Metro North Health | Mental Health

Annual Research Review 2024

Metro North Health's vision
Creating healthier futures together—where innovation and research meets compassionate care and community voices shape our services.

Metro North Health

Queensland Government

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Acknowledgement of Country

Metro North Mental Health acknowledges Aboriginal and Torres Strait Islander peoples as the First Australians.
We recognise their cultures, histories and diversity and their deep connections to the lands, waters and seas of Queensland and the Torres Strait.

We acknowledge the Jagera people and the Turrabul people as the traditional custodians of Meanjin (Brisbane), the land on which we meet, work, and learn. We pay our respects to Jagera and Turrabul Elders, past present and emerging.

Recognition of Lived and Living Experience, Carers, Families and Support People

Metro North Mental Health recognises the living and lived experience of people living with mental illness, problematic alcohol, and other drug use, as well as those impacted by suicide and trauma, their families, carers, and support people. We respect and value their opinions and their input into service delivery and change.

Foreword

Dr Kathryn Turner
Executive Director
Metro North Mental Health Service

A/Prof Kylie Burke
Director
Research, Strategy and Evaluation

Research and evaluation are essential for advancing learning within health services. The ability of health services to learn is critical to driving improvements in the experiences and outcomes of people who use our services, their families, carers and support people, staff well-being, and the efficient allocation of limited resources. Metro North Mental Health has a vision to become a service that fosters a culture of learning and continuous improvement, and that develops and integrates cutting-edge innovation to ensure we deliver best practices in mental healthcare. Research, evaluation, and quality improvement activities are fundamental to this vision. Our commitment to best practice requires a systematic and ongoing integration of research with clinical practice.

Metro North Mental Health (MNMH) has made significant investments in recent years to strengthen research capacity and foster a research culture. This has included the growth of the Research Team to facilitate opportunities for staff to integrate research into their practice across work areas and the introduction of a Research Support Committee to ensure high-quality research is undertaken that aligns with our strategic priorities. The work highlighted in the 2024 Annual Research Review indicates that these investments are paying off. We take pride in the diversity, volume, quality, and impact of activities aligned with MNMH's research priorities presented in this report.

MNMH is committed to focusing on the following research priorities in 2024:

1. Understanding mental health and problematic use of alcohol and/or other drugs.
2. Complex issues associated with mental health and alcohol and/or other drugs.
3. Under-researched populations.
4. Health systems research.
5. Innovation and evidence generating practice.
6. Digital solutions.

In 2024, MNMH staff initiated and completed numerous projects focused on these key priority areas. These efforts resulted in over 70 peer-reviewed publications. These publications applied diverse research methodologies, including randomised controlled trials, systematic reviews, observational studies, data linkage, and qualitative approaches. Notably, more than 65 of our staff contributed to this work, with representation across our allied health, lived experience, medical, and nursing workforces. Aligned with our goal of fostering partnerships to enhance research capacity, quality, and impact, these projects involved collaboration with multiple universities, health services, and non-government organisations across ueensland and Australia. An increasing number of MNMH staff are actively involved in research and evaluation activities, our research skills are increasing, and we are strengthening partnerships that will support future high-quality, high-impact projects.

A/Prof Stephen Parker
Director
Research

The work summarised in this annual review aligns closely with the vision, mission, enablers, and themes of the Metro North Research Strategy for 2023–2027. This strategy emphasizes Metro North's commitment to delivering exceptional health outcomes through globally recognised research, discovery, and excellence in knowledge translation.

The MNMH Annual Research Review highlights our success in implementing this strategy, which includes:

1. Emphasis on partnering with people with lived experience, families, carers and support people and communities, as well as a commitment to health equity, to ensure the relevance, quality, and impact of our esearch activities.
2. Fostering research career pathways for our workforce, including our success in the highly competitive Clinician Research Fellowship program.
3. Research aimed at leveraging digital technologies to enable more personalised, efficient, and high-quality care in the future.
4. The establishment of new partnerships and the strengthening of existing ones with academic institutions and the broader healthcare sector.

In 2025, MNMH will release its research strategy, outlining what we expect to achieve through research and evaluation activities over the 2025–2030 period and a road map for realising this. The achievements outlined in this annual review provide confidence in our ability to continue to foster a culture of learning and continuous improvement that will ensure we deliver best practices in mental healthcare in the future.

Finally, as always we wish to acknowledge everyone who has contributed to making this review a reality. We thank all the Metro North Mental Health and Alcohol and Other Drug Services staff, people with lived and living experience and our partners for their contributions to the report and for the work you do to enhance our capacity to provide high quality care. Thank you also to our lived experience artists who have shared their work in this publication, to Marie Greco from Metro North's Clinical Multimedia team for her creativity and excellence in designing a document that showcases our work. We would especially like to acknowledge Charlotte Mitchell and Tessa Clarkson for coordinating the report's preparation. Their efforts in liaising with clinicians and researchers, drafting content and design work are directly related to the quality of the document. We appreciate your efforts and look forward to doing it all again next year.

We hope you enjoy learning more about the work being undertaken at Metro North Mental Health and feel inspired by the quality of work included.

About Metro North Mental Health

Metro North Mental Health, inclusive of Alcohol and Drug Services, is situated within the larger Metro North Hospital and Health Services which delivers responsive, integrated, and connected care to over one million people, in an area stretching from the Brisbane River to north of Kilcoy. 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 Health Service, there are numerous opportunities for staff to be involved in research and development activities that benefit our consumers as well as making Metro North Mental Health an exciting and rewarding place to work.

Metro North Mental Health commenced as a Clinical Directorate with a single point of accountability and budget in July of 2014. As of 2024, Metro North Mental Health employs upwards of 2088 individuals across more than 1600 roles. Metro North Mental Health provides services for people with severe and complex mental health needs across the life span including perinatal, adolescence and young adults, adults, and older persons. We provide specialist services including consultation liaison, forensic mental health, alcohol and drug services, eating disorders, community mental health and inner-city homeless outreach services. The service supports the recovery of people with mental illness through the provision of recovery focused services for consumers and carers 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 allied health, 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 for crisis situations and are linked to specialist mental health and alcohol and other drugs services for assessment and care. Dedicated acute inpatient services are at the RBWH, TPCH and Caboolture Hospital. Community services are delivered from facilities located in Brisbane City, Fortitude Valley, Herston, Nundah, Chermside, Strathpine, Caboolture, and Redcliffe with outreach services to Kilcoy.

Metro North Mental Health is also the host site to a range of services provided to a state-wide catchment. The Metro North Mental Health's Alcohol and Drug Service (ADS) works under a harm minimisation model to help clients stop using, reduce use or to use more safely by providing trauma informed, evidence-based treatments including opioid and substance withdrawal management, and counselling at several multidisciplinary clinics. The Needle and Syringe program is working to help to stop the spread of HIV and Hepatitis C among drug users. Further, Adis 24/7 Alcohol and Drug Support offers a 24-hour, 7 day a week confidential support service for people with alcohol and drug concerns in Queensland, as well as their loved ones and health professionals. ADS works with the acute hospitals to provide 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.

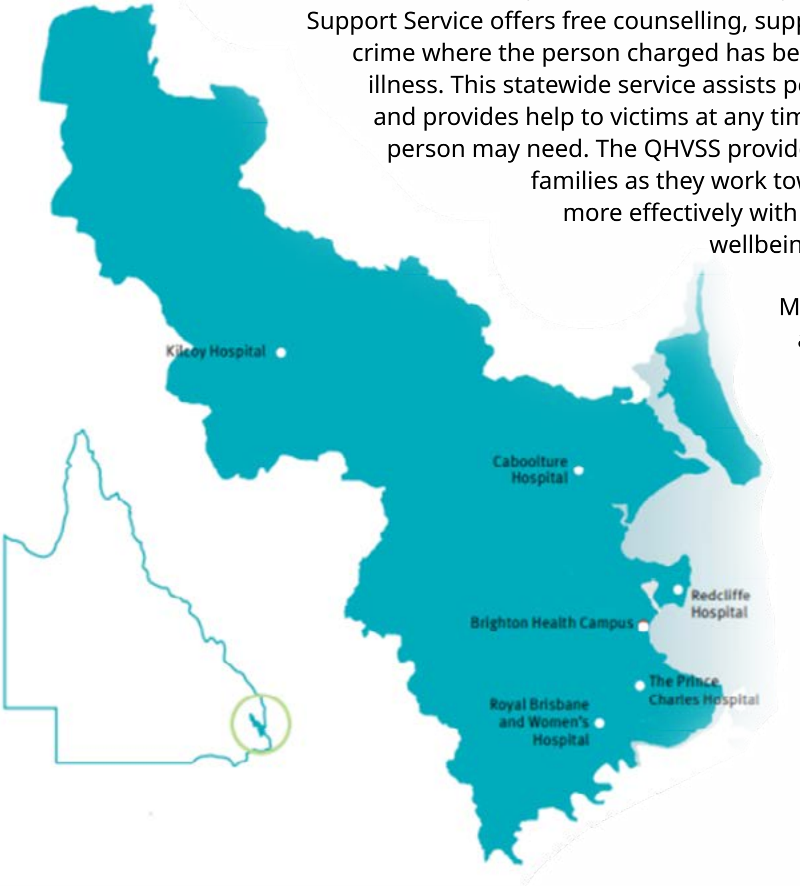
Queensland Eating Disorder Service (QuEDS) provides flexible treatment and support for people with eating disorders. QuEDS' assessment clinic at Spring Hill Community Mental Health Centre provides assessment, diagnostic clarification and treatment options, including individual outpatient therapy with QuEDS, or recommendations to external providers. QuEDS also provides tertiary consultation and education services to upskill and support providers across Queensland.

The Queensland Forensic Mental Health Service (QFMHS) co-ordinates a large multifaceted, state-wide forensic mental health service. Forensic mental health services provide support to a range of people experiencing mental illness, including people being treated under Forensic or Treatment Support Orders and people in contact or who are at risk of contact with the criminal justice system. QFMHS ensures consistency of standards across the individual services on a statewide basis, coordinating safety and quality activities, development, and oversight of the Forensic Services model of service, training and development, clinical leadership, and service planning and development. QFMHS acts as a Queensland State departmental and interdepartmental liaison.

The perinatal period is a time of great change which can bring both joy and stress to families and can affect all aspects of a person’s wellbeing. The Perinatal Mental Health services offers support to women, their partners, and families from the point of conception until a year after the birth of a baby (i.e., the perinatal period). The Perinatal mental health service provides non-acute, specialist assessment and treatment and referral of patients to further psychological or community services in addition to short term support and Telehealth consultations.

With offices in Brisbane, Cairns and Townsville, the Queensland Health Victim Support Service offers free counselling, support, and information to victims of crime where the person charged has been assessed as having a mental illness. This statewide service assists people to access their entitlements and provides help to victims at any time after the offence for a long as a person may need. The QHVSS provides early support for victims and their families as they work towards recovery and helps them cope more effectively with the offence and improve long term wellbeing.

Metro North Mental Health services are actively involved in research, seeking to build evidence base and constantly improve our practice, ensuring the quality of care provided to people and their families, carers and support people.



The 2024 Metro North Mental Health Research Symposium

On 27 August 2024, the 3rd Annual Metro North Mental Health Research Symposium was held at Caboolture Hospital.

The full-day Symposium featured an outstanding keynote presentation by Mr. Greg Pratt, who spoke about the aspects of consultation, engagement, partnership, leadership, and self-determination in Aboriginal and Torres Strait Islander research. His talk emphasised the importance of community-driven research, co-design, and partnership to achieve quality, sensitive healthcare through equitable access to inclusive research. Greg discussed the patient-participant-person paradigm and the importance of privileging First Nations leadership and ways of knowing, being, and doing. Greg's experience as a First Nations researcher supported the audience to explore the influence of personal, professional, and systemic confounders in realising self-determination of Aboriginal and Torres Strait Islander peoples.

We were also privileged to have two plenary lectures from Professor Andrew Teodorczuk, Director of Clinical Training at The Prince Charles Hospital, and Associate Professor Kylie Burke, Director Research Strategy and Evaluation at Metro North Mental Health Service. Andrew's presentation *"Teaching and research: two sides of the same coin"* explored the link between teaching and research, and why it matters for a researcher to be a good teacher, and vice versa. His talk also discussed best practices for medical education research, and the future potential of AI.

The second plenary of the day by Kylie was titled, *"Parenting: A motivator or barrier to recovery from serious mental illness?"* Kylie discussed the complexities experienced by parents who are living with serious mental illness and and/or problematic alcohol or other drug use. Kylie's presentation focused on the factors that result in parenting not being included as a part of recovery, highlighting the missed opportunities and associated risks, as well as the system level issues that have resulted in this critical aspect of the life course being neglected in bio-psychosocial models of healthcare.

The main program of the Symposium included a wide variety of research and quality improvement activities that have been occurring within the service and featured three award categories: the **Best Free Paper Presentation**, **Best Rapid Presentation**, and the **Lived Experience Choice Award.** Sally Mercier from the Spring Hill Community Mental Health Centre won Best Free Paper Presentation for her talk on refining the current phase of care model for application in the community mental health service. Kylie Page from Biala, Alcohol and Drug Service took out Best Rapid Presentation for her work on advancing treatment for people who inject drugs in a Needle Syringe Program. Katherine Moss, also from Biala, won the Lived Experience Choice Award for her investigation into perspectives on physical activity and its' barriers for inpatients under forensic mental health care.

A symposium such as this cannot happen without significant support. We particularly want to thank our sponsors: the RBWH Foundation and the Prince Charles Foundation *(trading as Common Good)* for their ongoing support of the Metro north Mental Health Research Symposium. We would also like to thank the organising committee with special thanks for Dr Tessa Clarkson for co-ordinating the event and our clinician and lived experience judges.

Lived experience panel discussion

Our Lived Experience Panel Discussion included five panellists *(see Figure 1).* The discussion was centred around partnering with people with lived and living experience, their families, carers, and support people. Panellists included Dr Alex Cook (retired Palaeontologist and Geologist and Independent Lived Experience representative), Mathew Tipping (MNMH Director of Lived Experience), Alana Boulton (Mental Health, Alcohol and Other Drug and Suicide prevention advocate), Lesley McDonald (Lived experience representative, nurse and Caboolture local) and Zoey Ka (Principal Project Officer, Lived Experience for Queensland Health). Based on the Metro North Mental Health's new Partnering with Lived Experience Guidelines *(see pg. 59)*, panellists discussed each of the seven principles, discussing examples of what the future of partnership should look like.

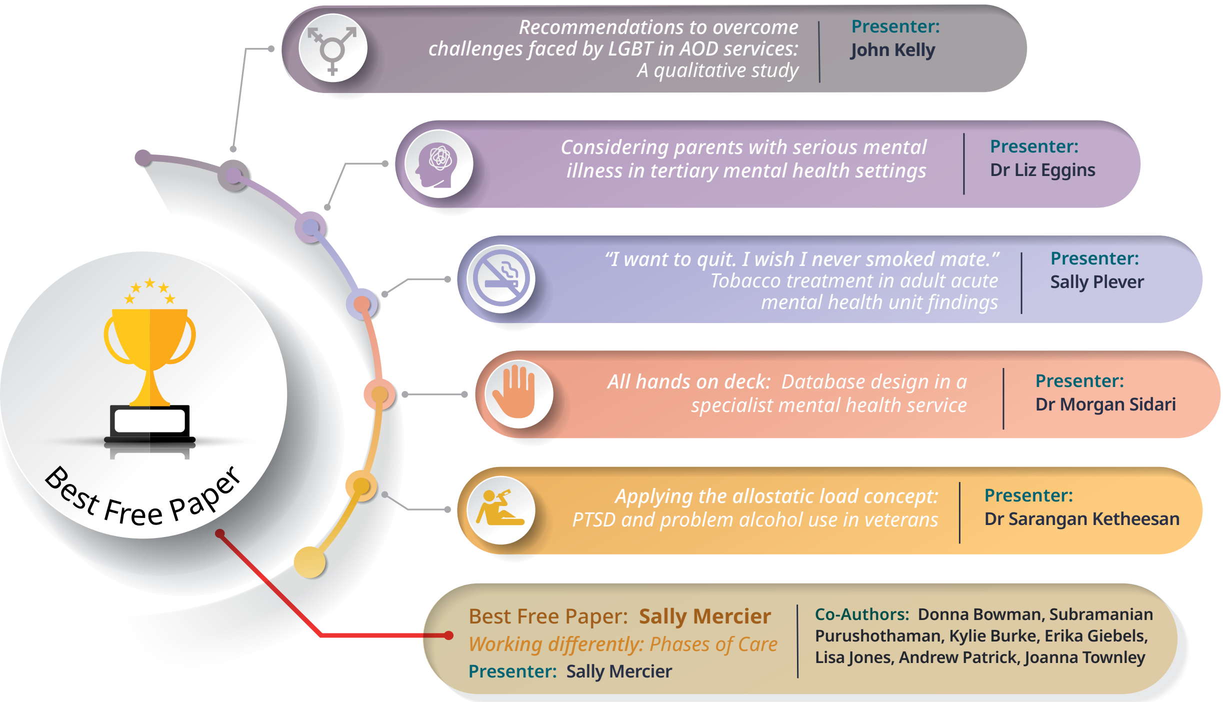
Figure 1. **Lived Experience Panel** *(L-R):* Mathew Tipping, Lesley McDonald, Alana Boulton, Zoey Ka, Alex Cook.

From left to right, top to bottom Matthew Tipping, Director Lived Experience; Greg Pratt, Keynote; Audience; Nina Meloncelli's masterclass;

Free Paper Presenters: Morgan Sidari, Liz Eggins, Sally Plever, John Kelly, Sally Mercier, Sarangan Katheesan;

Rapid Paper Presenters: Leanne Payne, Katherine Moss, Catriona Harwood, Kylie Page, Kalyani Terli; Liam Wishart, Operations Director RBWH; Acknowledgement of Country by Stephan Lane.

Free Paper Presentations



Recommendations to overcome challenges faced by LGBT in AOD services: A qualitative study
Presenter: John Kelly

Considering parents with serious mental illness in tertiary mental health settings
Presenter: Dr Liz Eggins

"I want to quit. I wish I never smoked mate." Tobacco treatment in adult acute mental health unit findings
Presenter: Sally Plever

All hands on deck: Database design in a specialist mental health service
Presenter: Dr Morgan Sidari

Applying the allostatic load concept: PTSD and problem alcohol use in veterans
Presenter: Dr Sarangan Ketheesan

Best Free Paper: **Sally Mercier**
Working differently: Phases of Care
Presenter: Sally Mercier
Co-Authors: Donna Bowman, Subramanian Purushothaman, Kylie Burke, Erika Giebels, Lisa Jones, Andrew Patrick, Joanna Townley

Best Free Paper: **Sally Mercier**

Working Differently *– Phases of Care*

Sally Mercier
Best Free Paper Winner

Presenter: **Sally Mercier**

Co-Authors: **Donna Bowman, Subramanian Purushothaman, Kylie Burke, Erika Giebels, Lisa Jones, Andrew Patrick, Joanna Townley**

Sally Mercier presented on the development and adapting a phases of care model to enhance its transferability and application in community mental health services. The project was funded by the CAHRLI AH-TRIP Start-up Grant and focused on refining the current model, articulating each phases clinical activities and interventions, and identifying current data collection processes. A total of 5 clinician focus groups and 1 lived experience focus group participated in the study and provided feedback on the proposed phases of care. The model is an adapted version of the Australian Mental Health Care classification system with additions from Metro North community team leadership. The focus groups were transcribed and thematically analysed.

