought, feeling and behaviour that are inconsistent with cultural norms. Reported prevalence rates vary, but consensus is that mental disorders are a worldwide phenomenon affecting around 20% of the population at some point in their lifetimes. Mental disorders can be understood as occurring on a continuum ranging from relatively mild and transient disturbances, commonly referred to as 'mental health problems' to severe, enduring and disabling conditions. When disturbances are of sufficient degree, one or more psychiatric diagnoses which classify disorders on the basis of symptomatology and clinical presentation may be applied. All may be disabling in some way but severity, duration and impact vary widely. The majority of people diagnosed with a mental illness will have a single 'episode' and recover completely, some will continue to have 'episodes' during which symptoms recur, and a minority will experience persistent symptoms associated with complex problems. The term severe mental illness (SMI) is typically (but not always) used in reference to conditions associated with psychosis and severe forms of mood disorders that have substantial detrimental impact on the lives of people affected.

Serious mental illnesses (SMI) such as schizophrenia, bi-polar affective disorder and major depression, are associated with premature death and excess morbidity. Life expectancy of people with SMI is curtailed by around 20% (10-32 years), primarily due to preventable and treatable physical health conditions, including respiratory, cardiovascular and metabolic diseases. Causes are complex but include health related behaviours – people with SMI are more likely to smoke tobacco and have diets high in fat and carbohydrates, and be physically inactive.

Improving the physical health of people with mental illness is recognised as an ethical and economic imperative internationally. Locally MNMH has been working actively since 2011, to engage clinicians and consumers in efforts to promote physical wellbeing. Increasing physical activity of consumers is a current priority.

While the benefits of physical activity are widely acknowledged and various interventions have been shown to increase activity and improve physical and psychological wellbeing of people with SMI, engaging consumers in activity programs and sustaining behaviour change (as in the general population) are key challenges. These challenges are being addressed in a randomised controlled trial at the RBWH.

A randomised controlled trial of interventions to promote adoption and maintenance of physical activity in adults with mental illness: Physically Active One Way or Another

Led by Dr Justin Chapman of QIMR, the trial will test the relative effectiveness of two interventions in promoting and sustaining physical activity. The interventions being tested are grounded in a theoretical model of behaviour that holds that performance of any activity is dependent on factors with the person (motivation and capability) and in the environment (opportunity).

Sixty participants, aged over 18, who are not currently meeting Australian activity guidelines, will be recruited from Metro North Mental Health. After completing baseline assessments they will be randomly allocated to either an intervention designed to promote motivation or one increasing opportunity for physical activity. People allocated to the motivational intervention will be given an interactive wrist-worn activity device (which provides real-time feedback about activity) and invited to (1) participate in weekly structured group motivational sessions and (2) keep a daily record of physical activities. People allocated to the opportunity intervention will have sponsored access to a community gym and be invited to complete a structured program designed to increase gym confidence and exercise.

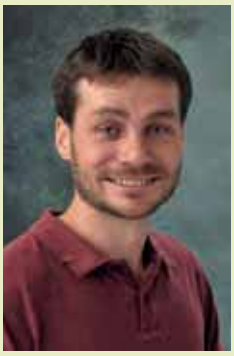
The main outcomes of the study will be physical activity assessed objectively using accelerometry, and acceptability of the programs assessed using semi-structured interviews about participant's perceptions of what worked for them and what was less helpful. Findings will be used to inform a larger pragmatic trial and shape interventions to be implemented locally.

The study is funded by a grant from the RBWH Foundation and in-kind support of Metro North Mental Health, QIMR and the PCYC.

Physical activity can improve fitness, muscular strength and balance, reduce metabolic risk factors such as high blood pressure and cholesterol, and assist with maintaining a healthy weight. Physical activity can also improve mood and psychological wellbeing, provide opportunities for social connection, and reduce stress and symptoms of mental illness such as depression, anxiety and some symptoms of psychoses.

People with mental illness commonly have low levels of activity, and face many barriers to adopting and maintaining an active lifestyle. To enable efficient delivery of physical activity interventions of people with mental illness, more research is needed on how we can better assist people who are experiencing mental health issues to become physically active and maintain this beneficial lifestyle behaviour for longer periods. To this end, MNMHS and QIMR Berghofer Medical Research Institute are partnering with PCYC Queensland to conduct research into physical activity behaviour change interventions for mental health consumers.

DR JUSTIN CHAPMAN, RESEARCHER AT QIMR BERGHOFER MEDICAL RESEARCH INSTITUTE



Dr Justin Chapman

Justin has worked with MNMH over several years, undertaking research for his PhD (2012 to 2015) in the service, and leading studies related to physical health and exercise of people experiencing mental health services. We invited Justin to tell us about his interests and experiences in research. He is Principal Investigator of **a t**

My research interests are implementation and evaluation of lifestyle modification interventions (mostly exercise and nutrition) for people with mental illness. I'm one-year post doctorate and enjoying the dynamic and challenging lifestyle that is research. I also like long walks on the beach and Pina coladas…….. kidding, I've never been a beach person. But on a more relevant note, I'm currently playing a leading role in a randomised controlled trial of interventions to promote physical activity in adult outpatients of Metro North Mental Health (specifically RBWH). This is an amazing opportunity to contribute to the growing evidence base that informs how mental health services can effectively deliver lifestyle interventions to people with mental illness. Achievements of any kind, be they small or large, are always the cumulative result of many factors, but the defining influences that have led me to delivering this trial would be: 1) People; 2) Dollars; and 3) Aspiration.

Research doesn't happen without people. Metro North Mental health staff have always been supportive of research, and even in the hectic work environment of a hospital, staff still manage to prioritise referring their clients to important research projects such as this. I'm always inspired by those who go above and beyond by informing all clients about current research initiatives, and provide encouragement and practical assistance, such as transport to participate.

As a young researcher, the professional support offered by Prof Michael Breakspear and A/Prof Sue Patterson has been invaluable on my short journey so far. The experience and wisdom offered by my mentors has led to dollars, which without - research also doesn't happen. We were successful in obtaining two grants for this trial (one with Metro North and one with Metro South). Combined with lots of in-kind contribution (another cornerstone of research) and some more dollars from collaborators, we've managed to turn our pilot project into a robust trial.

Finally, research doesn't happen without aspiration. It can be a hard slog sometimes, especially when balancing it with other work and family life. Research begins with a vision, and only with a healthy dose of aspiration, funding and people power can that vision be realised.

WHAT IS A RANDOMISED CONTROLLED TRIAL?

- Experiment - (in research) a method for testing hypotheses under conditions constructed and controlled by the researcher. During the experiment, treatments are implemented in an organised way and the effects of treatments are measured
- Randomised - the decision about which treatment a person participating in a trial receives is made randomly (chance)
- Controlled – the outcome measure for the people who receive treatment is compared to the same measure for people who do not receive the treatment being tested. Use of a control group increases confidence that any change observed is due to the treatment.
- Trial - the treatment is on trial – being tested - during an RCT with the result of the test used to support recommendations about the treatment
- Hypothesis – a prediction about what will happen as a result of the treatment being tested

cont.....

Defined formally, The RCT (or trial) is a prospective experimental method designed to quantitatively estimate the effect of a putative cause as reflected in predetermined measure of outcome. The hallmarks of the method, randomization and simultaneous control, were introduced to the medical context when Sir Austin Bradford Hill used both in a comparative experiment evaluating antibiotics in the mid 1940's (MRC, 1948). With the rise of evidence based medicine the RCT has become known as the 'gold standard' for assessing the effect of an intervention on an outcome – a hypothesised causal relationship.

Trials are designed to test a hypothesis (a proposed explanation), for example that treatment B will improve outcome Y in condition Z.

The classic RCT, (see Figure 1), involves division of an experimental population (people meet particular critieria), believed to represent a target population, by some random process (chance)into two exhaustive and mutually-exclusive subsets: the experimental and control groups. Based on the assumption that all participants have the same objective probability of receiving the intervention, any difference between treatment and control groups in observed outcome can be attributed to the experimental treatment.

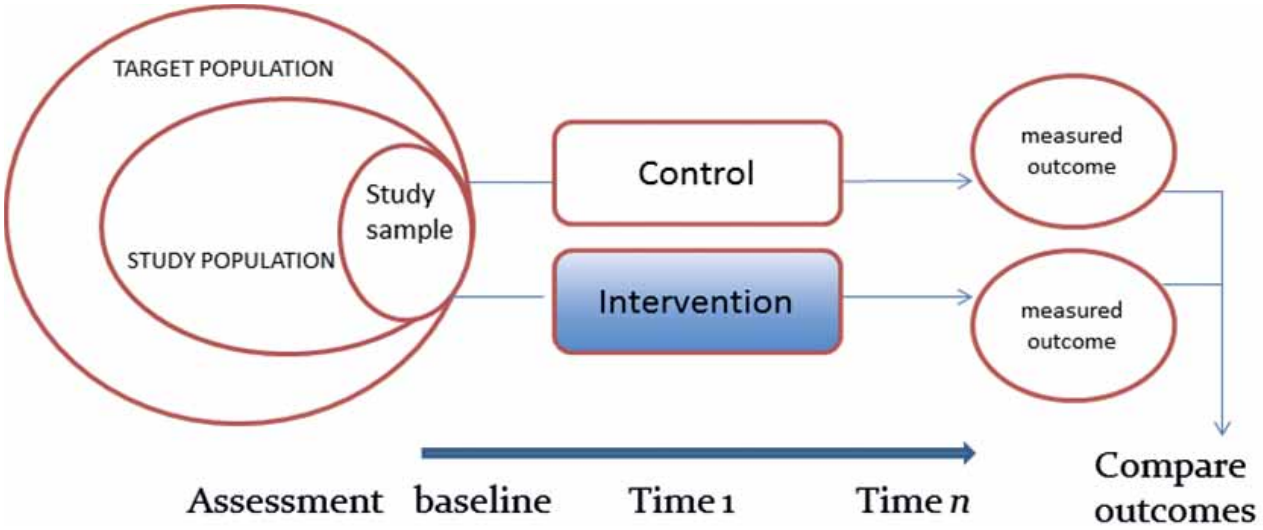


Figure 1. Diagrammatic representation of the RCT Method

RCTs have 'evolved' over time to enable use of the method to test a range of interventions (e.g. medicines, psychotherapy, service models and public health promotion campaigns) in diverse circumstances. The sample might be made up of individuals (e.g. people diagnosed with schizophrenia), groups (nurses), service units (e.g. wards) or communities. RCTs can broadly be categorised according to whether they are designed to test whether an intervention can work or whether and intervention does work when applied in 'the real world'.

Trials designed to test whether an intervention can work, formally known as efficacy trials, are characterised by tight controls on the sample (narrow inclusion criteria), a standardised intervention, and delivery of the intervention in a neutral context. These trials have high internal validity – leading to high confidence in relation to the result regarding the hypothesised cause – effect relationship) for the sample. Because the conditions are so tightly controlled 'external validity – i.e. the extent to which the findings are generalisable to the real world – is constrained.

Trials designed to test whether an intervention that shows potential (in an efficacy or small scale trial), or is already in widespread use, achieves intended outcomes are commonly described as pragmatic or effectiveness trials. While the fundamentals (including random allocation and control group comparison) are maintained a less restrictive approach might be adopted in relation sample criteria, intervention and context.

SNAP ACTION GROUP EVALUATION MNMH – TPCH

The SNAP Action Group The SNAP Action Group is run as a 30 minute session facilitated by a qualified Personal Trainer with assistance from one or more additional SNAP fitness employees and a MNMH-TPCH clinician. Sessions have been consciously designed based on the PTs observation of participants' posture, body language and observable neurological deficits. The chosen exercises are designed to be used and incorporated into day to day living.

Selected participants and staff involved in the implementation were interviewed to gather qualitative data about their experience of the group. All participants agreed that they found the SNAP Action Group enjoyable and reported feeling better after participating in the session. This finding was supported by the Subjective Units of Distress Scale (SUDS) results which showed that subjective levels of distress reduced by an average of 20 points after participants took part in the session. This was seen to be a significantly positive outcome following a brief 30 minute intervention.

When asked if they intended to use physical activity to manage their wellbeing, 97% responded that they intended to use it for managing their emotions, with all agreeing they intended to use it to feel better. There was consensus among respondents that the session was beneficial to their recovery. They all agreed that they would attend again if given the opportunity and that they would like to see more sessions on the ward. 93% also indicated that they would recommend the group sessions to other consumers. The benefit perceived by participants is further supported by one-on-one interviews in which participants gave overwhelmingly positive feedback, expressing intention to change following the sessions.

Recommendations and future directions

While the SNAP Action Group evaluation has been overwhelmingly positive, it has highlighted opportunities to strengthen the program and improve the health and fitness experience of consumers across settings.

Based on the findings, the following core recommendations have been developed:

- Increase fitness opportunities within the inpatient setting – either in cooperation with SNAP Fitness or other available means, and / or consider increasing the length of SNAP sessions;
- Consider the availability and use of more conducive spaces such as courtyards or outdoor areas to facilitate more movement and variety of exercises;
- Completion of routine medical clearances on admission so that facilitators of fitness activities can be aware of limitations and support participants accordingly.

Undertaking this evaluation highlighted several opportunities for future directions which would improve continuity of care and experience between hospital and community settings. Participants interested in fitness-based activities on discharge should be assisted to connect with appropriate services and activities. Furthermore, an opportunity exists to establish a community-based mental health fitness group which could be included in the Metro North Recovery and Clinical Programs Prospectus. Lastly, based on the success of the SNAP Action Group, consideration should be given to the implementation of similar collaborative relationships and programs with other Metro North mental health services.

