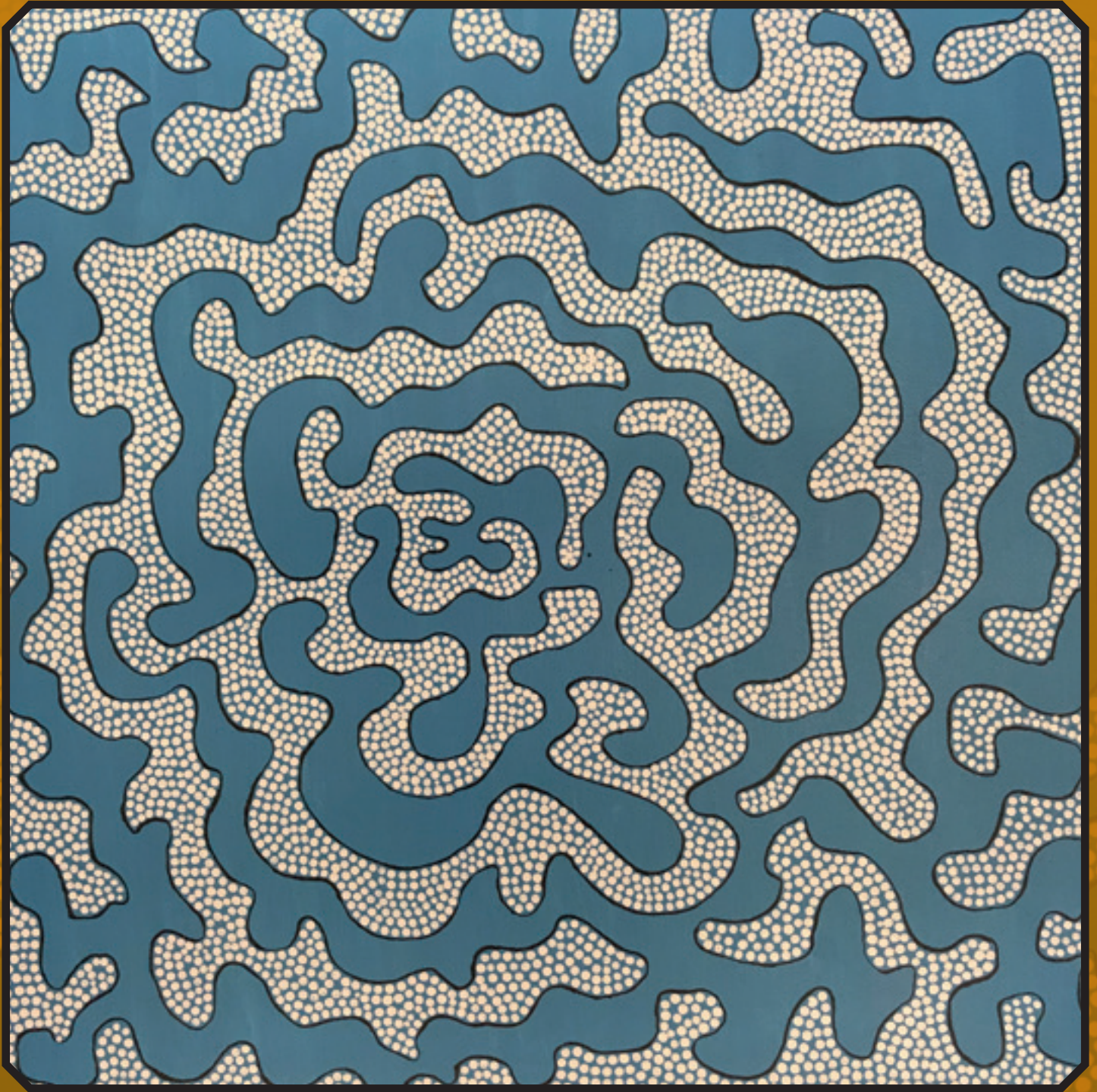


METRO NORTH MENTAL HEALTH RESEARCH DIGEST

2018



Queensland
Government

Cover images by **'Connection to Country' by Gordon Glenbar**

Gordon Glenbar is an Aboriginal man originally from Cherbourg. He has previously been employed with Corrective Services and Child Safety, and is now working as the Indigenous Mental Health Worker at Redcliffe & Caboolture Hospitals. In this role, Gordon provides cultural support and advocacy to Aboriginal and Torres Strait Islander consumers, their families and the mental health treating teams. Gordon believes that art is a way of connecting with culture, self-expression and assisting with Aboriginal and Torres Strait Islander people's mental health recovery.

Speaking of 'Connection to Country' Gordon says, *"My innermost thoughts and feelings when I completed the piece was: How I am connected to the land and people and how culture connects us all. The 3 colours used signifies simpleness, togetherness and happiness."*



**Queensland
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Interpreter Services Statement



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Foreword

As Executive Director of one of the largest mental health services in Australia, I am acutely aware of the interdependence of research and practice. With ever increasing demands on services, continually improving how we do business is an economic and ethical imperative. As evidenced by the research and related activity documented in this review, Metro North Mental Health staff are leading, and actively working to ensure we continually generate and use the evidence needed to improve services and outcomes.

It is an honour to oversee a service committed to full integration of research and clinical practice, and to share in the rewards of ongoing investment in infrastructure and people. Metro North Mental Health continues to support conjoint academic appointments, employ dedicated researchers, support clinicians to engage in post-graduate study and to promote access to a range of educational and training opportunities. The work presented in this report demonstrates strong growth in research capability and interest and the strength of our partnerships within the HHS and with a range of academic and non-government partners.

Staff across disciplines and service lines are working collaboratively to design and conduct research and support translation of evidence to practice. As you will see the work undertaken by, and in collaboration with MNMH is world class and wide ranging. Research spans multiple spectrums –ranging from basic discovery science through interventional clinical studies, to health services and policy research. Diverse methodologies are used to develop and refine understandings of the ‘cosmically complex’ mind and the systems within which people live, seek treatment and recover from mental illness. Some studies are funded by prestigious grants, others conducted with limited project grants and many, are conducted by dedicated clinicians who go the extra mile to integrate research in practice, with in-kind support of the service. The work is united in seeking to generate the

evidence needed to prevent mental illness and improve mental health across the lifespan. Within such a context highlights are difficult to identify but I take this opportunity to acknowledge two projects which have already had real world impact on – internationally and locally.

Work led by Associate Professor/ Consultant Psychiatrist James Scott’s team at the Faculty of Medicine University of Queensland examining the causes, correlates and experience of bullying has enabled bullying in schools to be recognised as a risk factor for disease by the Global Burden of Disease 2017 Study (GBD 2017). The Youth Mental Health research team, led by James conducted the analyses necessary to show that bullying in schools was causative of depression and anxiety in adolescents and adults. Bullying is only the third psychosocial risk factor to be recognised by GBD 2017, the other two being childhood sexual abuse and intimate partner violence.

GBD 2017 is enormously influential for the development of public health policies around the world. The inclusion of bullying in GBD 2017 will ensure that governments globally will be taking steps to fund and implement effective interventions that reduce bullying in schools, thereby preventing cases of anxiety and depression in the population.

A study into the work lives and wellbeing of non-clinical staff working within MNMH completed in 2017 has underpinned development and implementation of a service improvement plan at RedCab Mental Health. With support from the Executive, Jordan Duncan has worked closely with stakeholders to develop various initiatives which are collectively designed to create enabling, inclusive work environments, improve workforce health and encourage professional development.

I take this opportunity to welcome Associate Professor James Scott to the role of Director of Research for



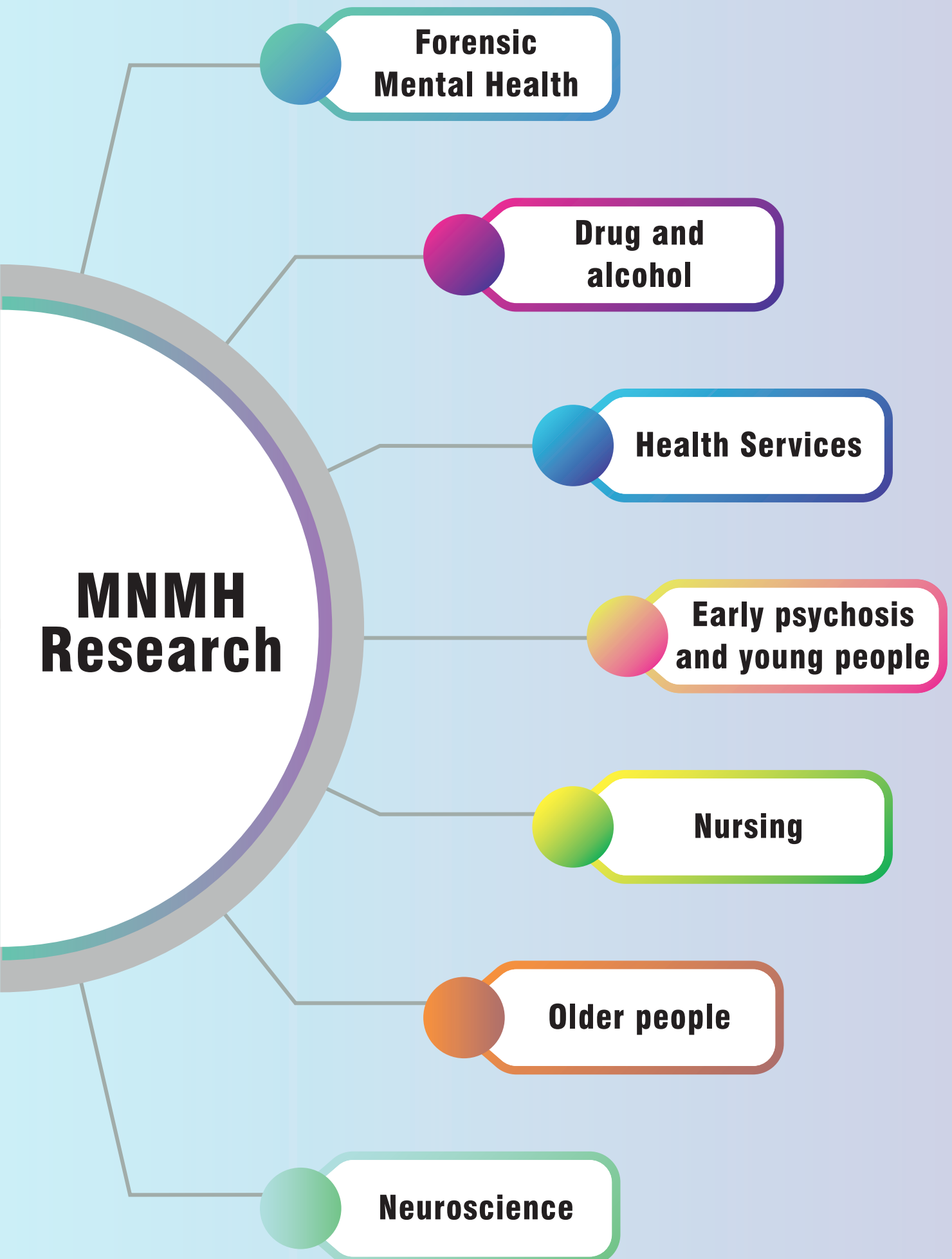
Prof Brett Emmerson AM
(Executive Director MNMH)

Metro North Mental Health. James is recognised internationally for his clinical and research expertise and leadership. Having worked in the service for 9 years, he has a thorough understanding of the complexities and needs of a tertiary mental health service. James will work with service researchers and collaborators within and beyond the service to enhance our reputation as a service committed to integrating research and practice.

I also take this opportunity to extend sincere thanks to Professor Michael Breakspear who, after 10 years at QIMR / Metro North Mental Health, has departed to Newcastle. The service has benefited greatly from his leadership, strong commitment to helping develop our research program and clinical and research expertise. On behalf of MNMH, I wish Michael and his family every success.

I commend this review to you, encourage you to with us to follow up on anything of interest to you. We welcome any feedback and ideas for development of research. With sincere thanks to all who contribute in so many ways to improving the lives of people affected by mental illness and promoting mental health.

Professor Brett Emmerson AM
Executive Director, Metro North Mental Health



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).

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, Strathpine, 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: 186 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.

2018 AT A GLANCE



A note from the Principal Research Fellow-Mental Health

Welcome to the Metro North Mental Health 'Research Digest' for 2018. I am very pleased to have had the opportunity again this year, to work with researchers and clinicians to represent their work, to give you a sense of the breadth and depth of research and related activities being undertaken in the service. The impressive summary of dissemination activities at the back of the review reflects the growing enthusiasm for robust evaluation of practice and development of research capabilities across the service. Now in my eighth year as Principal Research Fellow I have been delighted to watch research flourish across the service. I am privileged to work with clinicians, non-clinical staff, managers and directors within the service and collaborators from various agencies to support research designed to improve services and outcomes for people living with mental illness. You will see, as you scan the review, that the work covers the spectrum from the microscopic to society – from cutting edge

neuroscience to global studies of the burden of disease. Given the productivity and diversity of work it is impossible to represent it all here – The Digest is best considered a 'sample bag' of work from across various arms of the service and research themes.

To all who have contributed to this Review and make time to read it, I say THANK YOU.

Special thanks to Kellie Evans who has carefully collected and curated the submissions and gone above and beyond to photograph sometimes reluctant contributors!

Enjoy and please get in touch if you'd like to learn more about any of the stories in the Digest, have ideas for research or would like to participate in any way.

Kind regards Sue

Open Invitation

If you have any questions and would like more information about any of the research reported here, or would like to get involved in research, we would love to hear from you.

*Please feel free to contact me on
susan.patterson@health.qld.gov.au*

Inaugural Metro North Mental Health Research Forum

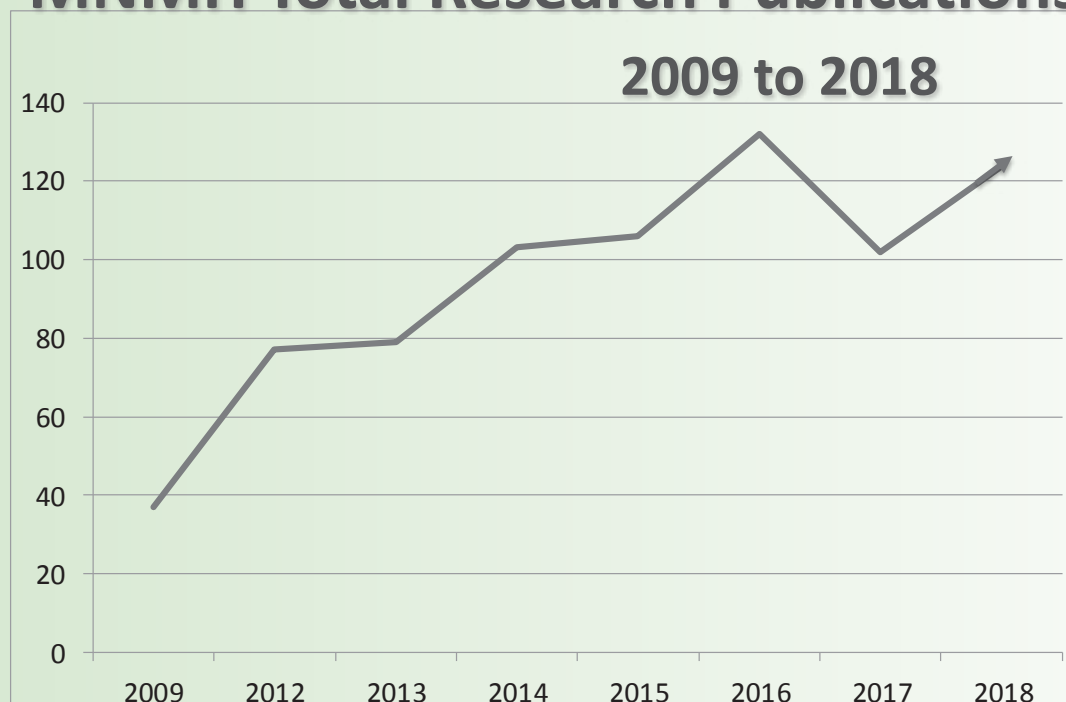
DEVELOPING A SHARED VISION FOR RESEARCH WITHIN MNMH

As demonstrated by publication figures (see graph), the numbers of conference presentations, and enrolment in higher degrees, research has flourished in MNMH over recent years. 2018 was a year to take stock, to think critically about the types and direction of research within the service and consider resourcing of research. To develop a shared vision for research within MNMH, the Executive Director convened a stakeholder forum.

MNMH Service directors, researchers and clinicians were joined by senior research staff from across the HHS at the inaugural MNMH Research Forum held in March 2018. At the forum, convened to inform planning for research in the service in coming years. The 46 participants joined in a range of activities designed to explore the questions below:



MNMH Total Research Publications



- Where are we and where to from here?
- What does research look like from your perspective/in your service or team?
- What works well and what could be improved?
- How would you like it to look in 5 years?
- What's needed to enable that? (money is not the answer)

Discussion generated insight regarding research priorities, constraints on research, factors enabling research currently and potentially in the future. The participants agreed that the substantial growth in research in recent years reflected high levels of motivation and increasing capabilities of staff and teams and that success to date provided a great foundation for further development. Discussion is summarised below.

Summary points:

Research priorities: translation of evidence to practice; implementation science; models of care; evaluation of practice and (quality improvement) initiatives, outcomes of service delivery including patient experience:

- Research should be co-designed and multidisciplinary.
- Research 'loop' should be closed – translate findings of research conducted in/supported by MNMH into practice locally.

Constraints on research: resources (time and funding) and capability, opportunities, communication gaps, geography and service structure (multiple sites) - red tape, bureaucracy/signing & multiple chained approvals process – especially when multi-institutional:

- Uncertainty about research resourcing and targeting (I do not have enough exposure or perspective on the research resources available; not clear what we have and how that can assist staff interested in starting evaluation/research).
- For research to flourish need to foster a culture of innovation, critical thinking and being open to doing things differently.

Enablers: shared commitment to improving services and patient outcomes, engagement with consumers, establish training, scholarships and mentoring programs, create dedicated clinical/research positions, dedicated/protected time (x4) built into job descriptions, establish research infrastructure and partnerships with universities:

- Access to research is limited – 'elite' few – inequitable distribution of resources.
- Research regarded as core business and essential to improving services and efficiency but limited access to resources leads to questions re organisational commitment to rhetoric.
- Personal investment of individuals is necessary but not sufficient, the system needs to have appropriate support in place to enable staff to successfully undertake research.