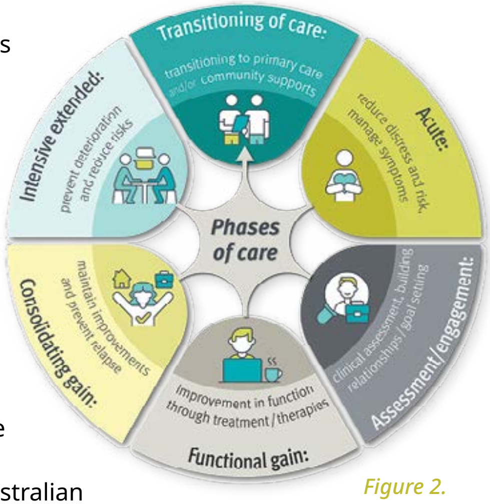
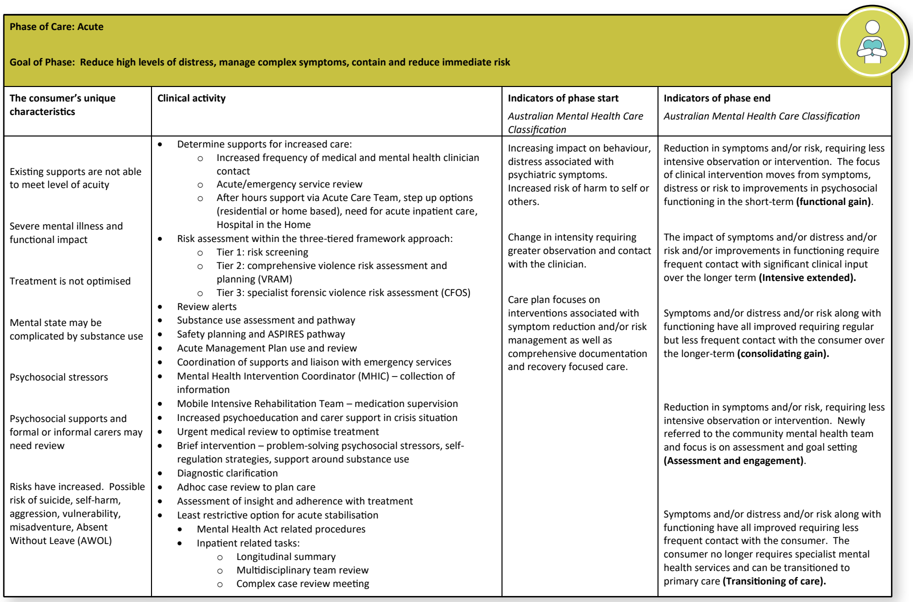


Figure 2.
Phases of Care

Themes that emerged when discussing implementation in the clinician focus groups included communication, such as, a preference for more detailed descriptions of clinical activities to encapsulate all the work done, and system concerns, such as, activity-based funding and if the model would impact day-to-day activities. Among other themes, the lived experience focus group addressed the necessity to use strengths based and recovery focused language, the value of including peer workers in each phase and the importance of clinicians learning about the consumer as a person and not just symptoms.

Figure 3 outlines an example of a phase of care document, including some of the identified relevant clinical activities in the Acute phase by the clinician focus groups.



Phase of Care: Acute

Goal of Phase: Reduce high levels of distress, manage complex symptoms, contain and reduce immediate risk

The consumer's unique characteristics	**Clinical activity**	**Indicators of phase start** *Australian Mental Health Care Classification*	**Indicators of phase end** *Australian Mental Health Care Classification*
Existing supports are not able to meet level of acuity Severe mental illness and functional impact Treatment is not optimised Mental state may be complicated by substance use Psychosocial stressors Psychosocial supports and formal or informal carers may need review Risks have increased. Possible risk of suicide, self-harm, aggression, vulnerability, misadventure, Absent Without Leave (AWOL)	• Determine supports for increased care: ○ Increased frequency of medical and mental health clinician contact ○ Acute/emergency service review ○ After hours support via Acute Care Team, step up options (residential or home based), need for acute inpatient care, Hospital in the Home • Risk assessment within the three-tiered framework approach: ○ Tier 1: risk screening ○ Tier 2: comprehensive violence risk assessment and planning (VRAM) ○ Tier 3: specialist forensic violence risk assessment (CFOS) • Review alerts • Substance use assessment and pathway • Safety planning and ASPIRES pathway • Acute Management Plan use and review • Coordination of supports and liaison with emergency services • Mental Health Intervention Coordinator (MHIC) – collection of information • Mobile Intensive Rehabilitation Team – medication supervision • Increased psychoeducation and carer support in crisis situation • Urgent medical review to optimise treatment • Brief intervention – problem-solving psychosocial stressors, self-regulation strategies, support around substance use • Diagnostic clarification • Adhoc case review to plan care • Assessment of insight and adherence with treatment • Least restrictive option for acute stabilisation • Mental Health Act related procedures • Inpatient related tasks: ○ Longitudinal summary ○ Multidisciplinary team review ○ Complex case review meeting	Increasing impact on behaviour, distress associated with psychiatric symptoms. Increased risk of harm to self or others. Change in intensity requiring greater observation and contact with the clinician. Care plan focuses on interventions associated with symptom reduction and/or risk management as well as comprehensive documentation and recovery focused care.	Reduction in symptoms and/or risk, requiring less intensive observation or intervention. The focus of clinical intervention moves from symptoms, distress or risk to improvements in psychosocial functioning in the short-term **(functional gain)**. The impact of symptoms and/or distress and/or risk and/or improvements in functioning require frequent contact with significant clinical input over the longer term **(Intensive extended).** Symptoms and/or distress and/or risk along with functioning have all improved requiring regular but less frequent contact with the consumer over the longer-term **(consolidating gain).** Reduction in symptoms and/or risk, requiring less intensive observation or intervention. Newly referred to the community mental health team and focus is on assessment and goal setting **(Assessment and engagement)**. Symptoms and/or distress and/or risk along with functioning have all improved requiring less frequent contact with the consumer. The consumer no longer requires specialist mental health services and can be transitioned to primary care **(Transitioning of care).**

Figure 3.
Example Phase of Care document. Phase of Care: Acute.

Overall, clinicians and people with lived experience endorsed the six phases of care with some recommendations and challenges for implementation identified:

1. The phase of care information be incorporated into a document which describes the community care teams model of care.
2. Develop associated documents and resources to support implementation.
3. Implementation and communication: Leadership team to consider challenges for implementation with the view to generate solutions.
4. Evaluation: Embed continuous improvement as part of the model of care.

Abstract

Community mental health teams are challenged by increasing demands on services. The Australian Mental Health Care classification system recognises mental illness is episodic in nature. At different times during the consumer's recovery their need for mental health services, the types of services required, and the intensity of service provision can vary. These are termed phases of care (acute, functional gain, intensive extended, consolidating gain and assessment; IHPA, 2023). This project aimed to refine the current phase of care model to contextualise this for use in the community mental health service. Forty-six clinicians, and four lived experience representatives participated in six focus groups to identify the phase of care model and clinical activities carried out in the relevant phases. Data was gathered from CIMHA to identify phases of care information recorded. Clinicians and people with lived experience endorsed the revised six phases of care model proposed, with some recommendations and challenges for implementation identified. The refined Australian Mental Health Care Classification be adopted in the service and phase of care information be incorporated into the community care teams model of care. Implementation should be evaluated in the future, and have resources developed to support implementation.

Free Paper Abstracts

Recommendations to overcome challenges faced by Lesbian, Gay, Bisexual and Transgender (LGBT) people in accessing mainstream alcohol and other drug (AOD) treatment services: *A Qualitative Study.*

Presenter: **John Kelly**

Authors: **Cassie Davis**

LGBT people experience challenges engaging in AOD treatment services, with poorer treatment outcomes compared to cis gendered and heterosexual people. This study explored the experiences of LGBT people accessing AOD services, developing service recommendations from the LGBT perspective. Fourteen self-identified LGBT people participated in semi-structured focus groups. The data was subjected to thematic analysis. Participants reported anticipated and actual experiences of minority stress and identified service provider's lack of understanding of LGBT-specific AOD use drivers as the main challenges. Avoidance of help seeking, varying levels of disclosure, and disengagement were common consequences. Inclusive and affirmative health services, treatment exploring LGBT-specific AOD use drivers, and LGBT-specific treatment options were suggested enhancements. The study underscores the need for trauma informed, inclusive and LGBT affirmative treatment approaches within mainstream AOD services.

> *"I have been repeatedly judged by professionals not accepting who I am and not understanding what it's like to be LGBT.*
>
> *Services don't understand that we're afraid of feeling persecuted by the health system or people in general"*
>
> – Gay, male, 40

> *"Being inclusive is more than slapping up a rainbow. It is showing that you are accepting – and not just tolerating."*
>
> – Gay, male, 40

Considering Parents with Serious Mental Illness in Tertiary Mental Health Settings.

Presenter: **Elizabeth Eggins**

Authors: **Kylie Burke**, Alina Morawska, **Bryce McMahon**, Louise Brennan

Parenting is one of the most challenging, yet rewarding, life roles. For parents experiencing mental illness, raising children can be a protective factor that drives recovery, but also a risk factor for stressors that can lead to relapse and re-presentations to mental health services. This multi-method research aims to understand the role of parenting support within tertiary mental health settings, with the overall aim of informing policy and practice. The research is situated within one of Australia's largest health services and is comprised of four components. First, a clinical audit. Second, a survey and semi-structured interviews with parents who are recovering from serious mental illness. Third, focus groups with clinicians who work with parents recovering from mental illness. Fourth, a systematic overview of reviews of parenting interventions within the context of serious mental illness. This presentation will first provide an estimate of the number and characteristics of people engaged with mental health services who are also parents. Second, it will quantitatively summarise parents' experiences of parenting while recovering, including their Quality of Life. Third, it will present the results of a qualitative thematic analysis of interviews with parents and clinicians in terms of barriers and facilitators of integrating the parenting role into tertiary mental health treatment. Fourth, it will synthesise the types and effectiveness of parenting interventions for parents recovering from serious mental illness. This research highlights the importance of multi-method approaches to clinical questions within health settings. This includes clinical data, existing evaluation evidence, and the voices and experiences of parents recovering from serious mental illness and treating clinicians. Collectively, these components will guide the implementation of parenting supports within tertiary mental health settings.

"I want to quit. I wish I never smoked mate." *Preliminary findings on the delivery and consumer experience of tobacco treatment in adult acute mental health units.*

Presenter: **Sally Plever**

Authors: Steve Kisely, Billie Bonevski, Dan Siskind, Coral Gartner

Over 55% of people in adult acute mental health units smoke tobacco, a modifiable risk factor for premature mortality. Qld Mental Health Services (MHS) have introduced routine smoking cessation in acute units, but little is known about delivery or consumer experience. This study presents initial findings on delivery of smoking cessation and consumer experience in adult acute mental health units. Between June 2022 to December 2022, a convenience sample of 160 inpatients reporting smoking, were recruited from adult acute inpatient units in two MHS. Participants were interviewed during admission and medical records audited after discharge for tobacco treatment. Most participants began smoking around 16yrs through family/friends. Over 89% had considered quitting, but only 26% used cessation supports. In one service, over 90% smoked during admission, triggered by cravings and boredom. Frustration over inconsistent smoking rules was common and dual vaping/smoking an emerging issue. Nicotine replacement therapy was poorly documented and likely suboptimal, with little discharge support provided. Optimising tobacco treatment in MHS has the potential to reduce mortality and improve health outcomes. Addressing inconsistent smokefree policies, improving delivery and documentation of tobacco treatment, and providing better discharge support may decrease consumer frustration and help lower smoking rates.

All hands on deck: *Acceptability and feasibility of a collaboratively designed database in a specialist mental health service.*

Presenter: **Morgan Sidari**

Authors: **Amy Hannigan, Joanna Malone, Kate Murphy, Service Development Team and Treatment Team, Queensland Eating Disorder Service**

REDCap
Research Electronic Data Capture

Health system databases are large and complex, accommodating many different services with varying functions and workflows. Arguably, it is not possible to create a single system that can fully address all of the diverse data needs of these services. For this reason, individual services must create their own databases that meet their niche needs and facilitate efficient data collection for clinical and/or evaluation purposes. Queensland Eating Disorder Service (QuEDS) staff have collaboratively designed a Redcap database to meet the needs of our busy, statewide specialist service. To assess acceptability and feasibility, QuEDS will be conducting a series of short interviews addressing barriers and enablers of its success and sustainability. These interviews will be conducted with all QuEDS staff prior to implementation, one month post implementation, and three months post implementation. Themes from the initial interviews covering acceptability will be discussed, as well as our plans for further qualitative analyses. Insights from this study could be used to inform similar transitions in other specialist services within Metro North Mental Health.

Applying the allostatic load concept to addiction and psychiatry: a preliminary study of problem alcohol use and PTSD in combat exposed veterans.

Presenter: **Sarangan Ketheesan**

Authors: Zoltan Sarnyai, **Bruce Lawford**, Jason Connor

Chronic exposure to stress results in increased allostatic load (AL) *(see Figure 4),* reflected in dysregulation across physiological systems. We analysed data from Gallipoli Medical Research to examine the relationships between AL, alcohol dependence (AD) and posttraumatic stress disorder (PTSD) in Vietnam Veterans. AL was quantified for 274 veterans through a quartile-based composite index of 25 biomarkers spanning multiple physiological systems. The likelihood of AD was determined through the Alcohol Use Disorders Identification Test (AUDIT) and PTSD by the CAPS-5. Non-AD and AD groups were compared by AL score. The sample was then stratified into four subgroups by PTSD and AD status (1. AD+/PTSD+; 2. AD-/PTSD-; 3. AD+/PTSD-; 4. AD-/PTSD+. These four groups were then compared by AL score. There was no significant difference between Non-AD and AD groups based on total AL score. There was a significant difference within the 4 PTSD/AD AL subgroups (F=2.689, df=3, p=0.047). Post-hoc tests revealed a significant difference between the AD-/PTSD- (mean 5.82, SD 2.87) and the AD-/PTSD+ (mean 6.92, SD 3.33) subgroups (p=0.05). The difference in AL seen when the groups were stratified according to PTSD status could be attributable to the known deleterious effects of PTSD across multiple biological systems.

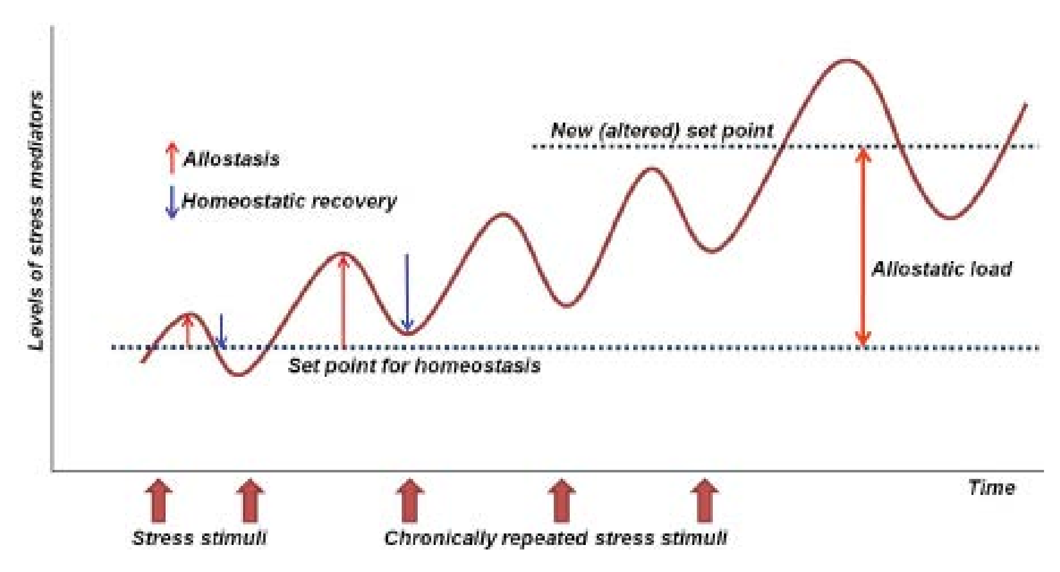
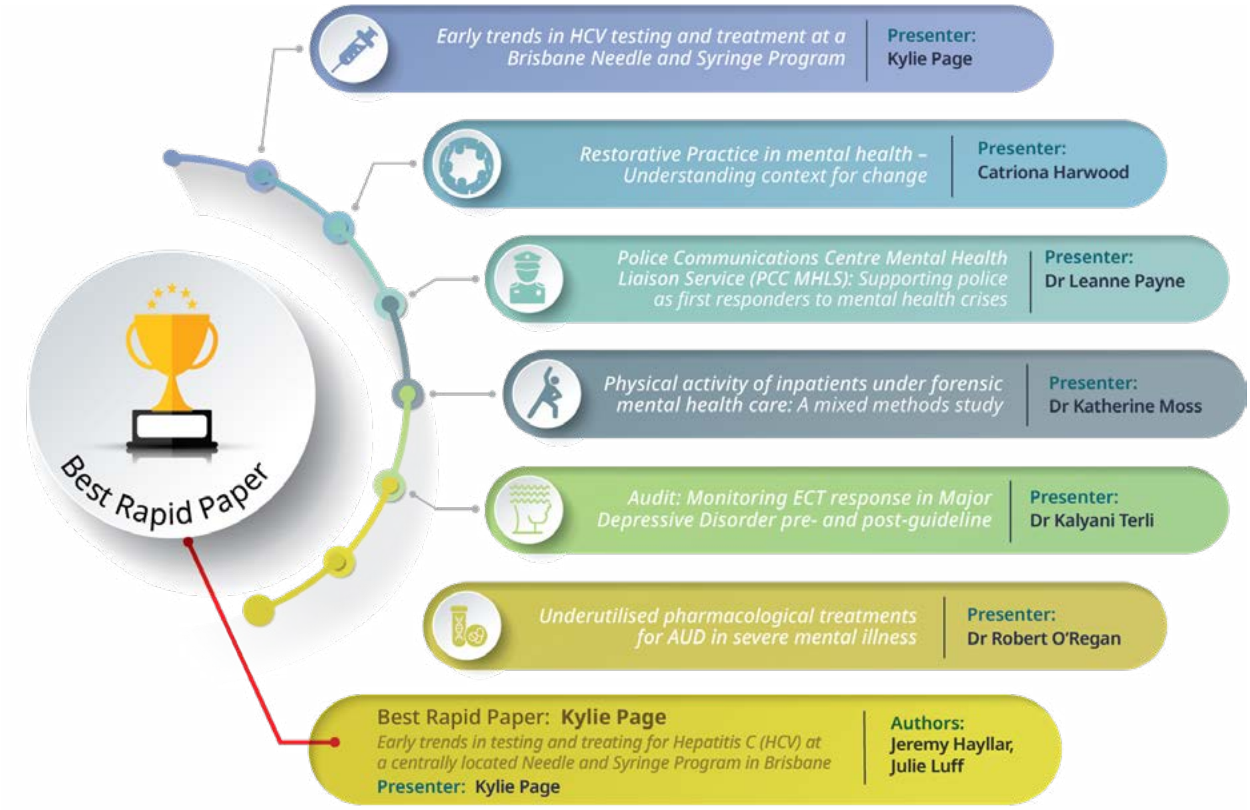


Figure 4. Allostatic Load. The differential stress hormones secreted by adrenal cortex and medullar (Sourced from: Lee, D. Y., Kim, E., & Choi, M. H. (2015). Technical and clinical aspects of cortisol as a biochemical marker of chronic stress. *BMB reports, 48*(4), 209–216. https://doi.org/10.5483/bmbrep.2015.48.4.275).

