METRO NORTH

MENTAL HEALTH RESEARCH DIGEST

2019

Mental Health Matters

Cover image by ***Kat Smirnoff, Kat's Mural Art***.

Kat Smirnoff is a local Brisbane mural artist commissioned by Metro North Mental Health, to paint murals on inpatient wards, as part the refurbishment of these wards. The refurbishment was part of The Development of Sensory Spaces on Adult Inpatient Mental Health Units Project undertaken by Occupational Therapists from RBWH. The cover image depicts the mural Kat painted on the I Ward balcony.

Positive feedback from consumers and clinicians following refurbishment, the more welcoming and therapeutic 'feel' of the balconies with one consumer commenting,

"The murals are amazing, and I enjoyed watching the artist paint them."

Queensland Government

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Interpreter Services Statement

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Foreword

Prof Brett Emmerson AM
(Executive Director MNMH)

Professor James Scott
Research Director MNMH

As Executive Director of one of the largest mental health services in Australia, I oversee interconnected inpatient, community and rehabilitation services providing assessment and treatment to Metro North's diverse population of around 1,000,000 residents. Metro North Mental Health (MNMH) encompasses a substantial drug and alcohol service and is also home to a range of specialist services including; The Perinatal Mental Health Service, Queensland Eating Disorders Service, The Queensland Forensic Mental Health Service and The Queensland Victim Support Service. MNMH has a budget of around 200 million and employs 1200 staff who work across multiple facilities providing care to people of all ages experiencing problems associated with mental illness.

MNMH works closely with a range of community services and government agencies to promote access to a spectrum of care which may be needed by individuals at any time. As a service we are committed to continually improving the process, experience and outcomes of care for consumers, and the health and wellbeing of our staff. To this end, we recognise research as an essential component of the health system and are actively engaged in development and application of robust research evidence in all elements of the service.

Metro North Mental Health has robust partnerships with a range of academic and research institutions, supports conjoint academic appointments, employs dedicated researchers, supports clinicians to engage in post-graduate study and promotes access to a range of educational and training opportunities. The work presented in this publication demonstrates the breadth and depth of the research undertaken by MNMH researchers and clinicians. Research using diverse methodologies as appropriate to the study, ranges from basic science, through studies of clinical interventions and health service delivery to global studies of the prevalence and burden of disease. 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 promote mental health, prevent mental illness, support early diagnosis and intervention and improve mental health across the lifespan. Within such context highlights are difficult to identify but I take this opportunity to acknowledge the extraordinary efforts of clinicians and researchers undertaking world leading work.

Highlights include:

- Impressive representation of the service by clinicians from across disciplines at National and International Conferences
- Award of prestigious NHMRC grants including $810,745 to James Scott and team for 'Identifying and treating patients with psychosis who are positive to anti-neuronal antibodies'
- Publication of the findings from National Health and Medical Research Council funded clinical trials examining nutraceuticals in treatment of major depressive disorder, and kava in treatment of generalised anxiety disorder in older people.

- Publication of an international cross-validation of the Geriatric Anxiety Inventory (GAI). Developed 12 years ago, the GAI is now available in 20 languages and in use globally.
- Award of a collaborative research grant of ~50K to a Metro North Mental Health/ QIMR Berghofer Medical Research Institute, led by Nurse Practitioner of the Perinatal Mental Health Service, Ms Tracey Mackle, to develop and test a screening tool for post-traumatic stress disorder in women during pregnancy and after birth.
- Collaboration of Warren Ward and Queensland Eating Disorder Service in an extensive program of research designed to improve outcomes of people affected by eating disorders. The program is funded by a grant of $3,670,400 by the Medical Research Future Fund.
- Appointment of MNMH Research Director, Professor James Scott, as Head of Mental Health at QIMR Berghofer Medical Research Institute. A key aim of the conjoint appointment is to grow the mutual research interests of the two organisations, providing staff at Metro North Mental Health with access to world leading research staff and facilities.
- Establishment of a nurse-led project to design and implement a model of Trauma Informed Care and Practice.

We are delighted to share the 2019 Metro North Mental Health Digest.

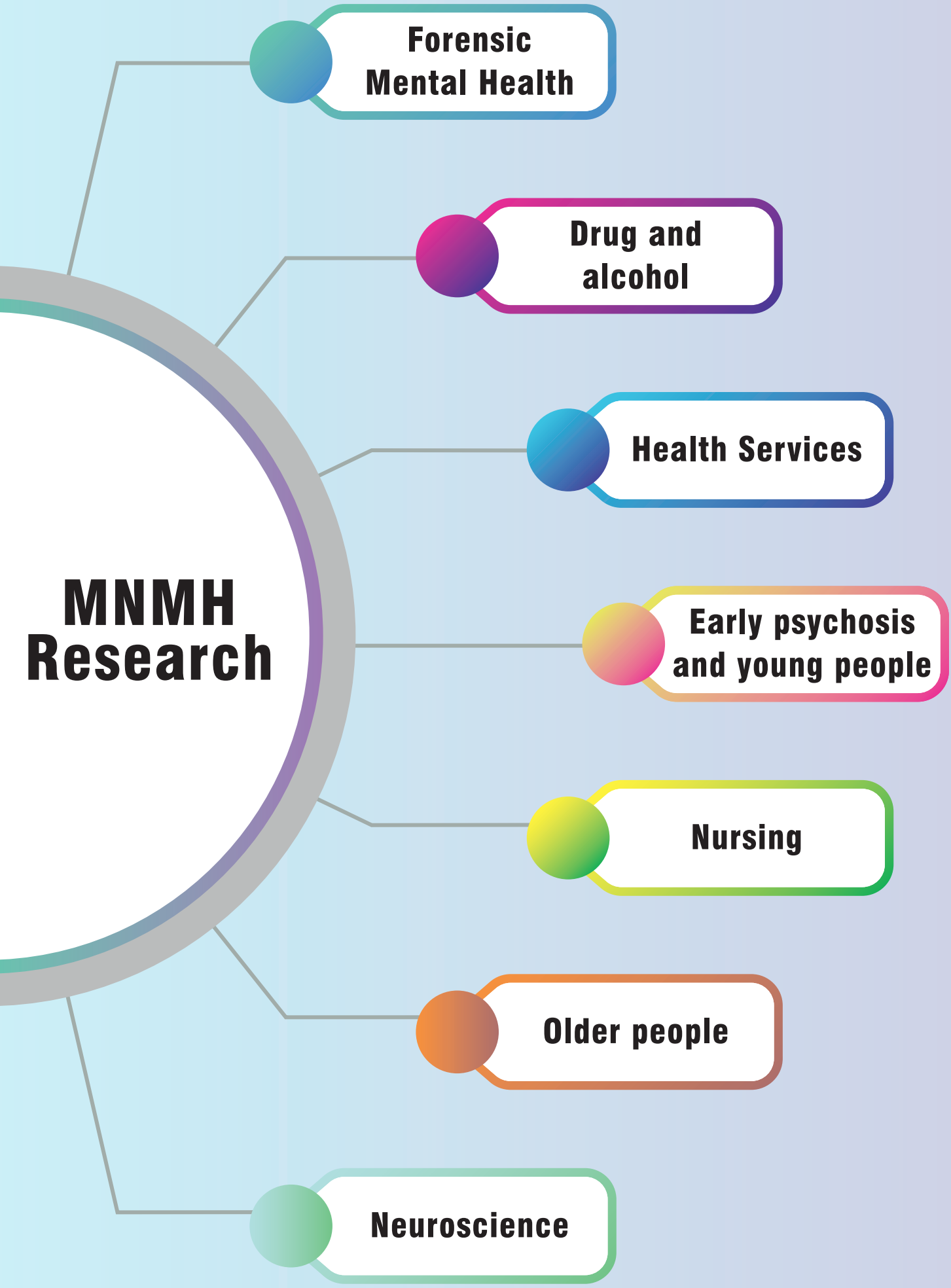
This publication showcases the important research and evaluation activities undertaken by clinicians and researchers working within the service, and with a range of partners. As you will see, the work described spans the spectrum from cutting-edge neuroscience, through clinical trials to evaluation of programs and health services research. While the subjects of interest vary widely, studies are all designed to generate evidence to improve the health care and outcomes of people affected by mental illness. The first-person accounts of researchers and clinicians included in the review highlights the interconnectedness of research and practice and the importance of support from an organisation in enabling their research.

As demonstrated throughout the digest, collaboration among a range of people and organisations is critical to ensuring mental health research is relevant and addresses the needs of different stakeholder groups. We would be delighted to hear from anyone interested in taking part in studies, who has research ideas or would like to explore possibilities for collaborative work. We are always open to developing new partnerships.

Congratulations to everyone involved.

Professor Brett Emmerson AM
Executive Director MNMH

Professor James Scott
Research Director MNMH


MNMH Research
Forensic Mental Health
Drug and alcohol
Health Services
Early psychosis and young people
Nursing
Older people
Neuroscience

Metro North Hospital and Health Service

Metro North Hospital & Health Service (MNHHS) delivers responsive, integrated, and connected care to a local population of over one million people, in an area stretching from the Brisbane River to north of Kilcoy, as well as providing specialty services for patients travelling from throughout Queensland, Northern New South Wales and the Northern Territory. In the 2018-19 financial year, Metro North HHS employed over 19,300 staff, had a budget of over $2.935 billion, and provided over 3.3 million service events.

MNHHS clinical services incorporate all major health specialties including medicine, surgery, psychiatry, oncology, women's and children, trauma, subacute and more than 30 sub-specialties. The Royal Brisbane and Women's (RBWH) and The Prince Charles Hospital (TPCH) are quaternary/tertiary referral facilities, providing advanced levels of health care which are highly specialised, such as, genetic health, burns treatment and heart and lung transplantation. Redcliffe and Caboolture Hospitals are regional hospitals, Kilcoy Hospital is a community hospital, and there is a clinical unit at the Woodford Correctional Facility.

Metro North HHS mental health, oral health, Indigenous health, subacute services, medical imaging and patient services are provided across many sites including hospitals, community health centres, residential and extended care facilities, and mobile service teams. Metro North HHS also has a dedicated Public Health Unit.

The Herston Campus is the home of a wide range of research and collaboration entities including the Clinical Skills Development Centre - one of the world's largest health care simulation centres – The University of Queensland, Queensland University of Technology, and QIMR Berghofer Medical Research Insitute. Private healthcare facilities are also co-located private hospital facilities at TPCH and Redcliffe campuses.

Our challenges and strengths

Metro North HHS is being faced with a rapidly growing and ageing catchment population with increasingly complex and longer-term care needs. While the rapid expansion in clinical knowledge and technologies presents many exciting opportunities, Metro North HHS must ensure that we provide cost-effective, high value healthcare that maximises patient outcomes and minimises waste. Innovation will be essential to ensure our clinical practice continues to align with contemporary evidence.

Metro North's focus on clinical excellence, and strong commitment to clinical research, education and training, ensures that we continue delivering cutting-edge, evidence-based, cost-effective, health care. Due to the scale of Metro North HHS, there are numerous opportunities for staff to be involved in research and development activities that benefit our consumers as well as making Metro North HHS an exciting and rewarding place to work.

Metro North's ***Putting People First*** strategy and ***Values in Actio***n initiative provide a robust framework for optimising the potential of our people by:

- fostering a culture of ethical and fair decision making
- improving efficiency and better connecting services across the health continuum and sectors
- acting on what we are hearing from our patients, staff and partners and
- adopting new technologies and innovative ideas.

Meaningful engagement with other health sector organisations, population groups, and individuals within our local community is a key strength for Metro North HHS. Collaboration with Brisbane North PHN, aged care providers, and other community-based health and social services, is critical for patients to have a safe and seamless journey through the health system. Metro North HHS is also actively engaging with local community groups and consumers, families, and carers, to ensure our services are responsive to their diverse individual needs. Of particular importance is working with Indigenous Australians to help Close the Gap and achieve reconciliation.

Metro North Mental Health

Metro North Mental Health (MNMH) commenced as a Clinical Directorate with a single point of accountability and budget as of 1 July 2014. In the 2019/20 FY, MNMH will employ 1200 (standard) FTE, with an annual budget of $217.3 million.

MNMH services are provided across the age spectrum including perinatal, child and adolescent, adult and older persons. A number of specialist services are also provided including consultation liaison, forensic, addiction, eating disorders, community mental health and an inner-city homeless team. The service supports the recovery of people with mental illness through the provision of recovery focused services and consumer and carer services in collaboration with primary and private health providers and our Non-Government partners. The service is a leader in clinical care, education and research. Training for all mental health disciplines is a priority. There are joint nursing and medical appointments and close links with multiple universities and specialist medical and nursing colleges.

All five public hospitals – Royal Brisbane and Women's Hospital (RBWH), The Prince Charles Hospital (TPCH), Caboolture Hospital, Redcliffe Hospital and Kilcoy Hospital – provide emergency response assessment in a crisis situation and are linked to specialist mental health and alcohol and other drugs services for assessment and care. Dedicated mental health acute inpatient services are at the RBWH, TPCH and Caboolture Hospital.

Across all of these facilities there are 340 inpatient beds comprising of 186 acute adult, 10 sub-acute adult, 12 adolescent, 40 Secure Mental Health Rehabilitation, 60 Community Care, 16 long stay nursing home psycho-geriatric and 16 state-wide alcohol and drug detoxification beds.

Community services are delivered from facilities located in Brisbane City, Fortitude Valley, Herston, Nundah, Chermside, Strathpine, Caboolture and Redcliffe with outreach services to Kilcoy.

MNMH is also the host site to a range of services provided to a state-wide catchment for both mental health and alcohol and other drug services.

The Alcohol and Drug Service (ADS) provides evidence-based treatments including opioid maintenance, substance withdrawal management, and counselling at a number of multidisciplinary clinics for patients with alcohol and drug dependence, many of whom also have comorbid mental health and medical problems. ADS works with the acute hospitals within Metro North to help early diagnosis of patients with substance use disorders, prevent complications, reduce length of stay, facilitate effective discharge planning/ community aftercare and avoid re-admissions. Queensland-wide consultation/ liaison, information, education, training and research services are also provided.

The Mental Health Directorate has a well-established governance structure with operational and clinical leadership at each of the four facilities. An Operations Director, Clinical Director and Nursing Director are appointed at each of the following:

- Metro North Mental Health – Royal Brisbane and Women's Hospital (MNMH-RBWH)
- Metro North Mental Health – The Prince Charles Hospital (MNMH-TPCH)
- Metro North Mental Health – Redcliffe Caboolture (MNMH-Red Cab)
- Metro North Mental Health – Alcohol and Drug Services (MNMH-ADS)

A note from the Principal Research Fellow-Mental Health

Hello! Thank you for picking up (or clicking on) the Metro North Mental Research Digest for 2019. This seventh edition is my last – after eight years as Principal Research Fellow at MNMH the time has come to move on. My time with the Directorate has been rich and rewarding – I've had the very great privilege of working with researchers, managers, clinicians and consumers committed to improving the lives of people affected by mental health problems. I have learned much about myself, health services and the complexities of the systems which surround us. I have witnessed compassionate clinicians providing exemplary care in challenging times and experienced support from colleagues in various roles across the service.

Compiling this report each year since 2013 has been a timely reminder of the extensive efforts being made to advance knowledge and understanding of mental health and illness and improve the ways clinicians and services collaborate with consumers. As you will see again this year, research and related activities undertaken by MNMH people are wide ranging – impressive in scope and diverse methodologically. As the report includes the lists of grants, publications and other dissemination activities that are commonly used as a measure of research activity MNMH's research funding and output are impressive. The report also goes behind the scenes, providing snapshots of the people engaging in research and service development and putting mental health issues in context. You can read about the impact of traumatic experiences on mental health and work going on to improve models of care in mental health and a ground-breaking study designed to develop a tool to assess for post-traumatic stress disorder related to pregnancy and birth. The stark statistics regarding mental distress and illness among LGBTQIA communities and prison populations draw attention to areas of need. As you'll see The Queensland Forensic Mental Health Service continues to lead the way in development of intersectoral partnerships to address the needs of people needing intervention from both mental health and justice services. In relation to the LGBTQIA population, the report showcases a MNMH initiative led by two clinicians at Redcliffe Caboolture designed to enable clinicians to be mindful of issues related to non-mainstream sexual orientation or gender identity and use of inclusive language and much more.

While it is my good fortune to gather the material for this report and I accept responsibility for any errors, credit belongs to those who have contributed in various ways. A huge thank you to clinicians, consumers and researchers who have shared their stories and given permission to reproduce their work.

Again, this year, I owe special thanks to Kellie Evans who has made sense of the chaos I send her way, maintained the MNMH research register and organised the material for this report, with good humoured professionalism.