Opportunities –build on success

- Build links with current and potential partners including universities and philanthropic organisations (e.g. RBWH foundation).
- Enhanced use of SARAS (link with clinical and research priorities).
- Engage registrars needing to do scholarly projects (and other student workforce).
- Develop a research agenda aligned with clinical and service development priorities (to ensure optimal allocation of resources).
- Ensure consistency with other national and local strategic and operational plans.
- Integrate research and practice – **research what you do and do what you research.**
- Development of consumer/carer engagement processes.
- Draw on skills and expertise within the service – develop mentoring program.
- Optimise use of service data – facilitate access.
- Development of hybrid model: organic curiosity based AND targeted research based on national and metro north strategic priorities.
- Establish staff scholarship and internal grants programs to encourage research and enable staff to have offline.

Research should be front and centre to drive efficiencies and value

Nursing Research

Mental health nursing is about compassion and care and our practice acknowledges the recovery journey for the consumer. Of critical importance to maintaining professionalism and providing the personalised care nursing is known for are critical reflection on practice, support for colleagues and new graduates and interdisciplinary collaboration.

Metro North Mental Health Nursing is committed to integration of research and evaluation with practice. Reflecting this, MNMH was strongly represented at the 2018 Australian College of Mental Health Nursing conference in Cairns with staff sharing work in several posters and presentations. This year Amanda Petrie, from Redcliffe-Caboolture Mental Health, with support from specialist nursing staff at RBWH, presented findings of her study into the clinician's perspective of Acute Management Plans for advanced nursing care. Congratulations to Helen Cartwright who was awarded the 2018 Paul Spurr prize for best clinical supervision presentation. Her presentation described three year's work with Peter Turrell examining the challenges of supervision for new nursing graduates as they grapple with articulating their clinical experiences, navigating the complexities of such a large organisation and culture, while moving forward with their professional development and education. Michelle Baker and Lorna Cave presented their ongoing, valuable work in clinical facilitation and supporting graduate mental health nurses in practice at The Prince Charles Hospital. We are also conducting a prevalence study to screen for sleep disordered breathing in a study in collaboration with physicians from the thoracic department at TPCH. Nomsa Wilkinson, Nurse Unit Manager of the Psychiatric Emergency Centre (PEC) at RBWH presented her work in a poster describing implementation of the Broset Violence Checklist. Use of this tool to predict violence and aggression risk is one of the measures MNMH is employing to address the rising incidence of

occupational violence experienced by health staff across settings. We congratulate Nomsa on graduation this year with a Nurse Practitioner Masters degree from Flinders University and recognition of her excellent performance in a letter of commendation from the University Chancellor. MNMH Nurse Educators Kylie Hall, Kobie Hatch and Janette Newell presented on use of consumer feedback to improve mental health nursing practice. Kylie presented how the team supported over 150 of our nursing staff in educational workshops, where they reflected on real examples of the consumer experience and identified key learnings from their own and organisational perspectives. Mental Health nurses from the RBWH Older Person's Mental Health Service facilitated a one day State-wide Symposium in which delegates, carers and consumers from public and private aged care services and inpatient and community mental health teams across the state presented work and participated in workshops.

Building on positive findings of local research, the Safewards program was rolled out to the inpatient wards at RBWH this year shortly after a nursing research study into implementation of this evidence-based suite of nursing interventions. The most valuable of the Safewards interventions was "Positive Words" where staff are encouraged to say something positive in handover to their colleagues coming on duty

about the people they were caring for and support this with a psychological explanation of observed behaviour. The importance of this work was recognised when the senior nursing leadership team at RBWH who initiated the Safewards program and study received a Quarrie award for consumer-focused nursing practice at RBWH. In particular, Cecelia Hiscox was recognised for her work with leading Safewards in her ward and was awarded the Sir Ian MacFarlane Award for Excellence in Nursing Clinical Practice by the RBWH Foundation. MNMH senior nursing research fellow, Niall Higgins with PhD student Jourdan Laurie have been researching the application of non-touch technology to monitor vital signs in high risk clinical settings to maximise patient safety. The ability to translate evidence-based health technology approaches into mental health nursing practice is important to developing our ongoing ability to deliver consumer care.

We take this opportunity to congratulate Tracey Mackle, Nurse Practitioner from the perinatal mental health service was awarded a prestigious Collaborative Research Grant. The grant will support Tracey and collaborators from QIMR-Berghofer and MNMH to develop and pilot a questionnaire to screen for PTSD in women during the perinatal period. This is an exciting and important project that will enable early detection and targeted intervention to support women, their children and families experiencing trauma related to pregnancy, childbirth and parenting.



CLINICIAN RESEARCHER: NOMSA WILKINSON

We invited Nomsa Wilkinson, Nurse Unit Manager of the Psychiatric Emergency Centre to tell us about her role and research.



Nomsa Wilkinson

Please tell us a bit about your role and work in mental health?

I am the Nurse Unit Manager in the Psychiatric Emergency Centre (PEC). We are the first point of contact for all mental health presentations to the Royal Brisbane and Women's Hospital. We assess patients and determine whether admission to the mental health wards is required. If not, we facilitate their discharge and follow up with community teams. We are an extremely busy team seeing approximately 500 consumers per month.

What role does research play in that?

All our service model and practice are informed by evidence about mental illness and interventions that work. While our primary role is to assess and provide short term management for patients, our service/team are committed to using every opportunity to contribute to the evidence base and implementing new practices that are supported by evidence.

Specifically in relation to my study, we have seen a massive increase in violence and aggression in the work place. Much of this is attributed to increasing amphetamine abuse. Effectively assessing for risk of aggression or violence, and intervening appropriately is one way we can promote safety for patients and staff. So, my research was motivated by real world experience and a need identified by the service.

How did you come to undertake your research?

I have always been interested in research and needed to do a project for my Masters. With the spike in aggressive incidents, it seemed like the perfect opportunity to undertake research on this topic and improve practice at the same time.

How did you select your research topic?

It was timely, achievable and likely to benefit the service and patients. Violence and aggression in health services is a major concern internationally and Queensland Health and Metro North have been doing a lot of work in the area. The Metro North Mental Health Nursing Leadership group were keen to ensure that high quality risk assessments were being consistently undertaken and patients managed appropriately. Implementation of the Broset tool was one way to potentially achieve this.

What did your research involve?

I looked into Implementation of the Broset Violence Checklist – a tool to predict violence and aggression in PEC – what is the evidence? The process involved literature review extensive consultation with Nursing leadership and staff, and Senior Research Fellow Niall Higgins to make sure the processes were clear and outcomes could be evaluated. Once we'd decided the Broset was the tool we wanted to use, implementation involved developing processes that could be integrated with standard practice, to minimise burden on staff.

What challenges did you need to overcome to complete the study?

There's lots of evidence showing how difficult it is to change and introduce new practices in health care. I think there's something like a 17-year gap between finding out that an intervention works and its use in routine practice. Because staff engagement is crucial both to implementation and uptake of a new practice, I worked hard to consult widely with staff involved in deciding which tool to use and how to implement the change but because we have such a large workforce, working different shifts, it was sometimes difficult making times to connect and ensure everyone was on board with the new practice. We used a range of strategies to disseminate information about the practice and prompt use of the tool.

Another research specific challenge was undertaking the literature search – there are so many journals and data bases and different sorts of research. Finding the right literature and then making sense of it was really time consuming and I needed to think differently to the way I do in clinical work. That said, research is really about problem solving and so is clinical practice – identify a problem or question, assess, diagnose, plan, implement and evaluate – it's a cycle.

What advice would you give someone in your position?

If you have a passion for research, you should do it. Put yourself out there, don't be afraid to ask for feedback and if you receive criticism, don't let it put you down. Work smarter and push forward.

Implementing the Brøset Violence Checklist (BVC) a tool to predict violence and aggression in the Psychiatric Emergency Department.

Nomsa Wilkinson, Nathan Dart, Clarel Crutchley

Metro North Mental Health, Royal Brisbane and Women's Hospital

Background

Aggression and violence is common in the health care system, especially in emergency departments and particularly in acute mental health settings. One component of a strategy to minimise the frequency and impact of this behaviour, is conducting a risk assessment of all consumers presenting to the Psychiatric Emergency Centre (PEC).

This approach recognises that not all consumers pose the same risk, whilst also identifying those of high risk of aggressive behaviour. Brøset Violence Checklist (BVC) is a six item checklist which assists in the prediction of imminent violence of psychiatric patients within a 24-hour period. It can be used by all nursing staff and if used appropriately, can assist in reduction of aggressive behaviour.

Brøset Violence Checklist Risk Summary Tool

Patient name: _____ LFN No: _____
Date: ____/____/____ Time: ____:____

	1	2
1. Confused	<input type="checkbox"/>	<input type="checkbox"/>
2. Irritable, easily annoyed or angered	<input type="checkbox"/>	<input type="checkbox"/>
3. Bulimic behaviour	<input type="checkbox"/>	<input type="checkbox"/>
4. Physically threatening	<input type="checkbox"/>	<input type="checkbox"/>
5. Verbally threatening	<input type="checkbox"/>	<input type="checkbox"/>
6. Attacking objects	<input type="checkbox"/>	<input type="checkbox"/>

Observer name: _____ Signature: _____
Designation: _____ Date: _____

Method

We introduced a Brøset based sticker that was placed in all medical charts of each patient that presented to PEC. Information for this assessment was taken from current observations as well as those documented within the previous 24 hours by police or the main Emergency Department. This score was included in handover when a patient was admitted to a ward. Its purpose is to assist with decisions for bed allocation and remind staff for the need for Safewards interventions.

Outcomes

A review of all aggressive incidents within a three month period revealed that the majority were accurately predicted in the PEC presentation. This included those still in the care of PEC staff across different shifts as well as those admitted to the wards. All four mental health wards of the RBWH have now completed training in Safewards, additional documentation has been implemented to combine the Safewards and Brøset into a combined strategy for better safe practice.

AIM

To present evidence of the BVC effectiveness in our clinical setting and summarise the experience of its use.

Conclusion

We found that although staff prediction of incidents was better than previous strategies there is more work to be done to increase the frequency of updating the assessments.



Consumer Involvement in Research

Involvement of people with lived experience of mental illness and/or mental health service use in mainstream mental health research is promoted on two grounds:

- **As a ‘good thing to do’** regardless of any impact on research, or people involved – from the ethical perspective, consumers have a right to involvement; and
- **As a means to an end** – as a way to improve the quality research. The means to the end argument is inherently political in that it involves challenging the traditional biomedical control of knowledge related to mental illness.



Evidence supports the view that incorporation of expertise grounded in lived experience of mental distress and service use with specialist researcher ‘know-how’ (to do research) does increase relevance and acceptability of research.

Evidence also indicates involvement can have positive impacts on the people involved.

Involvement in research has been linked with various benefits including recognition and development of personal strengths and abilities, greater self-awareness, self-respect, self-esteem, and self-confidence, improved quality of life, and increased social inclusion.

While legislation and funding requirements have supported development of robust mechanisms for user involvement in some countries, such as the UK, involvement is not yet robust or consistent in Australia.

As described by Clinical Director Dr Vikas Moudgil though, it’s high on the agenda at MNMH. His views are supported by Lisa Jones, Director of Recovery and Imani Gunasekara, Consumer Consultant with MNMH.

CLINICAL DIRECTOR, DR VIKAS MOUDGIL

It is my pleasure to be contributing to the current Research Report. It is rewarding to see our performance in enhancing research in mental health.

I would like to focus attention to the consumers and carers of our services. In the last few years we have taken significant important steps in dedicating our energies towards the recovery paradigm for our consumers. Peer workforce group has now been embedded in the inpatient services to provide ongoing support to the people needing more support at the front end and there is a plan to expand such input to the community services. We also have an increasing level of participation of consumers and carers consultants in the executive and senior managerial meetings and recruitments, which are assisting our services to be more responsive. We are currently looking forward to designing Metro North Consumer & Carer Partnership Co-Design model which will involve harnessing diverse perspectives and experiences coming together for the benefit of consumers and carers. This is a fascinating new era where we are working in partnership with the people who matter the most for us.

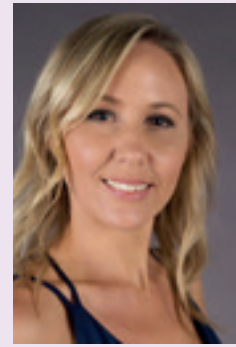


Vikas Moudgil

On that background, I would like to propose that our research activities are shaped by consumers and carers. We have seen some excellent work being generated by our consumer and carer consultants like “how to be a good nurse/doctor” from Imani Gunasekara. We need to harness this engagement and do more to assist us in shaping our services for the better future. I would suggest more topics to be initiated by the consumers and carers groups, which we should aim to accomplish with certain target. We should encourage outstanding agenda items for the consumers and carers in the research committee, enabling us to continue focussing our attention to their perspective. Our trainee registrars should focus their scholarly projects with topics generated from our consumers and carers.

DIRECTOR OF RECOVERY, LISA JONES

Over the past decade consumer and carer engagement within mental health has become increasingly important. In more recent years there has been a clear shift from token involvement because someone has a 'lived experience' to valuing the expertise that consumers and carers can play in research, service improvement and planning. Co-design is the new buzz word on the street and its garnering traction. As we continue to move along the recovery journey we are learning to lean in towards personal recovery and not simply focus on clinical recovery of symptoms. The key principle in co-design is that all voices are heard and considered from the outset ensuring that the consumer and carer voice is an integral part of shaping our future services. Louise Byrne, a lived experience consumer researcher is paving the way both nationally and internationally with her research on lived experience and peer work within mental health services. Her work is increasing the public and academic interest in this area. I believe it is exciting times for consumer and carer engagement in research and I am extremely happy to see the commitment our service has to driving this agenda forward.



Lisa Jones

CONSUMER CONSULTANT, IMANI GUNASEKARA

Imani has been a consumer consultant with Metro North Mental Health for several years. As a consumer consultant she draws on lived experience to engage with consumers, inform service development and promote a recovery focus across the service. Imani has also undertaken several quality improvement activities and research, focusing on understanding what consumers and carers expect of clinicians providing care. Here she shares her views about consumer involvement in research.



Imani Gunasekara

What is the role of lived experience in research?

Lived experience provides a unique perspective on research, focussing on topics that are chosen by the consumer. Research provides opportunities to explore aspects of Recovery that people with mental health challenges understand from personal experience, but which are not yet acknowledged by the mental health system or the world of academia. By doing this, lived experience in research can be a platform that gives voice and credibility to voices that are often ignored or unheard.

How should lived experience shape research?

People with lived experience are able to identify issues that have been deeply meaningful on their Recovery journeys, and that may not occur to an academic/clinician researcher. Consumers can draw upon expertise and insight based on their first-hand experience of the mental health system and their ability to identify with the people for whom the research is intended to benefit. Lived experience researchers ask questions that clinical/academic researchers may not think to ask, and throw light on issues that clinical /academic researchers may not find important.

What are your priorities for research?

I would like to see more quantitative research focussing on whether actively promoting a culture of Recovery within the mental health service correlates with improved outcomes for consumers and for the service.

How could the service promote consumer and carer involvement in and leadership of research?

It is laudable that the service supports consumer leadership in research and there are challenges associated with this. It is important to select consumers who are the "right fit" for research. It is important to address the power differential between the consumer and the academic / clinician researcher. Each consumer is different and will have different strengths and weaknesses, so it is important for the academic / clinician researcher to tailor their collaborative approach to suit the individual.

It is important to create the right environment for consumer research to germinate. This involves:

- *Mutual trust and respect.*
- *Valuing the consumer as an equal participant; sharing ownership, power, control and decision making.*
- *Training the consumer and the academic researcher to work collaboratively.*
- *Remuneration for the consumer.*

- *Making enough time for the consumer and acknowledging that this work may take more time than if it was undertaken by a clinician/academic researcher.*
- *Academic/clinical researchers shift from their role as experts to becoming facilitators, trainers, mentors and supporters.*

How do you use research in your roles?

A recent example was in facilitating Post Seclusion Consumer Debriefing Questionnaire Working Groups with nurses on the inpatient wards and in the community. There were three working groups, each consisting of 15 – 20 nurses. A power point presentation was developed in collaboration with Nurse Unit Manager, Scott Haworth and it referred to five national and international studies focussing on reduction and elimination of seclusion and restrictive practice. Specifically, we chose articles that focussed on the relationship between completion of seclusion debriefs and reduction in events of seclusion and restrictive practice. The articles were used as a springboard for discussion on strategies for increasing the number of seclusion debriefs completed at the RBWH, and potential challenges. The participants were given a package with the relevant journal articles to take home and read.

Any Final thoughts?

Working with consumer researchers may require more time and this may lead to a bigger financial commitment. However, the end product is research which is deeply relevant to the consumer, which works to combat stigma and which empowers people with mental health challenges. Collaborating with consumers enables more ethical research, de-stigmatisation and improved health services and health outcomes. The outcome of lived experience in research is a mental health system that respects and involves the people for whom the research is meant to benefit.

Further reading

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Mental illness and co-morbidity

Severe mental illnesses (SMI) such as schizophrenia, bi-polar affective disorder and major depression, are associated with multiple disadvantage, personal suffering, and social and economic costs.

Enduring illness is often associated with substantial impairment in self-care, social and occupational function and reduced quality of life. People with SMI commonly experience difficulties communicating effectively and have problems with some 'taken for granted' social skills; these difficulties can make it difficult to form

meaningful relationships leading to social withdrawal and/or exclusion. In comparison to the general population people diagnosed with SMI have fewer educational qualifications, are more likely to be unemployed and living in poverty, more likely to be homeless and have increased risk of involvement with the criminal justice system.

People living with SMI are also at risk of a range of 'co-morbidities' – that is, they commonly experience various physical and or mental health problems in conjunction with mental illness. SMI is associated with

increased rates of various chronic diseases and a 20% shortfall in life expectancy. People with SMI are also more likely to have a range of substance use problems and to be homeless. Addressing these inequities is an ethical and economic imperative, posing complex public health challenges. Not least because they are often the only health service with which people with SMI routinely have contact, public mental health services are obliged to provide holistic care, and to work closely with other service providers to ensure health and social care needs are met.

MENTAL ILLNESS AND PHYSICAL HEALTH

Recognizing the complexity involved in expanding the scope of care to encompass physical health, MNMH integrated research into 'Let's Get Physical' service development program established 2011. The research, conducted with academic and community partners, involves a longitudinal mixed-methods, modular study, RCTs of health behaviour interventions and surveys. Collectively studies (i) inform and investigate service development; (ii) translate evidence to practice; (iii) build research capacity.