Photo left to right: Wayne Freudenberg; Dermot Prior (PT); Karen Phillips; Tom Duggan (PT); Anthony Anderson; Tanisha Riddell.

SMOKING, MENTAL ILLNESS AND HEALTH

The personal and social burdens of tobacco related disease are immense. Each year, smoking kills an estimated 15,000

> The tobacco epidemic is one of the biggest public health threats the world has ever faced, killing around 6 million people a year. More than 5 million of those deaths are the result of direct tobacco use while more than 600 000 are the result of non-smokers being exposed to second-hand smoke. (WHO)

Australians and costs more than $A31 billion. The burden is unevenly distributed however with people living with severe mental illness (SMI) among those most affected.

People diagnosed with SMI, particularly schizophrenia, are much more likely than members of the general population to smoke tobacco with prevalence rates reported at up to 70%. People with SMI are also more likely to be heavy and long-term smokers, spend more on cigarettes, be more dependent on nicotine, and are less likely to quit. Thus people with mental illness have been identified as a group in need of special attention and targeted intervention. Contact with mental health services provides opportunities to engage people with mental illness in assessment of smoking and interventions of various kinds to manage nicotine dependence and promote cessation of smoking.

However smoke free policies and regulations have been inconsistently applied. Indeed it has been argued that smoking is embedded in the culture of mental health services generally and particularly inpatient units. This has been linked in part to views of staff and patients that smoking is a helpful in various ways, for example in management of symptoms of mental illness and relief of boredom in a setting where there is 'simply nothing else to do' and that cessation and prohibition of smoking could impact negatively on mental health and lead to increased aggression among patients. Research however demonstrates that people with SMI are as motivated to quit as the general population, that various interventions can be effective in reducing smoking and that the feared increased in aggression do not eventuate. Failure of mental health services to effectively integrate assessment and management of tobacco smoking in clinical care is considered a major barrier to improving health and life expectancy of people with SMI.

In line with legislation (The Queensland Tobacco and Other Smoking Products Act 1998) and Queensland Health policy, smoking is prohibited in all MNHHS facilities and grounds. The MNHHS Smoking Management Policy requires services and clinicians to support inpatients to quit smoking and specifies that there are to be no designated smoking areas and that staff are NOT to assist patients to smoke. MNHHS endorses use of the Queensland Health Smoking Cessation Clinical Pathway (The Pathway). The Pathway grounded in the 5As is an evidence-based decision support tool for staff to assist patients to quit smoking, should be completed for each patient. Services including mental health were required to implement the HHS policy and develop procedures for use of nicotine replacement therapy (NRT).

In line with best practice, MNMH adopted a multi-faceted strategy to implement of SMOKE FREE (see poster on page N) with an integrated evaluation designed to assess the impact of policy implementation from the perspective of various stakeholders. Data were collected in interviews and questionnaire based surveys from 50 patients,190 nurses and psychiatrists and other doctors working across the service. Findings regarding nurses and patients are still being written up but a paper reporting the views and experiences of psychiatrists has been published.

The study found that psychiatrists

- acknowledge the profession's obligations to proactively engage in holistic care, and generally endorsed total bans as appropriate in inpatient units.
- Generally agree that 'smoke free' is a good thing
- routinely, informally assess a patient's motivation to quit
- recognise that (some) patients are (or can be) motivated to quit and that sensitively delivered, personalised intervention in hospital is beneficial
- value opportunities to engage in critical discussion of the issue, to explore the tensions around 'rights to smoke' and the 'soft paternalism' inherent in smoke-free policy and legislation

Mental Health and Addiction Research

Research Article ISSN: 2398-5380

Implementation of Smoke free policies in psychiatric inpatient care: A mixed methods study of practices and views and of psychiatrists' in an Australian mental health service

Sue Patterson[1,2,3*], Wilsen Drew[1], Kirryn Chamberlain[1] and Brett Emmerson[1,4]

[1]Metro North Mental Health, Metro North Hospital and Health Service, Australia
[2]Department of Applied Psychology, Griffith University, Australia
[3]School of Dentistry, The University of Queensland, Australia
[4]School of Medicine, The University of Queensland, Australia

Abstract

Objective: to describe psychiatrists' views regarding implementation of smoke free policies in inpatient units, the acceptability and perceived helpfulness of a clinical pathway, and the frequency of provision and acceptability of various interventions.

Method: Sequential mixed-methods combining a questionnaire based survey with interviews with 43 psychiatrists working in two services in Queensland, Australia. Data were analysed descriptively and thematically.

Results: Psychiatrists agree that they have responsibility to assess smoking, encourage quitting and optimise management of nicotine withdrawal during admissions. Uncertainty remains about the rationale for 'smoke free', however. Psychiatrists express concern about 'rights' of patients and others, paternalistic restriction of choice and their roles as agents of government, rather than health professionals. Most psychiatrists assess smoking informally, with intervention titrated to perceived motivation to quit. The manner in which conversations are approached and interventions are offered is critical to engagement of patients.

Conclusions: Psychiatrists are overcoming longstanding ambivalence and therapeutic nihilism that have hindered integration of management of smoking in clinical care. Sustained improvement will depend on frank engagement with lingering concerns, careful management of the 'unintended' consequences of smoke-free policies and ensuring that clinicians are resources appropriately.

Metro North Hospital and Health Service *Putting people first*

Tobacco Free Wards in Mental Health

Karen Petty, Wilsen Drew, Jannette Newell, Steven Eisentrager, Sarah Childs, Jim Hunt, Michelle Taylor

Our dream destination is smoke free, with less smokers and well managed withdrawals!

Mental Health Services identified a number of initiatives to improve outcomes for mental health consumers and to help drive culture change in this area.

WHY DO ANYTHING?

People with mental illness smoke at more than double the rate of the general population.

Smoking related illness remains the leading cause of death for Australians with severe mental illness. (1)

Smokers have higher levels of depression and anxiety, and higher rates of suicide.

WE KNOW

Nicotine dependence treated successfully, results in a reduction in mental illness symptoms and improved social functioning.

Previously smoking has been condoned in mental health culture.

However, now it is seen for what it is; a serious addiction with often fatal consequences.

We began our journey to dispel the myths that fuelled smoking in our consumer population and support our clinicians as they navigated the roadblocks in the drive for better health outcomes.

So how do you dispel Ancient Myths?

It was recognised to succeed, we had to find a way to influence the 'culture of support for smoking' within every facet, including staff, consumers, and visitors but also gaps within our policies and legislation.

ENGAGEMENT

STAFF

To foster a change in culture, education sessions initially focussed on challenging myths and understanding the addiction model, then sought to help staff determine the importance of smoking cessation for optimum health!

This was followed by education sessions for staff designed to enable them to treat consumers effectively for their nicotine dependence (addressing physical, environmental and psychological triggers.)

Staff were not using the pathways, they told us they hadn't been shown how! So we responded with focused interdisciplinary education to increase competence in the use of the Smoking Cessation Clinical Pathway, strategies included: in-services, grand rounds, 1:1, doctors meetings, posters and integrating training into orientation to ensure consistency.

We developed and implemented the procedure

"Management of nicotine dependence and tobacco and related products in the mental health service" to provide clear direction and governance support.

KEEP LEFT

ROAD CLOSED AHEAD

CONSUMER AND CARERS:

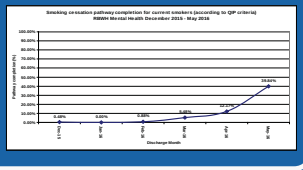
- Early engagement with the Consumer and Carer Executive Group
- Development of a consumer information letter and brochure, then distributed through inpatient meetings and outpatient Doctor's appointments
- Inpatient, visitor and countdown posters displayed in ward and community areas
- Information and reminders at regular ward meetings
- Ongoing consumer smoking cessation support groups.

Hurdles identified in NRT provision were overcome with the development, approval and use of the pre-printed Nicotine Replacement Therapy Medication Chart.

Our document is in demand for use across MNHHS, and we want to share it!

OUTCOMES:

- Graph shows Pathway completion is on the increase since we intervened!
- Anecdotal increase in the use of NRT, especially NRT gum;
- Improved nursing staff satisfaction, they report less time spent handling tobacco, leaving more time to engage with patients.
- Feedback from inpatients, visitors and staff about the benefits of having a positive experience of NRT, and well-managed withdrawal from nicotine.



Installation of Quitline phones in inpatient wards and community areas

Quitline 137848

References: Australian National Survey of Mental Health and Wellbeing. ABS 2008; AIHW National Drug Strategy Household Surveys; Cooper, J. Aust NZ J Psych 2012; Szatdowski L. Nicotine Tob Res 2014; Le Cook JAMA 2014; Bowden JA. ANZ J Psych 2011; Lasser K. JAMA 2000; Bohnert KM Addiction 2014.

Queensland Government

RESPIRATORY SYMPTOMS AND AIRWAYS DISEASE IN MH INPATIENTS

ABSTRACT

High rates of respiratory symptoms and airways disease in mental health inpatients in a tertiary centre

Background: People with severe mental illness (SMI) have a lower life expectancy in part due to a higher prevalence of cardiac and metabolic disease. Less is known of the prevalence of respiratory disease in this group.

Aims: This cross sectional, observational study aimed to assess the prevalence of symptoms associated with respiratory disease in patients admitted to an inpatient mental health unit.

Methods: A convenience sample of eighty-two inpatients had a structured interview and questionnaire completed. The questionnaire included self-reported diagnoses of common diseases and screening questions designed to detect respiratory disease and sleep disordered breathing. Targeted spirometry was performed on the basis of symptoms and smoking status.

Results: Patients reported high rates of respiratory symptoms including wheeze (38%), and dyspnoea (44%). 52% of patients reported daily tobacco use. Productive cough was significantly associated with tobacco use ($p < 0.005$). Ten patients (18%) had spirometry consistent with COPD of whom 6 did not have a formal diagnosis of COPD previously.

Conclusions: People with SMI have high rates of respiratory symptoms with a high prevalence of COPD on spirometry. Half of the COPD cases were not previously diagnosed suggesting a hidden burden of respiratory disease in patients with SMI.

Burke, A. J., Hay, K., Chadwick, A., Siskind, D. and Sheridan, J. (2017), High rates of respiratory symptoms and airways disease in mental health inpatients in a tertiary centre. *Intern Med J. Accepted Author Manuscript.* doi:10.1111/imj.13594

Alex Chadwick is a clinical nurse working in mental health inpatient care at TPCH. He writes about his involvement in the study: My role was to help the patients complete the questionnaires, conduct spirometry testing, complete ECG, liaise with Cardiac investigations to do single average ECG and collect data on vital signs, and report BMI. The study was insightful into how MH patients are unaware of physical health and lack of knowledge around getting help to improve their wellbeing. I am passionate about improving patient access to programs/and or activities to improve both their physical health and wellbeing.

Alex Commented, "It took only 3 months to collect the data, but 3 years to publish the paper."

Nursing Research

Ongoing research efforts from previous years have resulted in a Knowledge Translation research project that has become a positive experience for Metro North Mental Health nursing staff and consumers at RBWH. Safewards is an evidence based nursing model underpinned by the theoretical approach to improve therapeutic engagement, reducing conflict and containment in an acute mental health setting. It was designed in the UK to provide a means to positively engage with consumers of mental health services. After nursing staff on G Floor of the Mental Health Centre received education on the Safewards programme, we assigned a leader with five champions to each of ten communication based interventions.

Cecelea, the Nurse Unit Manager (NUM) of G Floor, has been a role model (fundamental to the Safewards) by recounting positive experiences from interactions with consumes to her staff and portrayed them within the framework of the Safewards model. She has found the practical activities in setting up Safewards have been successful with gathering traction for engagement with staff and consumers. The approaches in Safewards are practical, visual and aid Cecelea and her nursing staff to draw on communication styles and improve consumer and nursing interaction. Intangible goals such as practice change require real-world drivers that are championed by ward nursing leaders.

Nursing staff have changed their use of language in their interactions with consumers using the Safewards approach. The outcomes from the local research to date has shown a significant decrease ($p < 0.05$) in individual seclusion rates accompanied by a decrease in contentious behaviour which is a key component to a Recovery based model of nursing care. This approach continues to achieve the Safewards outcomes described from previous research. The project has been a positive experience for all at G Floor RBWH and is currently being rolled out across the remaining inpatient wards. The service will continue to build on this foundation and are currently rolling out an expansive training/education program to all acute inpatient units

We are also making exciting tentative steps toward a novel approach to monitoring vital signs such as pulse and breathing using newly developed technology. A collaborative approach with the Medical Engineering department at Queensland University of Technology has led to support of PhD student Jordan Laurie working with us. He is using his expertise in signal processing to study how these clinical measurements can be made in real time using everyday video cameras. We hope that advances in the way that nursing observations are performed may be better supported using similar technologies in the future. This aligns with our current focus to manage risk associated with aggression and important nursing observations whilst acute sedation protocols are being performed.

WE SPOKE WITH NURSE UNIT MANAGER CECELEA HISCOX ABOUT HER EXPERIENCES IMPLEMENTING SAFEWARDS.

Cecelea Hiscox

What is your experience as a NUM with Nursing Research?

I have been involved in various research projects over the course of my career. I have to say the Safewards project has been the one that I am most passionate about and has made the most significant cultural change to my team.

How did you find the Safewards trial and Project on MHG?