I take this opportunity to wish the next (yet to be named) Principal Research Fellow every success in the role.

Please, enjoy the report, share with others and get in touch if you'd like to learn more about any of the stories or studies.

With kind regards and very best wishes

Kind regards, Sue

Nursing Research

MNMH Nurse Leadership Group

Metro North Mental Health (MNMH) employs a large nursing workforce. Nurses are employed in a range of roles in all components of the service, providing and guiding care and practices. MNMH Nursing is committed to integration of research with practice and appreciates systematic quality improvement and evaluation as the keys to capacity to apply evidence based practice and drive the necessary practice changes required to provide contemporaneous care outcomes for the wellbeing of the people we serve.

Several MNMH nursing initiatives were presented at events such as the RBWH Older Person's Mental Health Service that facilitated their annual State-wide Symposium. 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.

Posters and presentations at the 2019 Australian College of Mental Health Nursing conference in Sydney this year by MNMH nursing staff focused on how our care and our practice acknowledge the recovery journey for the consumer. Scott Haworth, Robin Counsel and Imani Gunasekara, our Consumer Consultant, demonstrated the importance of working closely with our consumers to understand their perspectives on how we best work toward reducing restrictive practices. Julie Ewing presented how clinicians at MNMH care also for the physical health of our consumers and the various initiatives that we have introduced to our clinical practice. Bruce Collyer and Di Burrows presented the value of mental health specific points of practice for new staff entering our workforce.

Critical to this is maintaining professionalism and providing personalised care. Mental health nursing is known for our critical reflection on practice, support for colleagues and new graduates and interdisciplinary collaboration.

Melanie Sullivan and Lucinda Burton are our newly appointed project managers for the implementation of Trauma Informed Care and Practice (TICP). TICP is a strengths-based framework that is responsive to the impact of trauma, focusing on physical, psychological and emotional safety for both services, providers and users. It allows for survivors of trauma to rebuild a sense of control and is an opportunity to provide mental health nurses with a philosophy of care that connects our activities and strategies, such as Safewards and recovery-orientated practices.

The Perinatal Mental Health Service continues their valuable and exciting work to develop and pilot a questionnaire to screen for PTSD in women during the perinatal period. Led by Tracey Mackle, Nurse Practitioner, this important project will enable early detection and targeted intervention to support women, their children and families who experience trauma related to pregnancy, childbirth and parenting.

Jordan Laurie, an engineering PhD student, is just completing research on a video-based system for nursing observations that would be routinely performed for an acutely sedated patient in a contained mental health setting. His work is an important step toward taking these prototype techniques out of a lab environment and into less controlled circumstances such as mental health clinical settings.

Other research activity includes a near complete study by Jordan Laurie, a QUT engineering PhD student, on a video-based system for nursing observations that would be routinely performed for an acutely sedated patient in a contained mental health setting. His work is an important step toward taking these prototype techniques out of a lab environment and into less controlled circumstances such as mental health clinical settings. Work conducted in collaboration between Associate Professor Niall Higgins and University of Southern Queensland is looking at the possibility of using smartphones to infer mood from day-to-day phone conversations without requiring any additional action from the users. The aim of this project is to develop and validate a mood detection tool for specific types of mental illness that have a mood component. Successful development of a mood detection tool could potentiality enable early detection, facilitate early intervention, and subsequently prevent and/or reduce relapse.

CLINICIAN RESEARCHER: SCOTT HAWORTH

Scott Haworth

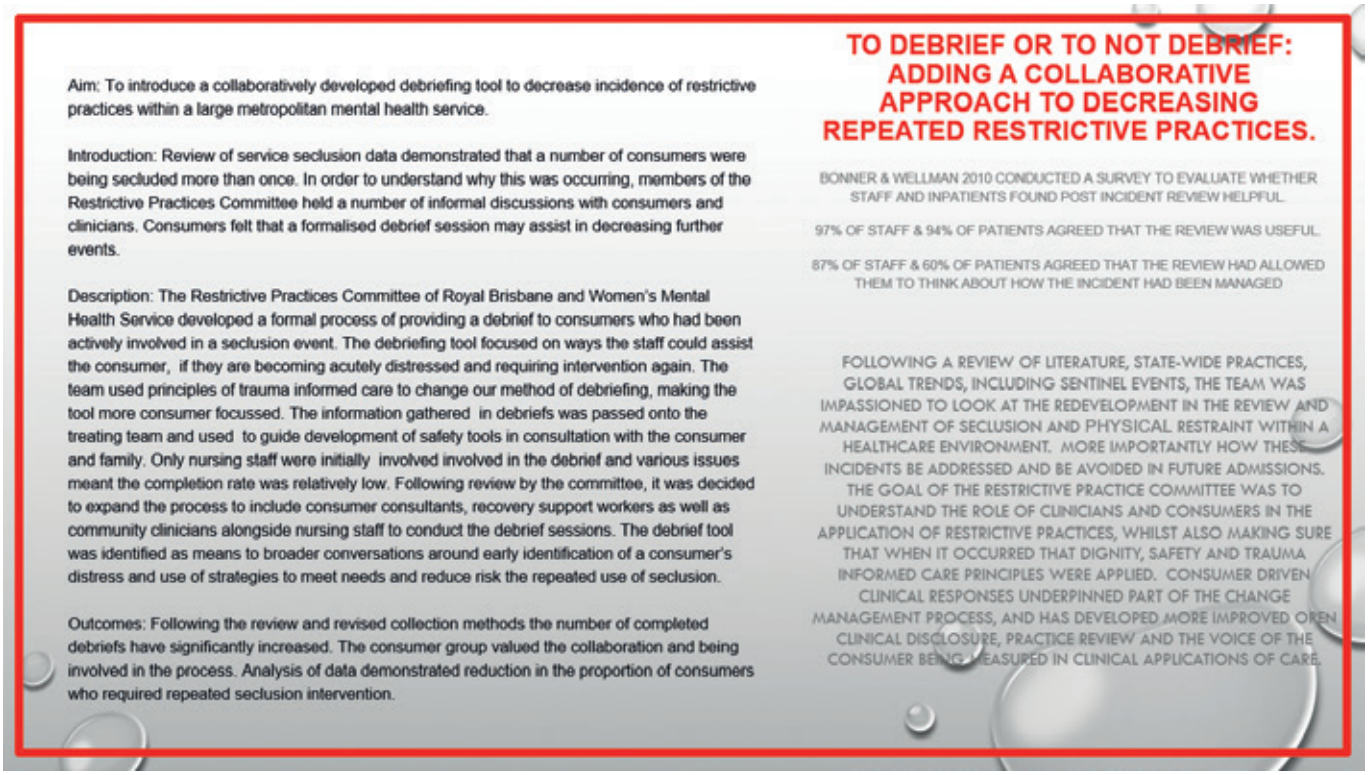
Nursing Director MNMH - Caboolture

Scott Haworth qualified as a registered nurse in 2007. Since then he has worked in a range of roles primarily in the mental health sector, across Australia. Recently appointed as Nursing Director at Redcliffe-Caboolture Mental Health, Scott leads and is professionally responsible for 413 nursing staff who provide care to consumers around the clock. Scott oversees the implementation and delivery of a range of clinical services and quality improvement initiatives.

Scott says,

> *'Research and evaluation are central to nursing practice; as a profession we are committed to evidence based, person centred care. In my experience, it's really important to reflect critically, in a rigorous way, on the services we deliver especially in relation to experience and outcomes of consumers. Research is also vital to ensuring a sustainable workforce. We need to better understand the challenges nurses face so we can develop appropriate support structures and ensure workplaces are safe places for staff and consumers'.*

Scott has recently been commended for his leadership in a project designed to reduce restrictive practices across the service. He and colleagues Imani Gunasekara (Consumer Consultant) and Robin Counsel (Nurse Unit Manager) recently presented a poster on this work at the Australian College of Mental Health Nursing Conference.



TO DEBRIEF OR TO NOT DEBRIEF: ADDING A COLLABORATIVE APPROACH TO DECREASING REPEATED RESTRICTIVE PRACTICES.

Aim: To introduce a collaboratively developed debriefing tool to decrease incidence of restrictive practices within a large metropolitan mental health service.

Introduction: Review of service seclusion data demonstrated that a number of consumers were being secluded more than once. In order to understand why this was occurring, members of the Restrictive Practices Committee held a number of informal discussions with consumers and clinicians. Consumers felt that a formalised debrief session may assist in decreasing further events.

Description: The Restrictive Practices Committee of Royal Brisbane and Women's Mental Health Service developed a formal process of providing a debrief to consumers who had been actively involved in a seclusion event. The debriefing tool focused on ways the staff could assist the consumer, if they are becoming acutely distressed and requiring intervention again. The team used principles of trauma informed care to change our method of debriefing, making the tool more consumer focussed. The information gathered in debriefs was passed onto the treating team and used to guide development of safety tools in consultation with the consumer and family. Only nursing staff were initially involved involved in the debrief and various issues meant the completion rate was relatively low. Following review by the committee, it was decided to expand the process to include consumer consultants, recovery support workers as well as community clinicians alongside nursing staff to conduct the debrief sessions. The debrief tool was identified as means to broader conversations around early identification of a consumer's distress and use of strategies to meet needs and reduce risk the repeated use of seclusion.

Outcomes: Following the review and revised collection methods the number of completed debriefs have significantly increased. The consumer group valued the collaboration and being involved in the process. Analysis of data demonstrated reduction in the proportion of consumers who required repeated seclusion intervention.

BONNER & WELLMAN 2010 CONDUCTED A SURVEY TO EVALUATE WHETHER STAFF AND INPATIENTS FOUND POST INCIDENT REVIEW HELPFUL.

97% OF STAFF & 94% OF PATIENTS AGREED THAT THE REVIEW WAS USEFUL.

87% OF STAFF & 60% OF PATIENTS AGREED THAT THE REVIEW HAD ALLOWED THEM TO THINK ABOUT HOW THE INCIDENT HAD BEEN MANAGED

FOLLOWING A REVIEW OF LITERATURE, STATE-WIDE PRACTICES, GLOBAL TRENDS, INCLUDING SENTINEL EVENTS, THE TEAM WAS IMPASSIONED TO LOOK AT THE REDEVELOPMENT IN THE REVIEW AND MANAGEMENT OF SECLUSION AND PHYSICAL RESTRAINT WITHIN A HEALTHCARE ENVIRONMENT. MORE IMPORTANTLY HOW THESE INCIDENTS BE ADDRESSED AND BE AVOIDED IN FUTURE ADMISSIONS. THE GOAL OF THE RESTRICTIVE PRACTICE COMMITTEE WAS TO UNDERSTAND THE ROLE OF CLINICIANS AND CONSUMERS IN THE APPLICATION OF RESTRICTIVE PRACTICES, WHILST ALSO MAKING SURE THAT WHEN IT OCCURRED THAT DIGNITY, SAFETY AND TRAUMA INFORMED CARE PRINCIPLES WERE APPLIED. CONSUMER DRIVEN CLINICAL RESPONSES UNDERPINNED PART OF THE CHANGE MANAGEMENT PROCESS, AND HAS DEVELOPED MORE IMPROVED OPEN CLINICAL DISCLOSURE, PRACTICE REVIEW AND THE VOICE OF THE CONSUMER BEING MEASURED IN CLINICAL APPLICATIONS OF CARE.

CLINICIAN RESEARCHER: JULIE EWING

Metabolic Monitoring Coordinator MNMH-RBWH

Julie Ewing

Please tell us a bit about your background and role at MNMH

I have been working within a plethora of Mental Health settings over the last 35 plus years. The majority of my career has been within NHS Scotland but since 2013 I have been based at the Royal Brisbane and Woman's Hospital. Since moving to Australia and joining Metro North Mental Health, I have worked as a Community Mental Health Clinician, GP Liaison Co-Ordinator, Primary Care Co-ordinator and currently as a Metabolic Monitoring Co-ordinator.

My current role focuses on developing organisational and cultural change, promoting a holistic model of Physical and Mental Health care, with positive outcomes for people with Severe Mental Illness. I need to integrate quality improvement relevant to strategic objectives into mental health nursing practice. A big part of my role is about building and sustaining the partnerships within and beyond health services that are needed to ensure people receive best care.

Where does research fit with that?

I believe that research is the pinnacle of providing and forwarding 'evidence-based practice'. With this in mind, I actively participate in a range of service research activities and utilise published evidence to support organisational change.

I also undertook a large audit entitled "Metabolic Monitoring & Physical Health Interventions Audit" December 2017 to May 2018. This initially entailed looking at published research in to provide context. The purpose of the Audit was to measure services offered to consumers in relation to their physical health needs and to ascertain if they were receiving interventions following screening, identification of risks and existing, but treatable physical health issues. Records of 92 consumers, from across in-patient and community services, were audited.

Following the audit, five focus areas were developed to provide a targeted roadmap to enhance clinical practice. Upskilling and supporting clinical practice, focus on local mental health service planning, creating other health partnerships and creating new innovative service models to maximise limited human and financial resources.

What do you find challenging and rewarding about research?

Undertaking research as a clinician can be challenging as you can become immersed in this process and have to be mindful of your time management. The huge reward you gain from researching is that the outcomes mean that you have the evidence you seek (or not, as the case may be). This then provides evidence to give you and the organisation direction in designing our service.

You recently presented at the Australian College of Mental Health Nurses 45th International Mental Health Nursing Conference, how was that experience?

Presenting at the Australian College of Mental Health Nurses 45th International Mental Health Nursing Conference in October 2019, was my first large conference presentation. This filled me with dread, however, the process of researching and preparing for this was invaluable. The information gained and the networking opportunities were invaluable.

Any hints for colleagues thinking about sharing their work in a similar way?

Despite practicing and timing myself for the presentation, I initially felt a little 'too' comfortable and started to 'ad-lib' and went over the time limit by a couple of minutes! Do not do this, stick to your script/plan.

A Physical health audit's impact on care design

To promote the integration of physical health and mental health, an audit of Metabolic Monitoring, interventions and follow-up was undertaken within a public mental health setting. The information gained from this audit became a further catalyst to promote the wellbeing of people with Severe Mental Illness (SMI) whom were identified as being 'at risk' or having current markers for developing physical illness, Metabolic Syndrome and an early mortality.

"In 2017-18, two thirds (67.0%) of Australian adults were overweight or obese (12.5 million people)". The current audit identified that 82% of consumers were classed as being overweight, a further increase of 15% in comparison to the general population. Furthermore, people with SMI, have a "10-25 year life expectancy reduction" and "deaths are mainly due to medical conditions such as cardiovascular disease, respiratory disease, infection diseases, diabetes and Metabolic Syndrome". Therefore, there is evidence for a need for service redesign and quality improvement and an organisational focus to redirect our approach in the management of the physical health of people with SMI.

Recommendations are to promote the Physical Health Agenda as part of core clinical mental health service and accountability including cultural change, with an essential duty of care to fully commit and engage with reducing the morbidity rates of people with SMI. A 2-year action plan with clear strategies, deliverables and desired outcomes to improve service performance on physical health improvement has been designed along with five focus areas to provide a targeted roadmap to enhance clinical practice; upskill and support clinical practice, focus local mental health service planning, create other health partnerships and create new innovative service models to maximise limited human and financial resources.