LGP research has examined practices, experiences and expectations of psychiatrists, psychologists and nurses in relation to metabolic monitoring, management of chronic disease, smoking cessation and holistic care. Consumer focused research has explored lifestyle and health related behaviour and

experiences and expectations of mental health services regarding oral and physical health care. Studies have afforded 100 consumers opportunities to engage in healthy lifestyle programs and contribute to knowledge. Since inception, 22 clinicians and 15 students have collaborated with the core multi-disciplinary research team. LGP research has generated 26 publications, and numerous presentations at local, national and international forums, and grounded sustained community and academic partnerships. Research-based insights have informed development of practice guidelines and interventions promoting consumer engagement in care. Research partnerships have supported collaborative establishment of health promotion programs and physical health clinics within mental health services. Robust research partnerships have supported establishment of GP, dietetics and

oral health clinics within MNMH and roll out of community based physical activity programs. Research capacity has grown as clinicians have been able to develop skills working with experienced researchers to develop and share evidence directly applicable to practice. Substantial grants have been awarded to further work.

Physically Active one way or another is a randomised controlled trial being conducted across Metro North and Metro South health Services. The trial is testing the effect of two interventions – one targeting motivation and the other providing opportunity for activity, one physical activity. Principal investigator Justin Chapman has been working with MNMH for several years now – we asked him about his research career and experiences.

JUSTIN CHAPMAN, QIMR RESEARCH FELLOW

So here we are, another year another dollar. Research is a funny thing... it takes significant investment in terms of organisational resources as well as personal energy, but the potential for research to impact change seems fairly limited most of the time. There are some great examples of new research evidence rapidly changing practice, such as evidence on the link between the HPV virus and cervical cancer leading to a National HPV vaccination program. However, in other areas research translation can be slow for a variety of reasons.

I'm a third-year postdoctoral researcher with QIMR Berghofer, and I work with Metro North Mental Health, Metro South Addictions and Mental Health, and community organisations such as PCYC Queensland. Broadly my research focus is on measuring and positively influencing healthy lifestyle behaviours (physical activity and nutrition) with people with mental illnesses.



Justin Chapman

Research translation in the area of lifestyle interventions for people with mental illness seems to have been very slow, which in some ways seems ironic because of how 'common sense' the treatment is. We've known for a long time that eating healthily and being physically active is beneficial for physical and mental health and wellbeing. The hindrance to implementation seems to be, not the complexity of the underlying neurobiological mechanisms involved in the treatment, but the diversity of influences that can affect intervention effectiveness.

Unfortunately [or fortunately] healthy living isn't available as a pill or injection. The effectiveness of lifestyle interventions can depend on many things, such as the facilitator's skill, the continually changing internal and external influences on participants' lives, the participant-facilitator therapeutic relationship, or the 'feel' of the intervention group and venue which may impact participant attendance. Evidence on intervention effectiveness – from perspectives of both cost and behaviour change – is one of the important components needed to drive translation of evidence into practice in this area.

The main study I'm currently leading is a randomised controlled trial of physical activity interventions for consumers of public mental health services (MNMHS and MSAMHS). Participants of both conditions receive an active group: (1) gym membership and a supervised exercise program delivered by an exercise physiologist; (2) motivational program involving use of fitness trackers for self-monitoring and health coaching. We ask participants to wear accelerometers during the interventions to objectively measure physical activity behaviour change, and we'll compare these measures to evaluate effectiveness. Qualitative interviews are providing insight into what components of the interventions may have helped or hindered and the experience of taking part in a research trial. Data collection is continuing but early indications are encouraging. Participants have told us they valued the opportunity to participate and are finding the interventions helpful.

Gym is something that I've wanted to do for a long time but with my size and that, I just felt a little bit uncomfortable in gyms. I thought if I'm involved in this study – because when I do commit myself to things I do try, to keep it up. So, I thought if I'm part of this research, even when the research finishes I'll be motivated to keep going

To go to a normal gym, it's financially unrealistic so this is great

Originally I wanted to be in the other group because the other group was motivational and I struggle with self-motivation. So, I felt like that would be a good group for me. But I was actually grateful that I was in the gym group because that's what I needed

I loved the idea of being in a group because other people– they're not really holding you accountable but you're doing this with them, the program, so it's really good incentive

I said before that evidence on effectiveness is one of the necessary components to drive research translation. The other component is: actually doing it. There are great examples of local programs and service initiatives that have changed practice primarily because people have decided to change practice. Physical health monitoring and intervention initiatives have had a strong focus over the last 5-10 years at both MNMHS and MSAMHS, as well as community organisations such as PCYC Queensland. The enthusiasm for taking a whole-of-person approach to consumer health and wellbeing only seems to be growing, which fills me with optimism that evidence generated from our RCT of physical activity interventions will one day be used to inform real-world practice.

MENTAL ILLNESS AND SUBSTANCE USE

Mental illness and substance use disorders also commonly co-occur.

Of people with a psychotic illness

36% of men and 17% of women will have an alcohol use disorder.

38% of men and 16% of women will have a drug use or dependence disorder.

In the past 12 months

One in 20 Australians aged 16-85 years experienced a Substance use problem.

48% of females and 34% of males who met criteria for an alcohol use disorder also met criteria for another mental disorder in the previous 12 months.

Such co-morbidity – or dual diagnosis – complicates treatment within a service and because alcohol and drug services and mental health services are separate, people with dual diagnosis commonly have to negotiate and engage with multiple service providers.

MNMH is working with the Alcohol and Drug Service (ADS) to reduce burden on consumers/clients and improve outcomes.

Here we report selected findings from a preliminary report on a quality improvement initiative aiming ultimately to improve integration and continuity of care to improve efficiency, effectiveness and experiences of staff and consumers/clients. (note: while 'consumer' is an accepted descriptor for a person receiving treatment through a mental health services, ADS refer to 'clients')

MENTAL HEALTH SERVICE AND ALCOHOL AND DRUG SERVICE– A QUALITY IMPROVEMENT PROGRAM

MNMH team leaders recognised the challenges facing clinicians managing the complexities associated with dual diagnosis – and agreed to invest in quality improvement initiatives to promote best practice. To ensure initiatives were appropriately targeted and addressed needs clinicians from across the service were involved in the process of design and implementation.

The quality improvement project began with collection of data to inform understanding of the problem. Data were collected through:

- review of MH clinical documentation to assess the extent of co-morbidity and completeness of documentation;
- questionnaire based surveys of mental health multi-disciplinary teams to scope current and potential activities and interventions related management of substance use related problems among consumers;
- literature review to identify models of practice employed to provide services to people with co-occurring mental illness and drug and alcohol issues;
- focus groups with key stakeholders from MNMH, the alcohol and drug service and NGO's providing services to the consumer group. To identify approaches currently used, factors influencing practice, training and skill development needs.

Data demonstrated:

- 25 % of those receiving treatment for a mental health problem at the mental health service had a recorded substance use problem.
- detailed substance use assessments were inconsistently recorded for mental health consumers with dual diagnoses.
- limited liaison between clinicians from mental health and ADS services.
- substantial variability in interventions provided by mental health clinicians. Most commonly recorded were 'motivational interviewing' and/or referral to ADS.

Stakeholders suggested that improvement could be affected by implementing Co-facilitated ADS consultation clinics, providing additional alcohol and drug related training for mental health clinicians and development of shared care models.

Facilitating a more integrated approach to service provision was considered likely to benefit clinicians and improve clinical outcomes for the dual diagnosis client group.

The final project report is due in July 2019 pending revisions inclusive of the progress in the three further smaller quality improvement activities, all currently in progress. A further documentation audit is indicated after introduction of new suite Substance Use assessment documentation. This will allow a more accurate measurement of dual diagnosis presentations and then inform further quality or research activity identifying barriers to dual diagnosis assessment and treatment provision experienced by mental health clinicians.

Dual diagnosis of mental illness and substance use disorder and injury in adults recently released from prison: a prospective cohort study

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Summary

Background People with mental illness and substance use disorder are over-represented in prisons. Injury-related mortality is elevated in people released from prison, and both mental illness and substance use disorder are risk factors for injury. Effective care coordination during the transition between criminal justice and community service providers improves health outcomes for people released from prison. However, the health outcomes and support needs of people with dual diagnosis (co-occurring mental illness and substance use disorder) released from prison are poorly understood. Here we aim to examine the association between dual diagnosis and non-fatal injury in adults released from prison.

Methods Pre-release interview data collected between Aug 1, 2008, and July 31, 2010, from a representative sample of sentenced adults (≥ 18 years) in Queensland, Australia, were linked, retrospectively and prospectively, to person-level, state-wide emergency department and hospital records. We identified dual diagnoses from inpatient, emergency department, and prison medical records. We modelled the association between mental health status and all injury resulting in hospital contact by fitting a multivariate Cox regression, adjusting for sociodemographic, health, and criminogenic covariates, and replacing missing covariate data by multiple imputation.

Findings In 1307 adults released from prison, there were 2056 person-years of follow-up (median 495 days, IQR 163–958). The crude injury rates were 996 (95% CI 893–1112) per 1000 person-years for the dual diagnosis group, 538 (441–657) per 1000 person-years for the mental illness only group, 413 (354–482) per 1000 person-years for the substance use disorder only group, and 275 (247–307) per 1000 person-years for the no mental disorder group. After adjusting for model covariates, the dual diagnosis (adjusted hazard rate ratio 3.27, 95% CI 2.30–4.64; $p < 0.0001$) and mental illness only (1.87, 1.19–2.95; $p = 0.0071$) groups were at increased risk of injury after release from prison compared with the group with no mental health disorders.

Interpretation People released from prison experience high rates of injury compared with the general population. Among people released from prison, dual diagnosis is associated with an increased risk of injury. Contact with the criminal justice system is a key opportunity to prevent subsequent injury morbidity in people with co-occurring mental health disorders. Engagement with integrated psychiatric and addiction treatment delivered without interruption during the transition from prison into the community might prevent the injury-related disparities experienced by this vulnerable group. The development of targeted injury prevention strategies for people with dual diagnosis released from prison is warranted.

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Rates of tobacco smoking among people with mental illness, are exceptionally high. Research demonstrates that as many as 70% of people with psychotic conditions smoke. Causation has long been a concern to researchers. James Scott and his team examined the evidence for a smoking causes schizophrenia hypothesis.

Evidence of a Causal Relationship Between Smoking Tobacco and Schizophrenia Spectrum Disorders

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There has been emerging evidence of an association between tobacco smoking and schizophrenia spectrum disorders (SSD). Two meta-analyses have reported that people who smoke tobacco have an ~2-fold increased risk of incident schizophrenia or psychosis, even after adjusting for confounding factors. This study aimed to critically appraise the research which has examined the association between tobacco smoking and SSD against the Bradford Hill criteria for causality, to determine the strength of the evidence for a causal relationship. Eight longitudinal studies (seven cohort studies and one case control study) were identified which examined tobacco smoking as an exposure and psychosis as an outcome. All seven cohort studies were assessed as being of high quality using the Newcastle-Ottawa Scale. Six of the eight studies found a statistically significant positive association between tobacco smoking and onset of SSD. These studies reported a consistent association with a moderate to large effect size and a dose response relationship. The studies adjusted for multiple potential confounders including age, sex, socioeconomic status, shared genetic risk, prodromal symptoms, and comorbid cannabis and other substance use. The studies did not adjust for exposure to childhood trauma or prenatal tobacco. There was substantial though inconclusive evidence supporting a causal relationship between tobacco smoking and increased risk of SSD. If a causal relationship does exist, nicotine is most likely responsible for this association. This raises serious public health concerns about the increasing use of e-cigarettes and other products, particularly by adolescents whose nicotine use may increase their risk of SSD. Research is urgently needed to examine the association between e-cigarette use and incident psychosis, particularly in adolescents and young adults.



HOMELESSNESS AND MENTAL ILLNESS

- 78% of rough sleepers have a mental health problem.
- Mental illness contributes to homelessness in Australia.
- More than a quarter (27%) of 81,000 people who accessed specialist homelessness services in 2016–17 had a current mental health issue.
- Over half (54%) of these people were also experiencing additional vulnerabilities
 - 3 in 10 clients (30% of 24,300 clients) reported both mental health issues and experiencing domestic and family violence.
 - 14% (or 11,200 clients) were experiencing both mental health issues and drug or alcohol issues.
 - A further 1 in 10 (10% or 7,900 clients) were experiencing all three vulnerabilities; domestic and family violence, drug or alcohol issues and mental health issues.

For more detailed information please see the AIHW Specialist Homelessness Services Annual Report 2017 and AIHW Sleeping Rough Report <https://www.aihw.gov.au/reports/homelessness-services>

HOMELESS HEALTH OUTREACH TEAM

The Homeless Health Outreach Team (HHOT) is attached to the Royal Brisbane Hospital but provide specialist mental health & dual diagnosis, assessment and intervention to people experiencing homelessness across the entire inner city area of Brisbane, spanning both Metro North and Metro South catchments. The team works collaboratively with government & non-government agencies to address the multiple needs of those who are homeless and experiencing a mental illness. The majority of clients supported by HHOT have a Schizophrenia diagnosis complicated by substance use concerns, however the team recognise that there are multiple factors that influence whether somebody becomes and then remains homeless and consider new consumers to their service with this in mind. In a year snapshot from February 2018 – 2019, HHOT received 1154 referrals (related to 817 distinct consumers) and worked ongoing with 255 people who required ongoing follow-up/support.

HHOT uses assertive outreach to engage homeless people experiencing problems with mental health, which in a practical sense means going to where homeless people congregate, wherever that may be. In Brisbane, this spans crisis shelters, backpacker hostels, parks, food vans, squats, and a variety of other areas including in one recent episode, inside a 7-11.

In order to ensure clinician safety, they employ a 2-person worker model as the potential for aggression and threats from both consumers and non-consumers alike is typically quite high.

HHOT's model of service is as elastic as the situations in which they provide it. It typically includes assertive mental health assessment and with subsequent ongoing management and treatment if indicated but it can also involve advocacy and linkage with other supports, family reunification, and any other reasonable intervention that has the potential to improve the life of their consumers. In certain circumstances this can also include use of the Mental Health Act (MHA) 2016 for consumers who are assessed as not having capacity to consent to treatment and short periods of hospitalization to treat acute periods of mental illness.

HHOT work not only with individuals and other agencies, but also at a systemic level to improve care and outcomes for people affected by homelessness. A representation of some of their work was detailed in four papers in the "Mental Health, Disability and Homelessness" edition of Parity (October 2018) published by the Council to Homeless Persons. The magazine examines homelessness from personal, local, social and global perspectives. <https://chp.org.au/parity/>. Excerpts of the papers are reprinted here ...

Emily Meyers is an Occupational Therapist who has worked in mental health across both hospital and community settings and has been based in HHOT for the past 4 years. In ***Breaking the Cycle of Homelessness for People who have Serious Mental Illness*** she described the complicated process of engaging her client Harry* in treatment and management in the context of understanding how an individual's symptoms interact with social conditions and experiences when providing services.

In his 20's Harry began to experience a number of symptoms that interrupted his ability to engage in occupations and relationships. The experiences of hearing voices, disorganisation and concerns for his safety significantly interrupted his ability to function. Harry would misinterpret his surroundings leading to conflict and difficulty communicating with others. Harry became extremely anxious and fearful for his safety, and frequently left accommodation due to concerns regarding safety and persecution. He increased alcohol consumption to manage the distress and anxiety associated with his symptoms, often resulting in a worsening of his condition and some involvement with the Queensland Police Service and the Correctional system.

In Harry's situation the complex interaction between homelessness and mental illness compounded the difficulties of his situation. The symptoms of schizophrenia (e.g., the presence of delusions, hallucinations, odd behaviours and unclear or confused thoughts) and the associated deterioration of

function contributed to his path to homelessness. Once he became homeless he was unable to engage in the occupations and tasks necessary to find and maintain stable accommodation. The treatment for his illness was often interrupted or non-existent leading to decline of his mental health. Before he had contact

with HHOT Harry's engagement with the services that may have been able to support him was minimal. One of the key factors in improving Harry's mental health and ending his cycle of homelessness was slow approach of the HHOT Indigenous Mental Health worker and clinician to build rapport and trust.

Ben Bushing is a Psychologist who has worked both in Australia and the UK and has been based in HHOT for the past 8 years. In **Service responses to homelessness: Jane in the concrete jungle** Ben describes the difficulty in engaging a woman who had been homeless for a long time but initially refused help from HHOT.

Jane had schizophrenia and had been homeless for 3 years. She had also lost her Centrelink pension as she fell further into the grip of her illness a few months after becoming homeless. She just couldn't work out the forms and had lost her phone so one day she just gave up. She existed on the kindness of strangers and told me that some of these strangers expected sexual favours in return. Every day was a grinding struggle to survive, all the while suffering with an untreated severe mental illness which muffled the quick and articulate mind she had relied on before everything went dark. She was polite but forceful in her refusal to talk with us. We didn't see her again for months, despite active outreach and asking at our nightly meetings with Micah Projects if they knew anything about her.*

She appeared again outside the Police Beat in Adelaide Street in Nov 2017. She again refused our help and declined to provide her name but she continued to mutter to herself and she looked thinner and more fearful. It was our assessment that Jane met the criteria to use the MHA 2016 and we admitted her to the Royal Brisbane Hospital with the assistance of QAS and QPS.

Every week saw marked improvement. After a few months she was offered a unit in a Department of Housing complex in the inner north of Brisbane. She got some photo ID and Centrelink started paying her again, although she's still waiting for the DSP. Jane improved so much that we were able to cease her involuntary status under the mental health act and she continued to take medication.



Ben Bushing

Barbara Baumgartner is a Senior Social Worker who has been with HHOT for 6 years and has worked both in hospital and community settings across Australia and Canada. Barbara collaborated with Sharleena Bramley of Salvation Army Pindari Services on **Flexible Housing Support for People with Mental Health Disability**. Pindari is one of the hostels that HHOT attend on a daily (and sometimes multiple times in a day) basis.

Barbara and Sharleena describe a successful and supportive partnership between their respective agencies that has improved outcomes for their clients and has streamlined responses to crises and new referrals given the fundamentally symbiotic nature of their relationship.

Barbara also wrote **Taking it to the Streets: Psychiatric Care by Videoconference for the Homeless**, describing use of secure video teleconferencing to enable delivery of mental health care for homeless people.



Barbara Baumgartner

While HHOT provides weekly medical clinics at inner city crisis accommodation and the team Psychiatrist goes out to see consumers who are unable to attend clinics, having a timely psychiatric review can be challenging and time consuming for the team and frustrating for consumers.