I was interested on embarking on Safewards project. I believe that the Safewards model is an evidence based model that is relatively straight forward and contributes to a positive change in culture. We chose to implement ten interventions as a pilot site with two other pilot sites in Mental Health Services. The majority of the staff on Mental Health G Floor, did one day training and were very motivated to start. There was a delay in the start process due to awaiting ethics and final approval which was frustrating as we couldn't implement the model until the pre surveys had been completed. Due to it being a research project there was a relatively short timeframe to implement all 10 interventions. On G floor we only implemented 9 which preliminary reports did indicate a change in culture and reduction in conflict and containment; the final results are yet to be published.

What do you think about the Safewards Model and its use on MHG Floor?

I think the model has been well entrenched on MHG and has shown a positive change in culture. The Mental Health Service at RBWH has decided to implement the model across the division. The model ensures that we have a cohesive approach. However with any model of this type it is worth revisiting the education to reinforce the cultural changes.

Tell us a little about Safewards and the Nursing Team on MHG?

Some of the staff were very motivated to start once they had completed their training. Some staff were reluctant to implement change and thought that their training was teaching them to "suck eggs". However over time as the team saw the interventions created change the staff came on board to implement the new model. We found that the majority of the Safewards interventions when modelled by staff and used effectively encouraged others to do the same. We have a diverse mix of staff on the ward, with different levels of experience and training. The Safewards model enabled a standardisation of approach and for some a set of new interventions. Safewards interventions were not unfamiliar to some nursing staff; the names of the interventions may have been different. For the majority of the nursing staff the Safewards model brought all staff back to basics to facilitate practice in a consistent way to reduce conflict and containment and promote better quality of care and a safer working environment.

Tell us about your presentation at an International Nursing Conference?

I was nervous to present at an international conference. However, enjoyed presenting a topic I was passionate about. I presented the introduction to Safewards on MHG and some of the challenges we faced and the positive outcomes we had achieved so far. When I had done the presentation we had not received any final results however I could comment on the anecdotal comments from the staff. It was interesting to meet other people from other states that had implemented Safewards. It was interesting to identify they had the same challenges and reinforced how well my team was doing with the implementation and change.

RESEARCH IN YOUR WORKPLACE

The diverse array of methods classified broadly as 'qualitative' are united in seeking to explore and understand, human and social experience and qualitative researchers are united in seeking to provide nuanced accounts of the phenomena they study through use of human expressions as the primary source of data. Behind such shared agenda, however are robust debates about the philosophy and pragmatics of research. One of the central debates is around the positioning of the researcher – widely recognised as critical to the research product - in relation to the phenomena of interest. Some qualitative researchers maintain that researchers should enter the field without pre-conceptions, or at least 'bracket them' to enable an impartial examination, that the researcher should maintain detached, professional distance. Others propose that research is appropriately conducted by 'insiders' - by researchers who share the characteristic, role, or experience under study. (for useful discussion see Corbin Dwyer S & Buckle J The Space Between: On Being an Insider-Outsider in Qualitative Research http://journals.sagepub.com/doi/pdf/10.1177/160940690900800105)

Here, Amanda Petrie describes her experiences as an 'insider'. Amanda, a clinical nurse with the Redcliffe Caboolture Acute Care Team grounded her work in her experiences and passion for improving clinical care and promoting consumer recovery.

Amanda Petrie

Introduction: I'm currently coming to end of my master's programme, and with that the completion of the dissertation phase of this degree. For my dissertation I had to complete a research study. In choosing a topic of interest for the study I looked to my work, to a practice environment that caused me to consider whether what I was doing and what we were doing as a service was delivering the intended benefit for the consumer. Speaking with colleagues about their practices and the ways we worked, I identified use of acute management plans (AMP) (see text box) in the emergency department (ED) setting, during times of crisis, as a key issue.

I have been involved in using AMPs within MNMH from development of the current document and process, to creating and implementing the strategy within the clinical setting. As there was very little research looking at the clinical application and utility of AMPs within the Australian context I began to question how they were being used locally, and with what effect. In contemplating my own practice and experience with the AMP I wondered about the experiences and views of my peers – about how they used the AMPs and how helpful the plans were in practice. With not much written about this in the literature and importance of working effectively with consumers in crisis, it seemed a worthwhile topic. To make the study manageable I chose to inquire into a specific and small cohort to begin with. Hence the group I chose for my study were mental health clinicians with whom I worked.

In seeking to understand experience I felt that a qualitative approach was the appropriate choice. Within this brief overview I won't go into the processes I engaged in to develop a research question and research design except to say that in the early stages there where many phone calls, emails and impromptu visits with Sue Patterson, a researcher who works with MNMH, for guidance. I do feel that in many of these visits Sue utilised the '5 why's' strategy of iterative interrogative approach to gently guide the development my research question that would ultimately guide the research design. Other senior staff also provided support and responses to my emails of distress which helped maintain my momentum, particularly when choosing my topic (I was interested in so many things) was really challenging. Gradually the topic and research questions became clear.

Topic: The topic for my research is *'Understanding mental health clinicians' experience with using acute management plans: A qualitative study'*. Data was gathered during semi-structured face to face interviews that took place in the settings of community mental health, the acute care team and the inpatient unit. Currently the study is at the stage of data analysis and I am hoping to have the results available for submission for presentation at the next mental health nurses conference.

Outcomes: *I'm in the process of analysing all the data from 14 interviews with clinicians from a range of disciplines*. There are some very interesting patterns and themes emerging but it's too early to report findings formally. Preliminary analysis suggests that participants who had more experience using the AMP were amongst those who described it as being 'not very useful'. In comparison, participants who report less knowledge of the AMP indicated that they had found it very useful.

I look forward to sharing with my managers and peers once I've made sense of the data. Also, I anticipate that this small project may initiate further inquiry into the use of AMP's and in particular the consumer experience. Further I would hope that, for all involved in exploring their experience of using the AMP's within the research setting, that this may generate a reflective process in the practice of supporting consumer self-determination and self-efficacy with the use of anticipatory planning tools.

Process issues: There were many challenges with conducting research. Access to academic supervision and negotiating the ethics and governance processes with both university and Queensland Health were the main problems. As an insider conducting research within my work setting I needed to make sure not to discuss the research topic outside of the research environment (when recruiting or interviewing), to maintain confidentiality and not influence potential participants. An advantage of being an insider was that recruiting was easier because I had regular contact with potential participants and colleagues and peers in my immediate work space wanting to participate to assist me as the researcher, even when they weren't so much interested in the topic.

> "The area that I found most difficult was not having access to a formal supervision process that supported the academic side of the masters within my work setting, and negotiating 2 governing HREC bodies (the University and health)."

Overall, I recommend my peers undertaking research projects for a number of reasons. Personally, it provides a structured process of looking at practice with a mindset of 'what's happening here?' 'how can this be improved?'. It's exciting to think that you may be able to provide unique insight into practice that then may be able to promote change or at least interest in what's happening within your environment.

What is an Acute Management Plan?

An Acute Management Plan (AMP) is a clinical document designed to provide relevant, succinct information to clinicians working in acute care teams, emergency departments, and other entry points into mental health services. The AMP is designed to help clinicians meet the needs of consumers when they are acutely unwell. AMPs are not completed for all consumers; they can be initiated when a need is identified by clinicians, emergency department staff and/or other stakeholders involved in providing care.

Factors considered in assessing need for an AMP include:

- Frequency of presentations to acute services or ED in person or by phone and contact with Queensland Ambulance or Police Services
- Complexity of health concerns and co-morbidities and related problems and numbers of service providers involved
- Risk of violent behaviours (as a result of their mental illness) toward themselves, others or property; and/or personal vulnerabilities
- AMPs do not repeat clinical records but should include information risks and triggers, support people, and planned actions
- A clinician reading an AMP should be able to identify a correct pathway for consumer
- AMPs are best regarded as 'living documents' to be developed collaboratively by clinicians and consumers over time

QuEDS

The Queensland Eating Disorder Service (QuEDS) is a specialist state wide service that provides consultation, training and treatment for people affected by eating disorders throughout Queensland. QuEDS is staffed by a multidisciplinary team including psychiatrists, psychiatric registrars, psychologists, mental health nurses, social workers, dietitians and occupational therapists. The service strives for a culture of quality assurance in treatment delivery, innovation in service development, and collaboration in clinical research. QuEDS has a range of partnerships and cooperative relationships with other government and non-government organisations to deliver training, consultation, treatment and research around eating disorders and related issues. QuEDS also includes the expertise of those with lived experience of eating disorders in the planning, development, delivery and evaluation of services. Currently QuEDS is collaborating with the Queensland Brain Institute and Asia-Pacific Centre for Neuromodulation to conduct study into deep brain stimulation for treatment-resistant Anorexia Nervosa; the University of Sydney to participate in NHMRC-funded trial of intranasal oxytocin for Anorexia Nervosa; the University of Queensland to evaluate a three-month intensive outpatient treatment program for transdiagnostic eating disorders and to develop family inclusive practice with carers affected by eating disorders. This is a major new area of service activity and will work carefully to safely and effectively support adult patients and their natural care systems, their families. QuEDS also has a long standing partnership with the Queensland Institute of Medical Research to support a worldwide genetics initiative in Anorexia Nervosa; the Butterfly Foundation and Primary Health Networks to promote early identification and effective early intervention in disordered eating problems; general medical services to support the inpatient care of people with eating disorders requiring hospitalisation for medical stability; and multiple Hospital and Health Services in Queensland to further service development throughout the state. Much of these achievement have been realised under the guidance of the QuEDS/EDOS founding team leader, Elaine Painter. With her retirement this year, the QuEDS research portfolio will be passed on to the new Service Development Team Manager (Amy Hannigan) to drive the agenda forward. The QuEDS leadership and team now look forward to many further research developments and clinical collaborations throughout 2018 and beyond.

Warren Ward - Director Queensland Eating Disorders Service (QuEDS) Metro North Mental Health – RBWH, Associate Professor School of Medicine University of Queensland

WE SPOKE WITH WARREN WARD ABOUT HIS WORK

Dr Warren Ward

What's your role with MNMH generally and the QuEDS specifically?

I am a senior psychiatrist in MNMH and Director of QuEDS, a statewide service that sits within MNMH.

What motivated you to work in the field?

Before eating disorders I had training in psychotherapy, psychological trauma, adult education and leadership and management, all areas that have been useful in working with eating disorders.

What do you see as your major contribution to the field?

Everything I have done has been as part of a team. The achievement I am proudest of is building the capacity of no specialist services statewide to assess and treat eating disorders. This achievement is largely due to the vision of my colleague Elaine Painter, recently retired founding team manager of QuEDS.

What do you see as the greatest opportunities?

We have great opportunities for prevention and early intervention. The biggest risk factor for eating disorders is extreme dieting, which causes changes in the brain that can lead not only to anorexia and bulimia, but also to binge eating and obesity.

What developments have you seen over your career?

When I began in this field over ten years ago there were no evidence-based treatments for anorexia nervosa in adults. There are now three manual used psychological treatments with demonstrated efficacy: CBT-E, SSCM and MANTRA.

What's your primary research interest?

I have always been interested in changes at a community and service level that can improve access, early intervention and effective treatment. A lot of my efforts have been in the area of training, evidence-based pathways and guidelines, and service reconfiguration to ensue people with eating disorders and their families receive the treatment they need.

What are your views about the involvement of people with experience of eating disorders and/or service use in research?

I have learnt a great deal from people who have recovered and their carers, and now try to routinely involve people with lived experience in training of health professionals. Such presentations help debunk stigma, myths and preconceptions and show that anyone can 'catch' an eating disorder and no one is to blame.

What factors enable research within the services?

For our service, some of the most helpful things have been encouraging curiosity and investigation by staff, sharing even modest research efforts at conferences to encourage interchange of views and experience, and partnerships with universities and other research institutions. At MNMH we have also been fortunate to have the support of Susan Patterson, the MNMH Senior Research Fellow.

What's one change you would like to see?

The one change I would like to see is that people with eating disorders present to any health clinician in Queensland, they are treated in a compassionate and respectful manner, with appropriate risk assessments acknowledging the high mortality rates of these conditions, and referral to effective treatment.What are your views about the involvement of people with experience of eating disorders and/or service use in research?

I have learnt a great deal from people who have recovered and their carers, and now try to routinely involve people with lived experience in training of health professionals. Such presentations help debunk stigma, myths and preconceptions and show that anyone can 'catch' an eating disorder and no one is to blame.

Mental Health and Addiction Research

oat open access text

Research Article ISSN: 2398-5380

Patients' perspective on inpatient treatment for eating disorders: A mixed-methods study of satisfaction, experience of care and perceived helpfulness of components of treatment

Sue Patterson[1,2]*, Rachael Bellair[1], Shane Jeffrey[1] and Warren Ward[3]

[1]Metro North Mental Health, Metro North Hospital and Health Service, Australia

[2]Department of Applied Psychology, Griffith University, Australia

[3]Department of Psychiatry, The University of Queensland, Australia

Abstract

Background: Inpatient treatment for anorexia nervosa is costly. Effectiveness is uncertain, influence by patients' ambivalence. While patients' insights and experiences are integral to quality, their views have received little attention.

Aims: Describe experience and perceived 'helpfulness' of treatment and attributes of clinicians valued by patients.

Methods: Sequential mixed-methods; triangulation of findings of questionnaire surveys and qualitative interviews.

Results: Analysis of data from 41 questionnaires and 16 interviews demonstrate that relationships with staff and co-patients are sources of succour and angst, shaping experience of care. Patients seek empathic, personalised treatment and opportunity to develop skills needed to support 'real world' recovery.