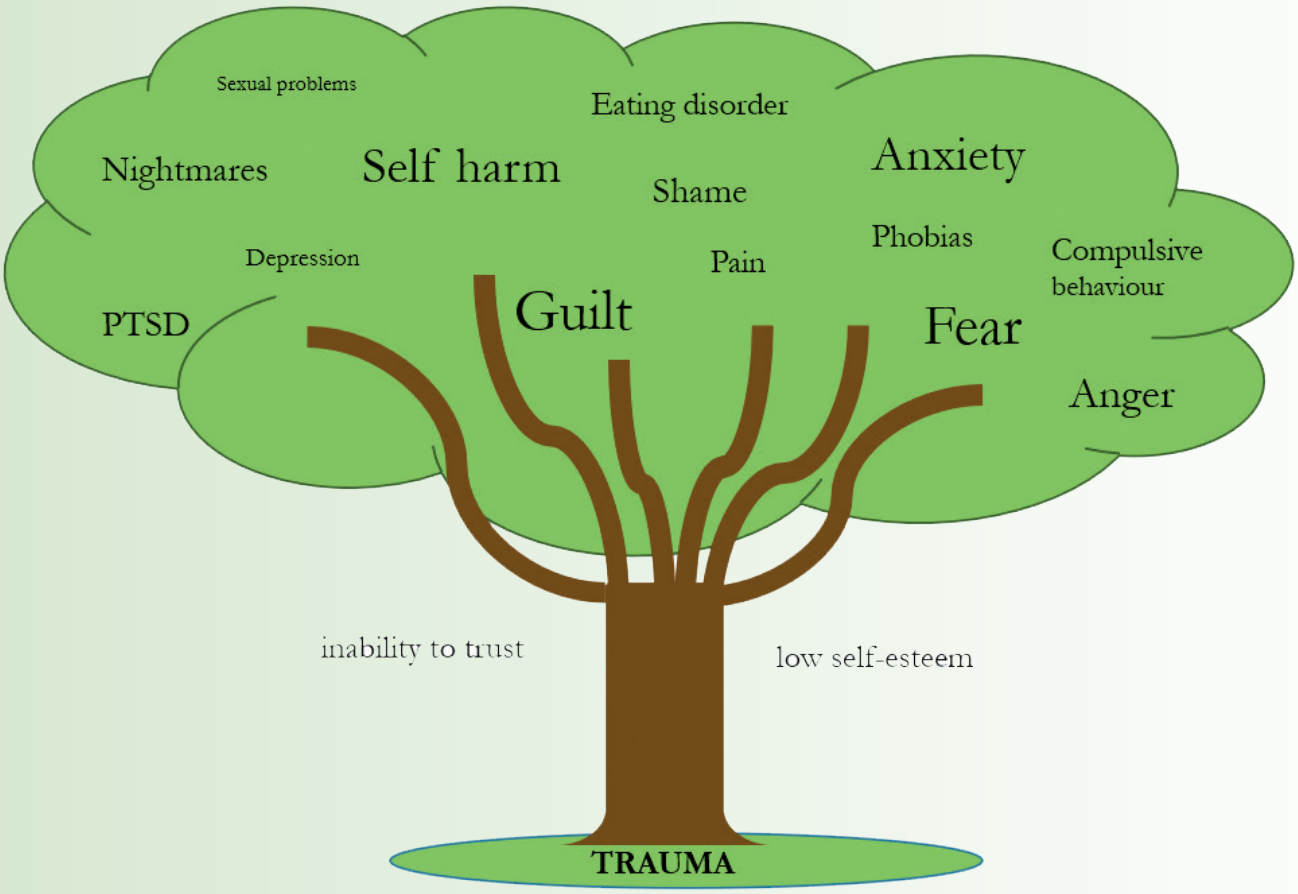
Trauma and Mental Health

Trauma of various kinds experienced at any time in life affects mental health in complex ways. People who have experienced complex trauma may experience a diverse array of difficulties. Trauma can complicate and delay normal development and increases risk for a range of mental health conditions including Post Traumatic Stress Disorder, Emotionally Unstable Personality Disorder, Anxiety Disorders, Schizophrenia and Bipolar Disorder, Dissociative Disorders, and Somatic Symptom Disorder. Trauma is common among people who experience eating disorders and substance dependence, and those who self-harm and/or experience suicidality.

Because trauma can affect a person's ability to regulate emotions, to form healthy relationships, feel safe and trust, can make accessing help can be very challenging. The way services respond is important for enabling recovery by minimising practices that may contribute to re-traumatisation. The guiding question when services focus on symptoms and diagnosis, is *what is wrong with this person?*

Trauma informed care however seeks to understand **what happened to the person to have affected them so profoundly** and appreciates the observed behaviours and difficulties as valiant attempts to survive and cope.

Increasingly, as described below and on page 12 mental health, and drug and alcohol treatment services are working to embed "Trauma Informed Thinking' and practices as foundational to care provided.



Nursing and Trauma informed Care

Melanie Sullivan (left) and Lucinda Burton (right)
Trauma Informed Care Project Team

Metro North Mental Health RBWH successfully secured funding through the Nurses and Midwives Certified Agreement (EB10) Innovation Fund to implement a nurse led Trauma Informed Care and Practice (TICP) Quality Improvement Process commencing 2019.

The Trauma Informed Care (TIC) project aims to provide the Mental Health Nursing profession with a model of care to reinforce a person-centred approach and complement current recovery-oriented practices and service models. A TIC service acknowledges the prevalence of trauma, recognises how trauma affects all individuals (consumers and staff) and responds by implementing trauma informed practices. TIC is a whole of organisation response, prioritising physical, psychological and emotional safety for all individuals. It is underpinned by a comprehensive understanding of the neurological, biological, psychological and social effects of trauma and is founded upon the key principles of safety, trustworthiness, choice, collaboration and empowerment. Research has shown that trauma informed care can reduce restrictive and coercive practices; improve consumer experiences of care; prevent re-traumatisation within health services and contribute to staff wellbeing through recognition of the impact of vicarious trauma.

The TIC project team, working in conjunction with a working party have completed the Trauma Informed Care Organisational Toolkit developed by the Mental Health Coordinating Council to identify service gaps and support development of a Trauma Informed nursing model of care. Priority areas of implementation include providing education to new graduate nursing staff, continuing nursing staff, allied health, medical, administrative, security and operational staff; policy and procedure review and amendment; recruitment and work force development and support of staff in the acknowledgement of vicarious trauma, burnout and compassion fatigue.

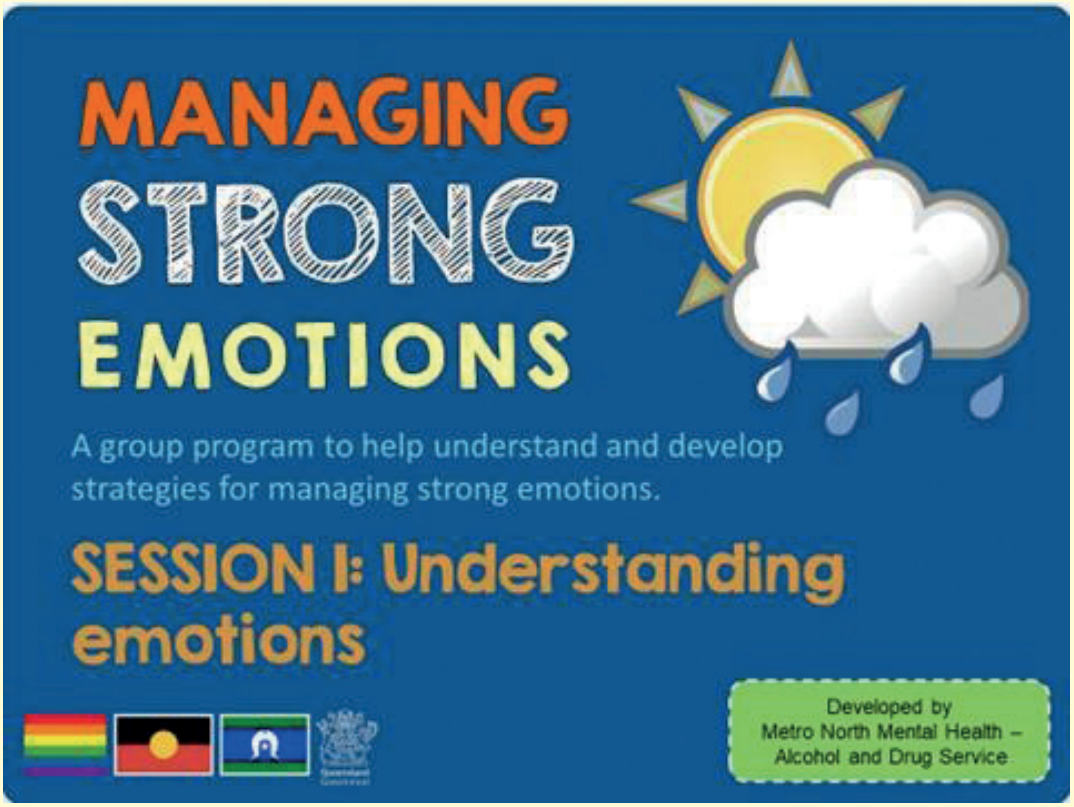
The TIC project team are rigorously evaluating the process and impact of their activities using mixed methods.

TRAUMA INFORMED CARE AND PRACTICE PROJECT AT METRO NORTH MENTAL HEALTH – ALCOHOL AND DRUG SERVICE (MNMH-ADS)

MNMH-ADS Trauma Informed Care and Practice Project Team

MNMH-ADS has developed and implemented a Model of Care: Trauma Informed Care and Practice for Alcohol and Drug Treatment. This is a project that commenced in 2018 and later received a grant from Metro North Alcohol and Drug Service (ADS) Executive Mental Health Alcohol and Other Drugs Branch, Clinical Excellence Division and also a further grant from Metro North Hospital and Health Service Acting CEO Jackie Hansen which allowed for completion of the Model of Care. The Model of Care involves 3 key components: (i) organisational practices (e.g. provision of trauma sensitive service, routine screening of all new clients for PTSD symptoms), (ii) workforce development (e.g. all staff have received training

in trauma informed care (TIC), psychosocial teams engage in more specific training and supervision) and (iii) psychosocial treatment (i.e. the provision of integrated treatment for co-morbid substance use disorders and trauma related symptoms). It has been a challenge to evaluate outcomes with such a wide ranging and heterogeneous project. Two key studies have been undertaken: the first measures change in staff perceptions of barriers and enablers to TIC pre and post training and the second evaluates our Managing Strong Emotions group assessing changes in variables such as participants' understanding of emotions and willingness to use strategies to regulate emotions pre and post session. The project has produced additional guidelines for Managing and Preventing Vicarious Trauma and the TICP Clinician Capability Framework. The TICP Project team comprised Dr Melissa Connell (project lead), Annakaturah Ralph (research officer), Nicole Brigg (project officer and group facilitator) and MNMH-ADS staff John Kelly (Biala Psychosocial Team Leader) and Kim Sander (MNMH-ADS Allied Health Director).



PROJECT LEAD – DR MELISSA CONNELL

Clinical Psychologist | Manager – Trauma Informed Care and Practice Project

Metro North Mental Health – Alcohol and Drug Service

Dr Melissa Connell

I am a clinical psychologist working in the area of trauma, substance use, and early psychosis research and intervention. I am currently working with MNMH-ADS managing the Trauma Informed Care and Practice Project. I have a background working with Assoc Prof James Scott on a variety of research projects examining psychosis in young people. I have a particular interest in complex trauma and psychological approaches to understanding and working with people who experience psychosis. I also work in private practice and have experience working with a wide range of mental health difficulties. I have worked in a number of different capacities in the mental health field which has helped to give me a broad perspective on the experience of mental health problems and how they can be treated. Working in research keeps me in touch with contemporary understandings and approaches to mental health problems so that I can always be reflecting on my practice and how it can be improved.

NICOLE BRIGG – PROJECT OFFICER & GROUP FACILITATOR

Project Officer & Group Facilitator

My role within the project team is to co-develop and implement the group therapy program and group facilitator training across MNMN-ADS sites, contributing to development of resources to support; implementation of the model of care, and support project evaluation. The group program content is psychoeducation and strategy based and the topics include; understanding emotions; emotions and the body; emotions and the mind; emotions and the heart/compassion; relationships and difficult emotions. Managing Emotion group programs are currently being run at Biala and Caboolture ADS sites with plans to commence in Chermside in coming weeks.

Nicole Brigg

Healing environments

The physical environment and design of mental health facilities shape the therapeutic space and impact on patient and staff wellbeing. Various features of the environment have been shown to influence the experience and outcomes of admission to an inpatient ward

Natural light is an important form of maintaining normal circadian rhythm; not enough or too much light or being dependent on artificial light can disrupt sleeping and eating patterns and affect concentration, performance of tasks and mood and arousal.

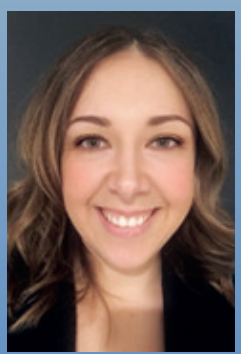
Access to gardens and contact with nature are known to be important for both patients and staff, promoting wellbeing, restoration of attention and relief from stress.

Visual art in healthcare facilities provides therapeutic benefits with patients reporting a preference for images of realistic natural scenes over stylized or abstract art.

Increasingly, design and refurbishment of health care environments is supported by an understanding of the complex ways the ambient environment and an individual's sensory preferences and processing interact to shape experience and healing.

Occupational Therapy is grounded in theories explaining human occupation and activities which underpin practice using evidence-based interventions. The body of knowledge that underpins occupational therapy, equips occupational therapists with specialist skills in environmental adaption to improving occupational performance for individuals with mental illness. One framework that is particularly useful in environmental design is grounded in an understanding of the ways people receive, process and respond to sensory information. Sensory approaches are also fundamental to a range of interventions.

A team of occupational therapists from the RBWH secured funding to refurbish balconies of the adult mental health inpatient wards at the RBWH, with design grounded in principles of sensory modulation. The team was additionally funded to build capacity of inpatient staff to use sensory approaches in their work and provide sensory interventions to patients. Here they outline the project and recommendations. The photos below demonstrate the massive change achieved with a very limited budget.



Project team: (L to R) Samantha Bicker, Danielle Manolis, Sally Mercier

Development of Sensory Spaces on Adult Inpatient Units

Background

Recognising the benefits of optimising environments using principles of sensory modulation, The Mental Health Alcohol and Other Drugs Branch (MHAODB) provided funding to support implementation and evaluation of sensory approaches in acute mental health inpatient units within the Metro North Hospital & Health Service. Two interlinked projects were completed: (1) development of sensory spaces within large outdoor balcony areas, and (2) the provision of training support to build the capacity of other clinical groups, to deliver sensory interventions in partnership with occupational therapists and deliver sensory interventions to consumers.

Purpose / Objectives

The evaluation described here was undertaken to assess the impact of the balcony refurbishment on use and experience of the spaces from the perspectives of clinicians and consumers, acceptability and perceived benefits of delivery of staff education in the use of sensory approaches; and, the delivery of clinical sensory interventions to consumers and carers. Two mental health inpatient units at RBWH, 'G Floor' and 'I Floor' were in scope.

Methodology

Designed to develop practically useful information, the evaluation employed mixed methods within a pragmatic frame.

Key Findings and Conclusions

Both projects were completed successfully. Balcony refurbishments were commended by clinicians and consumers. Positive feedback emphasised a more welcoming and therapeutic 'feel' of the balconies; clinicians and consumers reported enjoying the gardens, comfortable seating and art work and valued the opportunity to exercise in movement zones. Clinicians reported that consumers were more frequently using balcony spaces for relaxation.

The staff education in sensory approaches also indicated some changes in the understanding and use of sensory approaches in the inpatient units. Staff reported increased knowledge and confidence in using the approaches.

The clinical intervention in sensory approaches was found to be feasible, acceptable and valued by consumers. Consumers reported sensory sessions provided strategies to manage their feelings and they would recommend sensory sessions to their friends.

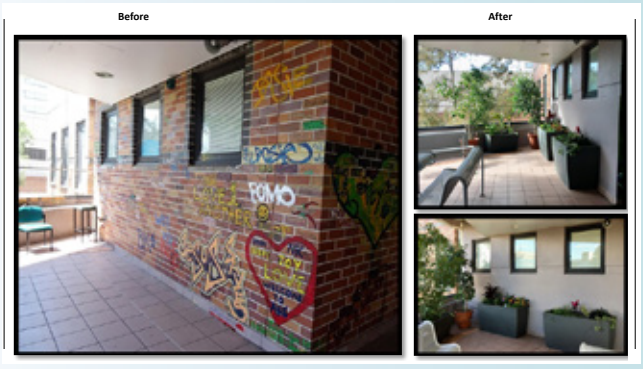
Consensus among clinicians was that further work was needed to embed and enable sensory approaches in practice and wanting future sensory approaches projects funded.

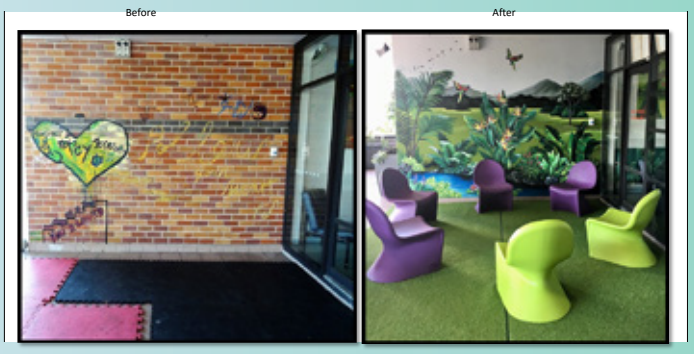
Recommendations

Clinical intervention in the area of sensory approaches is acceptable and valued by consumers, and should be a future funding consideration for the service.