Rapid Paper Presentations



Early trends in HCV testing and treatment at a Brisbane Needle and Syringe Program | **Presenter:** Kylie Page

Restorative Practice in mental health – Understanding context for change | **Presenter:** Catriona Harwood

Police Communications Centre Mental Health Liaison Service (PCC MHLS): Supporting police as first responders to mental health crises | **Presenter:** Dr Leanne Payne

Physical activity of inpatients under forensic mental health care: A mixed methods study | **Presenter:** Dr Katherine Moss

Audit: Monitoring ECT response in Major Depressive Disorder pre- and post-guideline | **Presenter:** Dr Kalyani Terli

Underutilised pharmacological treatments for AUD in severe mental illness | **Presenter:** Dr Robert O'Regan

Best Rapid Paper: **Kylie Page**
Early trends in testing and treating for Hepatitis C (HCV) at a centrally located Needle and Syringe Program in Brisbane
Presenter: Kylie Page | **Authors:** Jeremy Hayllar, Julie Luff

Best Rapid Paper: **Kylie Page**

Early trends in testing and treating for Hepatitis C (HCV) at a centrally located Needle and Syringe Program in Brisbane

Kylie Page
Best Rapid Paper Winner

Presenter: **Kylie Page**

Authors: **Jeremy Hayllar, Julie Luff**

Kylie Page presented preliminary findings on the Tempo Study; a project conducted in collaboration with the Kirby Institute. The national study is comparing approaches to enhance treatment among people who inject drugs (PWID). Clients of the Needle and Syringe Program (NSP) at Biala were invited to participate in the screening and treatment of Hepatitis C (HCV), where those with a positive HCV RNA outcome were followed-up for 12 months. At the time of Kylie's presentation, 18% of all participants tested RNA positive to HCV. Four key early findings were presented:

1. **Homelessness:**
    - 39% of all Tempo participants were homeless of which 23% were HCV RNA positive, whereas only 12% in stable accommodation were RNA positive.
    - *Implication:* People experiencing homelessness with significant substance use often lack mobile phones, medication security and have limited health literacy. This directly impacts their ability to attend appointments and sustain HCV treatment.

2. **First Nations peoples:**
    - Over-representation of First Nations peoples in RNA positive participants.
    - *Implication:* First Nation peoples were open to engaging with the NSP nurse but also carried a greater burden of disease.

3. **Opioid Agonist Therapy:**
    - Participants currently on Qld Opioid Treatment Program (QOTP) accounted for 43% of the total positive results.
    - *Implication:* Clients of QOTP are required to attend frequent reviews. Therefore, HCV screening and treatment should be available to clients at these reviews.

4. **Service Delivery Findings:**
    - 73% booked appointments were not attended, whilst 71% of all attendees were walk-ins.
    - *Implication:* The traditional medical model of booked appointments is failing. A flexible delivery service is needed to deliver better outcomes.

Abstract

More than 74,000 Australians are living with HCV. Many are from marginalised populations, including people who inject drugs (PWID). PWID are more likely to experience stigma in healthcare settings and difficulties in getting their health care needs met. Biala Needle Syringe Programs (NSP) has been operating in central Brisbane for over 35 years seeing 80+ clients daily. Biala is participating in a national study comparing approaches to enhance treatment among PWID attending NSP. NSP clients are invited to participate in the study for screening and treatment of HCV. Each participant receives financial compensation for their time, those with a positive RNA are followed-up for 12 months. Of screenings to date (April 2024), 20% tested RNA positive. 88% were homeless (rough sleepers), 50% had no mobile phone or other contact number and 80% were tested opportunistically. Successful treatment appears to work best in a flexible multi-modal setting. This national HCV study allows the Clinic Nurse to engage with clients on their terms and in their own time for screening and treatment. The lack of stigma and appointment restraints has given clients already excluded from the basic human right of shelter an opportunity to improve their health.

Restorative Practice in mental Health – understanding context to implement change.

Presenter: **Catriona Harwood**

Authors: **Kylie Burke, Tessa Clarkson, Michael Power**

This presentation outlines the context assessment development supporting a restorative culture. This Restorative Practice work has involved a partnership model between TPCH mental health services, and multiple stakeholders. The model includes a continuum of Restorative Practices informal to more formal Restorative interventions. The extension of Restorative Practice (stage 2) was developed from the evaluation of stage 1, as well as extensive engagement and context mapping using an EPIS (Exploration, Preparation, Implementation, Sustainment) framework to understand team culture and readiness for embedding restorative practice. The evaluation of the context assessment involved mixed methods. The presentation includes a process of context mapping exploring team culture, attitudes toward harm, and team priorities. This work aimed to enhance sustainability of change using implementation science framework aligning with complex systems of healthcare. Participation in RP training workshops shows promise that participating in workshops in RP assists build confidence in skills and increases likelihood they see as beneficial, irrespective of barriers in organisational unit The results also highlight the multiple systemic barriers and opportunities to a restorative approach in mental health. A relational approach, including a robust initial context assessment to better understand team culture is vital to engaging teams to implement changes, such as a restorative approach.

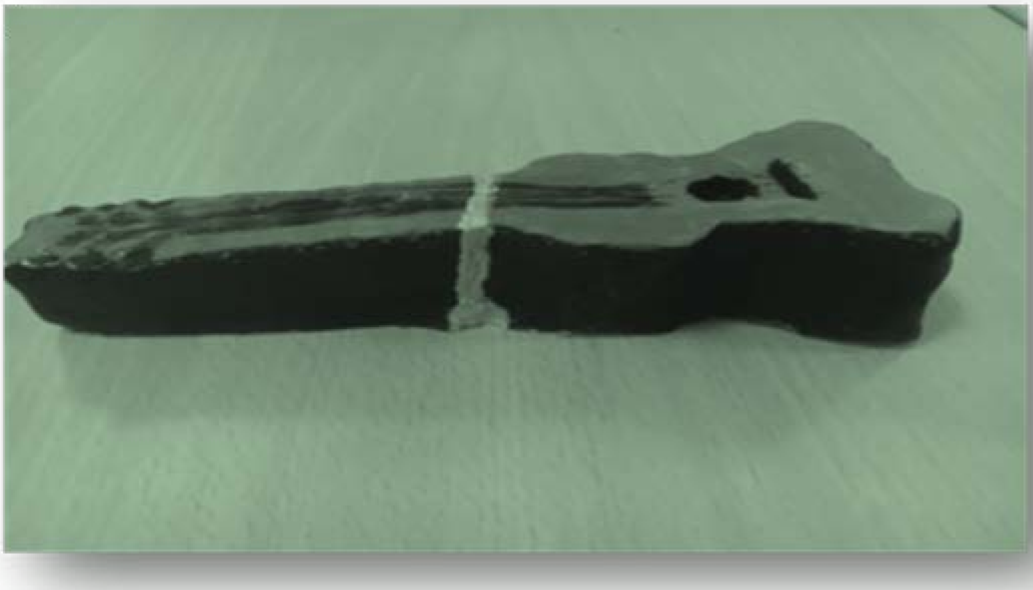


Figure 5. Art by Peer Recovery team member Rob Macintyre. Kintsugi Restorative Pottery Workshop series, SMHRU 2022.

Police Communications Centre Mental Health Liaison Service (PCC MHLS): *Supporting police as first responders to people in mental health crisis.*

Presenter: **Leanne Payne**

Authors: **Ed Heffernan,** Carla Meurk

The burden on police as first responders to people in mental health crisis continues to increase while police report feeling less than adequately skilled to manage such incidents. The PCC MHLS places clinicians directly into the Brisbane Police Communications Centre to provide real-time mental health information and advice to the Queensland Police Service (QPS). This study describes an example of a mental health liaison service that embeds mental health staff in a police communication centre and describes consumers and service episode characteristics, and outcomes for referrals received over a 12-month period (Jan to Dec 2023). Of the 3,549 referrals received, most consumers were known to the public mental health service and had a current or previous psychiatric diagnosis, the most common being psychoactive substance use and schizophrenia type disorders. The primary presenting problem was suicide/self-harm related. More than a quarter of referrals resulted in an Emergency Examination Authority being enacted while the most common QPS outcomes were 'Provided Community Assistance' and 'Welfare Check'. A fifth were referred on to mental health services. Mental health clinicians embedded in a PCC enables the provision of real-time information and advice to police leading to increased support for consumers in mental health crisis.

Audit: Use of clinical tools to monitor the response to ECT of patients with Major Depressive Disorder pre-and post-implementation of an ECT Guideline.

Presenter: **Kalyani Terli**

Authors: **Kylie Burke, Tessa Clarkson**

The RANZCP Practice guideline for the administration of ECT recommends baseline measurement of symptoms and cognition then ongoing close monitoring of the progress and cognitive side effects to enhance their management. This project is a part of the quantitative aspect of the quality improvement project in the Redcliffe-Caboolture Mental Health Service (RCMHS) It aims to determine if implementing ECT guidelines results in increased use of clinical tools in patients diagnosed with Major Depressive Disorder. The data was collected for three months pre-and post-implementation of guidelines by chart review and analysed using logistic regression and negative binomial regression. There is an increased rate of use of clinical tools at the start of the ECT course, showing statistically significant results. There was minimal improvement in the use of tools during follow-up ECT sessions. These findings may be a result of the current lack of resources and training to implement tools. Implementation of ECT guidelines in RCMHS has significantly increased the baseline measurement of symptoms and cognition of consumers diagnosed with Depressive disorder.

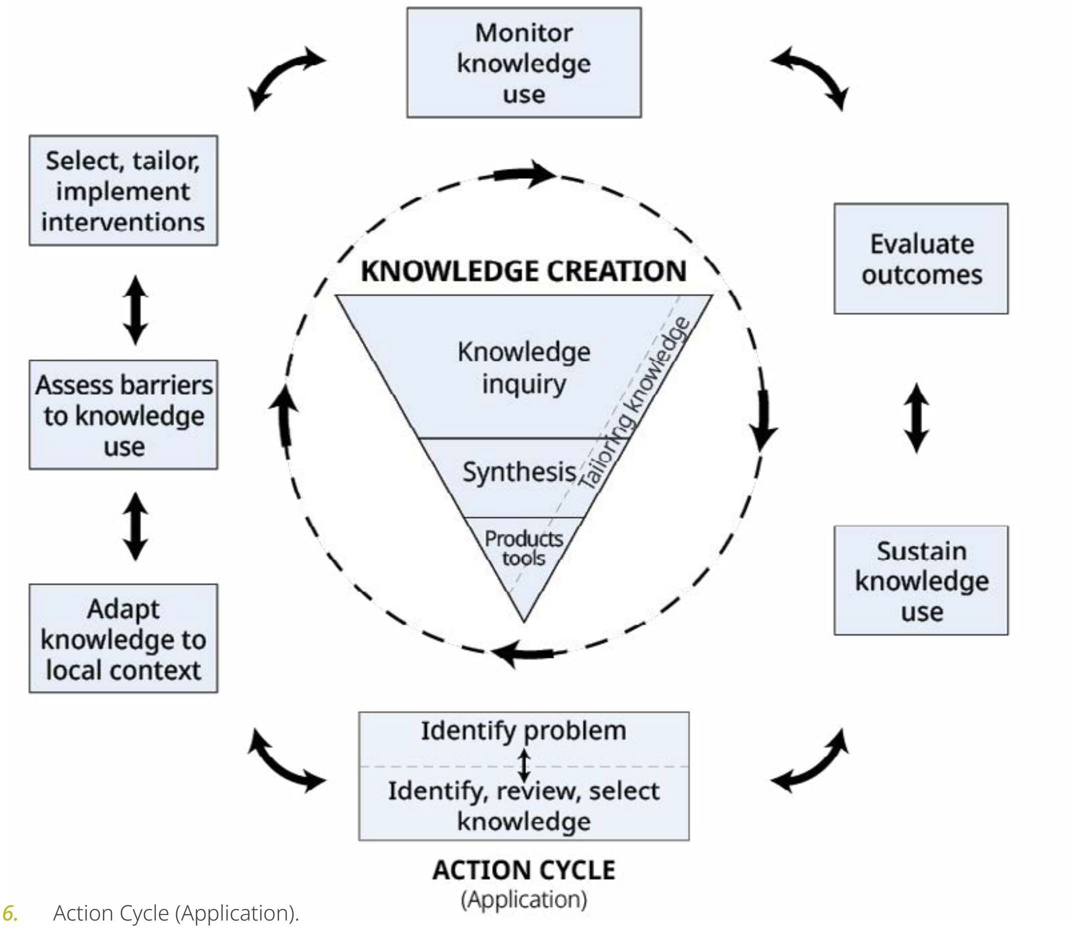


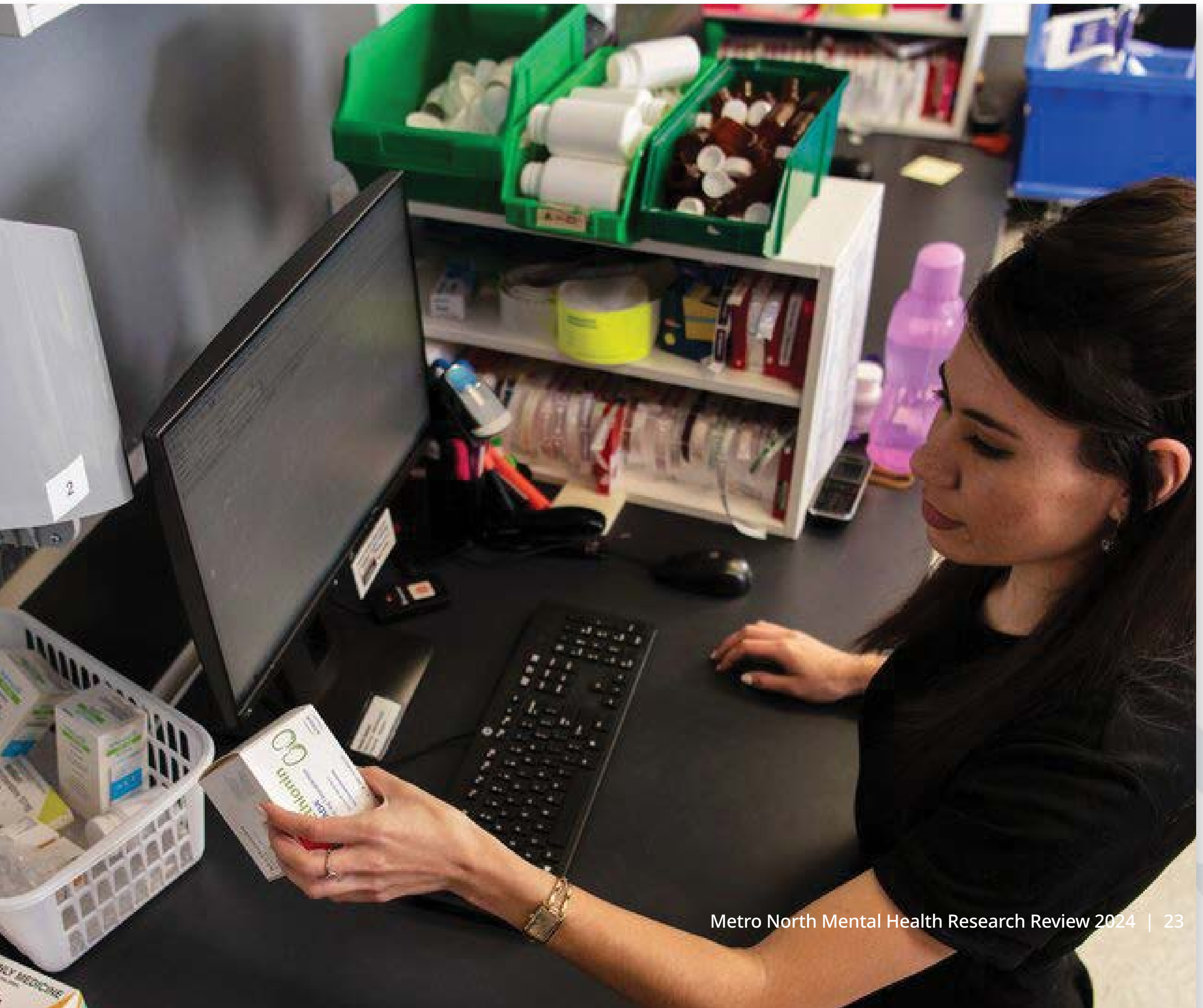
Figure 6. Action Cycle (Application).
(Sourced from: Graham, I. D.,
Logan, J., Harrison, M. B., Straus, S. E.,
Tetroe, J., Caswell, W., & Robinson, N. (2006).
Lost in knowledge translation: time for a map?.
Journal of continuing education in the health professions,
26(1), 13-24. https://doi.org/10/1002/chp.47).

Evidence-based pharmacological treatments for alcohol use disorder (AUD) such as opioid antagonists (e.g., naltrexone) are underutilized in patients experiencing severe mental illness.