Conclusions: While the focus of inpatient care is nutritional rehabilitation, matters of the 'mind' are important to patients and the skills and qualities of staff influence treatment engagement. Even where treatment is coercive, effort must be made to promote personalisation and flexibility and the non-authoritarian attitude valued by patients. After all, evidence based treatments can only be effective if patients engage. Further research should examine the process of care and outcome generation.

What is refeeding syndrome?

Anorexia nervosa is a serious mental illness with devastating physical consequences characterised by persistent energy intake restriction, low body weight and distortion of body image with an obsessive fear of gaining weight. Hospital admission is necessary for some when their life is threatened.

Refeeding is a process that aims to restore nutrition and weight in patients during hospital admission. However this refeeding process is complicated by the risk of patients developing refeeding syndrome. Refeeding syndrome has been defined as abnormal fluid and electrolyte shifts in response to the commencement of refeeding in malnourished patients. As the starved body begins to receive nutrition, a metabolic shift from fat to carbohydrate as the body's primary fuel is observed. This leads to an increase in cellular uptake of glucose, potassium, phosphate and magnesium, effectively lowering the serum concentrations of these electrolytes. If left untreated, cardiac failure, respiratory compromise, and fluid overload can follow. The severity of malnutrition has been identified as a marker for the development of refeeding, with severe hypophosphatemia being described as the hallmark indicator of refeeding syndrome.

ABSTRACT

A higher calorie refeeding protocol does not increase adverse outcomes in adult patients with eating disorders

Matthews K, Hill J, Jeffrey S, Patterson S, Davis A, Ward W, Palmer M & Capra S.

Background: Patients with eating disorders (EDs) are often considered a high risk population to refeed. Current research advises using 'start low, go slow' refeeding methods (~1,000 kcal/day, advancing ~500 kcal/day every three to four days) in adult patients with severe EDs in order to avoid the development of refeeding syndrome (RFS), typically characterized by decreases in serum electrolyte levels and fluid shifts.

Objective: To compare the incidence of RFS and related outcomes using a low calorie protocol (LC) (1,000 kcal) or a higher calorie protocol (HC)(1,500 kcal) in medically compromised adult patients with EDs.

Design: This was a retrospective pre-test - post-test study.

Participants/setting: One hundred and nineteen participants with EDs, medically admitted to a tertiary hospital in Brisbane, Australia between December 2010 and January 2017, were included (LC:n=26, HC:n=93). The HC refeeding protocol was implemented in September 2013. Main outcome measures: Differences in prevalence of electrolyte disturbances, hypoglycemia, edema, and RFS diagnoses were examined.

Statistical analysis performed: Chi-square, Kruskal-Wallis H tests, ANOVAs and independent t-tests were used to compare data between the two protocols.

Results: Descriptors were similar between groups (LC:28±9yrs, 96%F, 84% with anorexia nervosa, 31% admitted primarily due to clinical symptoms of exacerbated ED vs HC:27±9yrs, 97%F, 84% with anorexia nervosa, 44% admitted primarily due to clinical symptoms of exacerbated ED, $p>0.05$).

Participants refed using the LC protocol had higher incidence rates of hypoglycemia (LC: 31% vs. HC: 10%, $p=0.012$), with no statistical or clinical differences in electrolyte disturbances (LC: 65% vs. HC: 45%, $p=0.079$), edema (LC: 8% vs. HC: 6%, $p=0.722$) or diagnosed RFS (LC: 4% vs.HC: 1%, $p=0.391$).

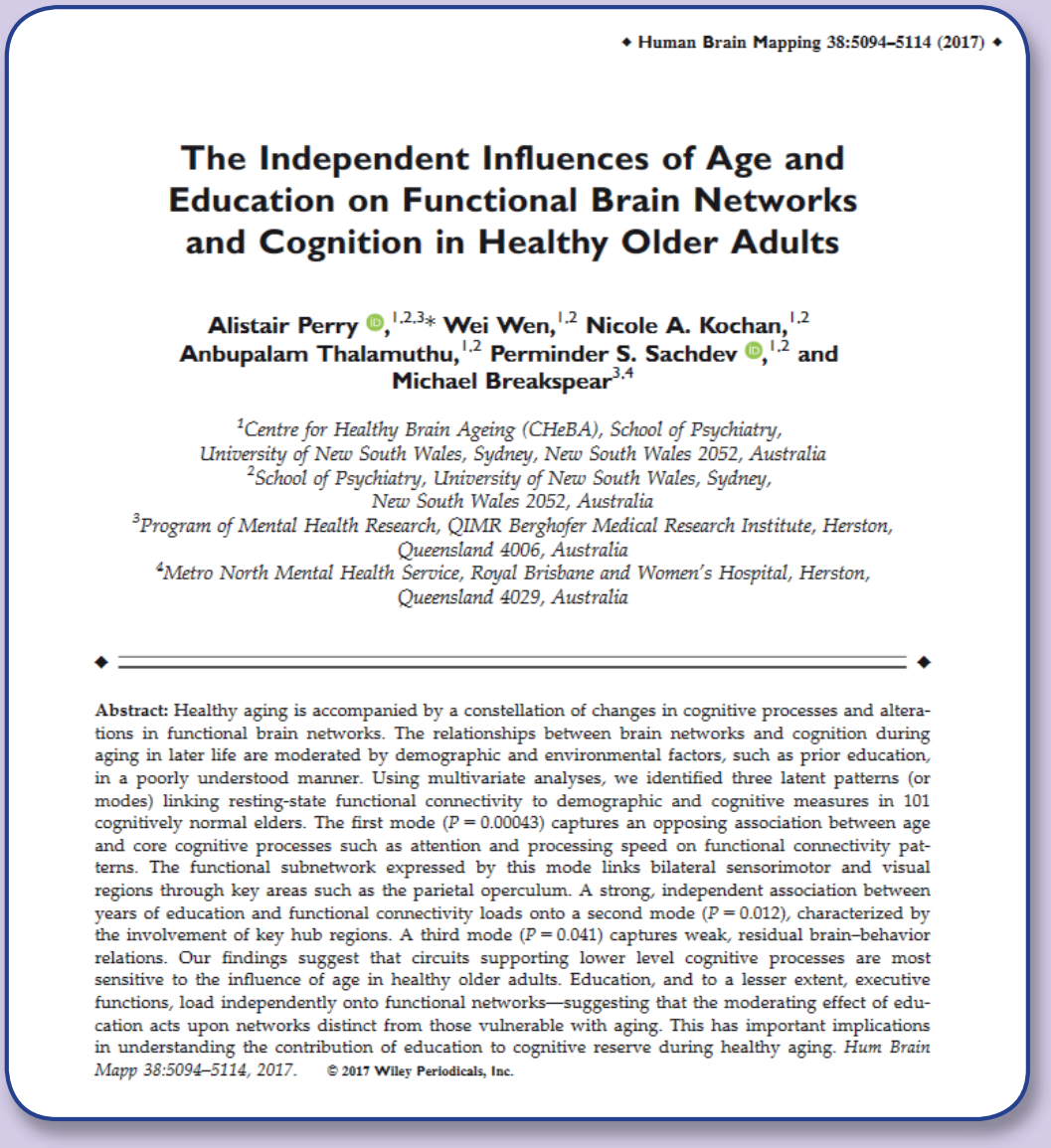
Conclusions: A higher calorie refeeding protocol appears to be safe, with no differences in rates of electrolyte disturbances or clinically diagnosed RFS, and lower incidence of hypoglycemia. Future research examining higher calorie intakes, similar to those studied in adolescent patients, may be beneficial.

Systems Neuroscience

Led by Professor Michael Breakspear, Consultant Psychiatrist at the RBWH, the Program of Mental Health Disorders (PMHD) at the QIMR Berghofer Medical Research Institute works closely with, and is co-funded by Metro North Mental Health Service. Researchers within PMHD come from 7 research teams that work across the breadth of biomedical research – genetics, epidemiology, neuroscience, molecular biology and computational biology – to understand the causes, mechanisms and nature of the serious mental health illnesses across the life time.

The independent influences of age and education on brain activity in healthy ageing

Healthy aging is accompanied by a number of changes in memory and behaviour, as well as age-related changes in the brain. Education is thought to act as a "cognitive reserve" that slows the influence of age on brain health and memory. However this effect is poorly understood. Our findings suggest that brain circuits supporting simple cognitive processes, such as the speed of thinking and the ability to concentrate, are most sensitive to the effects of age in healthy older adults. Education saves more complex cognitive functions such as decision making through a protective action on different brain networks. These findings suggest that the moderating effect of education acts upon networks distinct from those vulnerable with ageing and has important implications for understanding the onset and presentation of dementia.



◆ Human Brain Mapping 38:5094–5114 (2017) ◆

The Independent Influences of Age and Education on Functional Brain Networks and Cognition in Healthy Older Adults

Alistair Perry[1,2,3]* **Wei Wen**,[1,2] **Nicole A. Kochan**,[1,2] **Anbupalam Thalamuthu**,[1,2] **Perminder S. Sachdev**[1,2] **and Michael Breakspear**[3,4]

[1]*Centre for Healthy Brain Ageing (CHeBA), School of Psychiatry, University of New South Wales, Sydney, New South Wales 2052, Australia*
[2]*School of Psychiatry, University of New South Wales, Sydney, New South Wales 2052, Australia*
[3]*Program of Mental Health Research, QIMR Berghofer Medical Research Institute, Herston, Queensland 4006, Australia*
[4]*Metro North Mental Health Service, Royal Brisbane and Women's Hospital, Herston, Queensland 4029, Australia*

Abstract: Healthy aging is accompanied by a constellation of changes in cognitive processes and alterations in functional brain networks. The relationships between brain networks and cognition during aging in later life are moderated by demographic and environmental factors, such as prior education, in a poorly understood manner. Using multivariate analyses, we identified three latent patterns (or modes) linking resting-state functional connectivity to demographic and cognitive measures in 101 cognitively normal elders. The first mode ($P = 0.00043$) captures an opposing association between age and core cognitive processes such as attention and processing speed on functional connectivity patterns. The functional subnetwork expressed by this mode links bilateral sensorimotor and visual regions through key areas such as the parietal operculum. A strong, independent association between years of education and functional connectivity loads onto a second mode ($P = 0.012$), characterized by the involvement of key hub regions. A third mode ($P = 0.041$) captures weak, residual brain–behavior relations. Our findings suggest that circuits supporting lower level cognitive processes are most sensitive to the influence of age in healthy older adults. Education, and to a lesser extent, executive functions, load independently onto functional networks—suggesting that the moderating effect of education acts upon networks distinct from those vulnerable with aging. This has important implications in understanding the contribution of education to cognitive reserve during healthy aging. *Hum Brain Mapp 38:5094–5114, 2017.*

Psychiatry Scholarly Projects

Trainees in the Royal Australian and New Zealand College of Psychiatrist (RANZCP) Fellowship Program must successfully complete a Scholarly Project to obtain Fellowship. Prior to 2012, it had not been a formal part of the RANZCP Fellowship Training Program. The project must be original research in an area relevant to psychiatry and the trainees should plan the project early in training to complete by 60 months full time employment (FTE) training. The summative assessment is assessed as the standard expected at the end of Stage 3. The details of the requirements for Scholarly Project can be found on the RANZCP website for the members. In brief, trainees may select their own Scholarly Project topic but must submit a project proposal to their Branch Training Committee for approval.

Projects can be

- Quality assurance project or clinical audit
- Literature review
- Empirical research (qualitative or quantitative)
- Case series
- Equivalent project as approved by the Scholarly Project Subcommittee.

Metro North Mental Health (MNMH) is committed to support trainees in completing the scholarly projects. We are working to develop processes, infrastructure and capabilities across the organisation so that trainees have the best possible support to complete studies. We recognise, particularly the importance of developing the research knowledge base and skills of psychiatrists working across the service in order to increase access to supervisors. Currently across the MNMH we have a range of quite experienced psychiatrist supervisors for scholarly projects: Dr James Scott, Professor Gerard Byrne, Dr Michael Breakspear, Dr Bjorn Burger, Dr Ed Heffernan, Dr Mark Daglish, Dr George Bruxner and Dr Gail Robinson are all highly skilled research supervisors. Dr Sue Patterson, Principal Research Fellow can also be contacted also if psychiatrists would like more guidance around service based research.

Dr Charana Perera, psychiatric registrar working at Redcliffe Caboolture is nearing completion of a substantial study undertaken for his scholarly project. Charana, working with various colleagues over the last two years, has examined the pharmacological management of Bipolar Affective Disorder and the management of lithium across Metro North. The study which involved a retrospective audit of 383 files has provided important insights about the use of various medications and the extent to which practice accords with guidelines. Findings from Charana's study have important implications for service development and have already led to changes in practice regarding prescription of Sodium Valproate. Charana continues to write up his study for publication in peer reviewed journals and examination with submission expected around mid-2018. Three papers reporting components of the study are to be presented at the Royal Australia and New Zealand College of Psychiatrists Annual Congress in Auckland, NZ in May (see abstracts).

BIPOLAR DISORDER AND LITHIUM IN ROUTINE CARE

Bipolar affective disorder (BPAD) is characterised by two or more episodes in which mood and activity levels are significantly elevated (hypomania or mania) or depressed. Somewhere between 1 and 2 percent of the adult population will satisfy diagnostic criteria as some point in their lives. The onset and course of BPAD, including frequency and duration of the mood swings and the intervals between acute episodes varies between individuals; a 'typical' case is hard to describe but BPAD is commonly associated with substantial distress and disability.