Ongoing staff education in the use of sensory approaches would likely benefit further cultural change in the inpatient units.

Environmental adaptions were particularly valued by staff and would be worth considering further alterations in other service areas.





Mental Health problems after treatment in intensive care

Around 150,000 patients spend approximately 13 million hours in Australian intensive care units (ICUs) annually. The vast majority of patients will be discharged from ICU, but research shows that the experience of care is often suboptimal and that up to 80% of patients experience ongoing physical, cognitive and/or psychological impairments and reduced quality of life after discharge. The psychological impact of ICU is immense, with up to 60% developing a new psychological disability, and PTSD rates being comparable to Vietnam veterans. Although survival rates are high, many do not recover to their premorbid function. Half of all ICU patients are newly unemployed 12 months after their discharge. 30% never return to work, and another 30% never return to their pre-ICU income. This significant reduction in their quality of life has been shown to persist up to 15 years after discharge.

Families of patients also experience a range of challenges including a high burden of care, mental health problems and financial costs. Many have to move home, delay education or use their savings to support their loved on. Anxiety is common among family members of patients with as many as half of those closely involved in care, experiencing symptoms of PTSD, and 30% receive medication for depression and anxiety. The impacts of ICU on families have been shown to last as long as for patients.

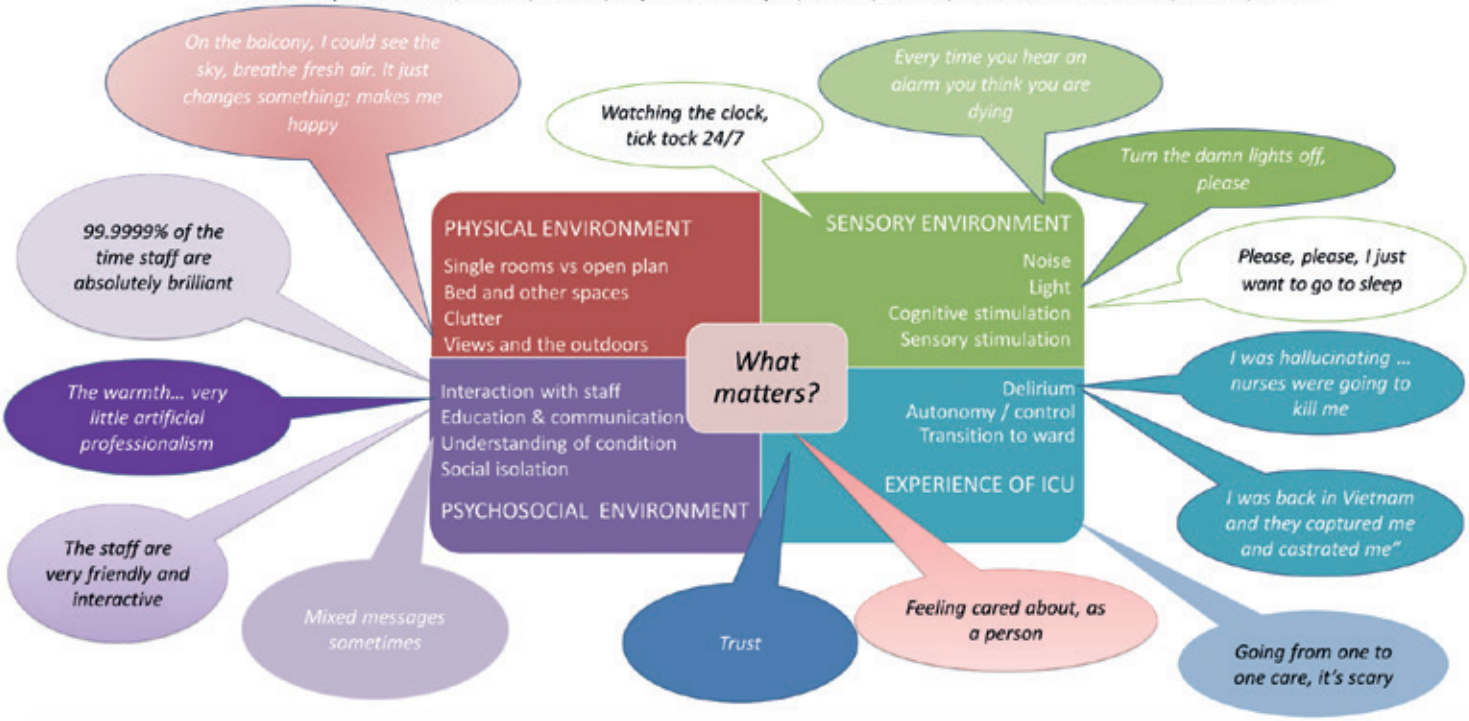
While some problems experienced by patients and family members during and following discharge from ICU relate to non-modifiable factors such as age, diagnosis and severity of illness, the ICU environment, which is modifiable, negatively affects patient recovery. Many have described feeling powerless, isolated and scared. The constant beeps and lack of daylight can disrupt their sleep and sense of where they are. Some report ongoing panic symptoms from the sounds of alarms or ambulances.

Metro North Mental Health researchers are collaborating with the Critical Care Research Group based at The Prince Charles Hospital and other stakeholders to redesign the intensive care environment to improve patient outcomes. Patient experience is a key consideration in this project. The team recently presented a poster at an International Conference on a study exploring the environment and experience of care from the patient's perspectives.

The lived experience of patients in an Australian intensive care unit

Oystein Tronstad[1,2,3], Dylan Flaws[1,4], India Lye[1], John Fraser[1,3], Sue Patterson[5]

[1]Critical Care Research Group, The Prince Charles Hospital, Brisbane, Australia, [2]Physiotherapy Department, The Prince Charles Hospital, Brisbane, Australia, [3]The University of Queensland, Brisbane, Australia, [4]Royal Brisbane Hospital, Brisbane, Australia, [5]Metro North Mental Health, Brisbane, Australia



Introduction:

- Up to 70% of ICU patients experience long-term complications
- The ICU environment adversely affects patient recovery and outcomes
- Currently there is no formal patient feedback or engagement when ICUs are designed

Aim:

- To inform co-design of an improved ICU bed-space

Objectives:

- To explore experience of ICU admission and what matters to patients and families
- To describe impact of environment on delivery and experience of care

Methods:

- A qualitative study of 'what matters' to ICU patients
- Data collected in semi-structured interviews (n=17), analysed using the framework approach

Results:

Patients reported:

- Delirium with vivid & life-like visions/dreams common
- Bed-spaces are too small and cluttered for staff to complete their duties
- The artificial light & constant noise prevented sleep, and alarms were scary and disruptive
- Natural lights, fresh air and views essential but rare
- The current environment contributed to boredom, social isolation, claustrophobia and fear

Conclusions:

- Patients reported that features of the current environment hindered their recovery and contributed to their ICU admission being a suboptimal experience
- An environmental redesign of ICU based on the requirements of the patients is urgently needed to improve patient outcomes and help deliver more personalised and effective care

Metro North Hospital and Health Service
THE COMMON GOOD
The University Of Queensland
criticalcare RESEARCH GROUP

The Queensland Eating Disorders 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 located at the RBWH. QuEDS also provides training to more than 3000 clinicians per year and hosts peer group support. 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 hubs are now well established at the Gold Coast and Sunshine Coast HHS. After a competitive bid to become the North QLD Eating Disorder hub in 2019, Cairns and Hinterland HHS will be developed as the 3rd Eating Disorder Specialist hub, servicing North Queensland in 2020.

QuEDS areas of research in 2019 have included service evaluation of a pilot carer peer mentor program in collaboration with Eating Disorders QLD and Dietetic peer group support, novel research in deep brain stimulation and research into best practice for carers and family inclusive treatment and single session family therapy in adult eating disorders.

Additionally, in 2019 QuEDS was named as a participating institution on a Medical Research Future Fund (MRFF) Million Minds research project led by University of Sydney (Inside Out Institute). Project MAINSTREAM will establish a centre for health systems research and translation in Eating Disorders; detection and intervention system-focused knowledge to drive better outcomes in mainstream care for eating disorders. This will work across 4 key strategies:

Strategy 1: Establish a national surveillance system to monitor detection and early intervention in health services, linking all available data across health system datasets (e.g. PHNs, Medicare, Hospital admissions, headspace, Innowell, Death Registry) and create a national profile of illness, to evaluate equity and access to interventions and outcomes for eating disorders.

Strategy 2: Develop a continuous lived experience lifetime survey on illness and treatment experience to link to the national surveillance system.

Strategy 3: Using the data from Strategy 1, develop health system and economic models that evaluate current and future interventions in relation to outcomes, cost-effectiveness, and equity of access.

Strategy 4: Informed by Strategies 1 to 3, undertake translation focused testing of scalable models of care for mainstream health settings to ensure interventions represent value for money and can be implemented into mainstream clinical practice and policy.

QuEDS will host a post-doctoral researcher for 4.5 years to perform QLD specific research under these 4 strategies.

Finally, QuEDS has had five submissions accepted to be presented at the International Conference for Eating Disorders which will be held in 2020.

QuEDS Team

PILOT CARER PEER MENTOR PROGRAM

Catherine Doyle, Amy Hannigan and Jacqueline Byrne

Eating Disorders Queensland and the Queensland Eating Disorders Service work closely with carers on a daily basis. We recognise that eating disorders have significant effects on families as well as individuals (Zucker, Marcus & Balik, 2006). In 2019 the two organisations jointly rolled out a pilot Carer Peer Mentor Program in Queensland. The program connected and matched carers currently supporting loved ones with eating disorders to carers who had previously supported a loved one to recovery. Carers can be impacted by a range of personal, social, occupational and economic difficulties (Goodier et.al, 2013). They can experience a high burden of care (Whitney et al 2005) and often feel isolated and excluded (Fox, Dean & Whittlesea 2017). Peer mentoring recognises the value of lived experience in a meaningful and compassionate way. The aim of the pilot was to provide support for carers through a structured and supervised peer mentor program. Evaluation will include quantitative and qualitative analysis of implementation, feasibility, acceptability and impact of the program to assist in continuous improvement in the area of carer need as we grow and expand the program in Queensland.

Presented by Catherine Doyle and Amy Hannigan
@ Australian New Zealand Academy for Eating Disorders 2019
Saturday 24th of August 2019

SOLVING THE SUPERVISION DILEMMA FOR DIETITIANS WORKING IN EATING DISORDERS – INNOVATIVE PROGRAMMES FROM A STATE-WIDE ADVISORY SERVICE

Amanda Davis (QuEDS) and Amy Davis (CYMHS EDP)

Provision of dietetic interventions in eating disorder (ED) treatment is an advanced practice area and high-level clinical supervision is recommended. Historically dietitians have not engaged in paid supervision, plus dietitians with adequate experience in EDs and supervisory training are often over-subscribed. Lack of supervision may contribute to dietitians feeling overwhelmed or unsupported in this workload, with inadequate knowledge of evidence-based practice. In 2018 QuEDS launched two innovative programmes to improve access to supervision and support to dietitians within Qhealth. 1. Facilitated-Peer Group Supervision (QuEDS f-PGS) for Dietitians (via video conference) with an educational component - closed group of 10, monthly 90minute sessions for 1 year. Pre, 6month and post completion surveys indicate increased levels of competence/confidence to work in this challenging field. In future, a generic QuEDS f-PGS package will be developed to facilitate roll out from other health professionals within QuEDS and other specialist ED services. 2. Dietitians Knowledge Pathway (QuEDS DKP) – desktop resource, targeted at dietitians and providing local knowledge. The user is guided through treatment guidelines, pathways, seminal references, online learning opportunities, professional associations, local resources etc. User determines pace and depth of learning. Pre- and post-completion quality surveys indicate users feel more confident and better informed. In future, the QuEDS DKP will be available as an online resource.

Delivered by Amanda Davis @
Australian New Zealand Academy for Eating Disorders Conference 2019
Friday 23rd of August

CLINICIAN RESEARCHER: BRIDGET JOHNSON

Psychiatry Registrar, MNMH – Caboolture

Bridget Johnson

Dr Bridget Johnson is a psychiatric registrar in her fourth year of training. After studying medicine at the University of Queensland and completing rotations across medical fields, Bridget recognised the importance of human connection to health and recovery from illness. She found herself drawn to psychiatry where connection is at the heart of treatment, and joined the training program after her intern year. Whilst remaining focused on clinical care, Bridget sees research, and particularly its application to clinical practice and service and improvement, as integral to her role and the future of psychiatry.

Bridget is completing her scholarly project - a requirement of training - examining the views and experiences of psychiatrists and registrars with two after hours, on call-rosters. As described in a presentation at the Australian and New Zealand College of Psychiatrists Congress in 2019, (abstract below) doctors generally experience after hours, on call duties as a necessary burden. Working after hours, that is at night, disrupts regular routine and personal life and can be tiring but also has 'up sides'.

OPTIMIZING PSYCHIATRIC AFTER-HOURS DUTY: THE IMPLEMENTATION AND IMPACT OF A SHORT CYCLE AFTER-HOURS ROSTER

B Johnson[1], G Bruxner[1], S Patterson[2,3]

[1]Redcliffe-Caboolture Mental Health Service, Caboolture, Australia
[2]Metro North Mental Health, Herston, Australia
[3]The University of Queensland School of Dentistry, Herston, Australia

Background: Long hours and on-call have long been a part of practising medicine – psychiatry is no exception. While 24-h care is a necessity, increasing acknowledgement of the interlinked risks to doctors' well-being and patients' safety associated with fatigue obliges health services to reconsider practices and develop rosters that optimize safety without sacrificing performance.

Objectives: Within an outer-metropolitan mental health service, a new 'short cycle' after-hours roster (SCR) has been created in response to an identified need and to bring it in line with national guidelines (AMA, 2016). This session will present the project aims to describe the acceptability and sustainability of the SCR, and the impact upon those involved.

Methods: Evaluation of impact of after-hours rosters before and after implementation of the SCR using questionnaires administered to the affected registrars/ Principal House Officers/Senior Medical Officers. Data describing perceived effects upon personal well-being, mood, social activities, education/training, lifestyle and absenteeism are being collected, along with general views about after-hours work.

Findings: Preliminary findings indicate largely negative effects of the current roster across multiple domains, with mixed views regarding specific preferences for number, length and frequency of shifts. Findings following implementation of the incoming roster will be presented at the Royal Australian and New Zealand College of Psychiatrists' (RANZCP) 2019 Congress.

Conclusions: Conclusions will be presented at the RANZCP 2019 Congress.

Alcohol and Drug Service

Metro North Alcohol and Drug Service provides treatment and support for people, their families and the local community who are experiencing problems related to alcohol and other substance use. The service offers a range of treatment services over four community health centres, and within three hospitals within Metro North Hospital and Health Service (MNHHS).

MNMH-ADS comprises three major services:

Allied Health

Provides a centralised intake point for intake and triage to determine the initiation eligibility for clients for further assessment, screening and/or referral via the ADIS 24/7 Alcohol and Drug Support and provides psychosocial interventions provided by social workers and psychologists providing assessment counselling, family and group work and police/court diversion programs.

Clinical Services

Providing withdrawal management (both inpatient planned and ambulatory outpatient), medically assisted treatment, including opiate replacement therapy, and alcohol pharmacotherapy, harm reduction programs (including needle and syringe programs, naloxone providing, and blood borne virus advice, screening and treatment) and hospital-based services (consultation liaison).

State-Wide Clinical Support Services

Providing education, training and consultation services with the Queensland alcohol and drug sector via Insight and Dovetail (youth specific).

The service employs around 100 staff. Each year the service will generate approximately:

- 7,500 new treatment episodes
- 46,500 service contacts
- 75,000 active treatment episodes
- ADIS will take approximately 30,000 telephone calls

The ADS is committed to supporting the integration of research and practice and actively encourages clinicians to critically evaluate their work and effect of interventions. The service hosts students completing research for a range of degrees and partners with various agencies to conduct studies relevant to our work. Reflecting the service commitment to engagement of clients a range of ongoing quality improvement activities are designed to ensure services are developed to meet needs.

"I liked being with other people with similar stories as mine"

"It was respectful, and I didn't have to spill my guts and tell my life story …

I got to choose the help I want

Clients provided positive feedback

"An ideal way to introduce new people to the service. They can find out about the services and choose the help they want"

"It worked better than I thought it would. It is a gentle way to engage with the service. You don't have to open up and be too vulnerable, yet get support and help"

From the clinicians' perspective

Subst Abus. 2020;41(1):19-23. doi: 10.1080/08897077.2019.1635064. Epub 2019 Jul 9.

Examination of a group entry model into alcohol and other drug (AOD) treatment: Improvements in attendance, retention, and clinical capacity.