Presenter: **Robert O'Regan**

Authors: Gough Kettle, **Emily Martin**, Gail Robinson, Steve Kisely, **Stephen Parker**

We conducted a systematic review as of January 2023. Results were restricted to English-language peer-reviewed academic journals and included randomised and quasi-randomised controlled trials, quasi-experimental studies, open-label studies, uncontrolled trials, as well as non-randomised interventional studies, and observational studies. Adults aged 18-65 with diagnoses of both psychosis and co-morbid AUD who had been treated with an opioid antagonist were included. The primary outcome was quantitative measures of alcohol consumption. Quality appraisal was completed using the Cochrane Risk of Bias tool and Joanna Briggs Institute (JBI) checklists. Seven studies (n=514) were included: three randomised controlled trials (RCTs), one retrospective chart review, one prospective open-label study and two post-hoc analyses of the included RCT trials. Six studies focused on naltrexone and one on samidorphan. All studies involving naltrexone identified some improvement in drinking behaviour. One RCT focusing on samidorphan did not show a benefit. Opioid antagonists were well tolerated across all studies. Naltrexone, but not samidorphan, may be effective in patients with psychotic spectrum disorders and comorbid AUD. Opioid antagonists appear to be generally well tolerated in this patient group.



Lived Experience Choice: **Katherine Moss**

Physical activity of inpatients under forensic mental health care: *A mixed methods study of patient knowledge, preferences, practices and identified barriers.*

Katherine Moss
Lived Experience Choice Award Winner

Presenter: **Katherine Moss**

Authors: **Ed Heffernan,** Carla Meurk, Megan L. Steele

Katherine Moss presented on how individuals detained in forensic mental health hospitals perceive their own physical activity, including their preferences and habits, and identified key barriers to engaging in physical activity within the forensic hospital setting. A total of 28 patients from the High Secure Inpatient Service (HSIS) at Wacol, Qld *(see Figure 7)* participated in the study by completing a short paper-based questionnaire and a semi-structured interview. The thematic analysis revealed five key themes.

Emerging themes and selected findings:

1. While physical activity is viewed as important and beneficial, knowledge remains lacking.
    - 96.4% considered physical activity important, however, 57.1% had never read any information about physical activity guidelines and were unable to describe why they should be doing physical activity.
2. Patients under forensic mental health care have individual physical activity goals, motivations, and preferences.
    - Top preferences for activity: Walking then gym.46.4% had a current goal, e.g., weight loss.
3. Environmental context and social influences impact engagement in physical activity.
    - Most wanted to exercise with others: “Always good to have someone motivating you” [P1].
4. Confidence and skills play a role in physical activity planning and adherence.
    - 96.4% felt confident about their capabilities, with some concerns about poor skills, effects of medication, lack of time and equipment.
5. Perceived barriers to physical activity include individual, service-related and environmental factors.
    - *“You’ve got to eat healthy, the food in here is not good.”* [P18].

Understanding patients’ unique perspectives and experiences is crucial, as their voices are essential in shaping effective forensic service delivery and driving meaningful change. This study bought to light the necessity for forensic services to do more in addressing the physical health issues and lack of physical activity opportunities available for inpatients. The next step is a national survey to investigate what forensic hospitals across Australia are doing to improve the physical health and activity of individuals under forensic mental health care and to use the results of this study and to national survey to formulate some Key Performance Indicators for benchmarking services and provide recommendations to forensic services.

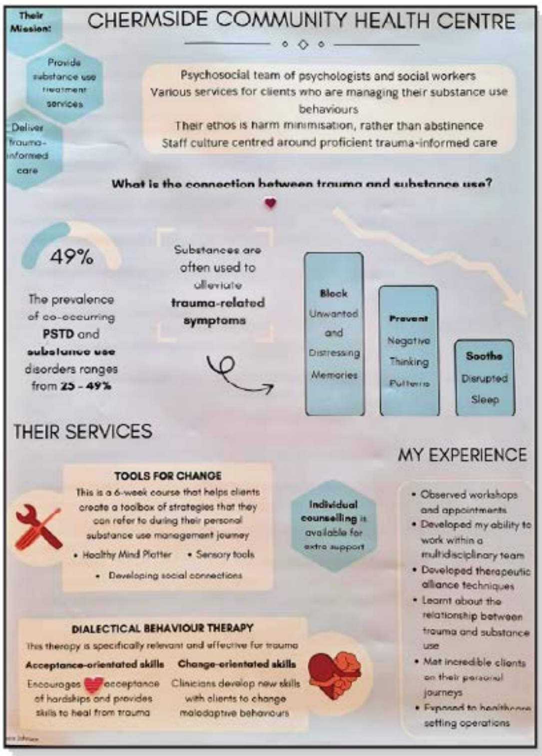
Abstract

Few studies have reported the perspectives of inpatients under forensic mental health care with regards to their physical activity and the barriers they face. Forensic patients are highly dependent on the availability of services; equally, an opportunity exists for physical activity to be prioritised, monitored and improved. This mix-methods study reports perspectives on physical activity of 28 patients under forensic mental health care using a structured questionnaire and semi-structured interview. Descriptive statistics were used to summarize patient data. Physical activity knowledge, preferences, practices, and barriers were qualitatively examined by thematic analysis. Five themes were identified: 1) while physical activity is viewed as important and beneficial by patients, knowledge remains lacking; 2) patients under forensic mental health care have individual physical activity preferences, goals and motivations; 3) environmental context and social influences impact engagement in physical activity; 4) confidence and skills play a role in physical activity planning and adherence; and 5) perceived barriers to physical activity include individual, service-related and environmental factors. This study highlights the overall preference expressed by forensic patients for lower intensity activity supervised by a known and supportive staff member. Forensic services need to be adaptive when considering how to offer physical activity opportunities while managing several service-related challenges.

Figure 7.
High Secure Inpatient Service, Wacol, QLD

Building research capacity through student collaboration

In 2024 Metro North Mental Health (MNMH) hosted five psychology honours students from the University of Queensland as part of their Work and Research in Applied Psychology (WRAP) course. The MNMH Research team hosted four students: Noah Behan, Mona Cui, Serena Chan and Jasmin Fletcher. The students gained valuable hands-on experience by working across various projects and collaborating closely with team members, including A/Prof Kylie Burke, Dr Tessa Clarkson, and Dr Liz Eggins, and the Director of Psychology, Anthony Bligh. Furthermore, Cassandra Davis from the Alcohol and Drug Service, hosted Maia Johnson. Their placements supported several projects within the service, enhancing their understanding of research and evaluation in mental health and/or alcohol and drug use. Students showcased their work through a poster session at the University of Queensland. MNMH looks forward to continuing this partnership with UQ, offering future students meaningful learning opportunities.



CHERMSIDE COMMUNITY HEALTH CENTRE

Their Mission:

- Provide substance use treatment services
- Deliver trauma-informed care

Psychosocial team of psychologists and social workers
Various services for clients who are managing their substance use behaviours
Their ethos is harm minimisation, rather than abstinence
Staff culture centred around proficient trauma-informed care

What is the connection between trauma and substance use?

49%

The prevalence of co-occurring **PSTD** and **substance use** disorders ranges from **25 - 49%**

Substances are often used to alleviate **trauma-related symptoms**

Block Unwanted and Distressing Memories

Prevent Negative Thinking Patterns

Soothe Disrupted Sleep

THEIR SERVICES

TOOLS FOR CHANGE

This is a 6-week course that helps clients create a toolbox of strategies that they can refer to during their personal substance use management journey

- Healthy Mind Platter
- Sensory tools
- Developing social connections

Individual counselling is available for extra support

DIALECTICAL BEHAVIOUR THERAPY

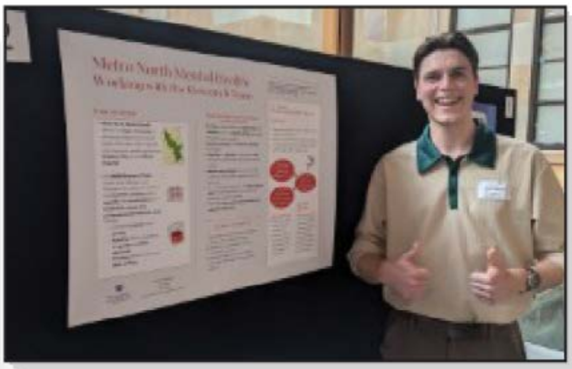
This therapy is specifically relevant and effective for trauma

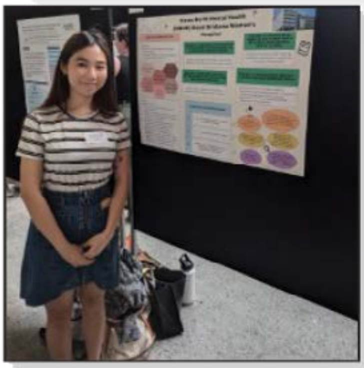
Acceptance-orientated skills
Encourages acceptance of hardships and provides skills to heal from trauma

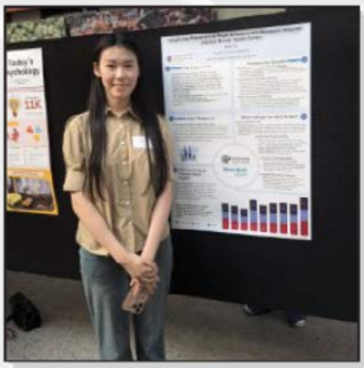
Change-orientated skills
Clinicians develop new skills with clients to change maladaptive behaviours

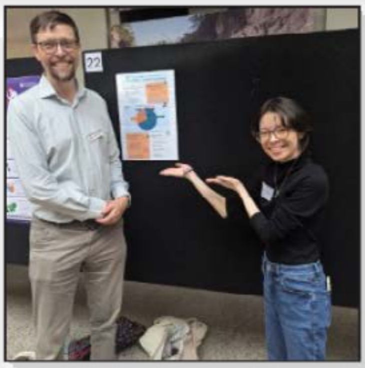
MY EXPERIENCE

- Observed workshops and appointments
- Developed my ability to work within a multidisciplinary team
- Developed therapeutic alliance techniques
- Learnt about the relationship between trauma and substance use
- Met incredible clients on their personal journeys
- Exposed to healthcare setting operations









Top left: Maia Johnson's poster
Bottom right: Anthony Bligh *(L)*

Group photo (L-R): Mona Cui, Noah Behan, Tessa Clarkson, Serena Chan, and Jasmin Fletcher

Mental health research and evaluation priorities

The 2024 Annual Research Review is themed around six strategic priorities that were developed through a process of extensive collaboration and consultation across Metro North Mental Health (MNMH). This groundwork involved a series of initial meetings and workshops where senior researchers across MNMH gathered, including representatives from our Lived Experience team, the three major hospitals, diverse discipline groups, and specialised services, to identify foundational principles, priorities, and targets for enhancing our research capacity.

Further refinement of the strategic plan was achieved through detailed consultations and with researchers, clinicians and those with lived and living experience and endorsed by MNMH Executive. Focus groups were held, featuring participants from our workforce including our Lived Experience team and Culturally and Linguistically Diverse (CALD) Mental Health workers. Future work will embed our commitment to research and improvement activities that increase access and provide culturally safe and responsive opportunities for Aboriginal and Torres Strait Islander peoples and communities to lead and to partner in projects that contribute to a service that is responsive to individual and community needs and that reduce or eliminate discrimination and systematic racism.

These efforts have defined our research priorities, which are integrated into our broader strategic plan, ensuring that all proposed research and evaluation activities are both meaningful and impactful. Clear articulation of these priorities will enable us to effectively align evidence-based methodology and practice with service priorities, fostering a shared commitment to continuous improvement within our services.

Our research priorities are structured around six core themes that guide the integration of research and evaluation within the Directorate and aid in identifying gaps in knowledge, evidence, and research activity across MNMH. Each project featured in this report aligns with one or more of these priorities, providing examples of how MNMH's research and service improvement initiatives contribute to improving the healthcare we deliver.

1. Understanding mental health and problematic use of alcohol and/or other drugs

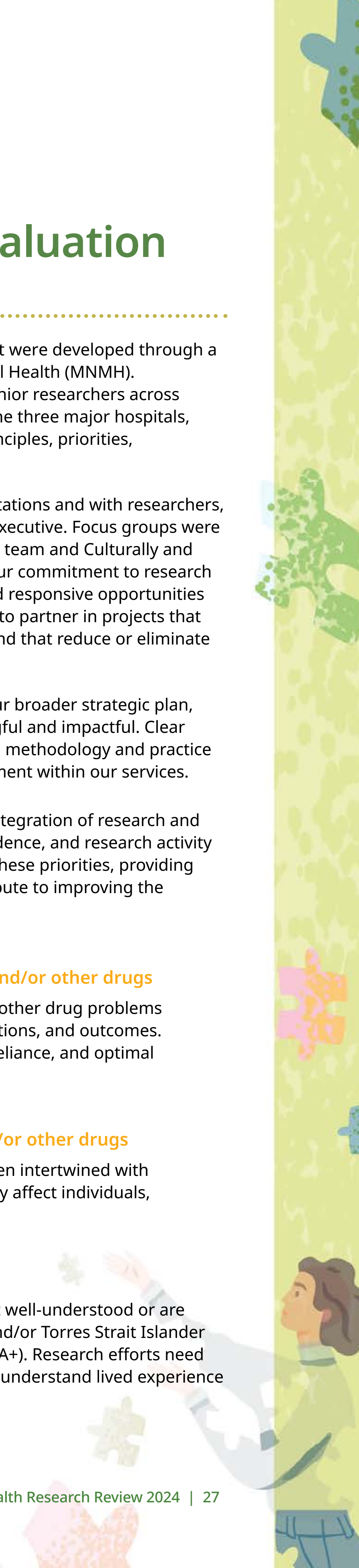
Understanding mental health and problematic use of alcohol and/or other drug problems requires creating and combining knowledge of their causes, interventions, and outcomes. It also involves comprehending factors that support the well-being, reliance, and optimal functioning of individuals and the community.

2. Complex issues associated with mental health and alcohol and/or other drugs

Mental health and problematic alcohol and/or other drug use are often intertwined with other health conditions and social disadvantages, which can adversely affect individuals, families, and carers.

3. Under-researched populations

In Australia, the needs of some populations and communities are not well-understood or are inadequately met by existing services (e.g., people from Aboriginal and/or Torres Strait Islander or cultural and linguistic backgrounds, women, older people, LGBTIQA+). Research efforts need to work in partnership with people to listen, develop trust and better understand lived experience of and preferences for mental health, alcohol and/or other drug care.



4. Health systems research

Health systems research focuses on improving outcomes, reducing inefficacies, and implementing system-wide changes that positively impacting the experiences of people with lived and living experience, their families and carers, and staff and shape mental health alcohol and other drug policy.

5. Innovation and evidence generating practice

Research focusing on practice innovation to identify and/or develop better ways to treat and support people. Innovations may broadly include specific interventions (e.g., pharmacotherapies, psychological therapies) and ways of working (e.g., the design and delivery of services).

6. Digital solutions

Digital solutions include innovations in telehealth delivery, personal electronic devices for supporting communication and deliver interventions, and adapting our information systems to support evidence-based decision making.

Priority 1: Understanding mental health and problematic use of alcohol and/or other drugs

Metro North Clinician Research Fellowship

Metro North's Clinical Research Fellowship program supports emerging and highly skilled clinician-researchers in developing and advancing a body of research aligned with the Metro North Research Strategy. The objectives of this program include enhancing opportunities and career pathways for clinician-researchers and enabling research within the hospital and healthcare service environment.

This competitive fellowship program is open to participants across all clinical disciplines working at Metro North sites, and up to five fellowships are awarded annually. Fellowship recipients are provided 0.4FTE salary support over three years with the goal of supporting them to pursue research without having to relinquish their clinical careers.

MNMH has been fortunate to have two staff awarded fellowships through this program over the past four years: Professor Dylan Flaws (2021-2024) and A/Prof Stephen Parker (2024-2027). Dylan was supported to complete the Greater Recovery After Critical Illness (GRACE) program of work that focused on the psychological impacts of care in the Intensive Care Unit environment. Stephen is being supported to undertake the Substance Use REcovery: Supporting Transition into Remission in Early Psychosis (SURE- STEP) program with the vision of delivering a collaboratively developed evidence-informed pathway of care that will improve the outcomes of people experiencing the First Episode of Psychosis and comorbid substance use.

A/Prof Stephen Parker
Director
Research

Interview with Associate Professor Stephen Parker – SURE-STEP (2024-2027)

What does the Clinician Research Fellowship mean to you?

Being awarded the Metro North Clinician Research Fellowship (2024-2027) has empowered me to dedicate my efforts to overcoming the everyday challenges that hinder clinical outcomes for young people experiencing their first episode of psychosis. The SURE-STEP program focuses on discovering innovative approaches to facilitate meaningful conversations that help identify and address concurrent substance use issues, which are known to affect prognosis adversely. Since commencing the Fellowship in August 2024, we've brought together a passionate and dedicated team that includes representatives with lived experience, developed robust protocols for key projects, and supported a variety of ongoing medical student initiatives aligned with the project's goals.

Why focus on substance use and early psychosis?

Working as the Clinical Lead at MNMH's Early Psychosis service, I was acutely aware of the high prevalence of substance use issues experienced by young people experiencing the first episode of psychosis. Cannabis and amphetamine use place young people at increased risk of developing psychosis and are known to complicate the recovery of people experiencing psychotic disorders. Within our own service, we noted and reported in 2024 on concerns about medicinal cannabis being increasingly used in the period immediately prior to psychosis onset for consumers referred to the Early Psychosis service (Lupke et al., 2024). Importantly, supporting people to achieve abstinence from cannabis and amphetamines after the onset of psychosis can have a big impact on the risk of relapse and repeat hospitalisations.

The extent of substance use by consumers is often under-recognised in clinical care. This is likely multifactorial, including consumers' reluctance to fully disclose their substance use (e.g., due to stigma or fear of repercussions) and staff either not asking about substance use or not asking about it in the right way. An example of this is illustrated in a 2024 case report focused on an MNMH Early Psychosis consumer who was experiencing recurrent losses of consciousness in the context of non-disclosed use of high-THC-concentrate cannabis products (Nadeem et al., 2024).

The impetus for SURE-STEP arose from the clinical experiences within MNMH Early Psychosis. The proposed program of work was developed and refined through discussion with key stakeholders, including the lived experience workforce, the Aboriginal and Torres Strait Islander workforce, the Alcohol and Other Drugs Service, and internationally recognised clinician academics external to Metro North with relevant content and methodological expertise.

What work is underway as part of the SURE-STEP program?

The SURE-STEP program has three core components: (1) **SUNRISE** (**S**ubstance **U**se **N**eeds: **R**evealing unmet **IS**sues in **E**arly psychosis), (2) **FOCUS-FEP** (**F**acilitating **O**pen **C**ommunication about Substance **US**e in **F**irst **E**pisode **P**sychosis), and the subsequent collaborative development of a care pathway. The **SUNRISE** project is a cross-sectional study exploring the extent to which substance use issues are identified in routine care. Additionally, this study will allow us to explore factors impacting the likelihood of substance use issues being identified. **FOCUS-FEP** will use qualitative methods to enable in-depth exploration of enablers and barriers to open communication about substance use in routine care from the perspectives of consumers, staff, and other stakeholders. The new knowledge emerging through these projects will be used to inform the collaborative development of a focused care pathway at MNMH with the goal of better supporting people experiencing the first episode of psychosis and concurrent substance use.