Lithium is widely regarded as the best treatment for patients with BPAD. However Lithium has a narrow therapeutic index; there is little difference between sub-therapeutic levels and toxicity. A substantial proportion of patients on long-term lithium therapy experience at least one episode of toxicity.

Due to the narrow therapeutic index and potentially severe effects of toxicity, guidelines internationally recommended close monitoring of patients on lithium. Lithium levels should be monitored regularly - every 3–6 months, depending on circumstance and setting. Moreover, good clinical practice guidelines oblige psychiatrists and other medical practitioners prescribing and managing lithium to routinely monitor adherence and side effects, and to educate patients in relation to use of the medication, risks and the need for therapeutic monitoring.

Studies in the United Kingdom, Europe and the United States demonstrating that practice commonly fell below acceptable standards have supported quality improvement activities. As a first step toward optimising practice across MNMH a team of researchers led by Dr Charana Perera set out to examine current practice. A clinical audit was undertake to describe management of lithium in treatment of bipolar affective disorder and mania within Metro North Mental and assess the extent to which practice accords with guidelines. Charana and colleagues are presenting three papers at the upcoming Royal Australian and New Zealand College of Psychiatrists (RANZCP) 2018 Congress. The papers (abstracts below) report the use of polypharmacy and management of bipolar effective disorder, use of valproate and carbamazepine in women of child bearing age and prescribing practices of lithium.

ABSTRACT

Use of valproate and carbamazepine in childbearing age women with bipolar affective disorder: Routine practice in a large Australian public mental health service district.

C Perera, S Patterson, D Debattista, U Wijayatunga, G Bruxner & P Wimalaguna

Background: Due to teratogenicity, valproic acid and carbamazepine are contraindicated in pregnancy and should be avoided whenever possible in women of childbearing age.

Objectives: To ascertain the extent to which valproic acid and carbamazepine are prescribed in childbearing age females with the diagnosis of Bipolar Affective Disorder (BPAD).

Methods: We performed an audit of pharmacotherapy of all patients of a large mental health service with a diagnosis of BPAD or mania on a census date. As part of the audit, cross-sectional data were collected relating to 383 patients. This provided a snapshot of pharmacotherapy and patient demographics including gender and age.

Findings: The sample included 218 women, 98 of whom were aged 17 to 45. 79 women were prescribed either Carbamazepine or Sodium Valproate. Nearly one quarter (n=23) were potentially child bearing. Comparisons of women <45 with older women and men 17 to 45 demonstrated that women of childbearing age were less likely than older female counterparts to be prescribed either medicine but no less likely than men of a similar age to be prescribed either medicine.

Conclusions: Prescription of medicine known to cause fetal harm to one in ten women with diagnosis of BPAD is cause for concern. It may be that doctors prescribing carbamazepine or sodium valproate provided patients with advice regarding contraception and potential harms, but many pregnancies are unplanned. Findings indicate a need for research to understand prescribing practices and potentially provision of further education regarding use of hazardous medications in childbearing age women.

ABSTRACT

Polypharmacy and guidelines. An audit of prescribing patterns of psychotropics in a major Australian mental health service district .

C Perera, G Bruxner, S Patterson, D Debattista, U Wijayatunga

Background: Antipsychotics and Mood stabilizers are both commonly used in the treatment for Bipolar Affective Disorder. Concomitant prescribing of an antipsychotic and mood stabiliser or two mood stabilisers is supported by RANZCP and NICE guidelines. Antipsychotic polypharmacy, however is discouraged due to risk of QT prolongation and sudden cardiac death.

Objectives: To ascertain the extent of antipsychotic polypharmacy, and concomitant prescribing of mood stabilizers and a in managing BPAD.

Methods: Audit of records of all patients (n=383) with diagnosis of BPAD open to a public mental health service on a census date. Data pertaining to demographics and prescribing patterns of antipsychotics, mood stabilizers, antidepressants, hypnotics and non-psychotropics were collected. Data were tabulated and analysed using simple descriptives.

Findings: The majority (73%) of patients were prescribed any mood stabiliser; two thirds (n=254; 66%) were prescribed Antipsychotics, with antipsychotic polypharmacy noted in 41 (16%). Three quarters of those prescribed any antipsychotic were also prescribed a mood stabilizer. Mood stabilizer-polypharmacy was observed in 42 of 279 (15%) patients prescribed any mood stabilizer).

Conclusions: Polypharmacy of antipsychotics remains a notable practice in managing BPAD in routine care despite being discouraged by guidelines which is of concern. Further understanding and knowledge among doctors in regards to prescribing practices and guidelines will enhance safe prescribing knowledge.

ABSTRACT

Safe and on time: An audit of Lithium prescribing practices across a major Australian mental health service district.

C Perera, S Patterson, D Debattista, U Wijayatunga, G Bruxner & P Wimalaguna

Background: Lithium remains important in the treatment of bipolar disorder but the narrow therapeutic index, toxicity and short and long-term potential side effects oblige care in prescription and monitoring.

Objectives: To assess the extent to which routine practice approximates guidelines for lithium prescription in two Australian mental health services.

Methods: A 24 month retrospective chart review of patients diagnosed with BPAD, open to services on a census date. Data extracted for each patient included lithium prescription, serum lithium levels, biochemical parameters, adherence, physical reviews, side effects and advice regarding lithium use. Reported tests and assessments were compared to NICE guidelines.

Findings: 110 patients had 1188 medical contacts with a total of 516 lithium serum levels. Lithium monitoring was consistent with guidelines for a minority (13%;n=14); less frequent than recommended for 25% (n=27) and more frequent for 62%(n=67) with up to 23 additional tests reported/patient. Percentages of all parameters recorded for all patients consistent with NICE guidelines were: lithium (56%); thyroid function (75%); renal function (82%); calcium (49%) and weight/BMI (40%). Potential adverse effects of lithium treatment, discontinuation and measures to mitigate risk were seldom discussed with documentation regarding effects of medication in 23% of medical consults.

Conclusions: Therapeutic monitoring of lithium and other serum parameters in routine practice appears suboptimal with under and over investigation identified. Noteworthy also are limited monitoring of other physical health parameters and little evidence of engagement with patients in discussion regarding important aspects of lithium treatment.

DISSEMINATION ACTIVITIES

JOURNAL ARTICLES

Abajobir AA, Kisely S, **Scott JG**, Williams G, Clavarino A, Strathearn L & Najman JM. Childhood maltreatment and young adulthood hallucinations, delusional experiences and psychosis: a longitudinal study. Schizophrenia Bulletin, (2017) 43(5), 1045-1055. doi: 10.1093/schbul/sbw175

Alghowinem S, Goecke R, Wagner M, Epps J, Hyett M, Parker G, **Breakspear M**. Multimodal Depression Detection: Fusion Analysis of Paralinguistic, Head Pose and Eye Gaze Behaviors. IEEE Transactions on Affective Computing, (2017) doi: 10.1109/TAFFC.2016.2634527

Al-Kaysi AM, Al-Ani A, Loo CK, Powell TY, Martin DM, **Breakspear M**, Boonstra TW. Predicting tDCS treatment outcomes of patients with major depressive disorder using automated EEG classification. J Affect Disorders, (2017) 208, 597-603.

Armstrong R, **Scott JG**, Whitehouse A JO, Copland D A, **McMahon KL**. & Arnott W. Late talkers and later language outcomes: Predicting the different language trajectories. Int J Speech Lang Pathology, (2017) 1-14. doi:10.1080/17549507.2017.1296191

Armstrong R, Whitehouse AJO, **Scott JG**, Copland DA, **McMahon KL**, Fleming S & Arnott W. A relationship between early language skills and adult autistic-like traits: evidence from a longitudinal population-based study. J Autism and Developmental Disorders, (2017), 1-12. doi:10.1007/s10803-016-3014-z

Avery N & **Patterson S**. Physical health in public mental health care: A qualitative study employing the COM-B model of behaviour to describe views and practices of Australian psychologists. Australian Psychologist, (2017) doi:10.1111/ap.12302.

Barron L, Barron R, Johnson J, Wagner W, Ward C, Ward S, Barron F, **Ward W**. A retrospective analysis of biochemical and haematological parameters in patients with eating disorders. Journal of Eating Disorders, (2017), 5-32.

Bhagwat S & Bruxner G. “Not quite out of the woods” - potential for misdiagnosis of delayed neurological syndrome of carbon monoxide poisoning as relapse of mental illness. Australasian Psychiatry, (2017) 25(5):494-496. doi: 10.1177/1039856217726695.

Bhatia S, Hayat M, **Breakspear M**, Parker G & Goecke R. A video-based facial behaviour analysis approach to melancholia. In Automatic Face & Gesture Recognition (FG 2017), (2017) 12th IEEE International Conference (754-761). IEEE.

Bidding C, Thurairajasingam S, Ramadas A, Teo A, Ho M, **Elangovan S** & Karbassi Z. Psychological Well-being among medical students in their clinical years. The Medical Journal of Malaysia, (2017) (accepted for publication Aug 2017).

Borschmann R, Thomas E, Moran P, Carroll M, **Heffernan E**, Spittal M, Sutherland G, Alati R & Kinner S. Self-harm following release from prison: A prospective data linkage study. ANZ J Psychiatry, (2017) 5,250-259, doi:10.1177/0004867416640090

Borschmann R, Young JT, Moran P, Spittal MJ, **Heffernan E**, Mok K, et al. Ambulance attendances resulting from self-harm after release from prison: a prospective data linkage study. Social Psychiatry and Psychiatric Epidemiology, (2017) 52(10), 1295-305.

Breakspear M. Dynamic models of large-scale brain activity, Nature Neuroscience, (2017) 20(3) 340-352.

Burke AJ, Hay K, **Chadwick A**, Siskind, D & Sheridan, J. In Press. High rates of respiratory symptoms and airways disease in mental health inpatients in a tertiary centre. Intern Med J. (2017) doi:10.1111/imj.13594

Byrne GJ. Is there anything to worry about? Australasian Journal on Ageing, (2017) 36, 96-97. doi: 10.1111/ajag.12346

Carr PJ, **Higgins N**, Rippey J, Cooke M, Rickard CM. ‘Tools, Clinical Prediction Rules, and Algorithms for the insertion of peripheral intravenous catheters in adult hospitalized patients: A systematic scoping review of literature. J Hosp Med, (2017) Oct,12(10). doi: 10.12788/jhm.2836. Epub 2017 Sep 6.

Chapman JJ, Roberts JA, Nguyen VT, **Breakspear M**. Quantification of free-living activity patterns using accelerometry in adults with mental illness. Sci Rep, (2017) 7,43174.

Chellamuthu R, Elangovan E, Karthikeyan K et al. Training allied mental health professional to use Mini International Neuropsychiatric Interview for clinical screening. Int Invention Journal of Medicine and Medical Sciences, (2017) 4(4) 34-40.

Cocchi L, Gollo LL, Zalesky A, **Breakspear M**. Criticality in the brain: A synthesis of neurobiology, models and cognition. Prog Neurobiol, doi:10.1016/j.pneurobio.2017.07.002.(2017)

Cumming P, Burgher B, Patkar O, **Breakspear M**, Vasdev N, Thomas P, et al. Sifting through the surfeit of

neuroinflammation tracers. J Cereb Blood Flow Metab. (2017) Jan 1:271678X17748786. doi: 10.1177/0271678X17748786. [Epub ahead of print]

Davey CG, **Breakspear M**, Pujol J, Harrison BJ. A Brain Model of Disturbed Self-Appraisal in Depression. Am J Psychiatry, (2017)174(9),895-903.

Davidson F, **Heffernan E**, Greenberg D, Butler T, Burgess P. Key performance indicators for Australian mental health court liaison services. Australasian Psychiatry, (2017) 25(6), 609-13.

Davidson F, **Heffernan E**, Greenberg D, Waterworth R & Burgess P. Mental Health and Criminal Charges: Variation in Diversion Pathways in Australia, Psychiatry, Psychology and Law, (2017) 24(6) doi.org/10.1080/13218719.2017.1327305.

Dissanayaka NN, Au TR, Angwin AJ, O'Sullivan JD, **Byrne GJ**, Silburn PA, Marsh R, Mellick GD, Copland DA. N400 and emotional word processing in Parkinson's disease. Neuropsychology, (2017) 31, 585-595. doi: 10.1037/neu0000333

Dissanayaka NN, Pye D, Mitchell LK, **Byrne GJ**, O'Sullivan JD, Marsh R, Pachana NP. Cognitive behaviour therapy for anxiety in Parkinson's disease: Outcomes for patients and caregivers. Clinical Gerontologist, (2017) 40(3): 159-171 doi: 10.1080/07317115.2016.1240131.

Emmerson B, Praskova A, **Fawcett L**, Crompton D & **Heffernan E**. Mental health services planning for G20 summit in Brisbane and assessment of impact. Australasian Psychiatry, (2017), 25(1) 60-65.

Erskine HE, Baxter A J, Patton G, Moffitt, TE, Patel V, Whiteford, HA, & **Scott JG**.The global coverage of prevalence data for mental disorders in children and adolescents. Epidemiology and Psychiatric Sciences, (2017) 26 4, 395-402. doi:10.1017/S2045796015001158.

Flanagan KJ, Copland DA, Chenery HJ, **Byrne GJ**, & Angwin AJ. Semantic feature disturbance in Alzheimer disease: Evidence from an object decision task. Cognitive and Behavioural Neurology, (2017) 30(4), 159-171. doi: 10.1097/WNN.0000000000000140.