Sander K[1], Wilson H[1], Kelly J[1], Bligh A[2].

⊕ Author information

Abstract

Background: Nonattendance in alcohol and other drug (AOD) treatment has been a persistent issue for service provision. The study reports on the outcomes of implementing a group intervention, titled Getting Ready for Change (GRFC), as the default entry pathway into an AOD counseling service that aimed to improve initial attendance and retention through reduced wait days and improved clinical capacity. *Methods:* Clients of the service ($N = 274$) were offered either an individual appointment (baseline) between September 2015 and February 2016 or a group-based appointment (intervention) between September 2016 and February 2017. The samples were compared in terms of demographics, principal drug of concern, wait days to initial and follow-up appointments, and attendance. *Results:* The implementation of GRFC reduced wait days to initial appointment from 15 to 5 days and improved initial attendance rates by 24%. Wait days to follow-up were reduced from 10 to 8, retention rates improved by 24%. Further, there was an increased service capacity to meet community demand. *Conclusions:* A group entry model into AOD treatment is a novel intervention, is easy to implement, improves attendance and retention in treatment, reduces wait days, and enhances clinical capacity.

KEYWORDS: Alcohol and drug; attendance; clinical time; group treatment; retention

STUDENT RESEARCHER: SAMANTHA FINNIS

Provisional Psychologist | Master of Clinical Psychology Student

School of Psychology and Counselling | Queensland University of Technology

Samantha Finnis

Psychology as a discipline is grounded in the integration of science with practice. The education and training required for registration as a psychologist are designed to support professional development of scientist-practitioners; that is, clinicians with the expertise required to provide services to deliver psychological interventions and services to support individuals, families, groups and communities and to scientifically study the phenomena that are the focus of their services and the outcomes of service provision. Psychologists are obliged to contribute to development of the discipline, and specifically to their fields of work. Here Samantha describes her experience undertaking research as part of her master's degree.

As a part of my Master of Clinical Psychology degree at QUT, I conducted research with ADIS 24/7 Alcohol and Drug Support, Metro North. I was fortunate enough to have the opportunity to work in collaboration with ADIS and conduct research with a clinical sample of participants. The ADIS team were very welcoming and willing to share their knowledge with me. While working with ADIS, I was able to learn from the ADIS counsellors, both as a researcher and as a clinician. Due to the scope of the project, I was required to actively engage in the project and on-site attendance was necessary. Whilst this time commitment may not be possible for some research students, I gained valuable experience from the time I spent observing and learning from ADIS counsellors.

The research project was both interesting and challenging. Initially, the aim of the project was to assess the impact that referral types may have on treatment outcomes for ADIS clients. The findings suggested that most participants preferred a personalised and supportive referral to connect them with their recommended treatment service (i.e. a warm referral). As a small sample of participants were recruited and retained in this project, statistical conclusions in regard to treatment outcomes were not able to be obtained. From this project, I learnt about the complexities of conducting research with this population, particularly recruitment and retainment of the sample. Although this initially created a barrier, this observation also prompted a second phase of research which explored the ADIS counsellors' views on research and recruitment.

As a result of this exploration, I discovered that many of the ADIS counsellors believed that the role of a counsellor was incongruent with that of a recruiter for research. This was a valuable finding and may assist with future research conducted at ADIS. Overall, I encourage students to seek opportunities that allow them to conduct research in a clinical setting as this will provide them with real-world experience.

REFLECTIONS ON THE GRADUATE CERTIFICATE IN HEALTH SCIENCE (HEALTH SERVICES INNOVATION)

Metro North Hospital and Health Services (MNHHS) and the Australian Centre for Health Services Innovation (AusHSI)at QUT have developed a new major for the Graduate Certificate in Health Science. The aim of the Health Services Innovation major is to increase the capacity of health professionals to implement innovative change in, and evaluate, the value of health services.

Of the MNHHS staff who enrolled in the program, two staff from Mental Health were excepted and share their experiences.

I initially said...

Anthony Bligh
Director of Psychology, MNMH

Please tell us a bit about your background and current role?

I am the Director of Psychology for Metro North Mental Health. This is a professional lead role, with responsibility for psychologists at MNMH-TPCH, MNMH-Redcliffe and Caboolture, and MNMH-ADS. I also provide strategic direction and guidance to the other MNMH professional leads for psychology.

What does your job description say about research and what does that look like in the real world?

My role description outlines my role in providing leadership and strategic direction for research across MNMH. In practice, this has involved my assisting others as a co-investigator in a broad range of research projects, including collaborations with local universities. I have found that being part of many different research teams has been a great way to learn more about different areas of MNMH, as well as the different skillsets of other MNMH clinicians and researchers. I have also learnt a lot about Metro North research governance processes, especially about collaborations with local universities. I've been very pleased to be a part of research projects with psychology Honours students, who have been a highly motivated and engaged group of researchers.

What motivated you to enrol in the Grad Cert?

I initially said "no" to the suggestion. However, said I would at least consider the course content before deciding. Upon reading it through I saw so many aspects of my role and could see that I may learn ways to manage the challenges I was regularly experiencing. I also saw I may learn the skills to assist in the implementation of evidence-based practice across MNMH. At that point, I was in!

What has that entailed?

In short, a lot of work… I've had to give up some of my weekends to this, and I found some of the assignments quite challenging. The lecture content was largely within usual work time, taken as a combination of PDL and usual work time with the support of Metro North. There were three coursework units (Implementation Science, Health Reform, and Cost-Effectiveness), and one longer independent study project over the final semester.

What sorts of research have been involved in completing the different subjects?

Within the coursework, assignments followed the course structure and learning objectives for each unit and no additional research beyond literature reviews were necessary; however, for the independent study component, a research or quality improvement project was required.

What was your improvement project?

I focused on a thorough, largely qualitative analysis of the effectiveness of implementation of Cognitive Behavioural Therapy for Psychosis (CBTp) training across MNMH, funded by a MNHHS SEED grant. The results have been fed back to MNMH executive, with recommendations to continue CBTp training across MNMH due to the beneficial outcomes realised by both consumers and clinicians since the initial training was completed. I am also hoping to see these results published in future.

What do you see as the role of implementation science in mental health services?

The implementation of evidence-based practice across MNMH has had its challenges historically. By taking an implementation science approach to thoroughly understanding the contextual barriers and enablers within services, success is much more likely. I also think that there are many potential interesting and likely influential implementation science projects within MNMH to be conducted.

What advice would you give to a colleague contemplating enrolling in the course?

Don't let the workload put you off. Yes, it will be stretch at sometimes, but it is not constant, and the benefits of learning these skills outweighs the effort put in, in my view. Metro North have certainly been highly supportive of our involvement in the course. Also, speak to myself or others who have done the course and we can answer any questions you have about it.

What do you know now that you wish you had known at the outset?

I didn't know how complex qualitative research was! I wish I'd done more training on this earlier. One pleasant but unexpected outcome has been the many networking opportunities and friendships developed with others in the course across Metro North.

Where to next?

From here, I am hoping to access some research funding to add some important components to my research and from this prepare a paper for publication. I am also seeking to be involved in other implementation science-based projects within MNMH and to continue to mentor and guide others completing the Graduate Certificate.

Psychologists generally struggle to fit research with practice – research suggests two reasons for this – one is that they are research saturated by the time the finish studies and the other is that the real world of clinical practice does not provide opportunities to conduct the sort of research they are taught during studies …. What are your thoughts about this conundrum?

This is true from my perspective. Psychologists are often very happy to leave research behind once they graduate. I think part of this is how much of the research conducted at university level is done as an individual. I think one of the best ways to encourage more psychologists back into research is to point out the benefits of working as part of a research team, especially if a collaboration with a university is possible.

RCTs are the gold standard of research and this is the focus of studies in Psychology. We also largely, if not solely focus on quantitative analysis in our studies. However, it is often not practical to conduct RCTs in our settings, and qualitative research may produce a more meaningful appreciation of the experience of our complex consumers, and the outcomes of our interventions.

Therefore, I think the way forward is to introduce psychologists to qualitative research methods, within experienced research teams.

RETURNING TO STUDY IN THE POST FACEBOOK ERA

A/Operations Director, MNMH-RedCab

Danielle Alchin

Please tell us a bit about your background and current role?

I am currently the Acting Operations Director for Metro North Mental Health – Redcliffe Caboolture, but during my first year of returning to study I was in a project role helping to prepare MNMH for accreditation against the National Safety & Quality Health Service Standards (2nd Ed). What was I thinking?!

My clinical background is psychology and my substantive role is as the Team Leader of the MNMH – Resource Team, an amazing group of dedicated people who love their roles supporting other clinicians, consumers and the service.

What motivated you to enrol in the Grad Cert?

A. Blissful ignorance about the actual workload of post graduate study . . . ?

B. Amnesia - perhaps I let the fond memories of my time at QUT's lovely little Carseldine campus sway my decision to return to study some 15 years after submitting my thesis and vowing "never again".

C. I was reinvigorated after completing a master class in compassion focused supervision for my psychology STAP accreditation and it sparked a desire to keep learning. I also really appreciated the opportunity to return to study in a supportive environment – I knew returning to study would be a shock to the system and having the support of a MNHHS coordinator was a big draw card. The partnership between MNHHS and QUT to design and deliver this program has also ensured that the course content is directly relatable and applicable to my work.

Returning to study - what did that involve?

Learning, and then in equal parts, both celebrating and cursing the modern student's referencing shortcut, EndNote. This did help me to navigate previous APA related PTSD (they're up to the 7th edition now, surely there are only so many ways you can italicise but not underline, indent and capitalise but not bold, hyphenate but not abbreviate).

Reacquainting myself with academic writing, the grading system, submission deadlines, and of course, all the catastrophising neurotic over-thinking, over-analysing and over-sharing that comes with your typical university student's performance anxiety. Word count, what word count? I needed all of those expressive descriptive adjectives Sue!

What sort of research are/will you be doing in this course?

According to my research protocol, I will be doing a mixed method review of barriers and enablers of post-seclusion consumer debriefing with associated quality improvement initiatives to implement and embed changes into clinical practice.

What I think I'm doing? Just asking a simple question – If we know something works, why don't we do it?

What do you see as the role of implementation science in mental health services?

Sometimes in healthcare, certain activities are taken for granted and accepted as standard practice – even if we know a better or more effective/efficient/safer way to do things. As a psychologist, I find that fascinating!

Implementation science provides us with evidence-based frameworks to help explore barriers and find strategies that help to ensure improvements are adopted and sustained.

What advice would you give to a colleague contemplating enrolling in the course?

Have realistic expectations – yes you will need to work on weekends.

Enjoy the learning.

Think about areas of your work that frustrate you, or that you are particularly passionate about – and then imagine how you could redesign them. This course gives you the opportunity to dedicate some time and thinking space to a substantial quality improvement activity within your workplace.

Where to next?

First things first, I just want to get through and finish my independent study project – hopefully sharing some learnings along the way and benefitting our consumers and the service.

Shared Decision Making

Health care is about decisions made by people who seek and provide health services. Decisions are made about health status and what, if anything might be wrong, what could and needs to be done, why, how and when and by whom, about potential risks and benefits of different treatment options.

Internationally policies advocate 'shared decision making'. Shared Decision Making is defined as "An interactive process in which both parties (patient and doctor) are equally and actively involved and share information in order to reach an agreement, for which they are both jointly responsible.

SDM involves (i) at least 2 participants (ii) least 2 alternatives with some positive value.

SDM is MORE than information sharing.

In Australia, national standards oblige Health Service Organisations to establish processes for clinicians to partner with patients and/or their substitute decision maker to plan, communicate, set goals and make decisions about their current and future care.

SDM is promoted in health care as an end in itself – that SDM respects patients' rights and is a good thing to do; and as a means to improving decisions and achieving better outcomes for services and patients. In the mental health context SDM is commonly promoted on both or 'mixed' grounds. SDM in mental health is grounded in recognition that clinicians and patients bring different types of (complementary) expertise to decision making: clinicians are recognised as experts in diagnosis and treatment and the outcomes associated with various treatment options and patients are experts in experience of their condition and their lives and have preferences for outcomes. Combining these two types of expertise will promote better decisions.

Imani Gunasekara, Consumer Consultant with the Metro North Recovery and consumer and carer participation team recently reviewed literature regarding SDM in mental health to develop an understanding of the origins of SDM and views about SDM. Findings of the review which were used to develop an education package, and are summarised on page 27.

Work on the literature review was supported by a small grant which enabled Imani to take time off from usual duties.

Asked to reflect on her experience undertaking the review, Imani wrote:

I really enjoyed learning about the history of medical decision making and development of shared decision making and seeing the education package (including a comprehensive power point presentation) come together, knowing we were developing something useful.

We've come a long way since Hippocrates who viewed patients as debilitated and incapable of functioning as a real moral agent. But this has mostly happened over the last 60 years – especially in mental health. It was not until the 1950s that Paternalism, benevolent deception (a process by which patients are misled by doctors to reduce the risk of negative effects of diagnoses and treatments, and medical authority were questioned. As part of widespread social change and challenges to authority, patients challenged doctors and claimed a right to information and being involved in their care and decisions. There's still a lot of work to do to ensure that decisions are really shared.

The tool developed through this project can be used across the service to encourage clinicians to embrace Shared Decision Making in their day-to-day practice.

This makes me happy with the work we have done.

Imani Gunasekara
Consumer Consultant MNMH

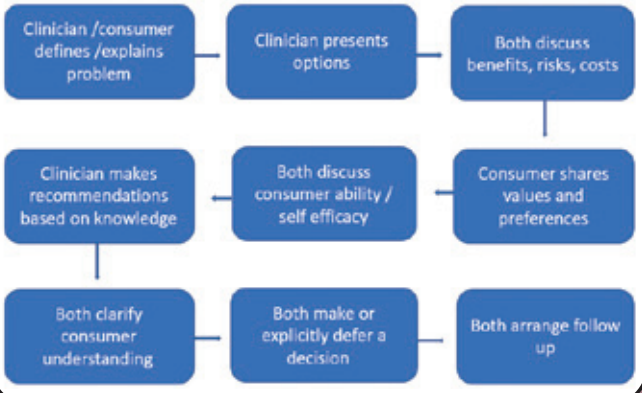
Benevolent Deception:
Henri de Mondeville
(1260 – 1316) until ~50 years ago

A process by which patients are misled by doctors in an effort to prevent possible negative effects from the disclosure of their diagnoses.

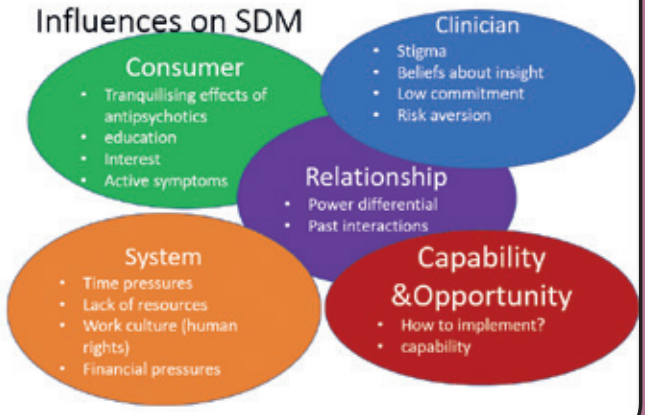
The Decision Making Spectrum

	Traditional paternalistic model	Shared decision making (SDM)	Informed decision making
Clinician	Active	Active	Passive
Consumer	Passive	Active	Active
Information	One way (Clinician to Consumer)	Two way (between Clinician and Consumer)	One way (largely) (Clinician to Consumer
Deliberation	Clinician alone or with other Clinicians	Clinician and Consumer (plus potential others)	Consumer plus potential others
Who decides?	Clinician	Clinician and Consumer	Consumer

Process for SDM



Influences on SDM



SHARED DECISION MAKING (SDM)

- Mental Health consumers are more likely to want SDM than patients in any other area of medicine, and most people with schizophrenia want involvement.
- Mental Health consumers more likely to want SDM if they have poor satisfaction with treatment/medication and have negative attitudes towards medication.
- Mental Health consumers are less likely to want SDM if they judge their decision making capacity as poor and are poorly educated.
- Mental Health consumers want the clinician to appreciate their experiences and directly and honestly share his/her knowledge.
- Mental Health consumers value two-way flow of information and feel empowered when they get information.
- Mental health clinicians agree, in principle with SDM but express concerns that that perceived power of the clinicians can limit consumer involvement and are concerned about the possible negative effects of sharing unfiltered information.

For more information about this topic, please contact Metro North Consumer and Carer Services.