As a means to address challenges, Brisbane HHOT began offering remote Psychiatric reviews by secure video conferencing via a tablet in May 2017. For these appointments, the Psychiatrist remains in his office, and the consumer could be in almost any setting, including: a rehab facility; family member's home; a park; on a sidewalk, in a car; or at crisis accommodation.

The use of tablets by outreach teams not only improves access to information for clinicians, but also reduces the amount of time needed to transport consumers to the clinic for appointments or drive the Psychiatrist long distances to see consumers in their own setting... Consumers have commented that they find it convenient to use, and that it prevents the stress that can arise from a visit to the clinic.

Acknowledging that video conferencing technology will never fully replicate an in-person visit, the increased access to psychiatric review for an underserved population is a positive development.

HHOT has also been working to improve the physical health of consumers. The team, with service-based researchers used mixed methods to evaluate an initiative

designed to ensure people with severe mental illness, who are homeless, had regular metabolic check-ups.

*Names have been changed

Metabolic monitoring of people with severe mental illness who are homeless: A successful quality improvement initiative

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Abstract

Aim: To inform service improvement by describing the process and impact of an initiative designed to enable metabolic monitoring among people with severe mental illness who are homeless and avoid services.

Method: A mixed methods observational study; analysis of quantitative and qualitative data from service documents, clinical records and interviews with service providers enabled a detailed account of the intervention and impact. To enhance transferability analysis was informed by a theoretical model of behaviour change.

Results: Provision of education, training, a portable monitoring kit and environmental restructuring was associated with substantial, sustained improvement in metabolic monitoring, with measures completed for ~90% of patients at six and 12 months post-implementation. Girth and/or BMI indicate risk of metabolic syndrome for most patients.

Clinical Implications: Given opportunity, capable clinicians motivated to improve patient outcomes, can integrate additional practices in routine care. Mobile metabolic monitoring is sensible, effective and acceptable to people who avoid services.

Cardiovascular assessment by HHOT, analysis of Barriers and Enablers using COM-B Model of Behavioural Change.

	Enablers	Barriers
Capability	<p>Advanced knowledge of mental illness and homelessness</p> <p>Advanced skills engaging people who are homeless in mental health treatment</p> <p>Knowledge of performance expectations</p> <p>Knowledge of 'the problem' (esp. increased risk associated with homelessness)</p> <p>Knowledge re access to phlebotomy clinics</p> <p>Competence in completion of procedures within scope of practice</p> <p>Ability to communicate risk and MM with patients</p> <p>Psychological flexibility – ability to extend role and work creatively</p>	<p>Limited knowledge of 'the problem' – cardiovascular risk in people with SMI and increased vulnerability of people who are homeless</p> <p>Inability/lack of skills needed to complete MM</p> <p>Assessments out of scope of practice</p>
Opportunity	<p>Public/political attention to physical health of people with SMI</p> <p>Longstanding commitment to improving physical health care within PMHS External pressure to achieve service KPI around MM</p> <p>External (service wide) recognition of achievement</p> <p>Consistent and coherent leadership – enable focus on goal</p> <p>'Can do', risk tolerant team culture, collaborative ethos</p> <p>Team model case management model; Interdisciplinary approach</p> <p>Team stability, experienced staff who 'know' each other</p> <p>Regular achievement of other KPIs (supports focus)</p> <p>Expectations clear and shared by leaders and clinicians</p> <p>Collective approach - commitment, problem solving, accountability and celebration of success</p> <p>Visibility of MM – prompts, reminders, and regular feedback</p> <p>Integration of MM in routine meetings and practices</p> <p>Provision of portable equipment; enhanced access to phlebotomy services</p> <p>Agreement to sign off MM when all reasonable action taken</p>	<p>Perception within and outside team of HHOS as separate from/different to broad service and other teams within service</p> <p>Team instability MM considered 'out of scope' for HHOS and/or professional/discipline role -</p> <p>Expectations uncertain</p> <p>Attendance at clinic required for MM and phlebotomy</p> <p>Patients' have alternate priorities – may not be concerned about physical health</p> <p>Patients' mistrust of health professionals</p> <p>Brevity of clinical encounters and the need to attend first to immediate safety</p> <p>Absence of dedicated resources - MM considered additional to usual practice</p>
Motivation	<p>Commitment to improving patient outcomes</p> <p>Appreciation that monitoring can improve outcomes – perception of benefit from intervention and risk associated with 'doing nothing'</p> <p>Self-efficacy – confident in conduct of assessments within scope of practice</p> <p>Trust in colleagues' commitment to improving practice</p> <p>Personal investment in quality care</p> <p>Desire to outperform other teams</p>	<p>Focus on/prioritising patient safety, management of psychiatric symptoms, and psychosocial crises</p> <p>Belief that patients will not accept intervention/perceive it as irrelevant or beyond scope for mental health service/clinicians</p> <p>Belief that responsibility rests elsewhere (with other services)</p>

MENTAL HEALTH AND ORAL HEALTH

With clinical and research attention focused on cardiovascular and metabolic health, oral health has been comparatively neglected, despite robust evidence of increased risk, inequitable outcomes and negative consequences of oral disease. People with SMI have higher rates of premature and total tooth loss, decay and filled teeth than the general population. Poor oral health negatively affects self-perceptions, function, quality of life and engagement in social activity, including employment; severe tooth loss is as debilitating as moderate heart failure.

Poor oral health is a complex problem, reflecting and increasing the social and functional disadvantage associated with SMI. As in the general population, poor oral health arises from the interplay of personal, biomedical characteristics, health related behaviours and socio-structural factors. Risk is increased in people with SMI however, by

symptoms and impact of illness, medications and concomitant social disadvantage. Critically, access to appropriate services is reduced. Cost of private services is prohibitive for people living in poverty and long waiting lists restrict access to limited publicly funded services. With stigma and discrimination complicating all these factors, WHO policy acknowledges improving oral health of people with SMI as a high priority and, in Australia people with SMI have been identified as a priority population.

MNMH has been working in partnership with the University of Queensland (UQ) School of Dentistry (SoD) for several years to improve access to oral health services and outcomes for people living with mental illness. The partnership supports inter-organisational education, conduct of research and delivery of activities promoting mental health in students and oral health among patients of INBMHS). A key initiative of the

partnership has been establishment, in 2016, of an oral health screening clinic (OHSC) within INBMHS outpatient departments. Under supervision, students complete basic oral health assessments for patients referred by a treating clinician. When necessary, patients are further referred for free dental treatment at the undergraduate or specialist dental clinics. Appointments are facilitated, in that they are made by mental health clinicians at dedicated clinics such that wait times are minimised. Over two years (2016-2017), 90% of 129 patients screened were referred for treatment; 70% attended at least one treatment appointment.

Here we summarise parts of a comprehensive evaluation of the clinic completed by Nicole Brigg as part of her role as Clinical Program Co-ordinator for Inner North Brisbane Mental Health Service.

CLINICIAN RESEARCHER: NICOLE BRIGG

Nicole is an Occupational Therapist who has worked in mental health for 19 years. She is passionate about enabling vulnerable people to access the support that they need. For the past four years, in her role as Clinical Program Co-ordinator, Nicole has been working to enable attention to physical health within mental health services. More recently she has worked on a project exploring the extent of comorbid substance use and mental health disorders in people attending Metro North drug and alcohol and mental health services. Nicole has also been active in the research field, undertaking interviews for a study looking into the views of consumers about physical health and completing a qualitative study of factors enabling people with complex problems related to mental illness to attend dental appointments. Previous research experience includes; a quantitative evaluation of service user expectations of accessing an acute care team and quantitative research evaluating efficacy of a group therapy program in reducing mental health symptoms completed for honours thesis. Nicole is currently part of a Metro North-Alcohol and Drug Service Trauma Informed Care and Practice Project Team, which is also undertaking project evaluation.



Nicole Brigg

DENTAL SCREENING CLINIC OUTCOMES REPORT 2018

“To be able to bite into an apple is all I want” - consumer feedback 2018

During 2018, in the third consecutive year of operation, the dental screening clinic provided screening and oral hygiene promotion for 58 mental health service users from both acute hospital and community mental health settings. Over 28 weeks from February to September, 26 final year dental students conducted clinics in community settings.

Consumers who were assessed as needing further treatment were referred with consent for a follow up dental examination appointment at the Oral Health Centre, in the undergraduate clinics or Special Needs Dentistry (SND) clinic as indicated. This year all 58 people screened accepted a referral.

Feedback from consumers was very positive. All consumers who completed feedback questionnaires agreed that they felt respected by and trusted the dentist and that the dentist clearly explained what was going to happen. All agreed that information and advice about oral health care was helpful. All but one said they would recommend the clinic to others.

I would absolutely recommend this clinic to others, I was very satisfied with screening and the outcome; they fixed my teeth really good and it was not too long to wait to get the appointment which was important, nothing to improve.

Clinicians also valued the clinic reporting that being able to access oral health care without having to navigate complex systems was helpful for consumers.

Relatively small things like getting to the dentist make a huge difference to people's lives. Dealing with pain and at the same time trying to navigate the system to get that pain addressed, is very difficult for people with SMI. Removing barriers to access makes a huge difference in so many ways.

I referred consumers. It is a great initiative. We should continue it.

The dental clinic program has again provided a tremendous opportunity for consumers to access a world class dental facility with extraordinary care, empathy and flexible service delivery.

Accessibility was a huge positive.

Dentistry Students spoke of increased understanding of mental health problems, development of confidence and skills relevant to working with people with mental illness. Working with people with mental illness had led to reflection on expectations and stigma.

Yes, it gave me a chance to communicate with patients at an environment that was familiar with them, and also brought me out of my comfort zone.

There seems to be a stigma surrounding people with mental illness but the screening gave me more confidence. It allowed me to be aware of the medical conditions and medications that people with mental health issues may have.

I found it interesting that many patients interacted like the general public in everyday situations; seeing this reduces the assumptions and stigma around people with mental health.

Several commented on learning more about the roles of other health professionals and how to work collaboratively.

I learnt about inter-disciplinary relationships as well.

Opportunities for development were also described.

I would have liked more opportunity for inter-professional learning - would have helped enrich the experience.

Evaluation evolves into a Qualitative Research Project :

Over two years (2016-2017) 90% of 129 patients screened were referred for treatment; 70% attended at least one treatment appointment.

While the established clinical pathway with the UQ Department of Dentistry was clearly critical to access we wanted to explore what enabled those seen at screening to attend the follow up appointment. Qualitative methodology was applied in a research project which was completed in 2018 with further plans to publish and present results exploring the enabling factors identified.

Queensland Forensic Mental Health Services

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 2018 has focussed 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
- 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.

PARTNERS IN PREVENTION: UNDERSTANDING & ENHANCING FIRST RESPONSES TO SUICIDE CRISIS SITUATIONS

Partners in Prevention, funded by Queensland Government's Suicide Prevention Health Taskforce, is a research informed implementation focused project coordinated by the Queensland Forensic Mental Health Service in collaboration with Queensland Ambulance Service, Queensland Police Service, Roses in the Ocean, Queensland Centre for Mental Health Research, Primary Health Networks and the community mental health sector. The project aims to develop a comprehensive and holistic evidence base to improve first responses to individuals experiencing suicide crises.

The Partners in Prevention suite of work comprises:

- A unique data linkage study of the demand, characteristics and health services utilization of individuals who experience a suicide crisis to which first responders attend
- A mixed methods study of knowledge, skills, attitudes and confidence of over 200 Queensland Police Service staff in responding to mental health and suicide crises
- A statewide services mapping of collaborative police, ambulance and mental health responses to suicide crisis situations, operating across Queensland
- Literature reviews to assess current evidence on optimal care pathways for individuals experiencing a suicide crisis
- Views of individuals with lived experience of suicide on optimal responses to suicide crisis situations



The centrepiece of Partners in Prevention is a globally unique data linkage study. This study seeks to better understand the demand that suicide crises place on first responders, the characteristics of individuals who make suicide related calls to emergency services, the types of responses that could best serve their needs, the capacity of services to deliver the responses, and how to improve continuity of care following a suicidal crisis that results in a call to police or ambulance emergency services.

Partners in Prevention Steering Group



Partners in Prevention Steering Group representation.



Older Persons Mental Health service (OPMHS)

Led by Professor Gerard Byrne, the OPMHS has strong links with the University of Queensland Academic Discipline of Psychiatry and Centre for Clinical Research, 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 OPMHS has a popular research registrar post. The program of work has focussed on dementia, anxiety and depression in older people. Work spearheaded by Professor Byrne, including development of an instrument for assessing anxiety in older people has been translated into more than 20 languages and is widely 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. As reflected in publications 2018 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.



Prescribing of psychotropic drugs and indicators for use in residential aged care and residents with dementia

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ABSTRACT

Introduction: It is well established that there is a high prescribing rate of psychotropic agents in residential aged care (RAC). The appropriateness of these medications has become controversial, given the limited data on efficacy and growing evidence of associated adverse outcomes.

Objective: To assess psychotropic prescribing in RAC including identification of potentially inappropriate prescriptions (PIPs) and common psychological and behavioral symptoms indicated for prescribing. These were viewed in context of dementia and different RAC facilities.

Methods: Electronic care plans of 779 RAC residents across 12 facilities were examined to elucidate psychotropic prescribing rates, PIPs, and indications for use.

Results: One in two residents (48.1%) were prescribed a psychotropic drug. The primary reasons for prescribing were depression (61.5%), anxiety (26.7%), sleep problems (25.4%), agitation (13.7%), psychosis (11.0%), and other behaviors (7.2%). Residents with dementia (56.6%) were more likely to be prescribed a drug for agitation and psychosis, and had a significantly increased prescription rate for antidepressants (OR = 1.50, 95% CI = 1.08–2.08, $p = 0.01$) and antipsychotics (OR = 1.88, 95% CI = 1.23–2.88, $p < 0.01$). Conversely, residents with dementia were less likely to receive medication to combat sleeping difficulties, with significantly lower benzodiazepine prescribing (OR = 0.63, 95% CI = 0.44–0.91, $p = 0.01$). Over half of all psychotropic prescriptions (54.0%) were potentially inappropriate based on the Beers Criteria. There was high variability of prescribing rates between homes.

Conclusion: There is a high prescribing rate of potentially inappropriate medications. Residents with dementia are more likely to receive medication for agitation and psychosis, and are less likely to receive medication to combat sleeping difficulties.



Depression symptomatology correlates with event-related potentials in Parkinson's disease: An affective priming study

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ABSTRACT

Background: Depression is a predominant non-motor symptom of Parkinson's disease (PD), which is often under recognised and undertreated. To improve identification of depression in PD it is imperative to examine objective brain-related markers. The present study addresses this gap by using electroencephalography (EEG) to evaluate the processing of emotionally valenced words in PD.

Methods: Fifty non-demented PD patients, unmedicated for depression or anxiety, completed an affective priming task while EEG was simultaneously recorded. Prime and target word pairs of negative or neutral valence were presented at a short 250 ms stimulus onset asynchrony. Participants were asked to evaluate the valence of the target word by button press. Depression was measured using an established rating scale. Repeated measures analysis of covariance and correlational analyses were performed to examine whether event-related potentials (ERP) varied as a function of depression scores.

Results: Key ERP findings reveal reduced responses in parietal midline P300, N400 and Late Positive Potential (LPP) difference waves between congruent and incongruent neutral targets in patients with higher depression scores.

Limitations: Comparisons of ERPs were limited by insufficient classification of participants with and without clinical depression. A majority of PD patients who had high depression scores were excluded from the analysis as they were receiving antidepressant and/or anxiolytic medications which could interfere with ERP sensitivity.

Conclusions: The present study suggests that the Pz-P300, N400 and LPP are ERP markers relates to emotional dysfunction in PD. These findings thus advance current knowledge regarding the neurophysiological markers of a common neuropsychiatric deficit in PD.

STEPPING FORWARD: REFLECTIONS ON SCHOLARLY PROJECTS

As part of training psychiatric registrars are required to complete a scholarly project. The RANZCP set out a range of options in relation to the projects – Registrars may elect to complete a quality improvement activity, a literature review or original empirical research – either quantitative or qualitative. Registrars must also find a consultant psychiatrist to supervise the project and negotiate time to undertake project related activities such that clinical and administrative responsibilities are met. All this while facing the challenges of multiple other training requirements and trying to maintain a healthy work-life balance.

These challenges and opportunities are explored in a paper by Faith Ng, a Consultant Psychiatrists at Redcliffe Caboolture and colleagues.

Regular Article

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Stepping forward: challenges and pathways to building a vibrant research culture through the Scholarly Project

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Abstract

Objectives: The Scholarly Project is a relevant task to support building a culture of research in psychiatry across Australia and New Zealand. However, there are several impediments to trainees' confident completion of this project. The authors review recent literature on the challenges voiced by trainees, as well as solutions posed by clinician-researchers and medical educators. Relevant strategies are highlighted, and several practical solutions to support the completion of the Scholarly Project are proposed.

Conclusions: There are several pathways available to alleviate barriers to trainees' timely commencement and completion of the Scholarly Project, including enhancing research capacity within services, familiarity with the requirements, access to supervisors and additional support for trainees.

CLINICIAN RESEARCHER: LUKE PURVEY

Luke Purvey is a psychiatry registrar working at Redcliffe-Caboolture Mental Health Service. We asked him to reflect on his experience selecting a scholarly project and to tell us a bit about his proposed study.

“As much as I have protested to the contrary, I do enjoy research”.

I have found that I can internally generate a multitude of essentially useless hypotheses that Wikipedia can assist in dispensing with. However occasionally I need to produce some research for a more useful cause, in this case, the scholarly project that forms a component of the Fellowship for psychiatry.

As I typically have great enthusiasm for researching abstract or unusual topics in psychiatry, I approached this as an opportunity to delve into the work of doomsday preppers or survivalists. Our Principal Research Fellow however threw me her most devastating line of “so what”, meaning what clinical outcome would come from this. My only answer of, I find these people fascinating, was probably not academic enough to launch into a research project but interest and fascination have to be integral to useful research in my opinion and this eventually led, with some assistance, to the current project.

The selection of the topic has been the most challenging element to the scholarly project but closely followed by trying to make the project as academic and scholarly as possible. As an almost exclusively clinical doctor who has an interest in personality-based disorders and challenges it becomes difficult to make the transition from what is merely interesting to what can become researchable and scholarly. The support of Dr Sue Patterson and Dr George Bruxner is invaluable in trying to corral my natural tendencies to investigating the fringes of psychiatry and personality and satisfy the “so what” element of clinical research.

Ultimately, I have chosen to use mixed methods to study psychiatrists’ views about Voluntary Assisted Dying. As used in legislation recently passed in Victoria and being considered in Queensland, the term Voluntary Assisted Dying (VAD) involves the self-administration of a drug prescribed by a medical doctor, for the purpose of causing death.