Frankland A, Roberts G, Holmes-Preston E, Perich T, Levy F, Lenroot R, Hadzi-Pavlovic D, **Breakspear M**, Mitchell PB. Clinical predictors of conversion to bipolar disorder in a prospective longitudinal familial high-risk sample: focus on depressive features. Psychol Medicine, (2017). doi:10.1017/S0033291717003233:1-9.

Gordon A, **Connell MT**, Davis PJ, Pepping CA, **Patterson S**, Salter K, **Scott JG**. A randomised waitlist control community study of Social Cognition and Interaction Training (SCIT) for people with schizophrenia. British J Clin Psych, (2017) doi: 10.1111/bjc.12161.

Gunasekara I, **Patterson S** & **Scott JG**. "What makes an excellent mental health doctor?" A response integrating the experiences and views of service users with critical reflections of psychiatrists in Australia. Health and Social Care in the Community (2017) 25(6),1752-1762. doi: 10.1111/hsc.12449.

Heitmann S, Aburn MJ, **Breakspear M**. The Brain Dynamics Toolbox for Matlab. bioRxiv. 2017 doi: org/10.1101/219329.

Heitmann S, **Breakspear M**. Putting the" dynamic" back into dynamic functional connectivity. Network Neuroscience, (2017). doi: https://doi.org/10.1101/181313.

Hielscher E, De Vylder J, Saha S, **Connell M**, & **Scott JG**. Why are psychotic experiences associated with self-injurious thoughts and behaviours? A systematic review and critical appraisal of potential confounding and mediating factors. Psychological Medicine,(2017) doi:10.1017/S0033291717002677

James K, Quirk A, **Patterson S**, Brennan G & Stewart D. Quality of intervention delivery in a cluster randomised controlled trial: a qualitative observational study with lessons for implementation fidelity.Trials, (2017) 18:548 doi: 10.1186/s13063-017-2189-8

Jeganathan J, Perry A, Bassett DS, Roberts G, Mitchell PB, **Breakspear M**. Fronto-limbic dysconnectivity leads to impaired brain network controllability in young people with bipolar disorder and those at high genetic risk. bioRxiv. (2017) doi:10.1101/222216

Johnston ANB, Weeks B, Shuker M, Coyne E, **Higgins N**, **Mitchell M**, Massey D. 'Nursing Students' perceptions Perceptions of the Objective Structured Clinical Assessment: An integrative review.' Clinical Simulation in Nursing, (2017) 13(3), 127-142. doi: 10.1016/j.ecns.2016.11.002

Kassbaum N, Hmwe Kyu H, Zoecker L, Erskine HE, **Scott JG**, & Vos T. Child and Adolescent Health From 1990 to 2015 Findings From the Global Burden of Diseases, Injuries, and Risk Factors 2015 Study. JAMA Pediatrics, (2017) 171(6), 573-592. doi:10.1001/jamapediatrics.2017.0250

Kerkman JN, Daffertshofer A, Gollo L, **Breakspear M**, Boonstra TW. Network structure of the human musculoskeletal system shapes neural interactions on multiple timescales. bioRxiv:181818, (2017)

Kerkman JN, Daffertshofer A, Gollo LL, **Breakspear M**, Boonstra TW. Functional connectivity analysis of multiplex muscle network across frequencies. Conf Proc IEEE Eng Med Biol Soc, (2017), 1567-70.

Kesby J, Eyles D, McGrath J & **Scott JG**. Dopamine, psychosis and schizophrenia: the widening gap between basic and clinical neuroscience.Translational Psychiatry, doi:10.1038/s41398-017-0071-9

Khatun M, Mamun AA, **Scott JG**, William GM, Clavarino A, & Najman JM. Do children born to teenage parents have lower adult intelligence? A prospective birth cohort study. PLoS One, (2017), 12(3): e0167395. doi: 10.1371/journal.pone.0167395.

Kinchin I, Doran CM, Hall WD, **Meurk C**. Understanding the true economic impact of self-harming behaviour. The Lancet Psychiatry, (2017), 4(12):900-1.

Kirk KM … **Ward W**, Wade TD, Bulik CM, Martin NG. The Anorexia Nervosa Genetics Initiative: Study description and sample characteristics of the Australian and New Zealand arm. ANZ Journal of Psychiatry, (2017) doi:/10.1177/0004867417700731

Lin H-Y, Cocchi L, Zalesky A, Lv J, Perry A, Tseng W-YI, Kundu P, **Breakspear M**, Gau SS, Brain-behavior patterns define a dimensional biotype in medication-naïve adults with attention-deficit hyperactivity disorder. bioRxiv. (2017) 190660

Lord AR, Li M, Demenescu LR, van den Meer J, … **Breakspear M**, Walter M. Richness in Functional Connectivity Depends on the Neuronal Integrity within the Posterior Cingulate Cortex. Front Neuroscience, (2017) 11,184.

Lv J, Nguyen VT, van der Meer J, **Breakspear M**, & Guo CC. N-way Decomposition: Towards Linking Concurrent EEG and fMRI Analysis During Natural Stimulus. In International Conference on Medical Image Computing and Computer-Assisted Intervention. (2017, September) (pp. 382-389). Springer, Cham.

Massey D, Burns J, **Higgins N**, et al., . Enhancing OSCE preparedness with video exemplars in undergraduate nursing students. A mixed method study. Nurse Education Today, (2017) 54, 56-61. doi: 10.1016/j.nedt.2017.02.024

McKeon GL, Robinson GA, Ryan AE, Blum S, Gillis D, Finke C & **Scott JG**. Cognitive outcomes following anti-N-methyl-D-aspartate receptor encephalitis: A systematic review, J Clin &Expl Neuropsychology, (2017) 1-19. doi:10.1080/13803395.2017.1329408

Mehta D, Bruenig D, Carrillo-Roa T, **Lawford B** et al. Genomewide DNA methylation analysis in combat veterans reveals a novel locus for PTSD, Acta Psychiatr Scandanavica, (2017), 1–13 doi:10.1111/acps.12778

Meredith P, Yeates H, **Taylor M**, et al., Preparing mental health professionals for new directions in mental health practice: Evaluating the sensory approaches e-learning training package. Int J Mental Health Nursing, (2017) DOI:10.1111/inm.12299

Mills NT, Maier R, Whitfield JB, Wright MJ, Colodro-Conde L, Byrne EM, **Scott JG** & Benyamin B. Investigating the relationship between iron and depression. Journal of Psychiatric Research, (2017) 94, 148-155 doi: 10.1016/j.jpsychires.2017.07.006

Moore SE, Norman RE, Suetani S, Thomas HJ, Sly PD & **Scott JG**. Consequences of bullying victimization in childhood and adolescence: A systematic review and meta-analysis. World Journal of Psychiatry, (2017), 7(1), 60–76. doi: 10.5498/wjp.v7.i1.60

Murphy JA, Sarris J, **Byrne GJ**. A review of the conceptualization and risk factors associated with treatment-resistant depression. Depression Research and Treatment, (2017) 4176825 doi: 10.1155/2017/4176825

Murphy K, Coombes I, Moudgil V, **Patterson S**, Wheeler A. Clozapine and concomitant medications: Assessing the completeness and accuracy of medication records for people prescribed clozapine under shared care arrangements. J Eval Clin Pract. 2017 23(6):1164-1172. doi: 10.1111/jep.12743.

Najman JM, Plotnikova M, Williams GM, Alati R, Mamun AA, **Scott JG**, Clavarino AM, Wray N. Maternal depression and family adversity: Linked pathways to offspring depression? Journal of Psychiatric Research, (2017) 88, 97-104. doi: 10.1016/j.jpsychires.2017.01.006

Najman JM, Bor W, Ahmadabadi Z, Williams GM, Alati R, Mamun AA, **Scott JG**, Clavarino, AM. The inter- and intra-generational transmission of family poverty and hardship (adversity): A prospective 30 year study. PLoS One, (in press accepted 19 Dec 2017)

Najman JM, … **Scott JG**, Wray N & Clavarino AM. Trajectories of maternal depression: a 27-year population-based prospective study. Epidemiology and Psychiatric Sciences. (2017) 26 1: 79-88. doi:10.1017/S2045796015001109

Ng F, **Scott JG** & Bruxner, G. Antineuronal antibody screening in early onset-cognitive decline. ANZ J Psychiatry, (2017) 51(7): 736-737. doi: 10.1177/0004867416670019

Nguyen VT, Sonkusare S, Stadler J, Hu X, **Breakspear M**, Guo CC. Distinct Cerebellar Contributions to Cognitive-Perceptual Dynamics During Natural Viewing. Cereb Cortex, (2017) 27(12), 5652-62.

Palmquist L, **Patterson S**, O'Donovan A & Bradley G. Protocol: A Grounded Theory of 'Recovery'- Adolescent Service Users' Perspectives. Open, (2017), 7:e015161. doi: 10.1136/bmjopen-2016-015161

Pathé MT, Haworth DJ, Goodwin T, Holman AG, Amos SJ, Winterbourne P, et al. Establishing a joint agency response to the threat of lone-actor grievance-fuelled violence. J Forensic Psychiatry & Psychology, doi.org/10.1080/14789949.2017.1335762.

Patterson S, Drew W, Chamberlain K & **Emmerson B**. Smoke free acute inpatient care: A mixed methods study of psychiatrists' views and practice in two Australian inpatient mental health settings. Mental Health and Addiction Research.

doi: 10.15761/MHAR.1000148

Perry A, Wen W, Kochan NA, Thalamuthu A, Sachdev PS, **Breakspear M**. The independent influences of age and education on functional brain networks and cognition in healthy older adults. Hum Brain Mapp, (2017) 38(10), 5094-114.

Pickering JW, **Flaws D**, Smith SW, **Greenslade J**, Cullen L, Parsonage W, Carlton E, Mark Richards A, Troughton R, Pemberton C, George PM. A Risk Assessment Score and Initial High sensitivity Troponin Combine to Identify Low Risk of Acute Myocardial Infarction in the Emergency Department. Academic Emergency Medicine, (2017) Nov 13. doi: 10.1111/acem.13343.

Prentice K, Blair B & O'Mullan C. Sexual and Family Violence: Overcoming Barriers to Service Access for Aboriginal and Torres Strait Islander Clients. Australian Social Work, (2017) 70(2), 241-252 http://dx.doi.org/10.1080/0312407X.2016.1187184

Roberts G, Lord A, Frankland A, Wright A, Lau P, Levy F, Lenroot RK, Mitchell PB, **Breakspear M**. Functional Dysconnection of the Inferior Frontal Gyrus in Young People With Bipolar Disorder or at Genetic High Risk. Biol Psychiatry, (2017) 81,718-727.

Roberts JA, Friston KJ, **Breakspear M**. Clinical Applications of Stochastic Dynamic Models of the Brain, art I: A primer. Biological Psychiatry: Cognitive Neuroscience and Neuroimaging, (2017) 2(3), 216-224 https://doi.org/10.1016/j.bpsc.2017.01.010

Roberts JA, Friston KJ, **Breakspear M**. Clinical Applications of Stochastic Dynamic Models of the Brain, Part II: A Review Biological Psychiatry: Cognitive Neuroscience and Neuroimaging, (2017) 2(3), 225-234 https://doi.org/10.1016/j.bpsc.2016.12.009.

Roberts JA, Perry A, Roberts G, Mitchell PB, **Breakspear M**. Consistency-based thresholding of the human connectome. Neuroimage, (2017) 145(Pt A),118-29,

Ryan A, Baker A, Dark F, Foley S, **Gordon A**, Hatherill S, **Scott JG**. The efficacy of sodium benzoate as an adjunctive treatment in early psychosis - CADENCE-BZ: study protocol for a randomized controlled trial. Trials, (2017) 18(1), 165. doi:10.1186/s13063-017-1908-5.

Sampaio F, Barendregt JJ, Feldman I, Lee YY, Sawyer MG, Dadds MR, **Scott JG**, Mihalopoulos C. Population cost-effectiveness of the Triple P parenting programme for the treatment of Conduct Disorder: An economic modelling study. European Child & Adolescent Psychiatry, (accepted 15 Dec 2017)

Santhanam-Martin R, Fraser N, **Jenkins A**, Tuncer C. Evaluation of cultural responsiveness using a transcultural secondary consultation model. Transcultural Psychiatry, (2017) 54(4), 488-501.

Scott JG, Giortz Pedersen M, Erskine HE, Bikic A, Demontis D, McGrath JJ & Dalsgaard S. Mortality in individuals with disruptive behavior disorders diagnosed by specialist services – a nationwide cohort study. Psychiatry Research, (2017) 251, 255-260. doi:10.1016/j.psychres.2017.02.029

Shine JM, Aburn MJ, **Breakspear M**, Poldrack RA. The modulation of neural gain facilitates a transition between functional segregation and integration in the brain. bioRxiv. (2017) eLife, 7:e31130.

Signal S, Taylor N, **Prentice K**, McDade M & Burke KJ Going to the dogs: A quasi-experimental assessment of animal assisted therapy for children who have experienced abuse. App Dev Science, (2017) 2, 81-93 doi.org/10.1080/10888691.2016.1165098

Signorini R, Sheffield J, **Rhodes N**, **Fleming C** & **Ward W**. The Effectiveness of Enhanced Cognitive Behavioural Therapy (CBT-E): A Naturalistic Study within an Out-Patient Eating Disorder Service. Behavioural and Cognitive Psychotherapy, (2017) doi: 10.1017/S1352465817000352.