Metro North Mental Health Consumer and Carer Engagement Partnership Framework: A new approach to partnership

Following a review of the Metro North Mental Health Consumer and Carer Engagement Group (CCEG), a co-design process was initiated to develop a new model of engagement and partnership for Metro North Mental Health. Four co-design workshops were held at different locations with a mix of consumers, carers, clinicians, Executives and Metro North community partner participants. Each workshop developed a shared understanding of the challenge of engagement and submitted team ideas These ideas were written on flags that were that turned into buntings of linked or common co-designed ideas. Summary reports were provided to individual workshop participants for feedback and a consolidated report grouping themes and ideas was circulated to all those who participated. A final workshop was held to consider all the ideas, vote on the preferred options, and work in small groups on how to translate ideas into practice. Appendix 1 is the list of ideas from all workshops that were then voted on and further developed at the final workshop.

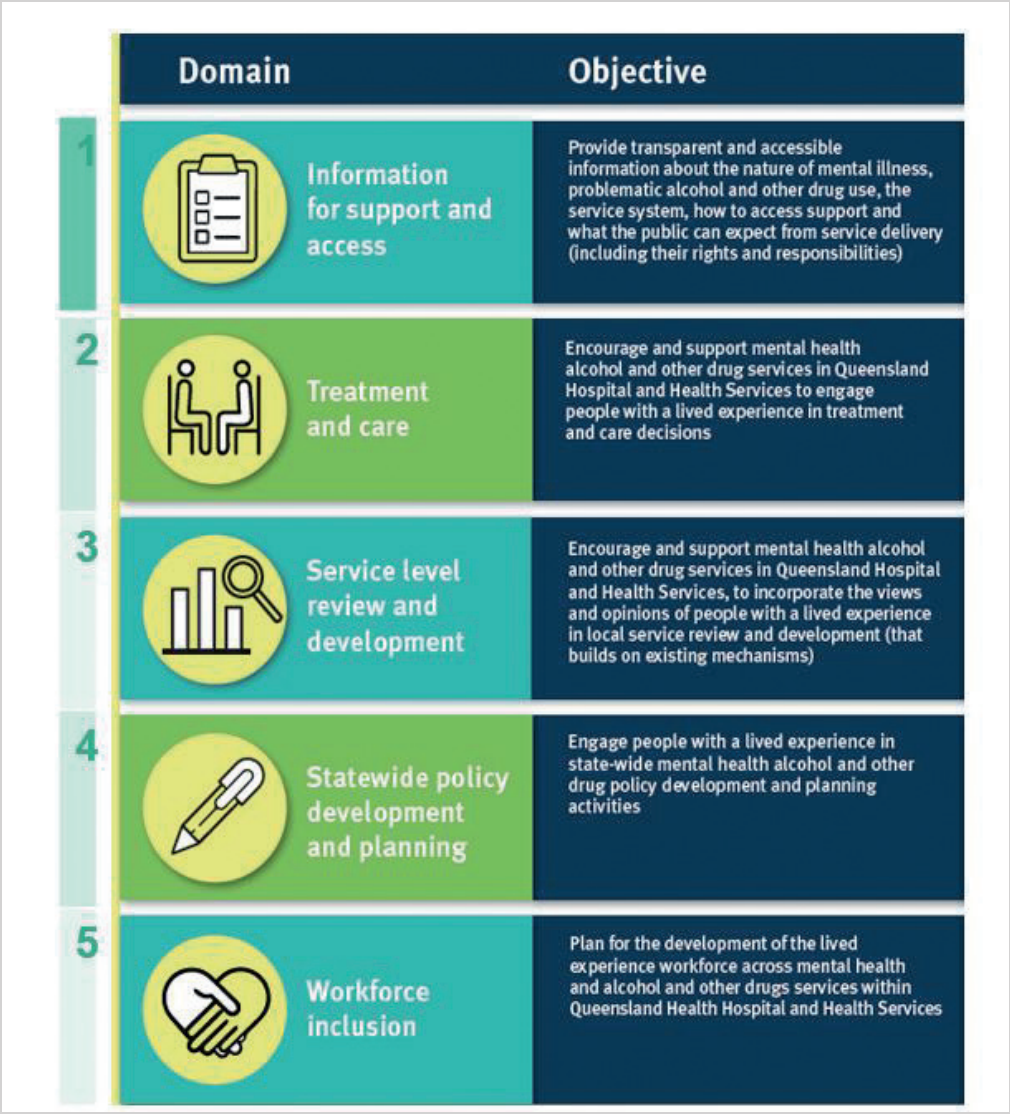


Figure 1: Mental Health, Alcohol and Other Drugs Branch (MHAODB) Lived Experience Engagement and Participation Strategy 2018-21 articulates levels of lived experience engagement and participation

Co-design methodology in a mental health service environment

Different points of view and power differentials

As the co-design workshops involved clinicians, consumers and carers, executives and community partners working together, it was important to set the expectations for working collaboratively and allowing space and time for discussion for ideas and issues.

Given power differentials, which can be pronounced in a mental health context for people with a lived experience of mental ill health, each workshop commenced with activities to address power differentials and offered 'break out' groups for consumers and carers to work together and provide opportunities for anonymity in expressing barriers, enablers and ideas prior to working with a mixed group. Clinicians and staff were asked to put their staff badges and lanyards away. Each workshop started with groups defining what partnership means for the purposes of the co-design initiative. Below are the characteristics that emerged out of the workshops to guide the process and way of working.

Ideas for a new approach: results of final workshop

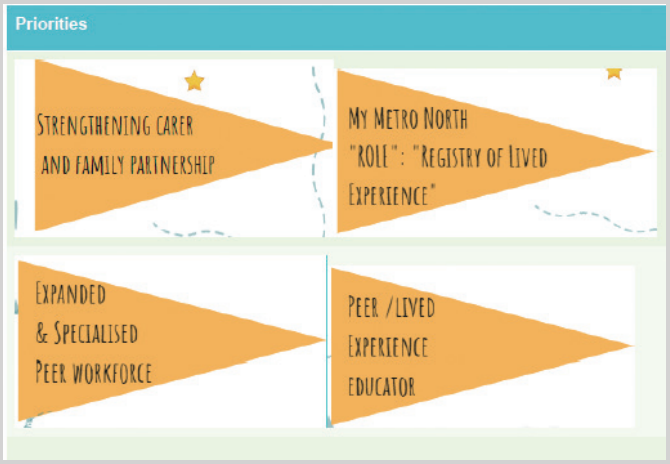
Each bunting flag of linked ideas was hung around the room with panels for voting beneath them. Participants were given three votes for their preferred group of ideas and then asked to give the idea flag that they preferred a gold star. Participants then worked through, in small groups, on the practical considerations and steps of the ideas.

Out of 10 groups of ideas, the following eight ideas emerged as the preferred options, listed in the order of 'votes' received:

1. Expand peer workforce
2. Consumer/ lived experience education role
3. Strengthening inclusion and partnership with carers and support people
4. Database/ registry of consumer and carers

Four other ideas that were also prioritised and determined to be linked to each of the ideas above were:

5. Community partnerships / intersectoral consumer engagement
6. Consumer / carer capability
7. Organisational culture
8. Platform for stories



Perinatal Mental Health Service

Pregnancy, childbirth and the early post-partum (collectively called the perinatal period) necessitates significant adjustment physically, socially and emotionally. While the perinatal period is often a positive time in the lives of women it can also be challenging. Various experiences and difficulties associated with pregnancy and child birth and adaptation can cause distress, and risk of a range of mental health issues is increased.

Some women experience substantial difficulties: for example, conception may be problematic necessitating intervention, pregnancy may be lost or deemed high risk, labour and birth may be complicated, the baby(ies) may experience health problems requiring intervention and adapting to parenthood can be experienced as distressing. Some women will experience symptoms of post-traumatic stress disorder (PTSD) with risk of PTSD increased when women have experienced trauma at other times in their lives. Early identification of women at risk of, or experiencing, PTSD is critical to enabling access to the effective treatments that are available and optimising outcomes.

Recognition of the burden and prevalence of mental health problems during the perinatal period support current clinical guidelines mandating routine screening for depression, anxiety and psychosocial risk, of all women during antenatal care (using the Edinburgh postnatal depression scale (EPDS) and the antenatal risk questionnaire (ANRQ). Recommendations promote repeat screening of the EPDS during antenatal care and at 6-8 weeks post-partum. The EPDS is designed to identify symptoms of anxiety and depression but it is not sensitive to symptoms of PTSD and no other tools are available to identify women who have experienced trauma and symptoms of PTSD.

A team of researchers from Metro North Mental Health and QIMR have received funding to address this gap.

The Pregnancy Birth and Trauma (PBT) study has been designed primarily to address improve identification of women at risk of, or experiencing, perinatal PTSD by developing and validating a tool that is acceptable to women and clinicians for use in routine practice.

Tracey Mackle
Nurse Practitioner -MNMH Perinatal MHS

Associate Professor Lucia Colodro-Conde
QIMR Berghofer Research Fellow

CLINICIAN RESEARCHER: TRACEY MACKLE

Tracey Mackle

Tracey Mackle is a Nurse Practitioner with extensive experience working in perinatal mental health. She recognises promoting the mental health and wellbeing of mothers and families as inherently valuable but also critical to achieving best outcomes for babies, at birth and to development across the life span. Tracey is passionate about providing the best clinical care and services possible to meet the diverse needs of families in the peri-natal period and sees research as essential to that. Here she tells us about research she is undertaking in partnership with a team from Metro North and QIMR Berghofer: The Pregnancy Birth and Trauma (PBT) study.

Tell us briefly about the research.

We are developing a questionnaire to identify women with symptoms of post-traumatic stress disorder (PTSD) during the period that goes from trying to conceive through the first year after birth.

What does this research mean for patients, research participants or the community?

Our pilot study is working towards the development of a screening questionnaire that could be incorporated in the perinatal health care system. The perinatal period goes from the conception to the first year after birth, a period in which women are in frequent contact with health care professionals. The availability of the tool will allow identifying women who are at risk of PTSD and an earlier intervention. This is expected to have an important impact in the health and wellbeing of the affected women and their communities.

The screening tool can be also used in research contexts and will help understanding perinatal PTSD and the strategies to prevent it and treat it.

Why is this research important and what has been achieved?

In Metro North we aim to provide a personalised, integral, effective, and trauma informed health care. Mental health is core in our scheme. While attention to postnatal depression is embedded in the system, we want to contribute to a better detection of perinatal PTSD, which will lead to earlier and more effective treatments.

What is next?

Once funding is secured, we would like to test the resulting screening tool in a second phase of the project, with larger samples and exploring not only the pregnancy and early postpartum contexts, as we are doing in this phase, but conception and late postpartum. We would also like to explore PTSD symptomatology in the women's partners, an issue that has been raised in our consultation process. The final aim is to incorporate the perinatal PTSD questionnaire in the perinatal health care protocols.

What has been achieved so far (February 2020)?

- *177 women have been recruited (1 left the survey incomplete, so it's effectively 176). Age: M = 28, SD = 5, range= 18-39; pregnancy week 17 (SD= 6).*
- *78 reported a traumatic event (98 did not).*
- *Of those reporting traumatic event, 50 were willing to participate in the interview (and 28 were not).*
- *The clinical interview has already been completed by 30 out of 50 women.*
- *According to the PSSI-5 (clinical interview), 7 out of 30 had a diagnosis of PTSD (and, the symptom severity scale indicated that 2 and 3 of them had a severe and very severe presentation, respectively).*
- *The full ACE was completed by 174 out of 176 women.*

Jane, a participant in the study wrote to the study team after completing the survey

"I found it very helpful and healing in a way. It's really good to know that support in the healthcare sector is changing. Slowly, but surely the government will offer the right support regarding trauma".

Jane

THE PRINCE CHARLES HOSPITAL (TPCH) HIGHLIGHTS

This year has seen a number of exciting outcomes in research in the mental health unit at TPCH, and there has been a strong effort among clinicians to develop research that addresses the challenges experienced by people living with mental illness. This is evident in a number of projects, for example, Associate Professor Andrew Teodorczuk's work on the evaluation of delirium, and Dr. Lisa Wright's investigation of sensory modulation in mental health care.

Throughout the year, TPCH mental health clinicians were involved in a number of published journal articles, conference presentations, and applications for research funding with collaborators. For example, Associate Professors Gail Robinson and Senthil Muthuswamy were successful in obtaining funding from the TPCH Foundation for an Innovation Grant exploring the implementation of restorative justice practices in the SHMRU at TPCH. This work is being led by Dr Michael Power from the Queensland Health Victim Support Group, and the project is now well into its implementation phase.

2019 began with TPCH negotiating funding from Janssen-Cilag to employ a part-time research developer for the mental health unit. This grant has allowed TPCH clinicians to have on site consultation and support for research projects, service evaluations, audits, and registrar scholarly projects. There is a growing interest to conduct more research at TPCH, and it has been a pleasure to have been in this role since March. The commitment of TPCH clinicians to the well-being of consumers is outstanding and provides a solid platform for doing the kind of research that consumers can see the benefit in.

SPOTLIGHT ON DELIRIUM RESEARCH

I am a Consultant working with the Older Peoples Team based at Chermside Community Centre and also a Professor of Medical Education based at Griffith University. For the past 15 years I have been a delirium researcher working both in the UK and for the last 3 years in Brisbane. Specifically, I lead an educational research program looking at developing best delirium education practice.

Education has been shown to be an effective non pharmacological strategy to prevent delirium which tends to be under recognised in clinical settings. Within the portfolio we cover the full continuum of delirium education from researching direct didactic staff teaching effectiveness to work based learning by means of mimetic processes and through to using realist methodologies to understand how best to educate families and carers.

Since 2016 I have been a board member of the Australasian Delirium Association and over the last year the chair of the organising committee for the biannual ADA 2020 DECLARED meeting. This is the largest meeting of deliriumologists in the Southern Hemisphere. The meeting will take place between the 2nd and 4th September 2020 at the Brisbane Convention Entertainment Centre and more details are available on the website. www.declared2020.com

Delirium is an illness which is very much "everybody's business" and occurs throughout the hospital in nearly all clinical settings with higher prevalence rates in ICU and surgical settings. Recently we are becoming aware of the financial toll of the illness as well as the distressing impact it has on families and carers. This year we published a Deloitte economic analysis that determined in a single year the cost of delirium in Australia is estimated to be $8.8 billion. We are also understanding the importance of delirium now in community settings and one of the highlights of 2019 was translating these understandings direct to front line nursing home staff by means of a large delirium teaching session that the Older Peoples team delivered in October 2019.

Unfortunately compared to other medical fields there is a dearth of research into delirium though this is changing through initiatives to raise awareness such as world delirium day and through the tireless work of the Australasian Delirium Association, European Delirium Association and American Delirium Society.

At Metro North we are fortunate to be able to address this research gap as we have internationally recognised researchers researching a wide range of topics including the complexity of delirium, delirium in ITU, neuroimaging in delirium, delirium in Psychiatric settings, risk factors and the effectiveness of multicomponent interventions. Together with colleagues such as Alison Mudge, Eamonn Eales, Connor O"Lunaigh, John Fraser, Michelle White, Karen Lee Steer, Dylan Flaws to name but a few, my aim is to build a delirium research team for Metro North and consolidate our expertise to be among the best in the world. Presently both RBWH and Prince Charles are listed within the top 10 hospitals in Australia in terms of delirium research impact on expertscape.com.

The potential to make a difference and harness our expertise is truly exciting. I would encourage you if you have an interest in contributing to our work to either contact myself or come along to the Australasian Delirium Association meeting in 2020.

Professor Andrew Teodorczuk

Andrew Teodorczuk
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BMJ Open

Economic impact of delirium in Australia: a cost of illness study

Lynne Pezzullo,[1] Jared Streatfeild,[1] Josiah Hickson,[1] Andrew Teodorczuk,[2] Meera R Agar,[3] Gideon A Caplan[4,5]

ABSTRACT

Objectives To estimate the economic impact of delirium in the Australian population in 2016–2017, including financial costs, and its burden on health.

Design, setting and participants A cost of illness study was conducted for the Australian population in the 2016–2017 financial year. The prevalence of delirium in 2016–2017 was calculated to inform cost estimations. The costs estimated in this study also include dementia attributable to delirium.

Main outcome measures The total and per capita costs were analysed for three categories: health systems costs, other financial costs including productivity losses and informal care and cost associated with loss of well-being (burden of disease). Costs were expressed in 2016–2017 pound sterling (£) and Australian dollars ($A).