The Fellowship has also allowed me the time to support medical students and novice researchers at MNMH to commence projects that will support the aims of SURE-STEP. This includes systematic reviews of the evidence relating to novel interventions for cannabis dependence, differentiating cannabis induced psychosis from schizophrenia, pharmacological treatment of drug-induced psychoses, predictors of substance use non-disclosure, and the optimal approach to screening for substance use in youth populations.

Figure 8.
The 2024 Fellows at the Fellows Welcome Breakfast, October 2024

(L-R)
Professor Steven Lane (Executive Director Research), Dr Eoin O'Sullivan, Dr Ashleigh Scott, and A/Prof Stephen Parker

(Dr Monica Ng was not in attendance but commenced her Fellowship in August 2024)

Interview with Professor Dylan Flaws – GRACE (2021-2024)

Prof Dylan Flaws
Psychiatrist
Mental Health Short Stay Unit,
Caboolture

What motivated you to apply for this Fellowship?

Over the past 50 years, intensive care medicine has advanced significantly, with a 90% survival rate for patients admitted to Australian Intensive Care Units (ICU) (Zimmerman, Kramer & Knaus, 2013). However, this success has created an unintended challenge: survivors now live with physical, cognitive, or psychological impairments for years after discharge, a condition known as Post-Intensive Care Syndrome (Nakanishi et al., 2021).

I first came across this phenomenon while working at the RBWH neuropsychiatry clinic, where multiple patients had survived a critical illness but had subsequently been diagnosed with conditions like ‘treatment resistant depression’ and ‘health anxiety’. While speaking with one patient, we explored beyond her depression, and she revealed years of poor sleep, frequent nightmares, adverse physical reactions to seeing an ambulance and waking up in panic upon hearing her alarm clock as it reminded her of an ICU ventilator. After hearing this, I was able to diagnose her with post-traumatic stress disorder, five years after her symptoms began.

I recognised this as a significant issue, but I also realised that psychiatry had a role in addressing it, so I applied for a Metro North Clinician Research Fellowship, seeking to shed light on the problem from a psychiatric perspective.

What has the fellowship supported you to achieve?

Since commencing the fellowship, I have contributed to over twenty peer-reviewed publications directly relevant to improving the ICU care experience and post-ICU psychological outcomes. Other highlights include the Early Psychiatric Assessment and Referral Intervention Study, the GRACE Conference, presenting my fellowship findings to hospitals in South India, and providing PhD supervision.

Early Psychiatric Assessment and Referral Intervention Study (EPARIS)

My Fellowship supported Redcliffe Hospital to establish one of Australia's first post-ICU clinics, which has been the focus of the Early Psychiatric Assessment and Referral Intervention Study (EPARIS). This study provided support for the feasibility and acceptability of the clinics, which will be used to inform future funding through the National Health and Medical Research Council for a fully powered randomised controlled trial to examine the clinical impact of clinics of this type.

GRACE Conference (Cambridge University, June 2024)

In June 2024, we took our work to Cambridge University, where they hosted an international summit bringing together 38 experts to address key challenges in improving outcomes after critical illness. After the conference, we set the agenda for the next 10 years of research, where discussions emphasised the need to account for heterogeneity, reassess ICU's role and adopt pragmatic trial designs toward Precision Recovery.

Figure 9. At the GRACE Conference.

Dissemination of new knowledge internationally, the India visits (August 2024)

In August 2024 I presented the findings from my fellowship to nine hospitals across south India. The presentations were well received, with many attendees planning to implement changes in their practice and clinical environments. Several expressed interest in replicating studies, and others sought ongoing collaboration. Some plan to visit Brisbane, and others expressed their enthusiasm for me to return and view their progress.

Overall, this trip significantly enriched the fellowship, fostering global interest and collaboration in improving post-ICU care. These interactions not only expanded the reach of our work but also sparked a broader conversation on the importance of international cooperation in advancing clinical practice. The outcomes of these visits hold promising potential for future developments, and it is exciting to anticipate the continued evolution of this work on a global scale.

Figure 10. Prof Flaws at the Royal Care Hospital, Coimbatore, Tamil Nadu

Supporting the next generation of clinician researchers (PhD supervision)

Supervision is important in both paying it forward to the next generation, but also gaining those mentorship and critical revision skills which are essential in moving from an early career researcher into a mid-career researcher. The non-clinical time made available through the Fellowship has enabled me to act as an advisor for three PhD candidates, including from within the Metro North workforce:

1. Oystein Tronstad, who is exploring 'The ICU of the Future'.
2. Jennifer Obazuaye, whose topic is 'Co-design of a Novel Assessment Tool to Investigate Parental Needs and Support Resources Associated with Paediatric Critical Illness Survivorship'.
3. Zemadu Aweke, who is examining 'Predictors of trauma recovery in adult major trauma patients'.

What is happening now you have finished the Fellowship?

Since completing my Clinician Research Fellowship, my professional career has taken a permanent shift. I was honoured to have been appointed an adjunct professor with Queensland University of Technology, as well as Chair of Rehabilitation Services with the Jamieson Trauma Institute. I now have ongoing funded research time dedicated to leading the theme of psychological recovery after trauma and I continue to collaborate with intensive care and trauma clinicians both locally and nationally.

Publication from 2024:

Time in ICU and post-intensive care syndrome: how long is long enough?

Flaws et al. Critical Care (2024) 28:34
https://doi.org/10.1186/s13054-024-04812-7

Critical Care

BRIEF REPORT **Open Access**

Time in ICU and post-intensive care syndrome: how long is long enough?

Dylan Flaws[1,2,3*], John F. Fraser[2,3,4,10], Kevin Laupland[1,5], Jayshree Lavana[6], Sue Patterson[2,7], Alexis Tabah[8,9], Oystein Tronstad[2,6,10,11] and Mahesh Ramanan[4,9,10,12]

Abstract

Background Our understanding of post-ICU recovery is influenced by which patients are selected to study and treat. Many studies currently list an ICU length of stay of at least 24, 48, or 72 h as an inclusion criterion. This may be driven by established evidence that prolonged time in an ICU bed and prolonged ventilation can complicate post-ICU rehabilitation. However, recovery after short ICU stays still needs to be explored.

Methods This is a secondary analysis from the tracking outcomes post-intensive care (TOPIC) study. One hundred and thirty-two participants were assessed 6-months post-ICU discharge using standardised and validated self-report tools for physical function, cognitive function, anxiety, depression and post-traumatic stress disorder (with clinically significant impairment on any tool being considered a complicated recovery). Routinely collected data relating to the ICU stay were retrospectively accessed, including length of stay and duration of mechanical ventilation. Patients with short ICU stays were intentionally included, with 77 (58%) participants having an ICU length of stay < 72 h.

Results Of 132 participants, 40 (30%) had at least one identified post-ICU impairment 6 months after leaving ICU, 22 (17%) of whom had an ICU length of stay < 72 h.

Conclusion Many patients with an ICU length of stay < 72 h are reporting post-ICU impairment 6 months after leaving ICU. This is a population often excluded from studies and interventions. Future research should further explore post-ICU impairment among shorter stays.

BMC

Authors: **Dylan Flaws**, John Fraser, Kevin Laupland, Jayshree, Sue Patterson, Alexis Tabah, Oystein Tronstad, Mahesh Ramanan

With most patients now surviving intensive care units (ICU), academic and clinical focus has shifted to quality of survival. Up to 80% of patients discharged from ICU experience ongoing cognitive, psychological, or physical impairments, known as post-intensive care syndrome (PICS), which can persist for years at great cost to patients, families and society. Traditionally, research on PICS has focused on patients with extended ICU admissions, often excluding those with shorter stays. However, new research reveals ICU stays as short as 72 hours can have a lasting impact, challenging this notion that only long-term patients suffer from PICS. Therefore, this study aimed to determine whether these patients also experience significant post-ICU impairments by examining varied lengths of ICU stays.

Researchers conducted a secondary analysis of data from the Tracking Outcomes Post-Intensive Care (TOPIC) study, assessing 132 participants six months after ICU discharge. Routinely collected data relating to the ICU stay were retrospectively accessed, including length of stay and duration of mechanical ventilation. Standardised self- report tools evaluated physical function, cognitive function, anxiety, depression and post-traumatic stress disorder (PTSD). Notably, 58% of participants had ICU stays shorter than 72 hours. Findings revealed that 30% of all participants exhibited at least one post-ICU impairment six months post-discharge, with 17% of those having ICU stays under 72 hours and 11% having been ventilated for 1 to 24 hours.

The prevalence of PICS among patients with a short ICU length of stay and brief periods of ventilation was considerable and represents a potential burden of morbidity that may be currently understudied and undertreated. Therefore, patients with short ICU stays are not immune to PICS and still risk facing significant impairments months after discharge. This challenges the traditional focus on long-stay patients and emphasises the need to include short-stay patients when exploring post-ICU impairments and developing preventive and therapeutic strategies. Going forward, healthcare systems will need to expand post-ICU programs to accommodate the needs of both short- and long-stay ICU patients.

PRIORITY ① ②

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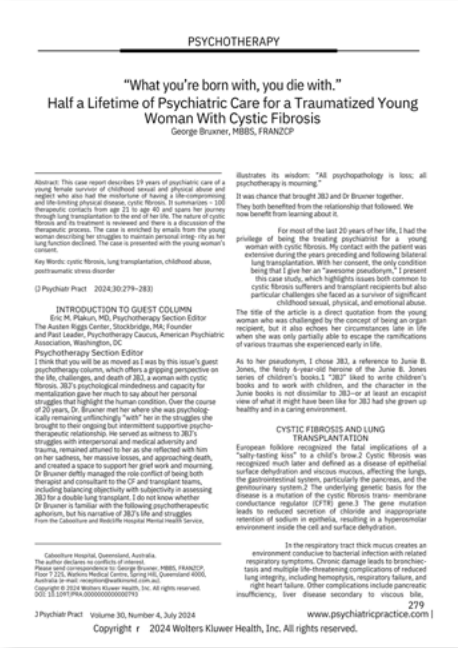
“What you’re born with, you die with.” Half a Lifetime of Psychiatric Care for a Traumatised Young Woman with Cystic Fibrosis



PSYCHOTHERAPY

“What you’re born with, you die with.”
Half a Lifetime of Psychiatric Care for a Traumatized Young Woman With Cystic Fibrosis
George Bruxner, MBBS, FRANZCP

Abstract: This case report describes 19 years of psychiatric care of a young female survivor of childhood sexual and physical abuse and neglect who also had the misfortune of having a life-compromising and life-limiting physical disease, cystic fibrosis. It summarizes ~ 100 therapeutic contacts from age 21 to age 40 and spans her journey through lung transplantation to the end of her life. The nature of cystic fibrosis and its treatment is reviewed and there is a discussion of the therapeutic process. The case is enriched by emails from the young woman describing her struggles to maintain personal integ- rity as her lung function declined. The case is presented with the young woman’s consent.

Key Words: cystic fibrosis, lung transplantation, childhood abuse, posttraumatic stress disorder

(J Psychiatr Pract 2024;30:279–283)

INTRODUCTION TO GUEST COLUMN
Eric M. Plakun, MD, Psychotherapy Section Editor
The Austen Riggs Center, Stockbridge, MA; Founder and Past Leader, Psychotherapy Caucus, American Psychiatric Association, Washington, DC
Psychotherapy Section Editor

I think that you will be as moved as I was by this issue’s guest psychotherapy column, which offers a gripping perspective on the life, challenges, and death of JBJ, a woman with cystic fibrosis. JBJ’s psychological mindedness and capacity for mentalization gave her much to say about her personal struggles that highlight the human condition. Over the course of 20 years, Dr. Bruxner met her where she was psychologically remaining unflinchingly “with” her in the struggles she brought to their ongoing but intermittent supportive psychotherapeutic relationship. He served as witness to JBJ’s struggles with interpersonal and medical adversity and trauma, remained attuned to her as she reflected with him on her sadness, her massive losses, and approaching death, and created a space to support her grief work and mourning. Dr Bruxner deftly managed the role conflict of being both therapist and consultant to the CF and transplant teams, including balancing objectivity with subjectivity in assessing JBJ for a double lung transplant. I do not know whether Dr Bruxner is familiar with the following psychotherapeutic aphorism, but his narrative of JBJ’s life and struggles illustrates its wisdom: “All psychopathology is loss; all psychotherapy is mourning.”

It was chance that brought JBJ and Dr Bruxner together. They both benefited from the relationship that followed. We now benefit from learning about it.

For most of the last 20 years of her life, I had the privilege of being the treating psychiatrist for a young woman with cystic fibrosis. My contact with the patient was extensive during the years preceding and following bilateral lung transplantation. With her consent, the only condition being that I give her an “awesome pseudonym,” I present this case study, which highlights issues both common to cystic fibrosis sufferers and transplant recipients but also particular challenges she faced as a survivor of significant childhood sexual, physical, and emotional abuse.

The title of the article is a direct quotation from the young woman who was challenged by the concept of being an organ recipient, but it also echoes her circumstances late in life when she was only partially able to escape the ramifications of various traumas she experienced early in life.

As to her pseudonym, I chose JBJ, a reference to Junie B. Jones, the feisty 6-year-old heroine of the Junie B. Jones series of children’s books.1 “JBJ” liked to write children’s books and to work with children, and the character in the Junie books is not dissimilar to JBJ—or at least an escapist view of what it might have been like for JBJ had she grown up healthy and in a caring environment.

CYSTIC FIBROSIS AND LUNG TRANSPLANTATION

European folklore recognized the fatal implications of a “salty-tasting kiss” to a child’s brow.2 Cystic fibrosis was recognized much later and defined as a disease of epithelial surface dehydration and viscous mucous, affecting the lungs, the gastrointestinal system, particularly the pancreas, and the genitourinary system.2 The underlying genetic basis for the disease is a mutation of the cystic fibrosis trans- membrane conductance regulator (CFTR) gene.3 The gene mutation leads to reduced secretion of chloride and inappropriate retention of sodium in epithelia, resulting in a hyperosmolar environment inside the cell and surface dehydration.

In the respiratory tract thick mucus creates an environment conducive to bacterial infection with related respiratory symptoms. Chronic damage leads to bronchiectasis and multiple life-threatening complications of reduced lung integrity, including hemoptysis, respiratory failure, and right heart failure. Other complications include pancreatic insufficiency, liver disease secondary to viscous bile,

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The author declares no conflicts of interest.
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Author: **George Bruxner**

For the most of the last 20 years of her life, Dr George Bruxner was the treating psychiatrist for a young woman with cystic fibrosis (CF). This case study tells a story of this resilient and courageous woman, where the management of her chronic disease was affected by childhood trauma and alcohol abuse. Under the pseudonym, “JBJ”, Dr Bruxner recounts their therapeutic contact with each other preceding and following bilateral lung transplantation. Dr Bruxner would like to express his gratitude to JBJ for allowing him to tell her story. We also would like to extend our appreciation to JBJ, as well as our thanks to Dr Bruxner for permitting us to share her story. We would also like to acknowledge Dr Philip Masel and the Cystic Fibrosis and Transplant Teams at TPCH who provided excellent holistic care for JBJ.

Diagnosed with CF as an infant, JBJ’s life was dictated by a disease that not only stole her lung function but also took her independence, her relationships – her life. Growing up JBJ was physically, emotionally and sexually abused, where upon referral at 22 years old, Dr Bruxner diagnosed her with posttraumatic stress disorder (PTSD) secondary to childhood abuse and emotional neglect. Despite this, JBJ fought to maintain control even as her lungs failed her. But when the opportunity for a lung transplant arrived, JBJ only saw it as a burden, agonising that *“someone has to die for me to live”*. At her lowest, she removed herself from the transplant list, only to rejoin later when her circumstances changed. At the age of thirty-one, JBJ receive bilateral lung transplants. After the transplant, JBJ’s lung function improved but underlying CF and treatment related complications and family stressors continued to persist. Despite these challenges, she found moments of joy in her work with children and the love of her partner. JBJ’s contact with Dr Bruxner became increasingly intermittent, reflecting stability and happier times. However, after five years of relatively good lung function, JBJ’s mental and physical health declined dramatically, and she passed away a year later.

> *Now*
> *more than ever,*
> *I am feeling CF at its worst.*
> *I never thought this disease could take*
> *any more from me, but here we are.*
> *CF is not only taking my ability to*
> *breathe, but it is also taking*
> *my self-esteem.*
>
> – JBJ

For nearly two decades, Dr Bruxner provided more than therapy – he became a steady presence in a life filled with instability. Their sessions offered a space where she could process her trauma, express frustrations and find moments of clarity amid the chaos of her illness. Beyond psychotherapy, he also acted as an advocate, helping bridge the gap between JBJ and her medical teams. While therapy couldn’t erase her suffering, it gave her a sense of agency. JBJ’s story highlights the complex intersection of chronic illness, trauma and mental health, showing how past experiences shape perceptions of self- worth and medical care. Her journey emphasises the importance of long-term psychiatric support, ethical considerations in transplant medicine, and the resilience of individuals facing lifelong adversity.