Suetani S, Mamun A, Williams GM, Najman JM, McGrath JJ & **Scott JG**. Longitudinal association between physical activity engagement during adolescence and mental health outcomes in young adults: A 21-year birth cohort study. Journal of Psychiatric Research, (2017) 94, 116-123. doi: 10.1016/j.jpsychires.2017.06.013

Suetani S, Mamun A, Williams GM, Najman JM, McGrath JJ & **Scott JG**. The association between adolescent psychopathology and subsequent physical activity in young adulthood: A 21-year birth cohort study. Psychological Medicine, (2017) 19, 1-10. doi:10.1017/S0033291717001660

Suetani S, Reddan J, **Anderson C**. Methamphetamine and psychiatry: A story of the colourless substance of abuse. Australasian Psychiatry, (2017) 25(3), 254-6.

Suetani S, Saha S, Eyles DW, **Scott JG**, & McGrath JJ. Prevalence and correlates of suboptimal vitamin D status in people living with psychotic disorders: Data from the Australian Survey of High Impact Psychosis. ANZ J Psychiatry, (2017) 51 (9), 921-929.

Suetani S, Saha S, Milad A, Eakin E, **Scott JG** & McGrath JJ. Common mental disorders and recent physical activity status: Findings from a National Community Survey. Soc Psych & Psychiatric Epid, (2017) 52(7), 795-802. doi:10.1007/s00127-016-1307-3

Suetani S, **Scott JG** & McGrath JJ. The importance of the physical health needs of people with psychotic disorders. ANZ J

Psychiatry, (2017) 51(1), 94-95. doi:10.1177/0004867416662151

Tan WH, Sheffield J, Khoo SK, **Byrne GJ**, Pachana NA. Influences on psychological well-being and ill-being in older women. Australian Psychologist, (2017) doi: 10.1111/ap.12297

Thomas HJ, Baguley CM, Connor JP & **Scott JG**. Two sides to the story: Adolescent and parent views on harmful intention in defining school bullying. Aggressive Behaviour, (2017) 43(4), 352–363. doi:10.1002/ab.21694

Thomas HJ, Connor JP, Lawrence DM, Hafekost JM, Zubrick SR & **Scott JG**. Prevalence and correlates of bullying victimisation and perpetration in nationally representative sample of Australian youth. ANZ J Psychiatry, (2017) doi: 10.1177/0004867417707819

Thomas HJ, Connor JP, **Scott JG**. Why do children and adolescents bully their peers?: A critical review of key theoretical frameworks. Social Psychiatry and Psychiatric Epidemiology, Nov 22. doi: 10.1007/s00127-017-1462-1.

Voisey J, **Lawford B**, Morris P et al. Epigenetic analysis confirms no accelerated brain aging in schizophrenia. Schizophrenia, (2017) 3 (26) doi:10.1038/s41537-017-0026-4.

Walker RM, Gillespie B M Keogh SJ, Thalib L, **Higgins NS**, & Whitty JA, Cochrane Database of Systematic Reviews, (2017) doi: 10.1002/14651858.CD011332.pub2

Ward W. The philosophy of anorexia. New Philosopher 2017, (18)

Gunasekara I, **Scott JG**, **Patterson S**. What makes an excellent mental health doctor?" A response integrating the experiences and views of service users with critical reflections of psychiatrists in Australia. Health and Social Care in the Community, (2017) Nov 25(6),1752-1762.

Wilson H & Magor-Blatch L. Apply what you know: Treating alcohol and drug problems. InPsych, (2017) 39(5) 8-11.

Wilson H, Palk G, Sheehan M, Wishart D & Watson B. Steering Clear of driving after drinking: a tailored e-health intervention for reducing repeat offending and modifying alcohol use in a high risk cohort. Int J Behavioural Medicine, (2017) 24, 694-702.

Abstracts

Boyle C & **Hall K**. Lived and learning: the growth of a co-facilitation education model. International Journal of Mental Health Nursing, (2017) 26(S1),4.

Collyer B, **Burrows D**, **Davies K** & **Chelemalashetty RJ**. Medication safety – more than calculations: implementation of a ental health safety awareness tool (Poster). International Journal of Mental Health Nursing, (2017) 26(S1),8.

Ewing J, **Padilla M**, **Turrell P** & **Kusemamuriwo R**. Olanzapine LAI and transition to GP Practices – A recovery model (Poster). International Journal of Mental Health Nursing, (2017) 26(S1),12.

Hiscox C & **Dart N**. Security staff in a Queensland inpatient unit – promoting a safer environment (Poster). International Journal of Mental Health Nursing, (2017) 26(S1),22.

Mitchell P, Frankland A, Roberts G,… **Breakspear M**, Fullerton J. Predicting conversion to bipolar disorder in a prospective longitudinal genetically high-risk sample. European Neuropsychopharmacology, (2017) 27:S516-S7.

Book

Mosley P, Smith D, Perry A, Silburn P, Coyne T, **Breakspear M**, editors. Predicting psychiatric symptoms after subthalamic deep brain stimulation for Parkinson's disease. 17th Quadrennial Meeting of the World Society for Stereotactic and Functional Neurosurgery; 2017: Karger.

Book Chapters

Byrne GJ. Anxiety in Late Life. In H Chiu, K Shulman, D Ames (Eds) Mental Health and Illness of the Elderly. Singapore: Springer Nature. (2017) doi: 10.1007/978-981-10-0370-7_13-1

Magis D, Gabrielli F, Roberts JA, Lisicki M, **Breakspear M**, Dallel R, D'Ostilio K, Schoenen J & Monconduit L. Electroencephalogram spectral bicoherence on resting phase: a potential reliable electrophysiological biomarker for migraine, p 67-68. SAGE London.

Newman M, Airey C, Blum S, **Scott JG**, Wong R, & Gillis D. Autoimmune Encephalitis: Clinical Features, Pathophysiology and Management. In A Minagar (Ed) Neuroinflamattion (2nd Edition). Elsevier. (in press)

Scott JG, **Hielscher E**, & Nurcome B. Hallucinations. In R.G.R. Levesque (Ed) Encyclopedia of Adolescence. Springer International Publishing. doi: 10.1007/978-3-319-32132-5_374-2

Scott JG, Ross C, Dorahy M, Read J, & Schäfer I. Childhood trauma in psychotic and dissociative disorders. In R.G.R Levesque (Ed) Encyclopedia of Adolescence. Springer International Publishing. doi: 10.1007/978-3-319-32132-5_374-2

Presentations 2017

Alexandrou E, Ray-Barruel G, Carr P, Frost S, Inwood S, **Higgins N**, Francis, L, Alberto, L, Mermel, L & Rickard C. Worldwide Variations in Peripheral Intravenous Catheter Insertion and Management Policies: Survey Results from the One Million Global Catheters Study. AVA 2017 Annual Scientific Meeting. Phoenix, Arizona, 16-19 September 2017.

Anderson J, Mead L, Curtin G, Robinson G, Tay G, **Higgins N** & Burke A. Screening for OSA in inpatients with schizophrenia: a feasibility study.Sleep Down Under 2017, 29th ASM of Australasian Sleep Association and the Australasian Sleep Technologists Association. Auckland, New Zealand. 25–28 October 2017.

Bennett E. Ante and post-natal mental illness and support' Child protection Symposium. Brisbane, 2 November 2017.

Boyle C & **Hall K**. Lived and learning: the growth of a co-facilitation education model. International Journal of Mental Health Nursing, ACMHN 43rd International Mental Health Nursing Conference. Hobart, 25-27 October 2017.

Breakspear M. Neurotechnologies in the ABA . Australian Brain Alliance Workshop. Melbourne Brain Centre, April 2017.

Breakspear M. Brain Network Disturbances in Affective Disorders, Brain and Mind Centre Research Committee Monthly Seminar Series. University of Sydney, 2017.

Breakspear M. Brain Network Disturbances in Affective Disorders. RANZCP Congress: 'Speaking our Minds. Telling our stories" Adelaide, 2017.

Breakspear M. Brain Network Theory, Computational and Cognitive Neuroscience New York University Shanghai Summer School. Shanghai, China, 2017.

Breakspear M. Brain Waves: Mechanisms of Metastable Cortical Dynamics. Keystone Symposia on Molecular and Cellular Biology. Santa Fe, USA, 2017.

Breakspear M. How to publish as an early career researcher. Organisation of Human Brain Mapping (OHBM). Vancouver, Canada, 2017.

Breakspear M. Neuroengineering Australia's future economic prosperity. Australian Brain Alliance April Workshop. Melbourne Brain Centre, 2017.

Breakspear M. Neurotechnologies in the ABA. Australian Brain Alliance, Brains at the Dome. Canberra, 2017.

Breakspear M. Prospective Imaging Study of Ageing: Genes, Brain and Behaviour, National Institute for Dementia Research, Australian Dementia Forum. Melbourne, 2017.

Breakspear M. The brain is a network: Defining neuroinflammation in major mental illness using blood. Clinical Neuropsychiatry in the 21st Century – New Developments, New Challenges. University of New South Wales, 2017.

Breakspear M. The phase transition theory of schizophrenia. Brain Modes 2017. Manesar, India, 2017.

Breakspear M. The phase transition theory of schizophrenia. STAR seminar series. National University, Singapore, 2017.

Breakspear M. Volatility Theory of Schizophrenia. Brain Connectivity Workshop (BCW 2017). Zurich, Switzerland, 2017.

Collyer B, **Burrows D**, **Davies K** & **Chelemalashetty RJ**. Medication safety – more than calculations: implementation of a mental health safety awareness tool. ACMHN 43rd International Mental Health Nursing Conference. Hobart, 25-27 October 2017.

D'Emden H, **Uhlmann C** & **Ward W**. Managing Eating Disorders and Diabetes (Workshop) (2017) ADS & ADEA Annual Scientific Meeting. Perth, 2017.

Durant L & **Daglish** M. 10 years of learnings: Operating smoke-free environments in drug and alcohol treatment facilities. Walk on the Wild Side (WOWS) 10: Diversity Symposium. Brisbane, 12 May 2017.

Erskine H & **Scott** J. Bridging the translational gap between the Global Burden of Disease Project and Clinical Practice. Unpacking GBD Workshop. Brisbane, 17 February 2017.

Erskine H & **Scott JG**. The Global Burden of ADHD and a Meta-Analysis of Long-term Outcomes, Sharing Insights in ADHD Conference. Melbourne, 27 May 2017.

Ewing J, **Padilla M**, **Turrell P** & **Kusemamuriwo R**. Olanzapine LAI and transition to GP Practices – A recovery model. ACMHN 43rd International Mental Health Nursing Conference. Hobart, 25-27 October 2017.

Flaws D & **Nitz M**. Depression, Delirium and Dementia. Aged Care Conference. RBWH, Brisbane 2017.

Flaws D. Development and impact of the EDAC Score and 2h accelerated diagnostic protocol. Australian Society of Medical Research (ASMR). Brisbane, 2017.

Flaws D. Predicting Delirium. Older Person's Mental Health Conference. RBWH, Brisbane 2017.

Flaws D. Predicting Delirium. TPCH Research Day. The Prince Charles Hospital, Brisbane, 2017.

Fleming C. Family Centred Practices in Healthcare: An EDOS Exemplar. Invited presentation. Collaboration for Allied Health, Research, Learning and Innovation (CAHRLI) Symposium. Brisbane, 2017.

Gardiner C. The Challenges of Nutritional Management of Acute Eating Disorder Patients in General Medical Setting. Australia and New Zealand Academy for Eating Disorders Conference. Sydney, 2017.

Hamilton B. (2017). Mental Health Court Liaison Service. State-wide Officer in Charge of Police Prosecutors conference. Brisbane, 10 November 2017.

Heffernan E, **Waterson E** & **Fitzgerald B**. Mental Health Court Liaison Service. State-wide Magistrates Court Conference. Brisbane, 31 March 2017.

Heffernan E. Disaster Plenary. Australian and New Zealand Intensive Care Society/Australian College of Critical Care Nurses. Gold Coast, 2017.

Herrin M, **Cassidy J**, **Jeffrey S**, **Graves L** & **Bunnell D**. Optimizing the Dietitian's Role in Multidiscipline Treatment. ICED Program. Prague, Czech Republic, June 8-10 2017.

Hielscher E, **Connell M**, Lawrence D, Zubrick S, Hafekost J & **Scott JG**. (2017). Association between psychotic experiences and non-accidental self-injury: Results from the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. The 16th Congress of the International Federation of Psychiatric Epidemiology (IFPE). Melbourne, 19 October 2017.

Hielscher E, Whitford T, **Scott JG** & Zopf R. When the body is the target – the role of body representations in non-accidental self-injury: A systematic review. Science of the Self International Research Forum. Sydney, 20 November 2017.

Hiscox C & **Dart N**. (2017). Security staff in a Queensland inpatient unit – promoting a safer environment (Poster). International Journal of Mental Health Nursing, 26(S1),22.

Jeffrey S, **Patterson S**, Rocks T & Wright H. A conservative refeeding approach in female inpatients with restrictive eating disorders is not protective of refeeding syndrome. ICED Program. Prague, Czech Republic, June 8 – 10 2017.

Jones L & **Groom Y**. Volunteer model for mental health consumers in Emergency Departments. The Mental Health Services (TheMHS) Conference. Sydney, 31 August 2017.

Kinner S, Clugston B, **Davidson F**, **Perrin M** & **Heffernan E**. Mapping the scope and character of prison mental health services in Australia: A national benchmarking project. Royal Australian and New Zealand College of Psychiatrists Faculty Forensic Psychiatry Conference. Vancouver, 31 August 2017.