Results There were an estimated 132 595 occurrences of delirium in 2016–2017, and more than 900 deaths were attributed to delirium in 2016–2017. Delirium causes an estimated 10.6% of dementia in Australia. The total costs of delirium in Australia were estimated to be £4.3 billion ($A8.8 billion) in 2016–2017, ranging between £2.6 billion ($A5.3 billion) and £5.9 billion ($A12.1 billion). The total estimated costs comprised financial costs of £1.7 billion and the value of healthy life lost of £2.5 billion. Dementia attributable to delirium accounted for £2.2 billion of the total cost of delirium.

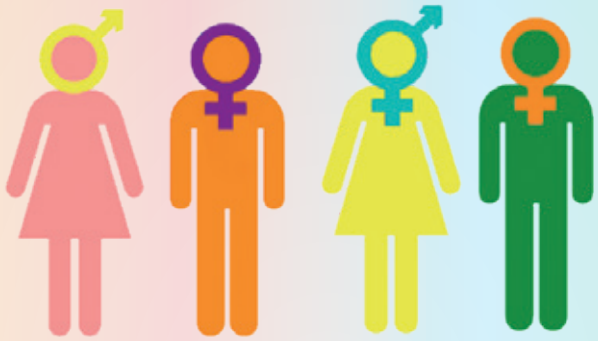
Conclusions These findings highlight the substantial burden that delirium imposes on Australian society—both in terms of financial costs associated with health system expenditure and the increased need for residential aged care due to the functional and cognitive decline associated with delirium and dementia. To reduce the substantial well-being costs of delirium, further research should seek to better understand the potential pathways from an episode of delirium to subsequent mortality and reduced cognitive functioning outcomes.

Strengths and limitations of this study

- This cost of illness study estimates the total annual financial and well-being impacts of delirium for the first time in Australia.
- This study also estimates the costs of dementia that are associated with delirium in Australia, with significant implications for other high-income western countries.
- This study is based on a non-systematic search strategy to find relevant cost inputs, noting that a number of inputs are sourced from official Australian Government statistics.
- There were a number of data gaps when estimating costs, meaning the results of this study are only indicative of the total cost.
- While this cost of illness study estimates the overall cost of delirium, more work is needed to identify cost-effective interventions to reduce the burden of delirium.

Mental Health and the LGBTIQ Community

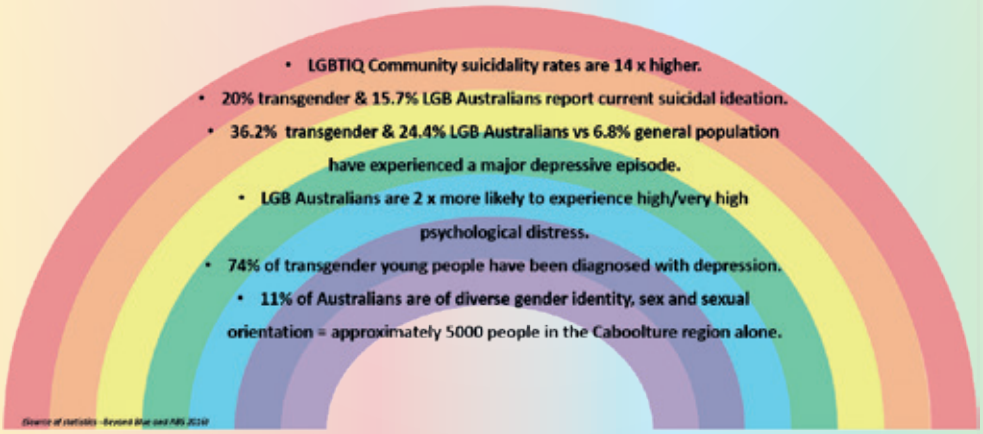
There is evidence for greater vulnerability to various mental health issues among lesbian, gay, bisexual, transgender, and intersex (LGBTI) people in Australia; depression, anxiety, and suicidal behaviours in particular. There is therefore a gap in addressing the psychological distress of LGBTI people, who experience disproportionately negative mental health outcomes in comparison with the general community, yet despite these poorer outcomes, are less likely to seek help than their mainstream counterparts (Quac, 2014).



71% of LGBTI+ people aged 16 to 27 indicated that they did not use a crisis support service during their most recent personal or mental health crisis.

32.6% of LGBTI+ people aged 16 to 27 who had not used a crisis support service during their most recent personal or mental health crisis indicated that their decision was due to anticipated discrimination.

34% of people don't identify gender/sexuality/diversity at time of presenting to mental health



The importance of Language

What is LGBTIQ inclusive language?

Inclusive language is a way of acknowledging and respecting the diversity of bodies, genders and relationships. People express their gender and sexuality in different ways.

Inclusive language ensures we don't leave people out of our conversations or our work. This includes both when we are communicating directly with someone, and when describing someone who isn't present. Inclusive language acknowledges the diversity of people we work with and serve.

What are the basics of using inclusive language?

Ask	No Assumptions	Use
If someone discloses to you that they're from one of the LGBTIQ communities, respectfully ask what terms they use to describe themselves, then use those terms.	Don't make assumptions about someone's gender, sexuality or relationship. Accept and respect how people define their gender and sexuality.	Use language that acknowledges that we have diverse relationships and families. This can mean using words like "partner" or "parents", particularly when describing groups of people.

Challenges to inclusive language use in health

- At times health professionals find that patients may identify using particular terms at one visit and different terms at follow up. In situations where identity is not very apparent, you may be reluctant to ask direct questions for clarification. This desire to "get it right" may impact the professional relationship, which can then have ramifications for patient and carer satisfaction and health outcomes.
- Staff must be mindful to use language that is inclusive of an individuals' identity, rather than impose on them language due to individual bias or what's "most comfortable." This acknowledges the systemic discrimination LGBTIQ patients often experience within the health care system and the position of "power "through our interactions and communication with patients, where they might feel their voice is being silenced due to incorrect use of language or misgendering.

(Source of Statistics: National LGBTI Health Alliance – Snapshot of Mental Health and Suicide Prevention Statistics for LGBTI People – February 2020, Beyond Blue & Australian Bureau of Statistics 2016)

Curt Singleton (left) and Anita Compton (right)

Two clinicians from Redcliffe Caboolture Mental Health, have been leading work to promote understanding of the complex mental health challenges faced by members of the LGBTIQ communities and inclusive, respectful practice. Curt Singleton a social worker and Anita Compton, an occupational therapist (pictured above) have been leading service-wide activities to raise awareness and encourage engagement. They have presented at forums within and beyond mental health, been disseminating resources and generally working to make services accessible and welcoming to all community members. The importance and value of their work has been recognised in exceptionally positive feedback on presentations and in Values in Action awards.

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 focused 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.

2019 Highlights:

- Publication of the findings from our NHMRC-funded clinical trial using nutraceuticals to treat major depressive disorder.
- Publication of the findings from our NHMRC-funded clinical trial using kava to treat generalised anxiety disorder.
- Publication of our international cross-validation of the Geriatric Anxiety Inventory (GAI), a scale which we developed 12 years ago and is now in widespread use around the world, available in 20 languages. We now have over 500 citations for our original paper and over 100 citations for our paper on the short form of our scale.

A Cross-National Analysis of the Psychometric Properties of the Geriatric Anxiety Inventory

Helge Molde, PhD ✉, Inger Hilde Nordhus, PhD, Torbjørn Torsheim, PhD, Knut Engedal, PhD, Anette Bakkane Bendixen, MD, Gerard J Byrne, PhD, María Márquez-González, PhD, Andres Losada, PhD, Lei Feng, PhD, Elisabeth Kuan Tai Ow, PhD ... Show more

The Journals of Gerontology: Series B, gbz002, https://doi.org/10.1093/geronb/gbz002

Published: 08 January 2019 **Article history**

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Abstract

Objectives

Assessing late-life anxiety using an instrument with sound psychometric properties including cross-cultural invariance is essential for cross-national aging research and clinical assessment. To date, no cross-national research studies have examined the psychometric properties of the frequently used Geriatric Anxiety Inventory (GAI) in depth.

Method

Using data from 3,731 older adults from 10 national samples (Australia, Brazil, Canada, The Netherlands, Norway, Portugal, Spain, Singapore, Thailand, and United States), this study used bifactor modeling to analyze the dimensionality of the GAI. We evaluated the "fitness" of individual items based on the explained common variance for each item across all nations. In addition, a multigroup confirmatory factor analysis was applied, testing for measurement invariance across the samples.

Results

Across samples, the presence of a strong G factor provides support that a general factor is of primary importance, rather than subfactors. That is, the data support a primarily unidimensional representation of the GAI, still acknowledging the presence of multidimensional factors. A GAI score in one of the countries would be directly comparable to a GAI score in any of the other countries tested, perhaps with the exception of Singapore.

Discussion

Although several items demonstrated relatively weak common variance with the general factor, the unidimensional structure remained strong even with these items retained. Thus, it is recommended that the GAI be administered using all items.

Kava for generalised anxiety disorder: A 16-week double-blind, randomised, placebo-controlled study

Australian & New Zealand Journal of Psychiatry
1–10
DOI: 10.1177/0004867419891246

Jerome Sarris[1,2], Gerard J Byrne[3], Chad A Bousman[4,5], Lachlan Cribb[2], Karen M Savage[2,6], Oliver Holmes[6], Jenifer Murphy[2], Patricia Macdonald[3], Anika Short[3], Sonia Nazareth[3], Emma Jennings[6], Stuart R Thomas[7], Edward Ogden[6], Suneel Chamoli[8], Andrew Scholey[6] and Con Stough[6]

Abstract

Objective: Previous randomised, double-blind, placebo-controlled studies have shown that Kava (a South Pacific medicinal plant) reduced anxiety during short-term administration. The objective of this randomised, double-blind, placebo-controlled study was to perform a larger, longer-term trial assessing the efficacy and safety of Kava in the treatment of generalised anxiety disorder and to determine whether gamma-aminobutyric acid transporter (SLC6A1) single-nucleotide polymorphisms were moderators of response.

Methods: The trial was a phase III, multi-site, two-arm, 16-week, randomised, double-blind, placebo-controlled study investigating an aqueous extract of dried Kava root administered twice per day in tablet form (standardised to 120 mg of kavalactones twice/day) in 171 currently non-medicated anxious participants with diagnosed generalised anxiety disorder. The trial took place in Australia.

Results: An analysis of 171 participants revealed a non-significant difference in anxiety reduction between the Kava and placebo groups (a relative reduction favouring placebo of 1.37 points; $p = 0.25$). At the conclusion of the controlled phase, 17.4% of the Kava group were classified as remitted (Hamilton Anxiety Rating Scale score < 7) compared to 23.8% of the placebo group ($p = 0.46$). No SLC6A1 polymorphisms were associated with treatment response, while carriers of the rs2601126 T allele preferentially respond to placebo ($p = 0.006$). Kava was well tolerated aside from poorer memory (Kava = 36 vs placebo = 23; $p = 0.044$) and tremor/shakiness (Kava = 36 vs placebo = 23; $p = 0.024$) occurring more frequently in the Kava group. Liver function test abnormalities were significantly more frequent in the Kava group, although no participant met criteria for herb-induced hepatic injury.

Conclusion: While research has generally supported Kava in non-clinical populations (potentially for more 'situational' anxiety as a short-term anxiolytic), this particular extract was not effective for diagnosed generalised anxiety disorder.

Nutraceuticals for major depressive disorder- more is not merrier: An 8-week double-blind, randomised, controlled trial

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ABSTRACT

Background: One of the most pressing questions in "Nutritional Psychiatry" is whether using combinations of different nutraceuticals with putative antidepressant activity may provide an enhanced synergistic antidepressant effect.
Methods: A phase II/III, Australian multi-site, 8-week, double-blind, RCT involving 158 outpatients with a DSM-5 diagnosis of MDD. The intervention consisted of a nutraceutical combination: S-adenosyl methionine; Folinic acid; Omega-3 fatty acids; 5-HTP, Zinc picolinate, and relevant co-factors versus placebo. The primary outcome was change in MADRS score. Hypothesis-driven analyses of potential moderators of response involving key SNPs, and BDNF were also conducted.
Results: Placebo was superior to the nutraceutical combination in reducing MADRS score (differential reduction -1.75 points), however a mixed linear model revealed a non-significant Group X Time interaction ($p = 0.33$). Response rates were 40% for the active intervention and 51% for the placebo; remission rates were 34% and 43% for active and placebo groups, respectively. No significant differences were found between groups on any other secondary depression, anxiety, psychosocial, or sleep outcome measures. Key SNPs and BDNF did not significantly moderate response. No significant differences occurred between groups for total adverse effects, aside from more nausea in the active group.
Limitations: Very high placebo response rates suggest a placebo run-in design may have been valuable.
Interpretation: The adoption of a nutraceutical 'shotgun' approach to treating MDD was not supported, and appeared to be less effective than adding placebo to treatment as usual.

Dissemination Activities

PUBLICATIONS

Published Abstracts:

1. **Haworth S, Counsel R, and Gunasekara I** (2019). To debrief or not to debrief: Adding a collaborative approach to decreasing repeated restrictive practices (Poster). International Journal of Mental Health Nursing, 28(S1),22.
2. **Ewing J** (2019) A physical health audit's impact on care design. International Journal of Mental Health Nursing, 28(S1),17.
3. **Collyer, B, Burrows D, Gunasekara I** (2019). Onboarding, to recovery (Poster). International Journal of Mental Health Nursing, 28(S1),10.

Journal Articles:

1. Ashton MM, Dean OM, Walker A, Bortolasci C, Ng C…**Scott JG**, et al. The Therapeutic Potential of Mangosteen Pericarp as an Adjunctive Therapy for Bipolar Disorder and Schizophrenia. Front Psychiatry. 2019 Mar 13;10:115. doi:10.3389/fpsyt.2019.00115.
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Books and Chapters:

1. C**lark S**, et al. Substance use and dependency. Lewis's Medical–Surgical Nursing ANZ 5th edition. Elsevier, Marrickville, NSW.

2. **Johnson J**, **Byrne G**. QT-prolonging agents with risk of torsades de pointes. Australas Psychiatry. 2019 Feb;27(1):92. doi:10.1177/1039856218794875.

Other Publications:

1. Capra C, Gardner M, **Scott JG**. Ed-LinQ Evaluation Framework.

2. Capra C, Garner M, **Scott JG**. Evaluation Framework for the Adolescent Extended Treatment Centre (AETC): Final Summary

3. Gardner M, Capra C, Erskine E, Whiteford H, **Scott JG**. Youth Residential Rehabilitation Units Service Evaluation Report.

4. **Mercier S**, **Manolis D**, **Patterson S** & **Bicker S**. Evaluation report: development of sensory spaces on adult inpatient mental health units.

CONFERENCE PRESENTATIONS – INVITED, ORAL AND POSTER

Invited Speaker:

1. **Andrew Teodorczuk**. Blackall CA. Delirium: the cognitive superbug. Hobart, Australia. July 2019.
2. **Andrew Teodorczuk**. Delirium Update, Older Peoples statewide symposium. Brisbane. August 2019.
3. **Andrew Teodorczuk**. European Delirium Association: Delirium Education: where are we now? Edinburgh. Sept 2019.
4. **Andrew Teodorczuk**. European Delirium Association: How to make delirium education effective. Edinburgh. Sept 2019.
5. **Andrew Teodorczuk**. European Delirium Association: The Wicked Problem of Delirium Education. Edinburgh. Sept 2019.
6. **Andrew Teodorczuk**. RACMA, Resilience and wellbeing: lessons from across the education continuum. Brisbane. Nov 2019.
7. **Andrew Teodorczuk**. Recent advances in management and assessment of delirium. Statewide Older Peoples Mental Health Symposium. August 2019.
8. **Andrew Teodorczuk**. Delirium: Past Present and Future. The Prince of Wales Hospital. May 2019.
9. **Andrew Teodorczuk**, Humphreys L. Doctors well-being, reflection and resilience. Grand Round, Redcliffe Hospital, April 2019
10. **Andrew Teodorczuk**. Nursing Grand Rounds: Delirium. Robina, October 2019
11. **Andrew Teodorczuk**. Prince Charles Grand Round: Delirium. Brisbane. June 2019
12. **Ed Heffernan**, **Fiona Davidson**, **Carla Meurk**. Mental health of police. RANZCP Congress. Cairns. 13 May 2019.