PRIORITY 1 2

A qualitative study of using nicotine products for smoking cessation after discharge from residential drug and alcohol treatment in Australia


ORIGINAL PAPER

WILEY

A qualitative study of using nicotine products for smoking cessation after discharge from residential drug and alcohol treatment in Australia

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Abstract

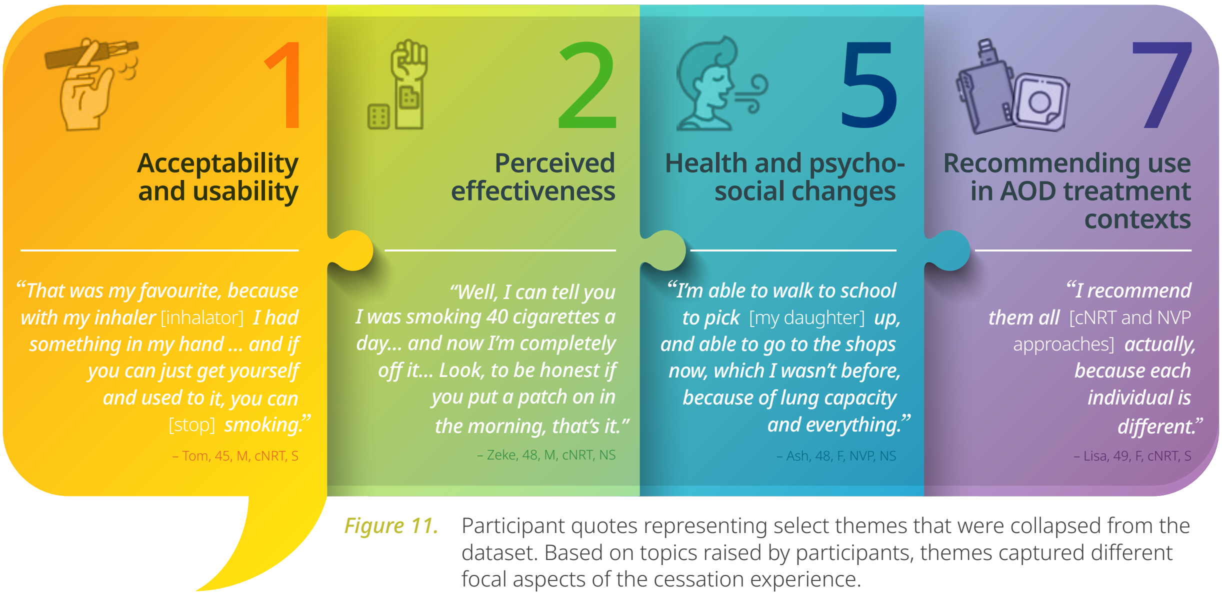
Introduction: Tobacco smoking is highly prevalent among alcohol and other drugs (AOD) service clients and, despite interest in quitting, abstinence is rarely sustained. Nicotine products may assist after discharge from residential treatment services, but little is known about client receptivity to them. This study examined AOD withdrawal service clients' experiences of two types of nicotine products for smoking cessation post-discharge, combination nicotine replacement therapy (cNRT) and nicotine vaping products (NVP).

Methods: We held semi-structured telephone interviews with 31 Australian AOD service clients in a clinical trial of a 12-week smoking cessation intervention using Quitline support plus cNRT or NVP delivered post-discharge from a smoke-free

Authors: Joshua Trigg, Jane Rich, Edwina Williams, Amanda Baker, Linda Bauld, Ron Borland, Chris Bullen, **Mark Daglish**, Adrian Dunlop, Coral Gartner, David Jacka, Dan Lubman, Victoria Manning, Rose McCrohan, Cathy Segan, Natalie Walker, Billie Bonevski

Tobacco smoking remains prevalent among clients of alcohol and other drug (AOD) services, with sustained abstinence often proving elusive despite a strong desire to quit. This study examined AOD withdrawal service clients' experiences of two types of nicotine products for smoking cessation post-discharge from a non-smoking residential facility: combination nicotine replacement therapy (cNRT) and nicotine vaping products (NVP). Researchers conducted semi-structured telephone interviews with 31 participants enrolled in a 12-week clinical trial that provided Quitline support alongside either cNRT or NVPs after discharge.

Participants reported that their primary motivation for switching to alternative nicotine products was to reduce health risks associated with smoking, with many previously attempting to quit using traditional cessation methods. For some, alternative nicotine products offered a sense of control, allowing them to manage their withdrawal symptoms while gradually reducing their dependence. Others appreciated the behavioural and sensory similarities to smoking. Conversely, while some participants found cNRT helpful in reducing cravings, others felt it lacked the sensory and behavioural components of smoking, making it less satisfying compared to other nicotine products. Furthermore, some participants reported struggling to find the right product or dose, while others encountered social stigma surrounding vaping and nicotine pouches. Notably, there was uncertainty about whether participants felt they could fully cease nicotine use altogether with some users continuing to use nicotine products indefinitely.


1

Acceptability and usability

“That was my favourite, because with my inhaler [inhalator] *I had something in my hand ... and if you can just get yourself and used to it, you can* [stop] *smoking.”*

– Tom, 45, M, cNRT, S

2

Perceived effectiveness

“Well, I can tell you I was smoking 40 cigarettes a day... and now I’m completely off it... Look, to be honest if you put a patch on in the morning, that’s it.”

– Zeke, 48, M, cNRT, NS

5

Health and psycho-social changes

“I’m able to walk to school to pick [my daughter] *up, and able to go to the shops now, which I wasn’t before, because of lung capacity and everything.”*

– Ash, 48, F, NVP, NS

7

Recommending use in AOD treatment contexts

“I recommend them all [cNRT and NVP approaches] *actually, because each individual is different.”*

– Lisa, 49, F, cNRT, S

Figure 11. Participant quotes representing select themes that were collapsed from the dataset. Based on topics raised by participants, themes captured different focal aspects of the cessation experience.

Nonetheless, findings indicate that both cNRT and NVPs were deemed feasible and acceptable methods for smoking cessation. Post-study access was hindered by financial constraints for cNRT and challenges in navigating prescription requirements for NVPs. While participants valued the behavioural support provided by Quitline, its utilisation was inconsistent, and some noted limited assistance specifically tailored to NVP-related cessation efforts. Social acceptance of both interventions was generally positive, with many participants expressing interest in receiving guidance on reducing nicotine consumption through NVPs. Overall, clients highly valued both interventions when combined with behavioural support for smoking cessation. However, challenges such as product accessibility, misinformation, and long-term dependence need to be addressed through clearer public health messaging and better support systems for individuals attempting to quit smoking completely.

PRIORITY 1

Australian Youth Self-Harm Atlas: spatial modelling and mapping of self- harm prevalence and related risk and protective factors to inform youth suicide prevention strategies

Epidemiology and Psychiatric Sciences

cambridge.org/eps

Original Article

Australian Youth Self-Harm Atlas: spatial modelling and mapping of self-harm prevalence and related risk and protective factors to inform youth suicide prevention strategies

E. Hielscher, K. Hay, I. Chang, M. McGrath, K. Poulton, E. Giebels, J. Blake, P. J. Batterham, J. G. Scott and D. Lawrence

Abstract

Introduction

Authors: E. Hielscher, K. Hay, I. Chang, M. McGrath, K. Poulton, **E. Giebels, J. Blake**, P. J. Batterham, J. G. Scott and D. Lawrence

Suicide prevention strategies have shifted in many countries, from a national approach to one that is regionally tailored and responsive to local community needs. Research which supports this localised approach is growing albeit with key gaps. Few studies have focused on youth, with most concentrating on suicide deaths which may not fully capture a complete understanding of prevention needs. This study, the Youth Self-Harm Atlas, was the first nationwide study to look at regional differences of self-harm prevalence and related factors in Australian young people. The Atlas study was led by a team at QIMR Berghofer and completed in partnership with Roses in the Ocean, Australia's leading suicide prevention NGO. The work was funded by a Suicide Prevention Innovation Research Grant.

The Atlas research team incorporated data from the Young Minds Matter (YMM) survey. YMM used area-based random sampling to recruit a sample of Australian adolescents (12 to 17 years old) to complete self-report survey questions on self-harm (i.e., non-suicidal self-harm and suicide attempts) in the previous 12 months. Using mixed effects regressions, the Atlas team built an area-level model with YMM survey and Census data to produce out-of-sample small area predictions for self-harm prevalence. Across Australia, there was large variability in youth self-harm prevalence estimates. Northern Territory, Western Australia, and South Australia had the highest estimated state prevalence. Psychological distress and depression were factors which best predicted self-harm at an individual level. At an area-level, the strongest predictor was a high percentage of single unemployed parents, whilst being in an area where ≥30% of parents were born overseas was associated with reduced odds of self-harm. Findings from the Atlas study should assist governments and communities with developing and implementing regionally appropriate youth suicide prevention interventions and initiatives. A comprehensive overview of the Youth Self-Harm Atlas study, including interactive geospatial maps of self-harm prevalence, can be found on AIHW's Suicide and Self-Harm Monitoring System website: https://www.aihw.gov.au/suicide-self-harm-monitoring/population-groups/young-people/youth-self-harm-atlas.

Figure 12 (a)

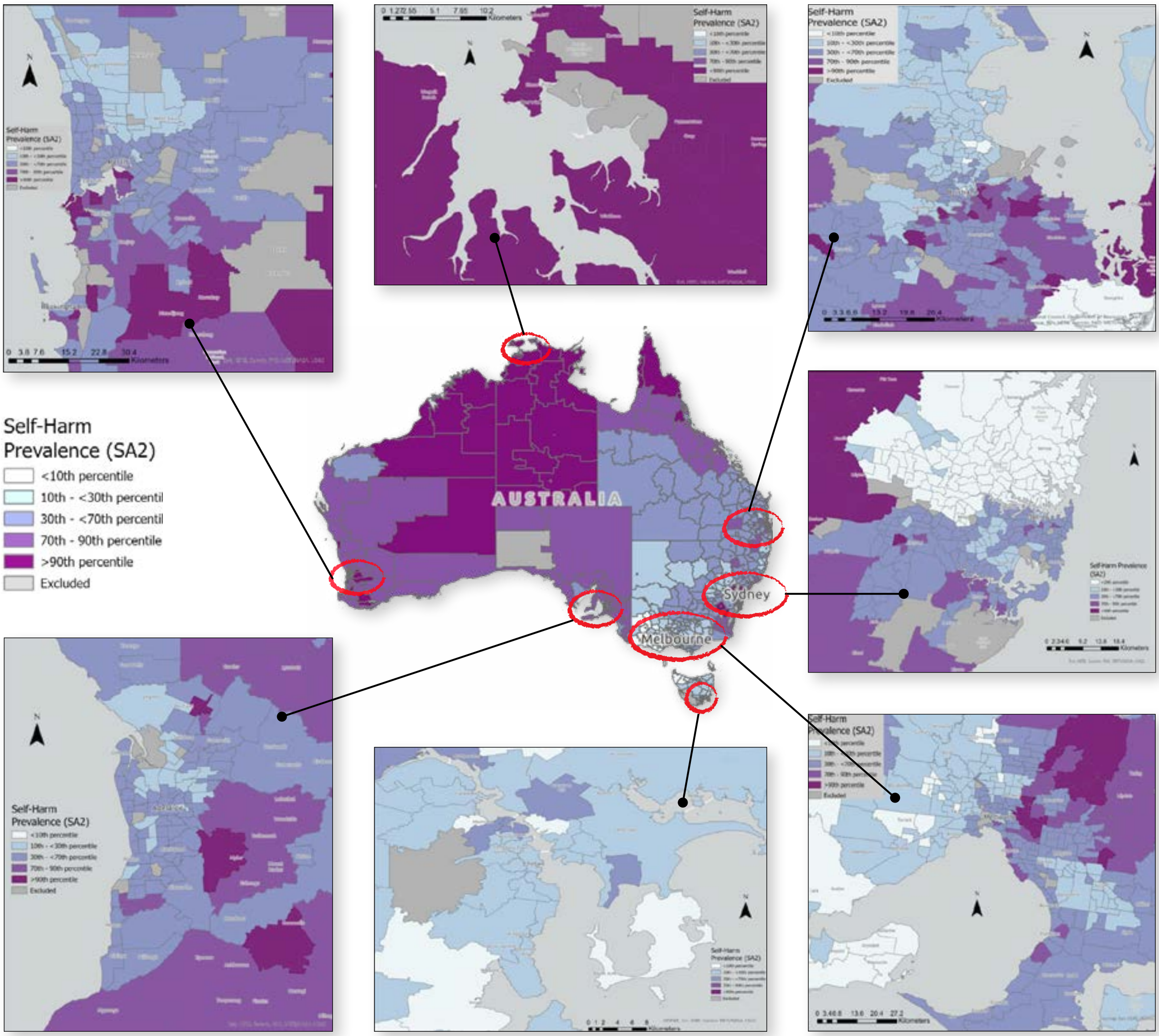


Figure 12 (b)

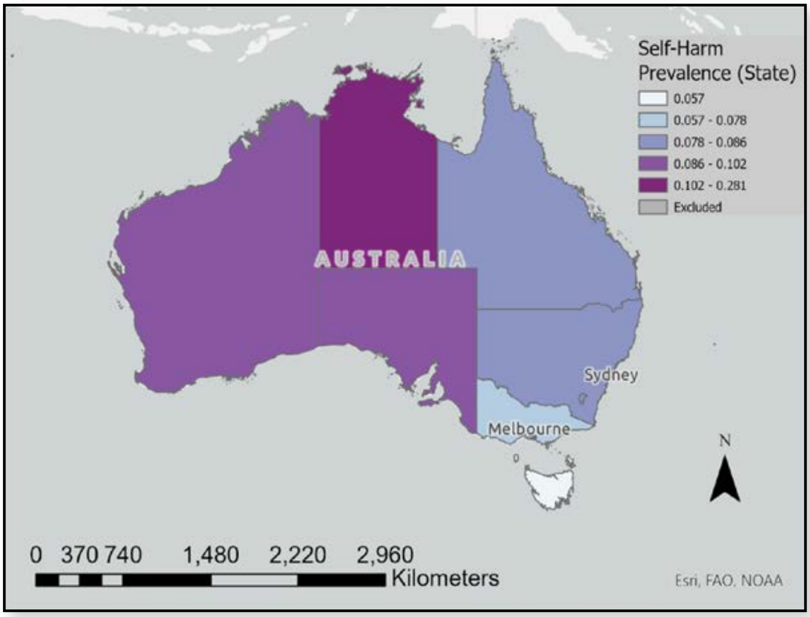
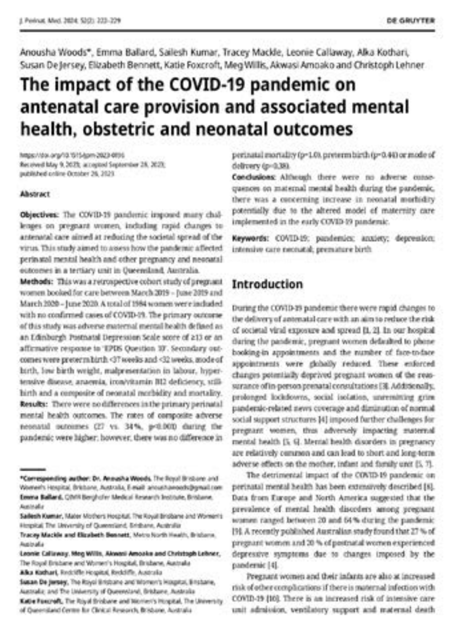


Figure 12. (a): Distribution of Statistical Area Level 2 (SA2) synthetic, 12-month self-harm prevalence estimates (2019);

Figure 12. (b): State-level synthetic, 12-month self-harm prevalence estimates (201), Australian-wide. The primary outcome is shown in these maps i.e., self-harm irrespective of intent. Capital cities (Zoomed in images) are presented in Figure 1a.

Interpretation note:
Figure 12 (a) - (b): Choropleth maps show the distribution of youth self-harm prevalence in each SA2 (i.e., size of suburbs within cities) and state, where "Dark Purple" indicates higher prevalence (i.e., above the 90th percentile), and "Light Blue" indicates lower prevalence of self-harm (i.e., below the 10th percentile). Excluded map regions (in grey) indicate missing data or regions with low quality data (5% of total SA1s across Australia).

The impact of the COVID-19 pandemic on antenatal care provision and associated mental health, obstetric and neonatal outcomes



J. Perinat. Med. 2024; 52(2): 222–229 DE GRUYTER

Anousha Woods*, Emma Ballard, Sailesh Kumar, Tracey Mackle, Leonie Callaway, Alka Kothari, Susan De Jersey, Elizabeth Bennett, Katie Foxcroft, Meg Willis, Akwasi Amoako and Christoph Lehner

The impact of the COVID-19 pandemic on antenatal care provision and associated mental health, obstetric and neonatal outcomes

Abstract

Introduction

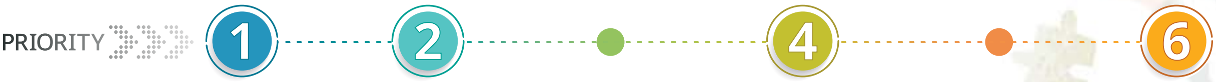
Authors: Anousha Woods, Emma Ballard, Sailesh Kumar, **Tracey Mackle**, Leonie Callaway, Alka Kothari, Susan De Jersey, **Elizabeth Bennett**, Katie Foxcroft, Meg Willis, Akwasi Amoako and Christopher Lehner

When the COVID-19 pandemic reshaped antenatal care to fewer in-person visits and altered screening protocols, a crucial question emerged – are these changes quietly putting newborns at risk? This study examined these shifts and explored how changes in antenatal care provision affected perinatal mental health, obstetric outcomes and neonatal health in a tertiary maternity unit in Queensland, Australia.

This retrospective cohort study analysed 1,784 pregnant women who sought antenatal care between March and June in both 2019 (pre-pandemic) and 2020 (pandemic). The primary outcome measure was adverse maternal mental health, assessed using the Edinburgh Postnatal Depression Scale (EPDS). Secondary outcomes included preterm birth, birth complications, neonatal morbidity and referral to social services. Data were extracted from electronic medical records and analysed using statistical tests to identify significant differences between groups.

In contradiction to global trends that indicate heightened anxiety and depression in pregnant women during COVID-19, this study found no significant differences in maternal mental health, as EPDS scores remained consistent between the two groups. However, neonatal morbidity rates increased significantly during the pandemic, with higher rates of neonatal resuscitation, special care admissions, respiratory distress and hypoglycaemia. The study also found that the fewer face-to-face antenatal visits could have contributed to missed diagnoses, including malpresentation and gestational diabetes. Despite these concerns, there was no rise in preterm birth or perinatal mortality.

These findings highlight the unintended consequences of modified antenatal care models during health crises. While telehealth provided continuity of care, reduced in-person visits may have contributed to increased neonatal complications. The study emphasises the need for balanced maternity care approaches that integrate remote consultations while ensuring essential in-person assessments. In preparation for the next inevitable health crisis, healthcare policies should address these gaps to optimise both maternal and neonatal outcomes.



From bedside to recovery: exercise therapy for prevention of post-intensive care syndrome

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https://doi.org/10.1186/s40560-024-00724-4

Journal of Intensive Care

REVIEW Open Access

From bedside to recovery: exercise therapy for prevention of post-intensive care syndrome

Keibun Liu[1,2,3*†], Oystein Tronstad[1,2,4†], Dylan Flaws[1,5,6], Luke Churchill[1,4,7], Alice Y. M. Jones[8], Kensuke Nakamura[9] and John F. Fraser[1,2,9,10]

Abstract

Background As advancements in critical care medicine continue to improve Intensive Care Unit (ICU) survival rates, clinical and research attention is urgently shifting toward improving the quality of survival. Post-Intensive Care Syndrome (PICS) is a complex constellation of physical, cognitive, and mental dysfunctions that severely impact patients' lives after hospital discharge. This review provides a comprehensive and multi-dimensional summary of the current evidence and practice of exercise therapy (ET) during and after an ICU admission to prevent and manage the various domains of PICS. The review aims to elucidate the evidence of the mechanisms and effects of ET in ICU rehabilitation and highlight that suboptimal clinical and functional outcomes of ICU patients is a growing public health concern that needs to be urgently addressed.