Psychiatrists and Voluntary Assisted Dying

People with mental illness who meet all of the requirements to access voluntary assisted dying have the same right to access voluntary assisted dying as other members of the community. However, having a disability or mental illness is not sufficient reason in itself for a person to access voluntary assisted dying.

In practice, Psychiatrists might be involved in consideration of VAD in one of two ways:

First, as specialists working with people experiencing mental disorders commonly associated with substantial distress and disability psychiatrists may be approached by patients seeking to end their lives specifically because living with mental illness and associated complex problems is perceived as intolerable. In these circumstances, legislation is clear in precluding eligibility for VAD specifically in relation to mental illness. The psychiatrist would thus be legally bound to decline to share information or commence any VAD related consultation.

Alternately, psychiatrists may be consulted under provisions of the legislation that require that, when there is reason to question decision making capacity, the co-ordinating medical practitioner refer a person to a registered health practitioner who has appropriate skills and training, such as a psychiatrist in the case of mental illness for assessment. While specifying that capacity to make decisions is assumed unless there is evidence to the contrary, the Victorian legislation notes decision making capacity may be questioned when a person seeking VAD has a current mental illness.

Notwithstanding the right to abstain from involvement, psychiatry as a profession and psychiatrists individually may be cast in ‘gate keeping’ roles assessing capacity of an individual to access VAD.

My study will explore both Psychiatrists’ attitudes toward VAD and approach to assessment of capacity in these circumstances.



Luke Purvey

While medication remains the mainstay of treatment of severe mental illness, most therapeutic guidelines also recommend some form of psychotherapy.

THINKING ABOUT PSYCHOTHERAPY: HOW DOES IT WORK?

The broad term 'psychotherapy' refers to an interpersonal intervention aiming to enable modification of feelings, thoughts, attitudes and/or behaviour. While provision of support, solace and guidance by one human to another through talking is "as old as humanity itself" and much psychiatric care is psychotherapeutic in intent, psychotherapy is distinguished, for the purposes of this discussion by three characteristics:

- Delivery by a trained professional to a person seeking help;
- Self containment - a discrete intervention separable from other components of care; and
- Use of theoretical models of human psychology or psychopathology as a framework.

The "complex mosaic" of interventions sheltered by the 'psychotherapy' umbrella is underpinned or informed by a bewildering array of theoretical models incorporating assumptions about human cognition, emotion and behaviour. Each theory, either explicitly or implicitly, posits causes of problems, pathways to symptom relief or recovery and mechanisms by which certain outcomes may be achieved.

However, links between theory and therapeutic practice and goals may not always be clear. Increasingly

psychotherapies are explained with reference to multiple theories. A range of therapeutic approaches may be applied in pursuit of similar goals, and a given approach may be applied with the intent of achieving various goals in relation to different problems.

While psychotherapy is delivered by professionals, psychotherapy is not an action done to, but a process undertaken with the person(s) receiving care. The practice of (most) psychotherapy involves development and maintenance of an interpersonal therapeutic relationship, the quality of which is consistently associated with outcome. The relationship is thus appropriately understood as both an essential active ingredient and the mechanism through which therapy is delivered.

Each of the therapeutic modalities incorporates multiple strategies and techniques (components) that might be used in combination or separately. Particular components might be 'specific' (unique to the particular modality) or 'non-specific' i.e. the 'common factors' shared with other therapeutic modalities including warmth, attention from the therapist, instillation of hope, feeling supported and the ritual associated with therapy. Components might be deployed in a pre-planned phased manner (e.g. manualised CBT for health anxiety) or in response to therapeutic progress indicating 'readiness' for the next step

(for example moving from reflection to interpretation in psychodynamic approaches or moving from a focus on motivational to action strategies using interventions built on the cycle of change model.

Often cast as a 'journey', the course of therapy will commonly vary in length, and intensity dependent on preference of the patient, therapist and constraints of an external system (for example managed care in the US). Therapy might be adapted over time to fit a changing clinical picture or as various external factors impact on participants and process and context influenced in unpredictable ways by cultural, social and demographic variables. Psychotherapies are thus complex interventions.

Apart from the importance of the therapeutic alliance, the mechanism(s) of action of psychotherapy are generally poorly understood. Because various models of psychotherapy appear to have similar effects (the equivalence paradox or dodo bird effect) and the same intervention can have different effects in different people or over time with the same individual, developing understanding about what works, how and for whom is important to ensuring efficient, safe care.

Researching psychotherapy

A diverse array of research methods

are employed to examine the process and impact of psychotherapies. While quantitative designs such as the randomised controlled trial or observational studies of outcomes can be useful in assessing effect of an intervention, understanding what happens and how therapies achieve (or do not) achieve goals requires a qualitative approach. Different qualitative approaches might be used depending on the aim of the study, the context and resources.

Collaborative (or co-operative) inquiry is a qualitative research methodology involving individual and collective exploration of experiences and critical reflection on action. Drawing on Schon's concept of the reflective practitioner, research is undertaken by not on the people involved—turning, according to Reason, the conventional "researcher-subject relationship on

its head". As described by Reason the inquiry takes place in four iterative phases.

The first phase involves coming together of people who share an experience, for the purpose of examination of an aspect of that experience. During this phase the group agrees ground rules and the process of the inquiry and the research focus and questions to guide the process are developed. Procedures for observation and recording experiences and agreed actions and outcomes are established.

In phases two and three the group applies agreed procedures – undertaking actions and recording process and outcomes – and critically reflects on experiences, planning 'next steps', including further actions as appropriate.

The final phase involves 'wrapping up' when a natural or imposed conclusion is reached. The group develops answers to research questions and prepares findings for dissemination. The approach is unapologetically political, democratic, relational, and experiential. It is also non-prescriptive; specifics of implementation such as duration, methods of data collection, analysis, and representation are the responsibility of inquirers.

Collaborative inquiries have been used in a range of settings internationally to develop understandings of practice and inform service developments. The approach has recently been used by a team located in Metro North Mental Health.

Collaborative Inquiry in a Community Mental Health Team

Clinician Researchers: Amanda Gatti, Wendy Cole, Derek Taylor

RESEARCHING WHAT WE DO

The Assertive Mobile Youth Outreach Service is a very small community-based mental health team that offers intensive, outreach mental health intervention to adolescents for up to two years. One of the challenges we have faced over time is knowing how to assess whether our service is effective in its aims, when we work with young people for such a long time during some formative years. Can we truly say that we have had an active role in facilitating recovery or has it been the outcome of the maturational process that occurs throughout a person's adolescent years?

In considering how to investigate this question further, the team met with Sue who spoke to us about the need to have a shared understanding of what the team does before we can investigate whether we are effective in what we do. Collaborative Inquiry was discussed as one method of working together to develop this shared understanding.

Despite encountering some ambivalence in doing this step of the process, the team did come together several times, with the purpose of engaging in a collaborative inquiry process. For me personally, this process was a fascinating observation into both the beliefs each team member held about their role, their practice and their colleagues; but also into the dynamics at play within the team.

One of the really interesting things that came from this process was the shift in attitude from one of ambivalence to one of valuing the opportunity to step away from everyday work tasks and actually consider what it is that we do and what that is like. Almost, an opportunity to 'think about thinking' about our work. The sessions allowed for the team to consider what each



Amanda Gatti, Wendy Cole (back), Derek Taylor

member needs from the rest of the team to be optimally productive and satisfied in their work and it also highlighted some of the parallel processes at play within the team that are also at play in the families that we work with. The process also allowed for explicit discussion about some of the pitfalls and barriers to the work that we do and also related to the difficulties that a team can face when they are not operating in a cohesive and explicit way.

The Collaborative Inquiry process was a nice fit with the AMYOS model of service, which very much emphasises the importance of effective team functioning as an integral aspect of effective client and stakeholder work. On a personal level, one of the positive things that came from this was the opportunity to truly understand my colleagues' beliefs and positions, rather than making the assumption that their beliefs and

interpretations are the same as my own when it comes to our work.

One of the very exciting things that this process has led to is the very real agenda to evaluate the AMYOS service in a qualitative way, rather than only utilising quantitative methods. The positive experience that the team has had in engaging in a qualitative process, has cemented our commitment to utilising this kind of methodology in our service evaluation efforts. More to come in this regard over the next two years

COGNITIVE BEHAVIOURAL THERAPY FOR PSYCHOSIS (CBTP)

Anthony Bligh, Director of Psychology, MNMH

Psychosis describes the experience of distortions in reality and is associated with a significant impairment in everyday functioning and treatment costs. It is characterised by delusions, hallucinations, and disorganized thinking that impact on a person's ability to communicate and perform the activities of daily life. While the prevalence rate of psychotic disorders is low, it makes up a substantial proportion of the burden of care in mental health services. In addition to the impact on consumers and their family, psychosis places a significant cost upon the community. Annual costs have been estimated to be over \$77,297 per patient in Australia, with lost productivity accounting for \$40,941, health sector costs accounting for \$21,714 and \$14,642 in other sector costs (Neil, Carr, Mihalopoulos, Mackinnon, & Morgan, 2014).



Anthony Bligh

Treatment of Psychotic Disorders

Although anti-psychotic medication has been the mainstay of treatment for individuals with psychosis, many consumers report significant impairment as a result, related to negative experiences from common side effects, which reduces adherence to medication as prescribed (Waterreus et al., 2012). While most report medications provide assistance, an estimated one quarter to one half of those diagnosed with schizophrenia continue to experience medication-resistant and distressing symptoms (Garety, Fowler, & Kuipers, 2000). In addition, as many as 82% will experience a relapse within five years of initial presentation (Robinson et al., 1999). Many individuals who have experienced psychosis are treated in community services and while they may not be acutely psychotic, they often continue to experience residual positive symptoms and on-going psychological problems that necessitate appropriate psychological treatment in order to maintain their engagement with services and avoid further relapses and hospitalisations.

Gaps in the Provision of Services

MNMH adult mental health and early psychosis services have a high number of consumers experiencing psychosis. A recent survey of psychologists in these services identified that only 20% had received training in Cognitive Behaviour Therapy for Psychosis (CBTp) – the psychological intervention that has the strongest evidence base for treatment of psychosis (Taylor & Perera, 2015). Consequently, the expertise and competency of clinicians in working with consumers with psychosis is highly variable. In addition to this, interventions are generally under-represented in activity data in mental health services in Queensland (22% of total service types for adult mental health services; Allied Health Mental Health Leadership Forum, 2017)

Defining the Solution - CBTp

We propose that clinicians working in adult mental health services should have access to practical training in the implementation of CBTp. Currently “core skills” in CBTp training can be accessed through Queensland Centre for Mental Health Learning online. While this module can assist in providing basic foundations of CBTp, it only educates the learner to be “CBTp informed” and does not teach how to implement CBTp. Furthermore, without ongoing supervision for those using CBTp, clinicians fail to develop the confidence and consolidation of skills that enables them to use this approach in their everyday work with consumers with psychosis. Our aim is to provide access to training that will develop competency in using CBTp and to provide ongoing support in the form of peer supervision groups to allow clinicians to continue to enhance their skills.

Why this Solution?

CBT for people with psychosis (CBTp) is recognized as an evidenced based therapy, as an adjunct to pharmacological treatment for residual psychotic symptoms. CBTp has been found to be more effective than other psychosocial therapies for hallucinations, emotional distress and depression, while similarly effective for overall mental state and delusions (Jauhar et al., 2014; Jones, Hacker, Cormac, Meaden, & Irving, 2012; van der Gaag, Valmaggia, & Smit, 2014).

CBTp has received endorsement from mental health consumers in the literature as well as local MNMH consumer representatives, who have recounted the success of CBTp in assisting them to manage psychotic symptom and discussed a range of novel benefits of CBTp including normalization, and appreciation of a more collaborative therapeutic approach than standard treatment approaches (Kilbride et. al., 2013).

CBTp has a growing body of evidence for its effectiveness in the treatment of psychosis in terms of the following:

- Reduction in distress of symptoms and symptoms themselves
- Reduction of relapse
- Improved social functioning
- Increased understanding of symptoms
- Reduction of days in hospital

CBTp has been researched recently within MNMH to demonstrate effectiveness in both individual and group-based approaches (Beames et al., in preparation for publication). This research trial demonstrated the utility of CBTp for MNMH consumers with flexible delivery options including group programs. While the research project provided pilot data on the effectiveness of the approach, the present solution will build on this to provide an ongoing training and supervision program, with opportunities for more wide scale research to build on previous projects.

Provision of training for clinicians in MNHHS in CBTp can also improve the following:

- Standardization of skills in provision of psychological support for consumers with psychosis
- Treatment that is informed by best practice guidelines (i.e. NICE)
- Greater confidence in clinicians' competency in working with consumers with psychosis
- Better therapeutic engagement between consumers and clinicians
- Reductions in medication that can assist in reducing the risk of metabolic syndrome
- Greater resilience and improved coping for consumers with psychosis

MNMH has been very fortunate to have received funding from a SEED grant to develop a training package for clinicians in the provision of CBTp. We are looking forward to working towards the goal of having training accessible by the end of 2018, which will continue into the future with the support of the MNMH educators.

Mental health collaborating in redesign of ICU

Metro North Mental Health is very pleased to be working with the TPC Critical Care Research Group, led by Professor John Fraser, on the ICU of the Future project. Funded by MNHHS, the project involves the collaborative efforts of a team of researchers, builders, architects, clinicians and technological companies; team members will work closely with patients and ICU clinicians in co-design of an ICU bed space. This project is grounded in a holistic approach to the patient's journey through ICU, encompassing mental health and wellbeing. Patient experience and needs are central to the project.

Intensive care units (ICU) provide treatment to critically ill patients whose survival depends on sophisticated technology and expert clinical care. The ICU is a busy, high stimulus environment, operating 24 hours per day. Machines and high technology devices are ever-present, clinicians and ancillary staff perform a range of tasks necessary to operation of the unit and patient survival and communicate with each other, patients and family members who come and go. The 'life and death' circumstances and intensity of care mean emotions are often heightened as staff, families and patients negotiate challenging circumstances. Technological and clinical advances have supported substantial increase in ICU survival rates such that >90% of patients will be discharged to further care or home.

Many patients, however, will have experienced complications during admission, and discharge does not equate to full recovery. Some complications associated with treatment in ICU are potentially preventable. While many ICU patients are discharged after a day or two, many spend weeks, if not months, awake and cognisant in the same bedspace. The environment can have a profound impact on ICU patients.

The available research evidence and reports from patients admitted locally and internationally indicate that the ICU patients' experience is far from optimal, and many survivors experience ongoing physical and psychological impairment sometimes related to experiences during admission. Attention is turning now to the quality of life post survival with prevention of delirium, a common complication of admission recognised as a high priority.

Delirium is a serious disturbance in mental abilities that results in confused thinking and reduced awareness of the environment, affecting up to 80% of ICU patients. ICU-delirium is highly distressing for patients and family members and complicates management. Delirium is associated with increased length of stay and mortality, and prolonged delirium is associated with PTSD and decreased global cognition and executive function scores, increasing risk of long-term mental and physical health problems.

With robust evidence demonstrating that the noisy, bright and busy ICU environment negatively affects patient recovery and increases likelihood of delirium, it is critical that the environment be improved. To date exploration of design and development of the ICU environment has been clinician centric, focused on facilitating provision of care and meeting the needs of clinicians. Scant attention has been paid to impact of the environment on patients and their views and experiences have been neglected in design of units.

With full support of Executive Director Prof Brett Emmerson, Dylan Flaws and Sue Patterson are involved in several interlinked studies which will contribute to development of the ICU of the future. Sue and Dylan are working alongside project manager Oystein Tronstad and others to develop the detailed understanding of the environment

and experiences, expectations and needs of clinicians, patients and their families needed to inform redesign. In combination with measures of environmental measurements such as light, sound, temperature and activity and investigations of patient sleep, the insights of patients will support development of a prototype that will be tested by patients and staff and refined as needed. In parallel, Dylan is working with the Critical Care Research Group to validate a newly developed electronic screening app that will help ICU staff detect delirium in their patients sooner. Timely diagnosis allows for the underlying causes to be identified and treated early, reducing the time the patient's brain is exposed to this harmful condition, and the distress it causes.

Lessons and learnings from this inclusive, participatory project have implications for design and development of mental health units. For further information please contact Sue Patterson.



CLINICIAN RESEARCHER: DYLAN FLAWS

Dylan Flaws received the 'Rising Star' award at the inaugural Metro North Hospital and Health Service Research Excellence Awards in 2016. We caught up with him to ask him about the award and find out what's happened since then.



Dylan Flaws

What did the Rising Star award mean to you?

The research award came at a time where I was transitioning from helping other researchers with their own projects to exploring my own research questions. My PhD was the first project where I felt I had been the lead decision-maker from inception, with my supervisors supporting me.

What impact did it have on you?

Being awarded the Rising Star award felt like a wonderful recognition of this seminal project, and gave me the confidence to continue to establish the road I continue to walk into becoming a clinician-researcher.

You were awarded your PhD in 2017... please tell us a bit about that

As I mentioned before, whilst I had been involved in previous research, my PhD was the first project where I was answering my own questions. I was exploring how we could better measure the risk of patients presenting with chest pain, and how these measures could be integrated into a service-delivery protocol. I also explored which statistical methods produced the most clinically sensible, and externally robust protocol, and validated these in multiple populations in Canada, USA and the UK.

What did you learn over the course of your PhD studies that continues to influence you?

I learned many research skills around how to define, collect, manage and interpret data, as well as how one goes about taking an important result and translating this into practice. I also learned just how rewarding research can be. The optimum protocol designed is now standard practice throughout New Zealand, and has attracted interest in India and USA. Looking at the amount of time that has been saved in New Zealand hospitals alone, this one idea may have allowed more hours of clinical work to occur than I will do by seeing patients in the rest of my clinical career; which is a humbling thought.

What research have you been involved in over the past four years?

Since completing my PhD, I have been primarily involved in applying the skills I learned from my PhD to Delirium. I have been collaborating with Prof. Gerard Byrne and A/Prof Alison Mudge in reviewing how we estimate delirium risk in older inpatients, and how this could inform our prevention strategies. I have also been working with Prof. John Fraser and the Critical Care Research Group to review how we screen for delirium in ICU, as well as how we can modify the ICU environment to reduce delirium risk.

You're nearing the completion of your specialist training in psychiatry – how do you propose melding research and clinical work once you're a consultant?

I aspire to continue working as a clinician-scientist, using my clinical exposure to keep my research directed at real clinical problems being faced, and using my research to inform my clinical practice. I'm particularly interested in further exploring the organic aetiology of psychiatric syndromes, as well as the psychiatric sequelae of physical illness.