13. **Ed Heffernan**, **Penny Dale**, **Yasmin Muller**, **Fiona Davidson**, Megan Steele, **Elissa Waterson**. From custody to community, the Indigenous Mental Health Intervention Program. RANZCP Congress. Cairns. 13 May 2019.
14. **Gerard Byrne**. Are self-ratings or informant-ratings of anxiety better in the presence of dementia? International Geriatrics and Gerontology Association – European Regional Conference. Gothenburg, Sweden. May 2019.
15. **Gerard Byrne**. Can suicide be prevented in older people? Centre for Health Services Research Geriatric Seminar. Translational Research Institute, University of Queensland, Princess Alexandra Hospital, Brisbane. November 2019.
16. **Gerard Byrne**. Risk in Older People: Assessment and Mitigation. Psychiatric Masterclass. Perth, Western Australia. March 2019.
17. **Gerard Byrne**. Trick question: Can suicide be prevented? Risk assessment and mitigation in older people. Australian Psychological Society – Psychology & Ageing Interest Group. Auckland University of Technology, Auckland, New Zealand. June 2019.
18. **James Scott**. Bullying: Definition, Prevalence and Longitudinal Outcomes at "The Causes and Consequences of Childhood Bullying. An Australian and Danish Workshop". Aarhus University Denmark. 30th October 2019.
19. **James Scott**. Neuronal antibodies in psychosis: What psychiatrists need to know. Lundbeck Institute Schizophrenia Masterclass. Werribee Victoria. 18 September 2019.
20. **James Scott**. Does smoking cigarettes cause schizophrenia? Medical Grand Rounds, Redcliffe Hospital. 23 May 2019.
21. **James Scott**. Long Acting Injectable Aripiprazole: A Clinician's Perspective. Lundbeck/Otsuka National Australian Conference. Byron Bay. 4 July 2019.
22. **James Scott**. Psychosocial interventions in schizophrenia: Back to the Future Vision 2020. Sydney. 30 March 2019.
23. **James Scott**. The mistaken identity of autoimmune encephalitis. Psyacademy. Melbourne. 21 September 2019.

Orals:

1. **Amanda Davis**. Innovative methods enhance confidence and competence of Dieticians to deliver dietetic interventions for eating disorders. Dietitians Association of Australia Conference. 13 August 2019.
2. **Amanda Davis**. Solving the supervision dilemma for Dieticians working in Eating Disorders - Innovative programmes from a state-wide advisory service. Australian New Zealand Academy for Eating Disorders 17th Annual Conference 2019. 23 August 2019.
3. **Amanda Davis**. Solving the supervision dilemma for Dieticians working in Eating Disorders - Innovative programmes from a state-wide advisory service. Dietitians Association of Australia 36th Annual Conference. 13 August 2019.
4. **Bozica Stumfol**. Application of EMDR therapy for an elderly man with a lifelong anxiety disorder: a case study. Older Person's Mental Health Statewide Symposium, RBWH, Brisbane. 9 August 2019.
5. **Carla Meurk**, Megan Steele, **Jackyln Schess**, Lorraine Yap, Jocelyn Jones, **Scott Harden**, Tony Butler, **Ed Heffernan**. Prevalence of mental disorder among justice involved youth: A cross-sectional survey. Justice Health Conference, Public Health Association of Australia, Sydney. 10 April 2019.
6. **Catherine Doyle**, **Amy Hannigan** and **Jacqueline Byrne**. Carer Peer Mentor Pilot Program: Feasibility and Qualitative evaluation. Australian New Zealand Academy for Eating Disorders 17th Annual Conference. 24 August 2019.
7. Justin Chapman, Stephen Tillston, Sarah Childs, Greg Pratt, Shuichi Suetani, Dan Siskind, and **Sue Patterson**. Building healthy communities through multidisciplinary community-based lifestyle interventions. Brisbane North Allied Health Conference, Chermside, Brisbane. 21 May 2019.
8. **Darren Neillie**. RANZCP Family Violence in Psychiatry Network: improving capacity of mental health services to respond to family violence. RANZCP Congress, Cairns. 14 May 2019.
9. **Dylan Flaws**. Clinician scientist perspective/career. Faculty of Medicine's annual MD Student Research Welcome and Expo for incoming medical students in 2020. 9 April 2019.
10. **Dylan Flaws**. Enabling clinical research through Partnership. The MNHHS Interactive Research Workshop. 13 August 2019.

11. **Dylan Flaws**. The role of research in ongoing medical training. Australian Medical Student Journal Research Symposium. 19 July 2019.
12. **Ed Heffernan**, **Carla Meurk**, Megan Steele, **Elissa Waterson**. Partnering with police to improve outcomes in mental health crisis situations. RANZCP Congress. Cairns. 14 May 2019.
13. **Ed Heffernan**, **Carla Meurk**. Partners in Prevention: Understanding and Enhancing First Responses to Suicide Crisis Situations. TheMHS Conference 2019. Brisbane. 28 August 2019.
14. **Ed Heffernan**, **Penny Dale**, **Yasmin Muller**, **Fiona Davidson**, Megan Steele, **Elissa Waterson**. From custody to community, the Indigenous Mental Health Intervention Program. TheMHS Conference 2019. Brisbane. 29 August 2019.
15. **Ed Heffernan**. Innovations in community services (symposium). TheMHS Conference 2019. Brisbane. 28 August 2019.
16. **Fiona Davidson**. Diversion down under: how well do Australian mental health court liaison services perform? Justice Health Conference, Public Health Association of Australia. Sydney. 10 April 2019.
17. **Gerard Byrne**. Assessment of anxiety in the presence of dementia. Annual Congress of the Royal Australian & New Zealand College of Psychiatrists. Cairns, Queensland. May 2019.
18. **James Scott**, Frances Dark, Julianne Fraser, **Faith Ng**, Stephen Parker, **Katherine Moss**. Eesharnan Mahendran and Brendon Eyre. Welcome to the breakfast club: fostering culture, diversity and mutual learning among registrars and early career psychiatrists through research. RANZCP Congress. Cairns. 13 May 2019.
19. **James Scott**. The aggressive child. Royal Australian and New Zealand College of Psychiatrist Congress. Cairns. 14 May 2019.
20. John Reilly, Calogero Longhitano, **Darren Neillie**. Violence risk assessment and management framework: mental health services. RANZCP Congress. Cairns. 14 May 2019.
21. Julie Ewing. A physical health audit's impact on care design. Australian College of mental Health Nursing conference. Sydney. 8-10 October 2019.
22. **Katherine Moss**, **Ed Heffernan**, **Carla Meurk**, Megan Steele. Physical health and mental illness: can implementation science assist in addressing the needs of forensic patients in secure facilities? RANZCP Congress, Cairns. 14 May 2019.
23. **Lisa Wright**, Pamela Meredith, Sally Bennett. "Why didn't you just give them PRN": Investigating the factors influencing the implementation in inpatient mental health units. Occupational Therapy 28th National Conference and Exhibition 2019, Sydney, Australia. 10-12 July 2019.
24. Megan Steele, **Carla Meurk**, **Jackyln Schess**, Lorraine Yap, Jocelyn Jones, **Scott Harden**, Tony Butler, **Ed Heffernan**. Substance use patterns of justice involved youth. Justice Health Conference, Public Health Association of Australia. Sydney. 10 April 2019.
25. **Melissa Connell**. Trauma Informed Care and Practice in MNMH-ADS. Queensland Health Mental Health Alcohol and Other Drugs Senior Leaders Group (SLG) forum. Victoria Park, Brisbane. 13 August 2019.
26. **Melissa Connell**, **Kim Sander**, **Annaketurah Ralph**, **John Kelly**, **Nicole Brigg**. Becoming Trauma Informed: MNMH-ADS journey of developing and implementing a model of Trauma Informed Care and Practice. Australian Winter School 2019. 25-26 July 2019.
27. Oystein Tronstad, **Dylan Flaws**, **Sue Patterson**, John Fraser. ICU of the Future - how redesigning the ICU environment can improve patient outcomes. 29th TheMHS Conference 2019. 28 August 201
28. Oystein Tronstad, **Dylan Flaws**, **Sue Patterson**, John Fraser. What are the short and long-term impacts of an ICU admission on the patient? 29th TheMHS Conference 2019. 28 August 2019.
29. Oystein Tronstad, **Dylan Flaws**, **Sue Patterson**, John Fraser. How does the ICU environment impact staff experience and patient care: implications for environmental development. World Congress of Intensive Care. Melbourne. 14-18 October 2019.
30. **Sally Mercier**, **Danielle Manolis**, **Sue Patterson**, **Samantha Bicker**. It makes sense, therapeutically: Creating sensory spaces in mental health inpatient units. 29th TheMHS Conference 2019, 28 August 2019 & Statewide Leaders' Forum, 13 August 2019.

Posters:

1. **Bridget Johnson**, **George Bruxner**, **Sue Patterson**. Optimising Psychiatric After-Hours Duty: The Implementation and Impact of a Short Cycle After-Hours Roster. RANZCP Congress in Cairns. 12-16 May 2019.
2. **Bruce Collyer**, **Diane Burrows** and **Imani Gunasekara**. 'Onboarding, to recovery'. Presented to: ACMHN 45th International Mental Health Nursing Conference. Sheraton Grand, Sydney Hyde Park, October 8 -10.
3. **Lisa Wright**, **Margherita Chiavone.** Psychiatric Intensive Care Units: Developing a Role for Occupational Therapists. Presented by L.Wright at Occupational Therapy 28th National Conference and Exhibition 2019, Sydney, Australia. 10-12 July 2019.
4. Oystein Tronstad, **Dylan Flaws**, **Sue Patterson**, John Fraser. What can ICU patients tell us about their experience and the impact of the environment on their recovery? World Congress of Intensive Care. 14-18 October 2019.
5. Oystein Tronstad, **Dylan Flaws**, **Sue Patterson**, John Fraser. When a flower doesn't bloom, you fix the environment where it grows, not the flower – Designing the ideal ICU. World Congress of Intensive Care. 14-18 October 2019.
6. **Scott Haworth**, **Robin Counsel** and **Imani Gunasekara**. 'To debrief or not to debrief: Adding a collaborative approach to decreasing repeated restrictive practices'. Presented to: ACMHN 45th International Mental Health Nursing Conference. Sheraton Grand Sydney Hyde Park. 8-10 October 2019.

Other Communication and Outputs

1. Hielscher E, **Scott JG**. "Researchers identify risk factors for teens attempting suicide". Brisbane Times (9 Dec). https://www.brisbanetimes.com.au/national/queensland/researchers-identify-risk-factors-for-teens-attempting-suicide-20191208-p53i0i.html.
2. Hielscher E, **Scott JG**, Diminic S. (2019). "For people with a mental illness, loved ones who care are as important as formal supports". The Conversation (17 October). https://theconversation.com/for-people-with-a-mental-illness-loved-ones-who-care-are-as-important-as-formal-supports-120344.
3. **Scott JG**. (2019). "Mum discovers heartbreaking note years after Victorian teen Cassidy Trevan's death". Channel 9 News (4 April). https://www.9news.com.au/national/victoria-news-mum-discovers-heartbreaking-note-years-after-teen-cassidy-trevans-death/34b1a51b-d0e0-44c3-b5eb-447ea1fa0540.
4. **Scott JG**. (2019). "Researchers count the ways children are abused in bid to uncover economic cost". ABC News (11 Mar). https://www.abc.net.au/news/2019-03-11/child-abuse-study-financial-cost/10883284.

RESEARCH GRANTS

Investigators (RBWH staff in bold)	RBWH Research Groups / Departments	Project Title	Granting Body	Total of funds awarded
James Scott, Stefan Blum, Belinda Lennox, Judith Greer, Brian O' Donoghue, Michael Benros, Dan Siskind & Shuichi Suetani	Metro North Mental Health	Identifying and treating patients with psychosis who are positive to anti-neuronal antibodies.	National Health and Medical Research Council.	$810,745
Rosana Pacella, Michael Dunne, **James Scott**, David Finkelhor, Ben Mathews, Francesca Meinck, Darryl Higgins, Holly Erskine, & Hannah Thomas	Early Psychosis	The first national study of child maltreatment in Australia: prevalence, health outcomes, and burden of disease.	National Health and Medical Research Council.	$2,311,217
Harvey Whiteford, Holly Erskine, **James Scott** & Meghan Enright	Early Psychosis	Nationally-representative population surveys of adolescent mental disorder in Kenya, Indonesia, and Vietnam (NAMHS).	Pivotal Ventures gift.	USD$2,942,531
Holly Erskine, **James Scott** & Harvey Whiteford	Early Psychosis	Adolescent Extended Treatment Facility Evaluation Framework.	Queensland Health.	$328,458
Ian Hickie, Nick Martin, **James Scott**, Nathan Gillespie, Daniel Hermens	Early Psychosis	Clinical and neurobiological predictors of onset of major mental disorders (mania, psychosis, severe depression), and associated functional impairment, in adolescent and young adult twins: A prospective longitudinal study".	National Health and Medical Research Council.	$1291,586
Ed Heffernan & **Elissa Waterson**	QFMHS	Developing guidelines for MH Police Co-responder Models.	MHAODB.	$50,000
Ed Heffernan	QFMHS	Mental Health and the Criminal Justice System: Developing the evidence-base to improve mental health and criminal justice outcomes for people with mental illness.	National Health and Medical Research Council ECF.	$193,596
Julia Crilly, Stuart Kinner, Gerry Fitzgerald, **Ed Heffernan**, Marianne Wallis	QFMHS	Improving Outcomes for people with acute mental illness in the emergency department: a data linkage study.	National Health and Medical Research Council.	$251,470

Investigators (RBWH staff in bold)	RBWH Research Groups / Departments	Project Title	Granting Body	Total of funds awarded
Chris Doran, Jacinta Hawgood, Lisa Wittenhagen, **Ed Heffernan** & **Carla Meurk**.	QFMHS	CQU Mates Data analysis.	CQU Mates.	$10,000
Ed Heffernan & **Elissa Waterson**	QFMHS	Metro North Hospital and Health Service Research Coordinator Grant.	Metro North Hospital & Health Service	$310, 832
Sarah Maguire, **Warren Ward**, Stephen Touyz, Natasha Nassar, Michelle Cunich, Ian Hickie, Janice Russell, Sloan Madden, Danielle Maloney, Claire Diffy.	QuEDS	MAINSTREAM Centre for Health System Research & Translation in Eating Disorders: detection and intervention system-focused knowledge to drive better outcomes in mainstream care for eating disorders.	The Commonwealth of Australia Medical Research Future Fund Million Minds.	$3,670,400
Lisa Wright	Occupational Therapy	Sensory Modulation Therapy Equipment.	TPCH Hospital Foundation, through The Common Good.	$7,041.91
Patrick Ho Ek Seng, **James Scott**, A Martin (UQ)	Early Psychosis	Stimulating social cognition in early psychosis (SSCEP): Effects of anodal High-Definition transcranial Direct Current Stimulation (HD-tDCS) to the right temporo-parietal junction (rTPJ) in young adults with early psychosis.	RANZCP New Investigator Grants 2019.	$6,000
Lisa Wright, Sally Bennett, Pamela Meredith	Occupational Therapy	Sensory Modulation in Mental Health Care: Phase two: Translating sensory modulation approaches into mental health practice: Outcomes of implementing a behaviour change intervention.	TPCH Hospital Foundation, through The Common Good.	$7,041.91
Lisa Fawcett, Nathan Dart, Niall Higgins	Nursing	Trauma Informed Care and Practice model of nursing care.	Queensland Health Nurses and Midwives Innovation Fund.	$369,781
Niall Higgins, Xiaohui Tao (USQ), Raj Gururajan (USQ)	Nursing	Remote patient monitoring via non-invasive digital technology: a preliminary evaluation of a system for respiratory observations.	Metro North Mental Health.	$8,566

Investigators (RBWH staff in bold)	RBWH Research Groups / Departments	Project Title	Granting Body	Total of funds awarded
Michael Breakspear, Nick Martin, **Gerard Byrne**, Stephen Rose, Olivier Salvado, Osvaldo Almeida, **Gail Robinson**, Michael Weiner, Nancy Pachana	Older Persons Mental Health	Prospective imaging study of ageing: genes, brain and behaviour (PISA).	National Health and Medical Research Council.	$6,465,047.40
Jerome Sarris, Chee Ng, **Gerard Byrne**, David Castle, David Camfield	Older Persons Mental Health	N-Acetyl Cysteine in the adjunctive treatment of obsessive-compulsive disorder: A 16-week, double-blind, randomised, placebo-controlled study.	National Health and Medical Research Council.	$850,448
Lisa Wright	Allied Health	AH-TRIP Knowledge Translation Bursary.	Metro North Allied Health, AH-TRIP.	$1,900
Tracey Mackle, **Sue Patterson**, Lucia Colodro Conde & Sarah Medland	Perinatal	Pregnancy, Birth and Trauma; designing a screening tool for post-traumatic stress disorder (PTSD) in the perinatal setting, Metro	Metro North Hospital & Health Service	$49,486

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

Queensland
Government