Main body This review commences with a brief overview of the current relationship between PICS and ET, describing the latest research on this topic. It subsequently summarises the use of ET in ICU, hospital wards, and post-hospital discharge, illuminating the problematic transition between these settings. The following chapters focus on the effects of ET on physical, cognitive, and mental function, detailing the multi-faceted biological and pathophysiological mechanisms of dysfunctions and the benefits of ET in all three domains. This is followed by a chapter focusing on co-interventions and how to maximise and enhance the effect of ET, outlining practical strategies for how to optimise the effectiveness of ET. The review next describes several emerging technologies that have been introduced/suggested to augment and support the provision of ET during and after ICU admission. Lastly, the review discusses future research directions.

Conclusion PICS is a growing global healthcare concern. This review aims to guide clinicians, researchers, policymakers, and healthcare providers in utilising ET as a therapeutic and preventive measure for patients during and after an ICU admission to address this problem. An improved understanding of the effectiveness of ET and the clinical and research gaps that needs to be urgently addressed will greatly assist clinicians in their efforts to rehabilitate ICU survivors, improving patients' quality of survival and helping them return to their normal lives after hospital discharge.

Keywords Exercise therapy, Intensive care unit, Post-intensive care syndrome, Rehabilitation

†Keibun Liu and Oystein Tronstad contributed equally to this paper.

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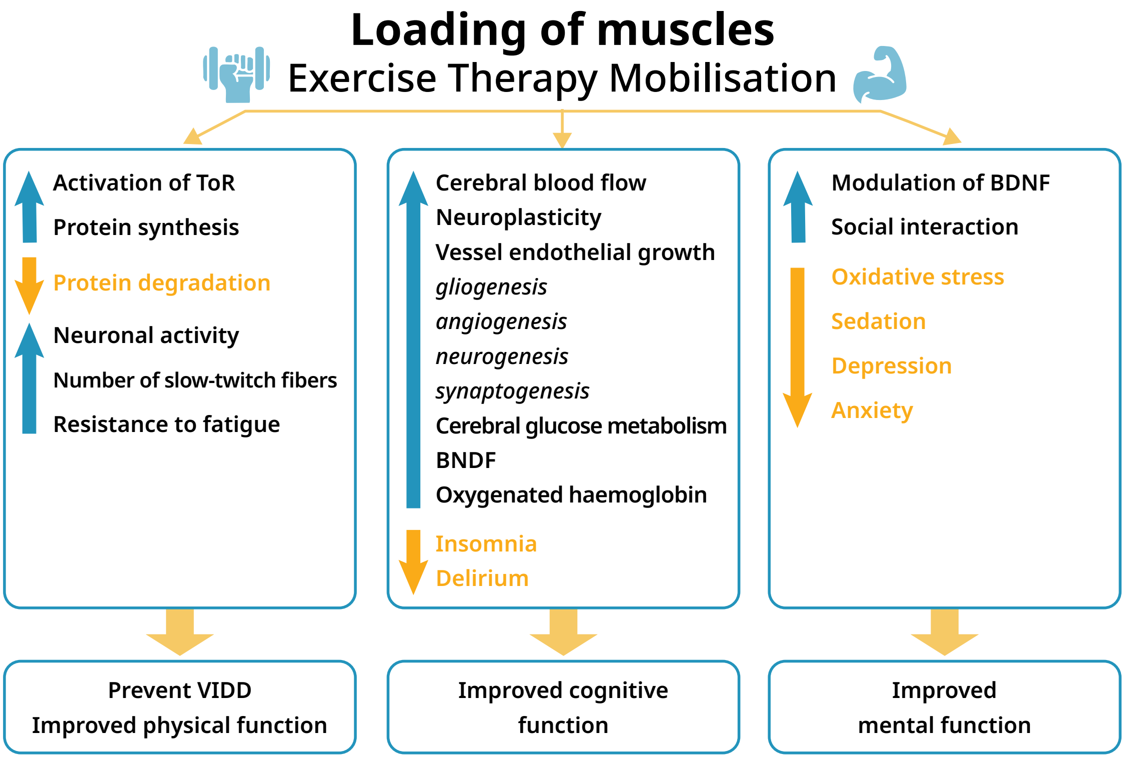
Authors: Keibun Liu, Oystein Tronstad, **Dylan Flaws**, Luke Churchill, Alice Y. M. Jones, Kensuke Nakamura, and John F. Fraser

Post-Intensive Care Syndrome (PICS), defined as persistent disabilities or dysfunctions after a patient leaves the intensive care unit (ICU), manifests in three key domains: physical impairments, cognitive decline, and mental health disorders. Prolonged immobilisation and critical illness lead to muscle atrophy, weakness, and functional decline, limiting mobility and independence. Cognitive deficits, including memory loss and reduced attention span – affecting nearly half of ICU survivors – complicate their return to daily activities and work. Furthermore, psychiatric conditions such as anxiety, depression, and post-traumatic stress disorder (PTSD) are common. To prevent and manage the various domains of PICS, this review provided a comprehensive and multi- dimensional summary of the current evidence and practice of exercise therapy (ET) during and after an ICU admission.



Loading of muscles
Exercise Therapy Mobilisation

↑ Activation of ToR
↑ Protein synthesis
↓ Protein degradation
↑ Neuronal activity
↑ Number of slow-twitch fibers
↑ Resistance to fatigue

Prevent VIDD
Improved physical function

↑ Cerebral blood flow
↑ Neuroplasticity
↑ Vessel endothelial growth
↑ *gliogenesis*
↑ *angiogenesis*
↑ *neurogenesis*
↑ *synaptogenesis*
↑ Cerebral glucose metabolism
↑ BNDF
↑ Oxygenated haemoglobin
↓ Insomnia
↓ Delirium

Improved cognitive function

↑ Modulation of BDNF
↑ Social interaction
↓ Oxidative stress
↓ Sedation
↓ Depression
↓ Anxiety

Improved mental function

Figure 13 Brief summary of mechanisms of exercise effects on physical, cognitive, mental functions (BDNF brain-derived neurotrophic factor).

For this review, ET is defined as any physical activity or intervention – passive (e.g., range of motion), assisted e.g., assisted lower limb exercises), or active (e.g., marching on the spot) – that assists patients in maintaining and/or improving muscle strength and physical function. ET helps preserve muscle mass and assists in improving endurance, coordination, and balance – decreasing the risk of readmission and enhancing overall physical independence. Beyond its physical benefits, ET helps reduce psychological distress and supports emotional well-being *(see Figure 13)*. ET promotes neuroplasticity, enhances cerebral blood flow, and supports neurogenesis, all of which contribute to improved cognitive performance and reduce executive dysfunction *(see Figure 14)*. Specifically, ET in ICU has been demonstrated to be a promising intervention to modify post-ICU neuropsychiatric outcomes and prevent delirium. On top of this, ET helps alleviate symptoms of psychological distress common to ICU survivors and provides patients with a sense of progress and control over their own recovery. Due to the social aspect of ET, the activity provides a regular opportunity for interpersonal connection, and thus reduces isolation. Overall, ET offers a holistic approach to recovery, addressing physical, psychological and neurological deficits.

Despite the evolving understanding of the effects of ET on PICS, there are still multiple gaps in the current evidence, underscoring the necessity for further extensive research. By ensuring individualised assessments and interventions are delivered at the right time and continuing after hospital discharge, exploring the optimisation of ET dosing and methodology of evaluation on patient outcomes, whilst incorporating multifaceted preventive measures and prediction models, we can usher in a new era of PICS management and prevention. This essential work should be prioritised to achieve the goal of ensuring ICU survivors do not merely survive but thrive in their post-ICU lives.

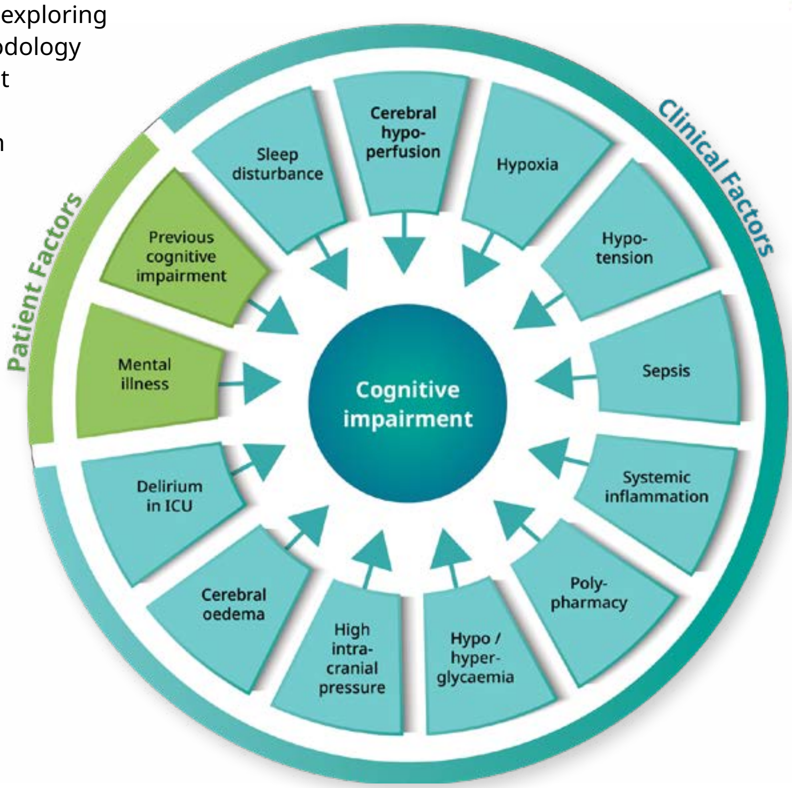


Figure 14.
Factors that influence post-ICU cognitive outcomes.

Priority 2: Complex issues associated with mental health and alcohol and/or other drugs

Factors associated with experiencing stigma, discrimination, and negative health care treatment among people who inject drugs

International Journal of Drug Policy

ELSEVIER

Research Paper

Factors associated with experiencing stigma, discrimination, and negative health care treatment among people who inject drugs

Timothy R. Broady, Heather Valerio, Maryam Alavi, Alice Wheeler, David Silk, Marianne Martinello, Anna Conway, Andrew Milat, Adrian Dunlop, Carolyn Murray, Charles Henderson, Janaki Amin, Phillip Read, Philippa Marks, Louisa Degenhardt, Annabelle Stevens, Bianca Prain, Jeremy Hayllar, David Reid, Mark Montebello, Alexandra Wade, Michael Christmass, Victoria Cock, Gregory J. Dore, Carla Treloar, Jason Grebely, on behalf of the ETHOS Engage Study Group

ARTICLE INFO

ABSTRACT

Authors: Timothy Broady, Heather Valerio, Maryam Alavi, Alice Wheeler, Dvid Silk, Marianne Martinello, Anna Conway, Andrew Milat, Adrian Dunlop, Carolyn Murray, Charles Henderson, Janaki Amin, Phillip Read, Philippa Marks, Louise Degenhardt, Annabelle Stevens, Bianca Prain, **Jeremy Hayllar**, David Reid, Mark Montebello... Jason Grebely.

Many people who inject drugs face stigma and discrimination in healthcare settings, leading to negative experiences that create barriers to essential medical care. Stigma in healthcare settings can lead to delayed treatment, poorer health outcomes and increased mistrust of medical providers, ultimately exacerbating health disparities among people who inject drugs. By examining the specific factors contributing to these negative experiences, this study aimed to better understand the barriers in accessing quality care and help inform interventions to promote more equitable and compassionate healthcare for this marginalised population.

Data was sourced from an observational cohort study as part of the ETHOS Engage project, which focused on people who inject drugs attending drug treatment clinics and needle and syringe programs in Australia. Participants completed a questionnaire involving injecting drug use (IDU)- and hepatitis C virus (HCV)-related stigma, and negative treatment by health workers. The authors found that a significant proportion of participants reported experiencing stigma and discrimination in healthcare settings. Specifically, many participants indicated that they had been treated disrespectfully, unfairly or provided substandard care by healthcare workers due to their drug use or hepatitis C status. The study emphasises the urgent need for systemic changes in healthcare practices to address the discrimination faced by people who inject drugs. By enhancing training, improving attitudes and adopting harm reduction strategies, healthcare systems can better serve this marginalised group. Moving forward, the focus should be on creating a more supportive environment that prioritises dignity and respect for people who inject drugs, fostering a shift in both healthcare delivery and societal attitudes. Ultimately, these changes will not only improve healthcare access but also contribute to broader public health goals.

Perspectives from alcohol and drug clinicians towards the introduction of peer workers within a tertiary alcohol and other drug treatment service

Authors: John Kelly, Emma Armitage

The integration of dedicated peer worker (PW) roles into alcohol and other drug (AOD) treatment settings has gained considerable attention, reflecting a broader shift toward incorporating lived experience into the therapeutic process of substance dependence recovery and care. PW roles can be defined as organisational positions whereby a person uses their own lived experience of AOD recovery, coupled with formalised training, to support clients as they navigate their own recovery and rehabilitation journey (Byrne et al 2021; Tracy & Wallace, 2016). The value of PWs within mental health services is well established and studies have found that PWs in AOD rehabilitation services like needle and syringe programs enhance clients' experiences, such as, normalising the recovery process and reducing stigma (Soloman, 2004; Emery et al 2024; Chen et al 2023). Yet despite this evidence base, significant barriers have impacted their implementation.

To implement a peer workforce, organisational culture and staff attitudes need to be considered as staff attitudes are one of the main barriers to the success of PW roles in mental health services (Ibrahim et al. 2020). When staff view PW's as valuable assets, there is greater cohesion and improved client outcomes, whilst negative attitudes can create barriers that undermine the potential benefits (Bachman et al., 2019). Therefore, the purpose of this study is to explore AOD clinical staff views of introducing a PW into a government tertiary AOD treatment service, to identify perceived benefits and challenges of PW's, to assist in the implementation of an AOD PW role. A cross-sectional survey with a sample of AOD clinical staff (n = 53) employed in a government AOD treatment service in Brisbane, Australia was used to obtain qualitative and quantitative measures of staff's perspectives. The results found that majority of staff (62%) believed that the inclusion of PWs would enhance service delivery and improve client engagement and treatment completion (51%). In contrast, 13% disagreed or strongly disagreed with this perspective.

> *A peer worker can provide a complementary approach to the clinical interventions. They would greatly enhance client participation, particularly in the group setting, and help clients feel more at ease accessing and staying in our service.*
>
> (Participant 49)

Strengths/benefits of a peer worker position within the AOD service

> *"People with lived experience can increase clinicians' understanding of a client's perspective, bridging potential bias and stigma and informing clinicians of things they have potentially not considered or not understood. They offer invaluable experience and perspectives for clinicians to take on board and can support teams and service development."*
>
> (Participant 9)

Positive themes that emerged were PWs ability to enhance engagement in treatment, advocate and support teams and impact on service culture. Participants believed that PWs can be seen as role models for recovery and that clients would feel more comfortable talking to someone with lived experience. A PW role was seen as a compliment to existing services, such as, monitoring progress and co- facilitating programs. Furthermore, PWs could be valuable when advocating and representing client needs. Overall, having the presence of PW within teams, and hearing PW perspectives in care planning was seen as a potential strength.

Barriers/concerns of a peer worker position within the AOD service

Common themes when discussing barriers/concerns of implementing PW within the AOD service, were role clarity and scope, organisational culture, boundaries and PW wellbeing. Over half of the respondents identified being unsure of the PW scope of practice, particularly distinguishing between clinical and non-clinical aspects of the role. Concerns were raised around qualifications and what constitutes lived experience, and that differing perspectives could lead to conflict in treatment teams or how the introduction of PW roles may be tokenistic. At a personal level, concerns around professional boundaries were queried as PWs may enforce their own lived experience rather than being client-centred. Furthermore, staff acknowledged the risk of PW burnout or relapsing to AOD use due to working within an AOD service.

> *It would be important to specify the lived experience we are seeking. Is it past dependency? Diagnosis? Treatment? What recency of lived experience qualifies someone as a peer worker? How do they demonstrate a history and duration of abstinence?*
>
> [Participant 31]

> *I don't think peer workers are non-judgemental. They promote their experience, which might be different to the client's. I have seen this happen. They didn't enhance engagement but pushed clients away.*
>
> [Participant 12]

> *Why can Peer Workers disclose and draw upon lived experience when working with clients, when other professional roles are discouraged from doing the same?*
>
> [Participant 19]

Conclusions and next steps:

Although most clinicians saw PW roles as beneficial, the authors suggest the following strategies to support the implementation in AOD services:

i. Service wide education on the value of peer work, the use of lived experience, recovery orientated care, and exploration of staff attitudes and beliefs

ii. Organisational readiness, including the development of clear role descriptions, clarification on lived or living AOD experience and establishing supervision and support for PW

iii. Leadership and governance, to demonstrate the services commitment to peer integration and ecovery practice.

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Repeated intentional foreign body ingestion, what can be done?

Emergency Medicine Australasia

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OPINION

Repeated intentional foreign body ingestion, what can be done?

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Authors: Paris Hoey, Kimberley Ryan, Clancy McDonald, Nathan Brown, **Kym Boon**, Florian Grimpen, Mark Appleyard

Repeated intentional foreign body ingestion (RIFBI) in patients with Emotionally Unstable Personality Disorder (EUPD) is a common clinical presentation to the emergency department. The relationship between repeated foreign body ingestion and a co-existent personality disorder diagnosis is complex, making it challenging to manage. Current guidelines suggest endoscopic retrieval for all ingested objects; however, this approach falls short when EUPD occurs. For patients with EUPD, repeated procedures and prolonged hospital admissions reinforce maladaptive behaviours and create a cycle of self-harm behaviours. Furthermore, existing clinical practice guidelines for patients with EUPD do not accommodate for RIFBI episodes. This prompted the authors to propose a new interdisciplinary acute management plan (AMP) to improve outcomes for these patients.

In March 2016, the AMP model of care was implemented at the Royal Brisbane and Women's Hospital (RBWH). In this model of care, treatment of the patient's underlying psychopathology is prioritised, and the goal is to safely reduce in-patient admissions, endoscopic procedures and utilisation of healthcare staff resources. The AMP is tailored to each patient – *Figure 15* outlines the AMP developmental process.