What advice would you give a clinician thinking about undertaking a PhD?

First, be brave enough to believe you can do it. I assumed that my idea was small. "If it was that simple, someone would've done it by now". It turns out we all have ideas that can change clinical practice. Second, don't be afraid to commit to a project. It's important to be interested in the topic, but it doesn't define the rest of your career. I'm going to be a psychiatrist with a PhD in Chest Pain. But my PhD was more about how I answered the question than the question itself, and that is relevant to all areas of psychiatry.

What is your vision for mental health research generally and what role can MNMH, as a specialist clinical service, play in achieving that?

I see research as having tendrils that filter to all parts of our service. Every staff member is involved in research. Whether it be critically reflecting on the latest literature and how it could change how they practise their job, inviting their patients to participate in the research happening in the service, or actively contributing to the creation of new knowledge. All these roles are to be nurtured in a service; whether it be seeing more staff having the confidence to enrol in research higher degrees, or simply feeling confident to apply the outcomes of that research to their daily work.

I know my research is going to reduce my lifetime earnings. It'll be worth it if I make the world better somehow...

You're soon to be a Dad – how will research and 'evidence' inform your parenting?

Truth is, I have no idea! I guess conducting research teaches us to be open minded, and have the humility to admit what we don't know. I'll see what the data shows when it starts coming in from May!

Queensland Eating Disorder Service

The Queensland Eating Disorders Service (QuEDS) provides specialist state-wide consultation, training and treatment services. Consultation services include face-to-face and teleconference services to clinicians in inpatient and community settings, as well as an outpatient assessment and consultation service for GPs at the RBWH. QuEDS also provides training to more than 3000 clinicians per year. Treatment services include a Day Program based at Finney Rd, Indooroopilly, and evidence-based outpatient treatments including CBT-e and SSCM. QuEDS values the expertise of those with lived experience, both consumers and carers, and regularly draws on such expertise for its training of clinicians and development of treatment guidelines. QuEDS regularly engages with service directors throughout the state to assist them in providing better services to people with eating disorders and their families. Satellite eating disorder services ('hubs') have recently been established at the Sunshine Coast and Gold Coast, with a third hub in North Queensland to come on line in 2019. QuEDS' areas of research in 2018 have included service evaluation, evaluation of refeeding protocols, and investigations of novel treatments including intranasal oxytocin and deep brain stimulation. QuEDS has research partnerships with various research institutions including QIMR, QBI, HIRF, the University of Queensland, and the University of Sydney.

CLINICIAN RESEARCHER: REBECCA OLLING

Rebecca Olling is a Social Worker and currently the Team Manager of Treatment at The Queensland Eating Disorder Service (QuEDS). As part of her final subject in her Masters in Mental Health (Family Therapy) she completed an independent mental health research project. Conducted as part of a wider evaluation of the recently introduced Intensive Outpatient Program, Rebecca's research used a qualitative method to explore the patient experience of family involvement in adult eating disorder treatment. Data related to family involvement was extracted from semi-structured interviews exploring the experience of the program and analysed separately. Here Rebecca describes her experiences with research.



Rebecca Olling

I originally trained as a Social Worker and I am now the Team Manager of Treatment at QuEDS. I also facilitate group therapy in the eating disorder day program, see individual patients in our outpatient clinic and co-facilitate the Fostering Recovery program with Eating Disorders Queensland. This group is a skills-based program for those caring for a loved one with an eating disorder, which is based on the work of Professor Janet Treasure.

When training as a Social Worker I didn't have a great deal of exposure to research within my Social Work subjects, however as I was completing a dual degree I chose research subjects as part of the Sociology stream. At QuEDS we regularly collect measures as part of our assessments, however I hadn't been involved in analysing the data collected.

I started my research journey as part of my Masters of Mental Health (Family Therapy). I feel that research plays an important role in the development of health services as it enables the service to examine the treatment offered, the way it's offered, and if it's considered useful to patients.

The most challenging part of beginning my research pathway was the ethics process. However, I was fortunate enough my research question was able to be imbedded in an a larger mixed-model evaluation of the QuEDS Day Program which already had ethics approval. Presenting the result section has surprised me, I had thought there would be a specialised formulated way to present results, however it's just presenting the themes verbatim, and analysing through a specific lens. I've already started to apply what I've learnt through my research in my work with individuals and families.

Overall, I found the process of research eye opening, with many aspects I hadn't considered before. I am extremely thankful to all the participants who participated in my research and to the staff at QuEDS for their support along my journey.

How do Adult Eating Disorder Patients Experience Family Involvement in their Treatment?

Rebecca Olling

Queensland Eating Disorder Service (QuEDS)

Abstract

This article considers family involvement in adult eating disorder treatment. Semi-structured interviews were used to examine how patients experienced family involvement in their treatment. Six participants whom had recently completed an eight-week intensive Day Program participated in this study. Themes were developed using the Framework Model of analysis. Considering the individual and their family through the lens of the family life cycle allows the clinician to view the eating disorder within the context of transition between life cycle stages. Differentiation of self, cut-offs and fusion also need to be considered when working with individuals and their family to ensure a healthy level of connection and separateness. It is suggested that family therapists can work with individuals and their family ensuring secondary tasks as part of transition between FLC stages are accomplished where possible ensuring the whole system continues with minimal interruption as the recovery journey occurs, while also working on taking responsibility for oneself while remaining connected to family. Results indicated that although sometimes challenging when unplanned, family involvement in adult eating disorder treatment is considered desirable and helpful.

Rebecca's research involved qualitative interviews with six patients who had recently completed the Intensive Outpatient Day Program run by QuEDS. Participants were women aged 19 to 46 years, diagnosed with anorexia nervosa (n=5) or bulimia nervosa (n=1). Analysis of interviews demonstrated that family play diverse but significant roles in the lives of adult patients with eating disorders. While some participants shared information with family members and wanted them to 'understand' the condition be involved in their treatment, others preferred to keep family more distanced.

I think my mum has had really good insight about me and my eating disorder, because I shared quite a lot with my mum.

When I first was diagnosed they had no idea, they were just like, 'What is wrong with you? Just eat, just eat normal.' And now they definitely understand, they have a lot more compassion.

....we have chats every now and then and she'll ask me my input, is this helpful, is this not helpful"

Yeah my aunty would always ask me how my day was and what happened which was helpful, I mean I usually didn't want to talk about it....

"Dad has a lot of questions, but I don't give him the chance to ask me.

....sometimes I don't want my family to help me. I don't want to tell them when I'm struggling because when I'm struggling, I don't want to eat.

I don't want to be forced to sit down and for them to be like, 'Oh, I can see you're struggling so I'm going to take control'.

A hopeful and helpful letter

Johanna Dalton – State Wide Coordinator

Training and Education – Queensland Eating Disorder Service (QuEDS)

Metro North - Royal Brisbane and Women's Hospital, Australia

Introduction

This poster addresses the results of a nursing led inpatient group that has been run since 2000 within a Royal Brisbane and Women's Hospital Mental Health Ward.

The National Eating Disorder Collaboration reported in 2012 that Eating Disorders affected nearly 1 million Australians and that approximately 15% of women will experience an Eating Disorder at some point in their life.

Although Eating Disorders are on the rise and there is media focus on celebrities who develop eating disorders, the illnesses remain not well understood (Nizette et. al.2013) and people working or living with Eating Disorders seem frightened of "saying the wrong thing".

Cards/letters common themes:

"I just want to be treated like a normal person"

"A non-judgemental approach is the most useful"

"Do not congratulate me for normal, every day things (e.g. finishing a meal) – this is condescending and abnormal"

"Please know that there is not much that you could say that would trigger or upset me"

"When nurses show me that wonderful, easy-going and beautiful people like them can enjoy their food, it makes me feel hopeful"

"It's nice when nurses acknowledge that we are allowed to feel like crap, that we don't have to be perfect, that everyone has crappy days"

The Group

If you could write a card or letter to nursing staff – future/hypothetic nursing staff, what would you say?

- ♦ What makes a good nurse to you?
- ♦ What helps?
- ♦ What doesn't help?
- ♦ What have been some of the most helpful comments or actions?
- ♦ What have been some of the least helpful comments or actions?
- ♦ Have a discussion as a group. Let the patients describe stories of their treatment experiences – do not let them shame/name/blame particular staff members.

At the end, pen a letter or card to nursing staff. This card may be used to inform undergraduate students and registered nurses within your workplace.

Where to from here?

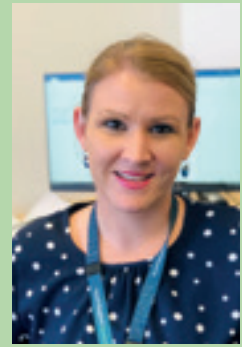
This poster and the current and future "Hopeful and Helpful Letters" will continue to guide undergraduate education with our partnered institutions and services.

We value the voice of the consumers and wish to harness their strength and lived experience in shaping their recovery and the education of our current and future staff.



STUDENT RESEARCHER: KIRRYN CHAMBERLAIN

Kirryn Chamberlain has worked for Queensland Health for more than a decade, in a range of administrative positions. Over the last few years she has also worked with researchers at MNMH voluntarily contributing to a range of research and evaluation activities. We invited Kirryn to tell us about herself and the path she is following to become a clinician researcher.



Kirryn Chamberlain

My name is Kirryn Chamberlain and I am enrolled in a Masters of Psychology. I have a passion for evidence-based practice to treat complex mental health conditions, as well as undertaking high quality research with outcomes to assist those suffering from clinical mental health conditions. I studied my Bachelor of Social Science (Psychology) through Swinburne University and completed my Honours degree at the Queensland University of Technology.

I commenced my psychology journey like most - I thought I knew what psychology was until I studied it. I never knew what the degree 'really' entailed. I commenced my degree with a very idealistic and almost juvenile goal in mind - I was going to 'help people'. I originally did not have a clear idea of how I was going to achieve this but, at the time, I was certain that it would only be through direct patient care. I especially felt blindsided by 4 years of statistics and the competitiveness among my fellow psychology students. I grew, not only as a student, but also as a person. I came to realise that psychology is competitive for a reason, and that is because psychology, 'in the real world', insists on exceptional quality, regardless if it is through direct patient care, research, policy or teaching. I embraced the competitiveness and, while there was a heavy emphasis on grades, my main driver was a thirst for knowledge. It wasn't until after I completed my Bachelor degree that I realised not everything was black and white and that my goal was somewhat under-developed.

I reached out to remarkably talented and dedicated clinicians and researchers within Queensland Health and I was inspired by their enthusiasm and overwhelmed with the possibilities for my career. While I was amazed with the holistic care of an Occupational Therapist and the advocacy of Social Workers, it became clear to me that I wanted to focus on the individual and that my pathway would be psychology. I applied to many psychology honours programmes with much trepidation that I would not receive an offer. This was quickly resolved, as I received an offer to most Universities I applied to. Honours can be summed up in one word – amazing. I learnt so much. I cried, I laughed and I grew. My thesis was the highlight, which involved a qualitative research project on grandparents, which further ignited my passion for quality research. I have nothing but respect and appreciation for the wonderful grandparents I had the pleasure of meeting throughout my project and I feel so grateful to have had such a moving experience with my thesis.

My original goal of 'wanting to help' remains consistent, as does my desire to work with complex mental health conditions. However, I have come to realise that there are multiple ways of achieving this. My passion for quality mental health research continues and I hope to move forward as both a clinician and as a mental health researcher. The next step involves obtaining my Masters in Clinical Psychology which will enable me to gain general registration - surprisingly though, this is not my main motivation. I honestly feel that the way in which I can best contribute to patients' lives, either through research or clinical work, is to have the most knowledge available. I am under no illusions; I know my road remains competitive and that Master's represents another challenge. I am remaining open to any opportunities that the future brings, and I hope to continue to grow my knowledge and experience and to ultimately achieve my goal to help those who are suffering from complex mental health conditions.

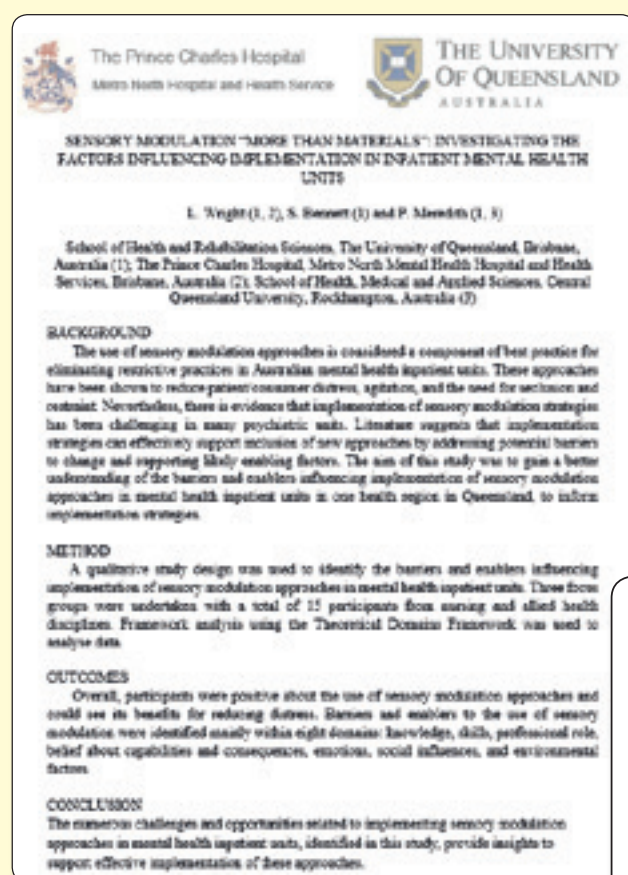
CLINICIAN RESEARCHER: LISA WRIGHT

Lisa is an Occupational Therapist who works as a clinical educator with Metro North Mental Health, based at The Prince Charles Hospital. She is undertaking research, designed to improve implementation of sensory modulation approaches in inpatient units as part of her PhD studies. Her work involves three linked studies, the first of which was completed during 2018. Lisa presented her studies at two major conferences. Lisa says

Conducting my first research project was both challenging and exciting. The process of applying for Ethics and Site Approval was daunting but was certainly made easier by the Ethics and Governance officers being so helpful. Analysing the qualitative data was fantasising and it gave me an in-depth understanding of the challenges faced in the clinical setting. My research journey has certainly been made easier by the support from the TPCF Foundation, The Common Ground through the New Researcher Grant. I look forward to continuing my research journey.



Lisa Wright



Educating mental health staff in sensory approaches using an e-learning package: a 3-month follow-up

Pamela Meredith, Sarah Hutchens, Lachlan Kerley, Michelle Taylor, Maddy Slattery

Abstract

Background/Aims: Emerging evidence suggests that people with mental illness report improved emotional regulation through the use of sensory approaches; however, incorporating sensory approaches into clinical practice requires training. While use of a sensory approaches e-learning training package has revealed short-term improvements in staff knowledge, confidence and attitudes towards sensory approaches, the preservation of these changes over time has not been investigated.

Methods: A multi-method longitudinal survey design was used. Data were collected pre-, post- and 3-months after participants completed a sensory approaches e-learning package. Surveys included multiple-choice questions, a Knowledge, Confidence and Attitudes Scale, and questions regarding the implementation of sensory approaches.

Findings: Three months following course completion, participant scores on knowledge (actual and perceived), confidence and attitudes about sensory approaches had decreased slightly from scores immediately after training; however, perceived knowledge and confidence remained significantly higher than pre-training. Most participants reported that they were implementing more sensory approaches 3 months after completion of the package. Key barriers to the implementation of sensory approaches were staff roles and time/resources.

Conclusions: This study revealed sustained improvements in clinician confidence and knowledge following completion of the package and identified factors influencing implementation. Findings highlight the need for continued educational support and workplace changes to increase the inclusion of sensory approaches in clinical practice.

Key words: ■ e-learning ■ Mental health ■ Sensory approaches ■ Training

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Do dependent codeine users need lower doses of buprenorphine maintenance?

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²The University of Queensland, Brisbane, Australia

Metro North Hospital and Health Service – Police services Unit

Background & Aims

In Australia on 1st Feb 2018 combination analgesics containing codeine (CACC) ceased to be available from pharmacists, becoming prescription-only, as a result of harms from their over use^{1,2}. Existing Medication Assisted Treatment for Opioid Dependence (MATOD) guidelines for the management of illicit opioid dependence with buprenorphine³ suggest most clients require a maintenance dose of 8 to 24mg³. Queensland public services target 40% MATOD retention rate at 12 months³. This study reviewed the appropriateness of these guidelines in the management of codeine dependent clients, focusing on demographics and buprenorphine requirement.

Methods:

This study presents a retrospective clinical audit of clients presenting with primary codeine dependence to two city MATOD clinics. As a pilot, case managers at clinic A identified active clients receiving MATOD with a history of codeine dependence, regardless of presentation date. To obtain a more representative sample at clinic B, a database search identified all clients presenting with codeine dependence between 1/1/16 and 30/6/18 for either MATOD or withdrawal management. Paper based charts were reviewed and demographics & treatment data were extracted by two clinicians, independently. This study was approved as a quality improvement project by the local human research ethics committee.