Kovacevic V. Breaking with tradition - senor mental health clinicians as expert witnesses in Magistrate Courts. Royal Australian and New Zealand College of Psychiatrists Faculty Forensic Psychiatry Conference. Vancouver, 31 August 2017.

Massey D, Burns J, **Higgins N**, Weeks B, Shuker M, Coyne E, **Mitchell M** & Johnston ANB. Enhancing utility and student engagement with OSCEs: Making change happen through innovative student support processes. Australian College of Nursing National Nursing Forum. Sydney, August 21 – 23 2017.

Mitchell M. No idle threat: Precursors to action in threateners with mental disorders. International Association of Forensic Mental Health Services. Croatia, 14 June 2017.

Mitchell M. Threats of Violence and Mental Illness: Types of threats, the Characteristics of Threateners and Risk Factors for Threat- Related Violence. Australian and New Zealand Association for Psychiatry, Psychology and Law Conference. Perth, 25 November 2017.

Mitchell M. Threats of Violence in a Threatening World: Practical Guidelines for Threat Assessment and Threat Management. Australian and New Zealand Association for Psychiatry, Psychology and Law Conference. Perth, 22 November 2017.

Perdacher E. Stay Strong Custody Project: culturally safe e-mental health tools in prison. Australian and New Zealand Association of Psychiatry, Psychology and Law Annual Congress. Perth, 25 November 2017.

Pittard J. Functional approaches to treatment within an eating disorders day program. Occupational Therapy Australia National Conference. Perth, 2017.

Roberts S & **Ward W**. Huppert M. Eating Disorders in the Peripartum and impact on Infant Mental Health and Feeding (Workshop) 2017 Australasian Marcé Society for Perinatal Mental Health 2017 Conference. Brisbane, 2017.

Scott JG & Sohal, R. Management of ADHD in Adults. Royal Brisbane and Women's Hospital Grand Rounds. Brisbane, 24 July 2017.

Scott JG, Abajobir A, Kisely S & Najman J. Childhood Maltreatment and psychosis outcomes in young adults. Royal Australian and New Zealand College of Psychiatrists (RANZCP) Congress. Adelaide, 2 May 2017.

Scott JG, **Connell M**, Betts K, Alati R, Najman J, Clavarino A, Mamun A, Williams G & McGrath JJ. Hallucinations in Adolescents and Risk of Mental Disorders and Psychosocial Impairment in Adulthood: a Birth Cohort Study 16th International Congress on Schizophrenia Research (ICOSR). San Diego, United States, 26 March 2017.

Scott JG, Pedersen M, Erskine HE, Bikic A, Demontis D, McGrath JJ & Dalsgaard S. Mortality in children and adolescents with disruptive behavioural disorders- a nationwide cohort study. (Invited Oral Presentation and Symposium Chair) The 16th Congress of the International Federation of Psychiatric Epidemiology (IFPE). Melbourne, 19 October 2017.

Scott JG. Against all odds. Office of National Assessments. Canberra, 4 May 2017.

Scott JG. Antipsychotics in the management of young people with psychosis. Keynote Lecture: Servier Educational Meeting. Brisbane, 22 April 2017.

Scott JG. Are Childhood and Adult ADHD the same disorders? Evidence for De Novo ADHD in adults. Plenary Speake, Inaugural Australian ADHD Professionals Association. Melbourne, 29 July 2017.

Scott JG. Beyond relapse prevention. Psychosocial interventions for early psychosis. Keynote Presentation; Symposium for supporting patients and families living with psychosis. Seoul, South Korea, 13 May 2017.

Scott JG. Clinical use of new antipsychotic agents in the management of young people with psychosis. Otsuka Educational Meeting. Perth, 7 February 2017.

Scott JG. Improving the quality of life in early psychosis. Asan Medical Centre. Seoul. South Korea, 11 May 2017.

Scott JG. Preventing mental illness: What can be done? The University of Queensland Health Matters Lecture Series. Brisbane, 23 May 2017.

Scott JG. Psychopharmacology in early psychosis. Otsuka Educational Meeting for Psychiatrists Daegu, South Korea, 12 May 2017.

Scott JG. The assessment and management of psychosis in adolescents. Invited Webinar Workshop for Far North Queensland Child and Youth Mental Health Services. 24 February 2017.

Scott JG. The management of first episode psychosis in adolescents and young adults. Keynote Presentation Monash Health Mental Health Service Annual Medical Staff Dinner. Melbourne, 18 July 2017.

Thomas HJ, Connor JP & **Scott JG**. Bullying behaviour in Australian youth: How common and what are the mental health risks? Australian Society for Medical Research: Queensland Branch Postgraduate Student Conference, Brisbane, 1 June 2017.

Thomas HJ, Connor JP & **Scott JG**. Prevalence and clinical correlates of bullying experiences in Australian adolescents. The 16th Congress of the International Federation of Psychiatric Epidemiology (IFPE). Melbourne, 19 October 2017.

Thomas HJ, Connor JP & **Scott JG**. Understanding why children and adolescents bully their peers. Society for Mental Health Research Conference, Canberra (Symposium Chair & Oral Presentation), 8 December 2017.

Vallelonga E & **Barnett H**. Stepping On - Building confidence and reducing falls. Tri-Nations Falls Forum. Brisbane, September 2017.

Vallelonga E & **Darbyshire C**. A sensorimotor group for older adults. Older Persons' Mental Health Statewide Symposium. Brisbane, August 25th 2017.

Vallelonga E. Engaging the senses: the trial and implementation of a sensorimotor group for older adults on an acute inpatient mental health unit. Occupational Therapy Australia, 'Through the Looking Glass' Mental Health Forum. Sydney, October 27th 2017.

Ward W. Reconfiguring general health services to meet the needs of adults with anorexia nervosa. NSW Eating Disorder Statewide Forum. Sydney, 2017.

OTHER COMMUNICATIONS AND OUTPUTS

Davis A & **Jeffrey S**. Renourishing the Undernourished patient. Australian and New Zealand Academy of Eating Disorders Autumn Workshop Series. Noosa, 2017.

Davis A & Niven H. Improving quality of QuEDS-CS to public hospital dietitians. Quality Activity. University of Queensland and Metro North Hospital and Health Service. Brisbane, 2017.

Fleming C. Engaging with and attending to the needs of families of people with eating disorders: Family Inclusive Practice. 'And Family' Month Program. Caboolture Hospital Education and Skills Centre. Brisbane, 2017.

Fleming C & **Marsland E**. Cognitive Behaviour Therapy for Eating Disorders. Training Program. Queensland University of Technology. Brisbane, 2017.

Heffernan E. Murder, Madness and Rights. Royal Australian and New Zealand College of Psychiatrists – Bostock Oration [Invited presentation]. Brisbane, 22 August 2017.

Heffernan E. Substance use disorders among Aboriginal and Torres Strait Islander People in custody: a public health opportunity. InSight Seminar Series [Invited presentation]. Brisbane, 2017.

Higgins N. Implementation of Safewards across three inpatient units. Insight and APSAD Seminar Series. Biala City Community Health Centre, Brisbane, 24 April 2017.

Meurk C. What do you want to know? Qualitative and quantitative research approaches. Queensland Emergency Research Collaborative (QERC) meeting – Emergency Medicine Foundation [Invited presentation]. Brisbane, 5 October 2017.

Meurk C. Partners in Prevention: Understanding and Enhancing First Responses to Suicide Crisis Situations. safeTALK: Suicide Prevention for Everyone Forum and Workshop [Invited presentation]. CQ University, Brisbane, 15 November 2017.

Meurk C. Partners in Prevention: Understanding and Enhancing First Responses to Suicide Crisis Situations. University of Melbourne, Centre for Mental Health, Seminar Series [Guest presentation]. Melbourne, 26 October 2017.

Mitchell M. Mental Disorder and Threats of Violence: Identifying Risk Factors. University College of London, Institute of Security and Crime Science [Guest presentation]. London, 7 June 2017.

Ward W. Training Workshop for Medical Practitioners. Centre for Integrative Health. Brisbane , 2017.

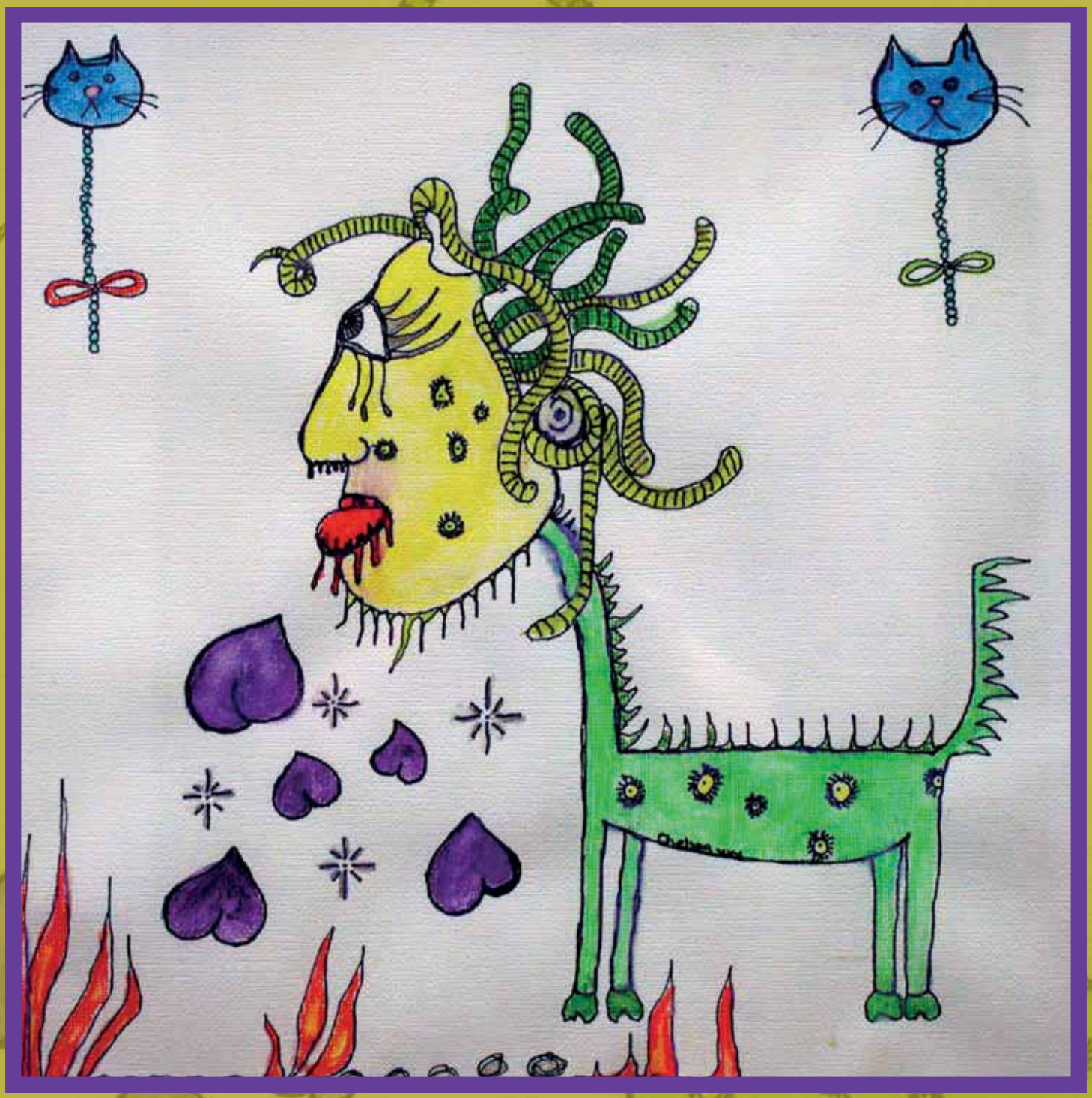
Ward W, Bowden T. Assessment and Management of people with comorbid Diabetes and Eating Disorders. Presentation to the Mental Health Professionals Network. Brisbane, 2017.

Ward W, Mulvey B, Adam B. Inpatient Management of People with Eating Disorders (Workshop) Centre for Eating and Dieting Disorders. Sydney, 2017.

Ward W, Scholey S. Inpatient management of eating disorders (workshop). Australian and New Zealand Academy of Eating Disorders Autumn Workshop Series. Noosa, 2017.

Oct 10, 2017, "World Mental Health Day' - Brothers Reid arrived back at QIMR Berghofer after 2.5 years travelling around the world on motorbikes to raise money for depression. Story featured on Channel 10 News Brisbane, Sky News Australia, The Courier Mail, The Herald Sun, Brisbane Times, News.com.au, ABC Radio Breakfast Show, Radio 4BC Drive program, Westender Magazine and Cosmos Magazine

Dec 10, 2017 "Australian researchers have embarked on a study that could detect Alzheimer's disease" – Story featured on Channel 9 National Nine News in Perth, Melbourne, Sydney, Adelaide, Brisbane and NBN Lismore, Central Coast Gosford, Newcastle, Coffs Harbour, Tamworth, Gold Coast, and 9News.com.au. Story ran on a Sunday night which is the biggest TV news night of the week and reached an audience of more than 1.6 million viewers.



Metro North Mental Health provides specialist assessment and treatment services for people of all ages experiencing problems with mental health and/or substance use. Integrated community and inpatient services are provided through three area based services: Inner North Brisbane, The Prince Charles Hospital, and Redcliffe Caboolture Mental Health Services.

Queensland
Government