Flow of participants - Clinic A

Open MATOD clients at clinic A with codeine dependence
N = 40

Clients excluded (N = 16)
* 6 duplicated in Clinic B dataset
* 3 treated with methadone
* 5 already on buprenorphine
* 2 codeine not primary substance

Included in Analysis
N = 24
All maintenance MATOD

Flow of participants - Clinic B

Clients presenting to clinic B 1/1/16 to 30/6/18 with codeine dependence
N = 95

Clients excluded (N = 17)
* 1 abstinent
* 1 already on methadone
* 7 already on buprenorphine
* 8 codeine not primary substance

Included in Analysis
N = 78

Separate presentations included in both withdrawal and MATOD
N = 4

Withdrawal Only
N = 18

Maintenance MATOD only
N = 56

Table 1	Clinic B withdrawal	Clinic B maintenance MATOD	Clinic A maintenance MATOD
	N (%) or Mean \pm SD	N (%) or Mean \pm SD	N (%) or Mean \pm SD
Number of participants	22	60	24
Age (years)	37 \pm 8.9	37 \pm 11	37 \pm 8.8
Male : Female : Transgender	13(59%) : 9(41%) : -	31(52%) : 27(45%) : 2(3%)	7(29%) : 17(71%) : -
Employed	10 (45%)	24 (40%)	12 (50%)
Unemployed	4 (18%)	15 (25%)	6 (25%)
Pension	5 (23%)	19 (32%)	6 (25%)
Student	3 (14%)	2 (3%)	-
Pain previous	4 (18%)	17 (28%)	2 (8%)
Pain current	5 (23%)	24 (40%)	15 (63%)
NSAID/Paracetamol complications	4 (18%)	12 (20%)	7 (29%)
Mental health history	18 (82%)	54 (90%)	22 (92%)
Current Anti-depressant	13 (59%)	38 (63%)	20 (83%)
Previous MATOD hx	9 (41%)	19 (32%)	2 (8%)
Current other opioid	1 (5%)	14 (23%)	2 (8%)
Previous other opioid	4 (18%)	11 (18%)	6 (25%)
Tobacco Use Disorder	12 (55%)	36 (60%)	17 (71%)
Alcohol Use Disorder	7 (32%)	14 (23%)	7 (29%)
Amphetamine Use Disorder	3 (14%)	6 (10%)	3 (13%)
Cannabis Use Disorder	9 (41%)	12 (20%)	9 (38%)
Hx of IV drug use	1 (5%)	7 (12%)	3 (13%)
Childhood trauma	4 (18%)	23 (38%)	11 (46%)

Figure 1: Relationship between codeine & buprenorphine doses

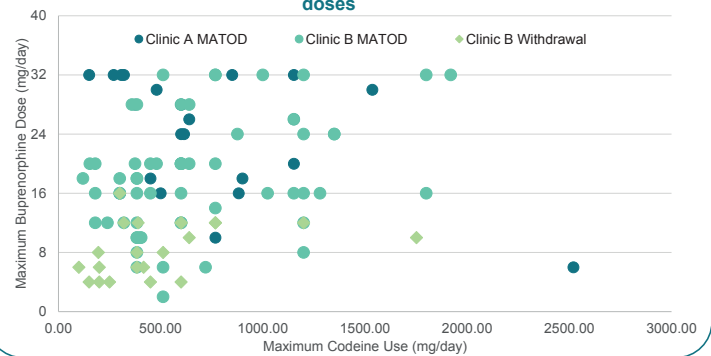


Table 2	Clinic B withdrawal	Clinic B maintenance MATOD	Clinic A maintenance MATOD
	N (%) or Mean \pm SD	N (%) or Mean \pm SD	N (%) or Mean \pm SD
Codeine use (mg/day)	508 \pm 377	679 \pm 435	726 \pm 516
Codeine use duration (years)	2.4 \pm 3.1	4.3 \pm 3.6	5.8 \pm 6.5
MATOD duration	7.0 \pm 3.7 (days)	1.0 \pm 0.7 (years)	5.2 \pm 3.3 (years)
Stabilised* buprenorphine (mg)	-	15 \pm 7.5	16 \pm 7.3
Maximum buprenorphine (mg)	8.6 \pm 3.6	18 \pm 7.8	24 \pm 7.7
Current buprenorphine (mg)	-	17 \pm 9.2	19 \pm 8.6
MATOD \geq 1 year duration	-	28 (47%)	22 (92%)

Results

There were 106 treatment episodes where 102 codeine dependent clients were commenced on buprenorphine. The mean codeine doses, maximum and current buprenorphine doses at both clinics were recorded (Table 2). There was no significant relationship between the stated dose of codeine at presentation and the maximum dose of buprenorphine required during either withdrawal or maintenance MATOD (Figure 1). Clients seeking withdrawal management typically had a shorter duration of codeine use and a lower mean dose of codeine than clients requiring maintenance treatment.

At 12 months, 49% of clients in clinic B were still engaged in MATOD, exceeding the 40% retention goal set by the 2018 Queensland MATOD clinical guidelines. Contrary to expectation, the frequency of new clients presenting with codeine dependence decreased after February 1st 2018, with perhaps a spike at the end of 2017 (Figure 2).

Figure 2: Clinic B New opioid registrations per quarter

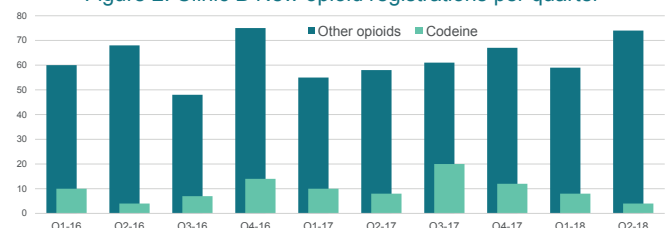
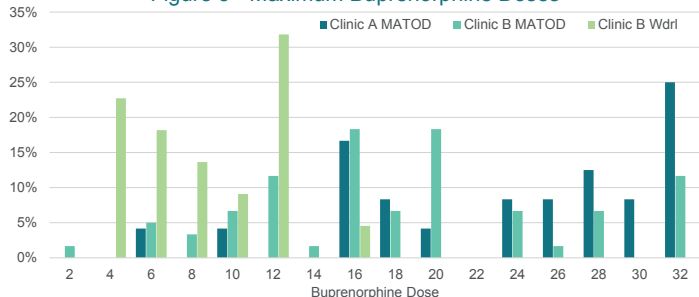


Figure 3 - Maximum Buprenorphine Doses



Discussions and Conclusions:

This study highlights the complexity found in this group of codeine dependent clients; with high rates of childhood trauma, depression, chronic pain and polysubstance use. Buprenorphine requirements were similar to those expected of illicit opioid users (Figure 3). Thus, the characterisation of codeine as a "weak" opioid, implying the need for lower doses of opioid substitution medication, is inaccurate. Dose estimation is difficult, with codeine dose at presentation a poor indicator of buprenorphine requirement. In part this may reflect the pharmacokinetics of codeine; with rates of codeine conversion to morphine dependent on CYP2D6 activity. Surprisingly, presentations related to codeine significantly decreased after CACC rescheduling to prescription medication only.

Implications for Practice:

Service guidelines should be adapted to accommodate the wide MATOD dose ranges that may be required by clients presenting with primary codeine dependence. Doses of buprenorphine required in those presenting with codeine dependence appear similar to those presenting with illicit opioid dependence^{4,5}. Retention remains an issue and Alcohol and Drug services must strive to address the needs of the broad spectrum of clients with opioid dependence.

Notes: *Buprenorphine is used throughout for brevity but refers to both buprenorphine-mono and buprenorphine/naloxone combination products. *Stabilised buprenorphine is the dose when transitioned from daily dosing in clinic to community pharmacy dosing. **Acknowledgements:** The authors would like to thank Deb Caspersen, Jason Dalla Lana and David Mines for their assistance in conducting the audit.

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A higher-energy refeeding protocol does not increase adverse outcomes in adults with eating disorders

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Introduction

Patients with eating disorders (EDs) are often considered a high risk population to refeed. For refeeding syndrome (RFS) management, current recommendations advise using 'start low, go slow' refeeding methods (commencing at 4,000kJ/day) in adult patients¹. In contrast, higher energy refeed protocols (commencing at 10,000kJ/day) are considered safe in adolescents, resulting in faster weight gain & shorter lengths of stay²⁻⁴.

The Royal Brisbane Women's Hospital (RBWH) protocols previously consisted of a low energy, oral diet. This was then replaced with a higher energy, nasogastric feeding protocol in September 2013 (see Figure 1).

Methods

This study aimed to compare the incidence of RFS and related outcomes between medically compromised, adult patients with EDs treated using the conservative protocol (C) with those treated with the assertive protocol (A) (6,000kJ). RFS was assessed using the Rio, et al.⁵ criteria: at least one severely low electrolyte and the presence of peripheral oedema and a severe disturbance to organ function.

A retrospective pre-test - post-test study was used to examine differences in prevalence of electrolyte disturbances, hypoglycaemia, oedema, and RFS diagnoses, in patients admitted between 2010 and 2017. Chi-square, t-tests and ANOVAS were used to analyse findings.

2010 to September 2013 Conservative feeding protocol

Commence feed at **4,000kJ**
Increase 2,000kJ every **three to four days**
Goal rate of **10,000kJ**
Oral diet preferred

September 2013 onwards Assertive feeding protocol

Commence feed at **6,000kJ**
Increase 2,000kJ every **two days**
Goal rate of **12,000kJ**
Enteral feeding

Figure 1. Protocol changes at RBWH for medically compromised patients with eating disorders

Results

Eligible participants = 119 (C: n=26, A: n=93).

Descriptors were similar between groups ($p>0.05$):
C: 96%F, 28±9years, 85% with anorexia nervosa vs
A: 97%F, 27±9years, 84% with anorexia nervosa.

✓ Participants refeed using the assertive protocol had lower incidence rates of hypoglycaemia (C: 31% vs A: 35%, $p=0.012$).

⊖ No differences (see Table 2) ($p>0.05$):

- Electrolyte disturbances (C: 65% vs A: 45%),
- Oedema (C: 8% vs A: 5%),
- Diagnosed RFS (C: 4% vs A: 1%),
- Length of stay (18±14 vs 15±10 days),
- Time taken to reach medical stability (7±5 vs 6±5 days), or
- Weight gain in the first week (0.9±2.1kg vs 1.7±1.9kg).

Conclusions

This study demonstrates that a higher energy refeeding protocol is safe to treat medically compromised, adult patients with EDs, with no cases of RFS. Continuous enteral feeds were also associated with fewer episodes of hypoglycaemia.

Table 2. Adverse events experienced by medically treated patients with eating disorders

	Conservative n = 26 n (%)	Assertive n = 93 n (%)	p-value
Minimum of one electrolyte disturbance in the initial 14 days	17 (65)	42 (45)	0.079
Minimum of two electrolyte disturbances in the initial 14 days	5 (19)	17 (18)	1.000
Three electrolyte disturbances in the initial 14 days	2 (8)	3 (3)	0.300
Incidence of severe hypokalaemia (<2.5mmol/L)	2 (8)	1 (1)	0.120
Incidence of severe hypophosphataemia (<0.32mmol/L)	1 (4)	1 (1)	0.391
Incidence of severe hypomagnesaemia (<0.50mmol/L)	0 (0)	0 (0)	-
Incidence of hypoglycaemic events	8 (31)	9 (10)	0.012
Presence of peripheral oedema	2 (8)	6 (7)	0.722
Presence of severe organ disturbance	0 (0)	0 (0)	-
Refeeding syndrome using the Rio et al. ⁵ criteria	0 (0)	0 (0)	-
Refeeding syndrome documented	1 (4)	1 (1)	0.391

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Impact of oral ketamine augmentation on hospital admissions in treatment-resistant depression and PTSD: a retrospective study

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Abstract

Rationale Depressive episodes are the leading cause of mental health-related hospital admissions in Australia, and 44% of those admitted have a previous history of hospitalisations for depression (Admitted patient mental health-related care: (Australian Institute of Health and Welfare Aust Hospital Stat 2011–12, 2013). Despite numerous available antidepressant treatments, many patients do not respond to conventional therapy, having what is called ‘treatment resistance’ (Fava Biol Psychiatry 53:649–659, 2003). In recent years, ketamine has risen to prominence as an effective, rapidly acting antidepressant (Ketamine: a light in the darkness: Paleos and Ross 28–33, 2013). However, customary intravenous (IV) and intramuscular (IM) routes of administration and relapse rates after cessation remain barriers to more widely adopted usage. **Objectives** This study represents the largest retrospective review of patients receiving long-term oral ketamine for treatment-resistant depression and post-traumatic stress disorder (PTSD). Our purpose was to examine the safety and efficacy of oral ketamine therapy in an outpatient setting as measured by changes in hospitalisation for psychiatric episodes. **Methods** Hospital records of 37 patients who received oral ketamine treatment were reviewed to compare the number

and duration of psychiatric hospital admissions before and after treatment. Records were also screened for adverse medical events and changes in ketamine dosage over time.

Results Following treatment, inpatient hospital days were reduced by 70%, and hospital admissions were reduced by 65%. The dose of ketamine patients required was stable over time with no evidence of tolerance building. There were no serious adverse events and no long-term negative effects associated with ketamine.

Conclusions Oral ketamine offers a promising pharmacologic adjunct to depression treatment. It may offer a more approachable alternative to IV or IM ketamine. The results warrant further investigation into the safety and efficacy of oral ketamine for psychiatric treatment.

Dissemination Activities

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71. Roberts JA & **Breakspear M**. Synaptic assays: using biophysical models to infer neuronal dysfunction from non-invasive EEG. *Brain*, (2018) 141(6), 1583-1583.
72. Roberts JA, Gollo LL, Abeyesuriya R ...**Breakspear M**. Metastable brain waves. *Nature Communications*, (2018) 347054.
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82. **Scott JG**, Thomas HJ & Erskine HE. Improving Australia's population mental health: An ounce of prevention is worth a pound of cure. *ANZ Journal of Psychiatry*, (2018) in press.
83. **Scott JG**, Tunbridge M & Stathis S. The Aggressive Child. *Journal of Paediatrics and Child Health*, (2018). 54(10), 1165-1169. doi:10.1111/jpc.14182
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93. Tan WH... **Byrne GJ**, Pachana NA. (2018) Influences on psychological well-being and ill-being in older women. *Australian Psychologist*, 53(3): 203-212.
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96. Turner A, McGrath JJ, Dean OM ... **Scott JG** et al. Protocol and rationale: A 24-week double-blind, randomised, placebo controlled trial of the efficacy of adjunctive *Garcinia mangostana* Linn. (mangosteen) pericarp for schizophrenia. *Clinical Psychopharmacology and Neuroscience*, (2018) <http://www.cpn.or.kr/journal/view.html?uid=887&vmd=Full>
97. Van der Meer J & **Breakspear M**. Neuroscience: Modeling the Brain on Acid. *Current Biology*, (2018) 28(19), R1157-R1160.
98. Walker RM, Keogh SJ, **Higgins NS** et al. Foam dressings for treating pressure ulcers. *International Journal of Nursing Studies Int J of Nursing Studies*, (2018) 87, 140-147.
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100. Young JT, **Heffernan E**, Borschmann R Et al. Dual diagnosis of mental illness and substance use disorder and injury in adults recently released from prison: a prospective cohort study. *The Lancet Public Health*, (2018) 3(5): e237-e248. doi: 10.1016/S2468-2667(18)30052-5
101. Yucel M, Oldenhof E, Serge H **Daglish M** et al. A transdiagnostic dimensional approach towards a neuropsychological assessment for addiction: an international Delphi consensus study. *Addiction*, (2018) e-pub ahead of print doi:10.1111/add.14424
102. Zimmermann J, Perry A, **Breakspear M**. et al. Differentiation of Alzheimer's disease based on local and global parameters in personalized Virtual Brain models. *Neuroimage Clin*, (2018) 19, 240-251.

Books and Chapters:

1. Newman M, Airey C, Blum S, **Scott JG**, Wong R & Gillis D. (2018). Autoimmune Encephalitis: Clinical Features, Pathophysiology and Management in A Minagar (Ed) *Neuroinflammation* (2nd Edition). Elsevier.
2. **O'Sullivan J** & Fitzgibbon C Changing how you feel through your senses – Sensory Modulation Resource Manual. *Sensory Modulation: Brisbane*.
3. **Scott JG**, Hielscher E, & Nurcome B. (2018). Hallucinations. In R.G.R. Levesque (Ed). *Encyclopedia of Adolescence*. Springer International Publishing. https://10.1007/978-3-319-32132-5_374-2
4. **Scott JG** & **Burgher B**. (2018) Psychotic Disorders in *The Encyclopedia of Child and Adolescent Development* Jeremy Jewell (Ed). New York, Wiley (In Press Accepted 20 December)

CONFERENCE PRESENTATIONS – INVITED, ORAL AND POSTER

Invited Speaker:

1. **Davidson F.** Results of the national mental health court liaison services benchmarking project. NHMRC Centre for Research Excellence in Offender Health Annual Symposium. Sydney
2. Erskine H & **Scott JG.** (2018). Outcomes of ADHD and clinical implications. School Nurses Association of NSW 19th Annual Conference, Gold Coast, 13 July 2018
3. **Heffernan E.** Meeting Wider needs in a Mental Health Crisis. Australasian College for Emergency Medicine's (ACEM) first Mental Health in the Emergency Department Summit. Melbourne.
4. **Heffernan E & Meurk C.** Partners in Prevention: Understanding and Enhancing First Responses to Suicidal Crisis Situations. Queensland Mental Health Commission. Brisbane.
5. **Heffernan E & Meurk C.** Partners in Prevention: Understanding and Enhancing First Responses to Suicidal Crisis Situations. Suicide Prevention Taskforce. Brisbane.
6. **Heffernan E & Meurk C.** Partners in Prevention: Understanding and Enhancing First Responses to Suicidal Crisis Situations. Queensland Health Data Linkage Symposium. Brisbane.
7. **Heffernan E.** Meurk, C. Partners in Prevention: Understanding and Enhancing First Responses to Suicidal Crisis Situations. Lived Experience Summit. Brisbane.
8. **Power M.** Recent developments in supporting victims of serious violence in forensic mental health systems, Mental Health Review Tribunal Masterclass, Brisbane. 17 October 2018.
9. **Power M.** International innovations in the use of restorative practice in forensic mental health, State-wide Forensic Psychiatrists Professional Development session, Brisbane, 22 May 2018.
10. **Scott JG.** Does smoking tobacco cause schizophrenia? A review of the evidence. Physical Health and Smoking Cessation Mental Health Clinical Collaborative Forum, Brisbane.
11. **Scott JG.** Managing Psychosis in Youth. Queensland Faculty of Child and Adolescent Psychiatry Conference Brisbane, Australia
12. **Scott JG.** Neuronal antibodies in psychosis: What psychiatrists need to know. Tasmanian Branch of the RANZCP, Hobart, Australia. 19 September 2018.
13. **Scott JG.** Managing ADHD in patients with early psychosis. Diagnostic and clinical challenges. Queensland Early Psychosis Forum, Brisbane.
14. **Scott JG.** Does prescribing stimulant medication for ADHD in children and adolescents cause psychosis? Clinical Insights: ADHD Networks, Brisbane, February 17, 2018.
15. **Scott JG.** Child and adolescent suicides in Queensland: What lessons can we learn? Research in the Rounds: Queensland Family and Child Commission, Brisbane, Aust. 22 February 2018.
16. **Scott JG.** Clinical dilemmas in anti-neuronal antibody positive patients with psychosis. Australian Psychosis Conference, Sydney, Australia. 14-16 September 2018.
17. **Scott JG.** The clinical management of ADHD and psychosis. Australian ADHD Professionals Association 2nd Annual Conference, Sydney, Australia. 28 July 2018
18. **Scott JG.** The prevalence of anti-neuronal antibodies in patients admitted with first episode psychosis and their clinical outcomes. University of Queensland Centre for Clinical Research Seminar, Brisbane, Australia. 18 April 2018
19. **Scott JG.** Atypical antipsychotics and quality of life in people living with schizophrenia. Royal Australian and New Zealand College of Psychiatrist Congress, Auckland, New Zealand. May 13-17, 2018.
20. **Scott JG,** Gillis D, Ryan A, Hargovan H & Blum S. The prevalence of anti-neuronal antibodies in patients admitted with first episode psychosis and their clinical outcomes. Schizophrenia International Research Society, Florence, Italy. 4 April 2018.

Oral Presentations:

1. **Ayres A, Chen R, Mackle T, Bruxner G** & Kothari A. Barriers and facilitators affecting engagement of pregnant women with an Australian perinatal mental health service: a cross-sectional study. The Royal Australian and New Zealand College of Psychiatrists 2018 Congress. Auckland, New Zealand. May 13-17, 2018.
2. **Baker M & Cave L**. Adventures in clinical facilitation: Supporting graduate mental health nurses in practice. ACMHN 44th International Mental Health Nursing Conference, Cairns, Australia, 24-26 October 2018.
3. **Bennet J & Loutitt T**. An Update on Eating Disorders: Evidence, Screening and Treatment. Consultation Liaison Workshop 16th National Consultation Liaison /Perinatal Infant Mental Health Nurses Annual Conference. Brisbane, Australia. June 6, 2018.
4. **Bicker S & Holley S** Thriving in a challenging healthcare landscape: The role of mental health occupational therapy clinical practice collaborative. Occupational Therapy Australia NT-QLD Regional Conference, Surfers Paradise, Australia, 26-27 October 2018.
5. **Bicker S**. Evaluation of the establishment of an occupational therapy assessment clinic in MNMH Occupational Therapy Australia NT-QLD Regional Conference Occupational Therapy Australia NT-QLD Regional Conference, Surfers Paradise, 26-27 October 2018.
6. **Breakspear M**. Neuronal models of dynamic functional connectivity: Linking scales and data modalities" Org Human Brain Mapping (OHBM 2018) Singapore, 17-21 June 2018.
7. **Breakspear M**. Failure to excite the second model! Incomplete cortical phase transitions during active sleep in preterm neonates", Brain Connectivity Workshop (BCW 2018), Stanford University, USA 22-29 June 2018.
8. **Breakspear M**. Brain Dynamics: On Networks, Modes and Waves. Research Centre Translational Neuroscience Seminar, Department of Neurology, Johannes Gutenberg University, Mainz, Germany, September, 2018.
9. **Breakspear M**. Failure to excite the second model! Incomplete cortical phase transitions during active sleep in preterm neonates. Max Planck Institute for Metabolism Research Seminar, Cologne, Germany, September 2018
10. **Breakspear M**. Challenges and opportunities for human brain mapping/neuroimaging research in Australia" 1st Organisation Human Brain Mapping Australian Chapter Symposium, Florey Institute of Neuroscience and Mental Health, Melbourne, 12 October 2018.
11. **Breakspear M**. Metastable brain waves. The 11th Australasian Workshop on Neuro-Engineering and Computational Neuroscience (NeuroEng 2018), University of Sydney, Sydney. 27-29 November 2018.
12. **Breakspear M**. Computational Psychiatry The 38th Annual Scientific Meeting of the Australasian Neuroscience Society, Brisbane. 3-6 December 2018
13. **Bicker S**. Mercier S & Hubbard C A pilot project – Dedicated occupational therapy advanced clinicians delivering personalised sensory interventions on adult inpatient mental health units. Occupational Therapy Australia NT-QLD Regional Conference, Surfers Paradise, Australia, 26-27 October 2018.
14. Black F, Walford K, **Ferris L**, Beer N & **Meurk C**. Understanding Insight: An exploratory study in a forensic psychiatric inpatient setting. WM HHS Research Day Program. Brisbane.
15. **Cartwright H & Turrell P**. Group supervision with graduates: A three year experience. ACMHN 44th International Mental Health Nursing Conference, Cairns, Australia, 24-26 October 2018.
16. **Clugston B, Green B**, Phillips J, Samaraweera Z. Ceron J, **Meurk C & Heffernan E**. Fitness for Police Interview. Forensic Advanced Trainees Lecture Series. Wacol.
17. **Connell M & Scott JG**. Voices and visions in the general population: exploring the influence of appraisals on distress. Australian Psychosis Conference, Sydney, Australia. 14-16 September 2018.
18. **Connell M**. Beyond medication: Supporting people to live with their voices. Queensland Faculty of Child and Adolescent Psychiatry Conference, Brisbane. 8 September 2018.
19. **Daglish MRC**. The Psychiatrist as accidental drug dealer. Australian & New Zealand Association of Psychiatry, Psychology & Law Qld Branch Annual Dinner, Brisbane, May 2018.
20. **Daglish MRC**. Drugs of Abuse and Human Brain. DABIT-CL Connect Conference, Brisbane June 2018.
21. **Daglish MRC**. An addiction psychiatry perspective on prescription opioids. Faculty of Pain Medicine Consultative Forum. Melbourne, June 2018.

22. **Daglish MRC**. Rubin's Vase: treating alcohol and mental health co-morbidity. Lundbeck Institute: Schizophrenia Weekend Seminar. Melbourne, August 2018
23. **Daglish MRC**. Pregabalin & Opioids: Lethal Interaction? Focus on Pain Group, Pain Conference, Brisbane October 2018.
24. **Daglish MRC**. Opioid Replacement Therapy & Pain: Addiction Psychiatry. Medicines Management 2018, 44th SHPA National Conference. Brisbane, Nov 2018
25. **Daglish MRC**. Optimising Treatment. Individior Sponsored Seminar. APSAD Conference, Auckland, New Zealand. 4-7 November 2018.
26. **Dale P**. Indigenous Mental Health Intervention Program. June 2018. Statewide Clinical Networks' Combined Forum.
27. **Dalton J**. Eating Disorders in Acute Care: Empowering Enrolled Nurses. Enrolled Nurses - Acute Care Conference, Brisbane, August 23-24, 2018.
28. **Dalton J**. The diet that triggered an eating disorder? Discussing diet and exercise safely. Linking Diet with Disease AUSMED Conference, Brisbane June 18-19, 2018.
29. **Dalton J**. The National Agenda for Eating Disorders. The Australian College of Mental Health Nurses Queensland Branch Therapy Bytes Workshop, Brisbane July 21, 2018.
30. Dark F, **Scott JG**, Baker A, Parker S, **Gordon A**, Newman, E., Gore-Jones, V., Saha, S., Lim, C. C. W. and Penn, D. (2018). Randomized controlled trial of social cognition interaction training. Royal Australian and New Zealand College of Psychiatrist Congress, Auckland, 15 May 2018.
31. **Davidson F**. Results of the national mental health court liaison services benchmarking project. NHMRC Centre for Research Excellence in Offender Health Annual Symposium. Sydney.
32. **Davidson F, Perrin M**, Clugston, B. National Prison Mental Health Service Benchmarking Report. Prison Mental Health Service State-wide Forum. Brisbane. 21 June 2018.
33. **Duncan S**. Out of the Clinic and Into the Paddock: Equine Psychotherapy. ACMHN's 16th Consultation Liaison Special Interest Group/7th Perinatal and Infant Mental Health Special Interest Group Annual Conference, Brisbane. 7 June 2018
34. **Ferris L, Meurk C, Waterson E, Heffernan E**. Understanding and enhancing first responses to suicide crises. In Ferris (Chair), 'Risk, mental health and social identity: New evidence from the lab to the field', Symposium. Society of Australasian Social Psychologists. Wellington, New Zealand. 5-7 May 2018.
35. **Flaws D**. Reducing the burden of mental health – the role of doctors and research. AAHMS Clinical Sciences Forum: Foundations and Frontiers. Brisbane, 23 August 2018.
36. **Flaws D**. Predicting delirium. Junior Doctor Conference, Brisbane, 24 June 2018.
37. **Fleming C & Doyle C**. Carer Peer Mentor Support for Families Affected by Eating Disorders: establishment of a state-wide program in Queensland. Australia & New Zealand Academy for Eating Disorders Conference: Courageous Conversations: Furthering Understanding Embracing Change. Melbourne, Australia. 3-4 August 2018.
38. **Gardiner G, Bellair R, Hannigan A & Patterson S**. Evaluation of Weight and BMI Data for Queensland Eating Disorder Service (QuEDS). ANZAED Conference. Melbourne, Australia, 3-4 August 2018.
39. **Ghosh S, Bruxner G** & Kothari A. A tale of two teenage pregnancies: Medico-Legal and ethical complexities around termination of pregnancy for under 14 year old women. The Royal Australian and New Zealand College of Psychiatrists 2018 Congress. Auckland, New Zealand. May 13-17, 2018.
40. **Green B**. Treatment pathways among persons found not criminally responsible. 38th Australian and New Zealand Association of Psychiatry, Psychology and Law Annual Congress. Tasmania, Australia. 21-24 November 2018
41. **Hall K, Hatch K & Newell J**. Listening to learn: A unique opportunity to read, reflect and respond. ACMHN 44th International Mental Health Nursing Conference, Cairns, Australia, 24-26 October 2018.
42. **Hatch K & Boyle C**. Skill check your clinical supervision practice. Pre-conference workshop. Australian Clinical Supervision Conference, Melbourne, Australia. 22-24 May 2018.
43. **Hatch K**. Quality or quantity? The Challenges of supporting access to nursing clinical supervision within a large metropolitan mental health service. Australian Clinical Supervision Conference, ANMF House Melbourne Victoria, 22-24 May 2018.
44. **Heffernan E, Bosley E, Meurk C, Ferris L, Waterson E**. et al., Partners in Prevention: Understanding and Enhancing First Responses to Suicide Crises: People, Evidence, Services. Council of Ambulance Authorities Conference. Auckland, New Zealand 6-9 August 2018.

45. **Higgins N, Dart N & Fawcett L.** Implementing Safe Wards: What factors should be considered? 2018 MNHHS Nursing and Midwifery Conference Leadership: A Voice at all Levels, Brisbane.
46. **Hunt J.** Methamphetamine. Advanced practice nursing and vulnerability: a seminar for nurse practitioners and advanced practice nurses. Australian College of Nursing.
47. **Kelman P & Boyle C.** Looking back-moving forward. Australian Clinical Supervision Association Inaugural Conference, Melbourne 22-24 May 2018.
48. Kothari A, **Williams S, Ballard E & Bruxner G.** Prescribing Antidepressants and Anxiolytic Medication To Pregnant Women: The Perception Of Risk Of Foetal Teratogenicity Among Australian Specialists And Trainees. The Royal Australian and New Zealand College of Psychiatrists 2018 Congress. Auckland, New Zealand. May 13-17, 2018.
49. **Louttit T.** Diabetes and Eating Disorders. AUSMED Nurses Conference, Brisbane, May 29, 2018.
50. **Mackle T.** Anti-what? Common psychotropic prescribing practices. Australian College of Nurse Practitioners Prescribing Symposium, Brisbane, Australia. 16 February 2018.
51. **Mackle T.** Anti-what? Common psychotropic prescribing practices. Australian College of Nurse Practitioners Prescribing Symposium Sydney, Australia. 11 May 2018.
52. **Matthews K, Hill J, Jeffrey S, Patterson S, Davis A, Ward W,** Palmer M & Capra S. A higher energy refeeding protocol does not increase adverse outcomes in adult patients with eating disorders. Dietitians Association of Australia. May 2018.
53. **Matthews K, Hill J, Jeffrey S, Patterson S, Davis A, Ward W,** Palmer M, Capra S. Medically compromised, extremely underweight adult patients with eating disorders can be safely refeed using a higher energy feeding protocol. Australia and New Zealand Academy for Eating Disorders National Conference, Melbourne. August 2018.
54. **Meurk C.** Partners in Prevention: Understanding and Enhancing First Responses to Suicide Crisis Situations. Queensland Centre for Mental Health. Wacol. Brisbane. 31 May 2018.
55. **Meurk C, Heffernan E, Ferris L & Waterson E.** Partners in Prevention: Understanding and Enhancing First Responses to Suicidal Crisis Situations. West Moreton HHS Research Day Program. Brisbane. 6 September 2018.
56. **Mitchell M.** Anything is possible: increasing the odds in forensic therapy part 1. 38th Australian and New Zealand Association of Psychiatry, Psychology and Law Annual Congress. Tasmania, Australia. 21-24 November 2018.
57. **Moss K, Meurk C, Steele M & Heffernan E.** The Physical Health, Activity and Self-Identified Barriers to Exercise of Patients with Severe Mental Illness Residing in a Secure Facility. West Moreton HHS Research Day Program. Brisbane. 6 September 2018.
58. **Moudgil V.** Closing the gap for People with Mental Illness. The Royal Australian and New Zealand College of Psychiatrists 2018 Congress. Auckland, New Zealand. May 13-17, 2018.
59. **Moudgil V.** Reproductive and sexual health in women with mental disabilities. The Royal ANZ College of Psychiatrists 2018 Congress, Auckland, NZ, May 13-17, 2018.
60. **Moudgil V,** Nolan-Isles F & Stockwell A. Atlas – Working with Community Mental Health. The Royal ANZ College of Psychiatrists 2018 Congress, Auckland, New Zealand, May 13-17, 2018.
61. **Perera C, Bruxner G & Patterson S.** Use of valproate and carbamazepine in childbearing age women with bipolar affective disorder. Routine practice in a large Australian Public mental health service district. The Royal Australian and New Zealand College of Psychiatrists 2018 Congress. Auckland, New Zealand. May 13-17, 2018.
62. **Perera C, Bruxner G & Patterson S.** Safe and on time: An Audit of Lithium prescribing practices across a major Australian mental health service district. The Royal ANZ College of Psychiatrists 2018 Congress. Auckland, New Zealand. May 13-17, 2018.
63. **Scott JG.** Rational prescribing of antipsychotic medication in young people with early psychosis. Tasmanian Trainees in Psychiatry, Hobart, Australia. 19 September 2018.
64. **Scott JG.** Testing for antineuronal antibodies in patients with psychosis. Statewide Senior Leadership Meeting for the Qld Mental Health, Alcohol and other Drug Services, Brisbane, 13 September 2018.
65. **Scott JG.** A systematic review and critical appraisal of the association between prescribed stimulants for ADHD and risk of psychosis. The Royal Australian and New Zealand College of Psychiatrists 2018 Congress. Auckland, New Zealand. May 13-17, 2018.
66. **Scott JG.** Anti-neuronal antibodies and psychosis: What psychiatrists need to know. Royal ANZ College of Psychiatrist Congress, Auckland, New Zealand. May 13-17, 2018.

67. **Scott JG, Kesby JP**, Thio S & Erskine HE. A systematic review and critical appraisal of the association between pharmacotherapy for ADHD and risk of psychosis. Royal Australian and New Zealand College of Psychiatrist Congress, Auckland, New Zealand. May 13-17,2018.
68. **Scott JG**. The prevalence and treatment outcomes of anti-neuronal antibody positive patients admitted with first episode of psychosis. 14th International Congress of Neuroimmunology, Brisbane. 27-31 August 2018.
69. Suetani S... & **Scott JG**. Longitudinal association between physical activity engagement during adolescence and mental health outcomes in young adults: A 21-year birth cohort study. Royal ANZ College of Psychiatrists Congress, Auckland, New Zealand. May 13-17,2018.
70. Suetani S ... & **Scott JG**. The association between adolescent psychopathology and subsequent physical activity in young adulthood: A 21-year birth cohort study. Royal Australian and New Zealand College of Psychiatrists Congress, Auckland, 17 May 2018.
71. Thomas H, Ahmadabadi Z, Najman J...**Scott JG**. Adolescent bullying victimisation and risk of intimate partner violence in early adulthood: A prospective follow-up study. 23rd World Congress of the International Association for Child and Adolescent Psychiatry and Allied Professionals, Prague. 23-27 July 2018.
72. Thomas H, Erskine H, Santomauro D, Ferrari A, Whiteford A & **Scott JG**. The global prevalence of bullying victimization: A systematic review and meta-analysis. Society for Mental Health Research, Noosa, 29 November 2018.
73. **Waterson E, Heffernan E, Steele M**. et al. Translating Research into Practice: The Indigenous Mental Health Intervention Program. West Moreton HHS Research Day Program. Brisbane. 6 September 2018.
74. **Wells J**. Anything is possible: increasing the odds in forensic therapy part 2. 38th Australian and New Zealand Association of Psychiatry, Psychology and Law Annual Congress. Tasmania, Australia. 21-24 November 2018.
75. White A, **Scott JG**, Thomas H. Chronic physical illness in childhood and adolescence and the association with mental illness. Faculty of Child and Adolescent Psychiatry Conference of the Royal ANZ College of Psychiatrists, Perth, Australia. 17 October 2018.
76. White A, **Scott JG** & Thomas H. Chronic physical illness in childhood and adolescence and the association with mental illness. Royal Australian and New Zealand College of Psychiatrists Congress, Auckland. 17 May 2018.
77. **Williams S, Ballard E, Bruxner G** & Kothari A. Prescribing antidepressants and anxiolytics to pregnant women: the perception of risk of fetal teratogenicity amongst Australian specialists and trainees. RCOG World Congress, March 2018.
78. **Wright L**, Bennett S & Meredith P. Sensory Modulation approaches in mental health care: Investigating the factors influencing implementation in inpatient mental health units. Occupational Therapy Australia NT-QLD Regional Conference, Surfers Paradise, Australia, 26-27 October 2018.
79. **Wright L**, Bennett S & Meredith P. Sensory Modulation More than Materials. Investigating the factors influencing implementation in inpatient mental health units. 12th National Towards Elimination of Restrictive Practice Forum, Hobart, Tasmania. 7-8 November 2018.

Poster Presentations:

1. Carr PJ, **Higgins NS**, Cooke ML, Mihala G & Rickard CM. Vascular access specialist teams for insertion of and prevention of vascular access device failure: A Cochrane Systematic Review. 5th World Congress on Vascular Access, Copenhagen Denmark, June 20-22, 2018.
2. **Daglish MRC**, Reilly S &, Hayllar J. Do Dependent Codeine Users Need Lower Doses of Buprenorphine Maintenance? ASPAD, Auckland, New Zealand. 4-7 November 2018.
3. **Dalton J**. A hopeful and helpful letter. Nursing and Midwifery Leadership Conference, Brisbane.1 March 2018.
4. **Ghosh S**. Tale of Two Pregnancies: Medico-legal and Ethical complexities around Termination of Pregnancy for under 14. RCOG World Congress 2018, Singapore. 21-24 March 2018.
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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.