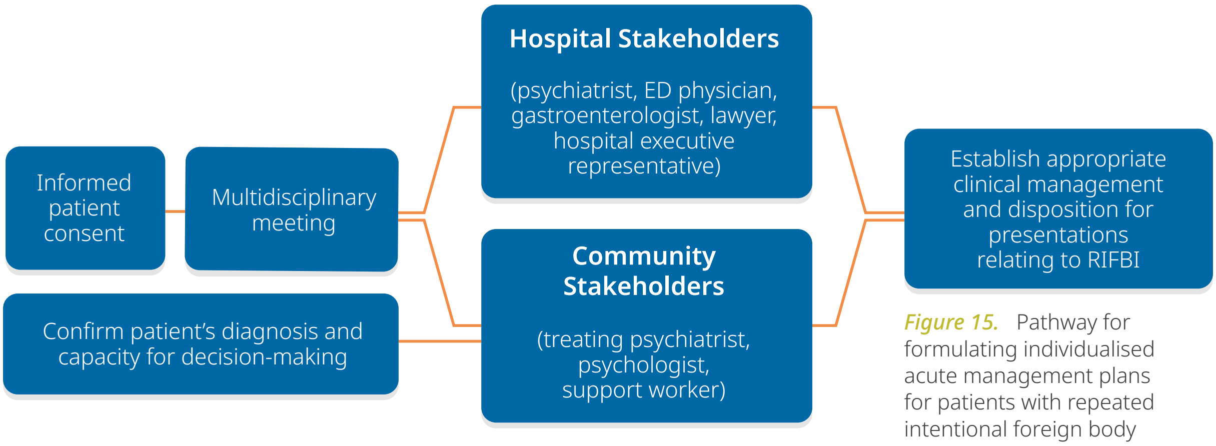

Figure 15. Pathway for formulating individualised acute management plans for patients with repeated intentional foreign body ingestion (RIFBI).

By focusing on a tailored, interdisciplinary approach, the AMP reduced the cycle of repeat procedures and prolonged hospitalisations, offering more sustainable, effective management of self-harm behaviours and emotional regulation. This shift provides a comprehensive and supportive framework for managing these complex cases in emergency settings. Nonetheless, further research as to what extent the model of care changes outcomes at patient and service levels is warranted.

Does mental illness in adolescence/young adulthood predict intimate partner violence?

Journal of Psychiatric Research

Does mental illness in adolescence/young adulthood predict intimate partner violence?

Jake Najman, Gail M. Williams, Alexandra M. Clavarino, James G. Scott, Tara McGee

ARTICLE INFO

ABSTRACT

Authors: Jake Najman, Gail Williams, Alexandra Clavarino, **James Scott**, Tara McGee

Domestic violence has many mental and physical consequences. These include depression, anxiety and substance use disorders. While domestic (otherwise called intimate partner) violence contributes to poor mental health, there is a need to examine the reverse sequence, that poor mental health predicts subsequent intimate partner violence (IPV). Do depression and anxiety experienced before a person has an intimate partner predict whether their relationship will involve high levels of IPV?

This study takes data from a long-running study. Pregnant women and the children to whom they gave birth joined the study at the mother's first obstetrical visit. These mothers and their children have been followed-up for over 30 years. The children's mental health was assessed when the child was 14 and 21 years of age. At 30 years the children (now adults) completed a questionnaire assessing the extent to which they experience physical abuse, emotional abuse, harassment or coercive control in their current relationship (all findings were based upon measures from the Composite Abuse Scale – CAS). The study examines the degree to which depression, anxiety or antisocial behaviour reported by the child at 14 and 21 years predict IPV at 30 years of age. Child delinquency or aggression at 14 years predicted whether this child experienced physical abuse, harassment or coercive control at 30 years of age. If the child has higher levels of depression, delinquency or aggression at 21 years of age, that child was more likely to experience physical abuse, emotional abuse, harassment and coercive control in their intimate relationships at 30 years of age.

Poor mental health in the adolescent and early adult periods predict a consistent pattern of IPV in adult intimate relationships. These findings point to the need to know more about (i) whether early intervention programs to improve mental health outcomes could lead to a reduction in IPV; and (ii) why poor mental health might contribute to increased levels of IPV.

PRIORITY ② ⑤

An interview with Dr Kate Murphy and Amy Hannigan

Recently, we caught up with Dr Kate Murphy and Amy Hannigan from Queensland Eating Disorder Service (QuEDS) to discuss current projects and the future of eating disorder research.

Supportive Meal Therapy Training for Mental Health Nurses

At QuEDS, we've been looking at ways to enhance the therapeutic role mental health nurses play during supportive meal therapy (SMT). We know that nurses often find themselves sitting alongside patients in moments of intense anxiety around food, unsure exactly how to turn these interactions into meaningful therapeutic opportunities. In response, we've developed a workshop specifically designed to empower nurses with a structured, trauma-informed approach to these meal-based interventions. The focus is on deepening their understanding of psychological dynamics like transference and countertransference and helping them feel more confident about how to therapeutically engage during mealtimes. We're hopeful this approach will help nurses unlock the full potential of their role in recovery.

Systematic Review to Inform the QuEDS Guidelines for Inpatient Admissions

In Queensland, we're seeing increasing complexity and higher numbers of people, which makes clear, evidence-based guidelines critically important. Right now, however, there are significant gaps in the research that directly affect clinical decisions, especially regarding guidelines for hospital admissions.

One area where we see this gap clearly is in determining when an individual experiencing an eating disorder requires a hospital admission to support their nutrition for medical stabilisation. At present, guidelines often highlight cardiovascular parameters – such as QT intervals, heart rate, and blood pressure – as markers of risk. But when our team recently undertook a systematic review (Murphy et al., 2024) to assess the evidence linking cardiovascular parameters to serious adverse outcomes like cardiac arrest or death, we found surprisingly limited research. Out of over 12,000 unique studies screened, only two studies directly addressed whether specific cardiovascular markers predicted severe medical complications in individuals with eating disorders.

The limited evidence creates genuine practical difficulties. Our clinicians regularly communicate with GPs and hospital staff about patient admissions, and these clinicians understandably want clear, evidence-based criteria. Clinicians must be confident in triaging between outpatient and inpatient care – ensuring those at highest risk get immediate hospital support, while also appropriately managing less acute cases in outpatient settings. Without clarity, we face challenges in maintaining trust in our relationships with referrers and Queensland hospitals.

The QuEDS difference

Fortunately, QuEDS is well-positioned to address this critical research gap. As part of routine assessment and triage practices, cardiovascular parameters, but a broader set of clinical markers that are used to assess the need for inpatient admission here at QuEDS and in hospitals across the world. Although our recent review focused on cardiovascular parameters, our vision for future research is broader. We aim to use our existing data collection processes (including our new Redcap system) to enable an evaluation of all predictors we currently use for triage and assessment purposes, not just cardiovascular ones.

We hope this approach offers a promising way forward: embedding research directly into our daily clinical practice. Rather than isolated studies, our everyday service data can become a robust platform for meaningful, primary research. Over time, we hope to contribute to an international body of research clarifying which clinical parameters best indicate the imminent need for inpatient medical stabilisation. Equally important will be identifying which parameters suggest people may safely benefit from stepped up care within the community setting.

If we can address these critical gaps, we believe that clinicians involved in primary care and hospital settings will feel more confident to implement our guidelines in their practice. Most importantly, improved guidelines mean improved safety and outcomes for people. By continuing to embed quality improvement and research within our standard practice, we hope to ensure that the future of eating disorder care is increasingly evidence-based, effective, and responsive to people's needs.

The QuEDS team would like to thank the MNMH Research Team for their collaboration on the systematic review – especially the incredible expertise and patience of Dr Liz Eggins, without whom we could not have conducted this systematic review. Furthermore, the MNMH Research Team would like to thank Dr Morgan Sidari for her contribution to the writing and collation of this interview.

Figure 16. QuEDS team at their 2024 planning day.

Systematic review:

1. **Murphy, K., Sidari, M., Eggins, E., Parker, S.** & Waldmann, J. (2024) *Cardiovascular risk factors for serious adverse health events in individuals with eating disorders: A systematic review.* Unpublished. Available from https://www.crd.york.ac.uk/PROSPERO/view/CRD42024583403.

Understanding and treating eating disorders: Commentary on two publications by first author, Sinead Day

RESEARCH ARTICLE

Posttraumatic stress disorder (PTSD) and complex PTSD in eating disorder treatment-seekers: Prevalence and associations with symptom severity

Sinead Day[1] | **Phillipa Hay**[2,3] | **Christopher Basten**[4] | **Susan Byrne**[5,6] | **Amanda Dearden**[7] | **Mandy Goldstein**[7,8] | **Amy Hannigan**[7] | **Gabriella Heruc**[9] | **Catherine Houlihan**[10] | **Marion Roberts**[11,12] | **W. Kathy Tannous**[13] | **Chris Thornton**[14] | **Natalie Valentine**[15] | **Deborah Mitchison**[16]

Abstract

Although childhood trauma and posttraumatic stress disorder (PTSD) have been well-researched in eating disorder epidemiology, prevalence rates are unavailable for complex PTSD (CPTSD). Under recently introduced *ICD-11* criteria, individuals with CPTSD have both PTSD symptoms and additional disturbances in self-organization (DSO). Using *ICD-11* criteria, this study aimed to determine the prevalence of PTSD and DSO symptoms, diagnostic rates of PTSD and CPTSD, and childhood trauma exposure in eating disorder treatment-seekers. Participants (*N* = 217) were individuals attending residential, partial

Journal of Affective Disorders

Research paper

Residential versus day program treatment for eating disorders: A comparison of post-treatment outcomes and predictors

Sinead Day, Deborah Mitchison, Haider Mannan, W. Kathy Tannous, Janet Conti, Amanda Dearden, Aunty Kerrie Doyle, Katherine Gill, Amy Hannigan, Catherine Houlihan, Lucie Ramjan, Rebekah Rankin, Natalie Valentine, Phillipa Hay

Individuals with eating disorders have long been recognised to commonly present with other mental health conditions and history of exposure to traumatic events such as childhood abuse. However, previous research on eating disorders and trauma had not differentiated between rates of post-traumatic stress disorder (PTSD) and complex PTSD (CPTSD).

Our study, *Posttraumatic stress disorder (PTSD) and complex PTSD in eating disorder treatment-seekers: Prevalence and associations with symptom severity*, included a large sample of adults with eating disorders from three types of treatment settings: residential care, at Australia's first eating disorder residential program (Wandi Nerida) on the Sunshine Coast; a long-running eating disorder day program at the Queensland Eating Disorder Service; and multiple private practices around the country (Day et al., 2024). At admission to treatment, participants completed measures of eating disorder symptoms, history of childhood trauma, and trauma-related symptoms.

We found that nearly a third (28.4%) of the sample met criteria for CPTSD and 3.8% met criteria for PTSD. These trauma-related symptoms were more severe in higher levels of care and were associated with more severe eating disorder symptoms. Exposure to childhood trauma was common (e.g., nearly half of participants reported a history of emotional abuse) and generally did not differ between treatment settings. These findings highlight that trauma- related disorders are common among individuals with eating disorders and should be part of routine assessment regardless of treatment setting. Eating disorder services may benefit from incorporating trauma-focused interventions and principles of trauma-informed care, particularly as individuals with this comorbidity represent a more severe subgroup of the eating disorder population.

The findings from this study form part of a larger evaluation of residential treatment for eating disorders, with another recent paper (Day et al., 2025) comparing this treatment setting to day program treatment. The results of this evaluation support the effectiveness of residential treatment and its potential benefits over a day program setting for individuals with severe eating disorder symptoms. These findings are promising for the ongoing rollout of eating disorder residential care around Australia, aiming to bridge the gap in care between inpatient and outpatient services.

Figures 17. Residential day program site.

Figures 18. Day program treatment room *(R).*

Stimulant medications in the management of bulimia nervosa and anorexia nervosa in patients with and without comorbid attention deficit hyperactivity disorder: A systematic review

Eating Behaviors

Stimulant medications in the management of bulimia nervosa and anorexia nervosa in patients with and without comorbid attention deficit hyperactivity disorder: A systematic review

Mark L. Vickers, Hong Yin Chan, Stephen Elliott, Sarangan Ketheesan, Vinay Ramineni, Lars Eriksson, Kirsten McMahon, Belinda Oddy, James G. Scott

Authors: **Mark L Vickers, Hong Yin Chan, Stephen Elliott, Sarangan Ketheesan, Vinay Ramineni**, Lars Eriksson, Kirsten McMahon, **Belinda Oddy**, James G Scott

People with attentional problems are at increased risk of eating disorders. Given the need to further examine the safety and efficacy of its treatment, this systematic review synthesised the evidence on stimulant medication in the management of patients with bulimia nervosa (BN) or anorexia nervosa (AN) with or without comorbid attention deficit hyperactivity disorder (ADHD). Researchers conducted a systematic review in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) guidelines. A protocol for the review was registered with Open Science Framework (OSF) Registry and critical appraisal of the literature was conducted using Joanna Briggs Institute (JBI) Critical Appraisal Tools.

Thirteen articles (out of 2171 articles from an initial search) met inclusion criteria including two quasi-experimental studies, one randomised controlled trial, four case series, and six case reports. A total of 26 cases were included from studies and 32 from case series/reports. Only two cases from a single case report had a diagnosis of AN, while the remainder had BN. From included studies, case series and case reports, five forms of stimulant medication were identified in the treatment of BN or AN including methylamphetamine, lisdexamfetamine, methylphenidate, dextroamphetamine sulphate and mixed amphetamine salt. In nearly all cases of BN there were reported reductions in eating disorder symptoms. However, the rates of adverse effects were high and included weight loss, decreased appetite, tachycardia, dry mouth, fatigue, insomnia, restlessness, nausea, bruxism, headache, palpitations, blood pressure changes, irritability, anxiety, depressed mood, and diaphoresis. Therefore, due to the small number of studies, few participants, lack of controls and the open label nature of existing research there is currently insufficient evidence to support the use of stimulants to treat eating disorder symptoms in BN. No evidence was found to support the role for stimulants in AN. The preoccupation with weight loss in BN and AN means that misuse of stimulant medication for appetite suppression may be more likely in this population. Further research is needed to ascertain the safety and efficacy of stimulants in people with eating disorders. The authors recommend considering screening patients with BN for ADHD to avoid misuse of stimulant medication in clinical practice.

Priority 3: Under-researched populations

Professor Gerard Byrne: 44 years of service


Prof Gerard Byrne

Emeritus Professor Gerard Byrne has had a long and illustrious career as the University of Queensland Mayne Professor of Psychiatry and the Director of Older Persons Mental Health at the RBWH. He has made major contributions to academic psychiatry with international recognition and played a key role in building the research culture and capacity within out service. These contributions include the joint development of the Geriatric Anxiety Inventory with Professor Nancy Pachana, and instrument that is widely used and cited around the world. He has authored four textbooks that remain a valued resourced across the mental health disciplines, focusing on community based older persons mental health care, anxiety in older people, and psychosocial aspects of medicine. His contributions to academic psychiatry were acknowledged through the RANZCP Senior Researcher award in 2012.

Professor Byrne has been the Director of the Older Persons Mental Health Service at the RBWH since 1997 and established the first integrated hospital and community older persons mental health team in QLD. He also played a critical role in the collaborative establishment of the RBWH Memory Clinic, fostering and supporting strong working relationships between the mental health and medical services.

As Professor Byrne's retirement approaches, his loss will undoubtably be felt. It was a pleasure to learn from his wisdom as he reflects on his career and the ways he has been able to successfully integrated research into clinical practice.

An interview with Professor Gerard Byrne

Could you share a short snapshot of your career?

I have been associated with Queensland Health for 44 years since taking up a PGY2 position at TPCH in 1981. After sampling internal medicine and cardiac surgery during PGY2 and PGY3, I decided to undertake psychiatry training. I was influenced in my career direction by positive experiences I had had as a medical student with Prof Leslie Kiloh at the Prince of Wales Hospital in Sydney and by excellent role models at TPCH, including directors of psychiatry Dr Donald Grant and Dr Thomas George.

My psychiatry training involved rotations at the Wolston Park Hospital and the Inala Child Guidance Centre, as well as at TPCH. After completing my training in psychiatry, I started work at the Royal Brisbane Hospital and the University of Queensland in 1988 and have been at RBWH ever since – 37 years altogether.

Tell us about your career trajectory at the RBWH.

I was fortunate to arrive at RBWH at a time when Prof Beverly Raphael AM was both head of the UQ Department of Psychiatry and director of the RBWH Mental Health Service. She arranged a conjoint UQ/QH position for me, which allowed me time to complete my PhD. I studied bereavement in older widowers. After Prof Raphael's retirement, I was greatly assisted by Prof Brett Emmerson, who was for many years the director of the RBWH Mental Health Service and then the MNMHS.

My clinical work was initially at the Hospital Alcohol and Drugs Service (HADS) and then in general adult psychiatry in the dilapidated World War One buildings on the Rosemount Campus. I had a longstanding interest in old age psychiatry but there was no old age psychiatry service at RBWH. However, this all changed in 1994 when the Australian Government (under PM Paul Keating) called for expressions of interest for grants to establish old age psychiatry services. We obtained such a grant and when the RBWH Mental Health Centre opened in 1995 we opened our fledgling integrated hospital and community old age psychiatry service. We were fortunate in attracting excellent medical, nursing, allied health, and administrative staff.

How has the RBWH old age psychiatry service grown?

Over time, the community component has grown in size and complexity, although the number of inpatient beds has remained the same. Once the Royal Australian and New Zealand College of Psychiatrists established a program of advanced training in old age psychiatry, we provided advanced training posts. We introduced an annual statewide symposium in older persons' mental health, which has now been running for many years, and has beamed interstate.

I conducted outpatient clinics which attracted older people with a variety of mental health problems as well as cognitive impairment. It turned out that physician and geriatrician Dr Catherine Yelland was also seeing patients for general geriatrics as well as cognitive impairment. We joined forces in the late 1990s and established the RBWH Memory Clinic in the outpatient section of GARU on the Rosemount Campus. This flourished and is now operating out of the ground floor at STARS. The memory clinic provided a platform for both industry-sponsored and investigator-initiated research projects. Over more than 25 years, we trialled many oral and intravenous agents for Alzheimer's disease. None appeared to work. We also conducted a series of studies into anxiety in older people, including those with cognitive impairment.

Tell us about your collaborative work.

In collaboration with clinical geropsychologist Prof Nancy Pachana we developed and tested the Geriatric Anxiety Inventory (GAI). We collaborated with researchers around the world and now the GAI is available in more than 30 languages. We provide it free of charge to researchers and have licensed it via UniQuest to the U.S. Veterans' Administration.

I was fortunate to have had a series of excellent PhD students who pursued a diverse range of topics including behavioural and psychological symptoms of dementia, epidemiological aspects of anxiety in older people, and anxiety in people with Parkinson's disease. Several of these students were highly productive, including Dr Daniela Gonçalves and Prof Jerome Sarris. Subsequently, in a series of NHMRC- unded clinical trials led by Jerome Sarris, we investigated the effect of nutraceuticals as augmentation strategies in common mental disorders.

My productivity was greatly enhanced by my PhD students and advanced trainees in old age psychiatry, and by fruitful collaborations with other researchers, including with Prof Nancy Pachana, Prof Jerome Sarris and Prof Nadeeka Dissanayaka. I was assisted for many years by research nurse Liz Arnold, whose organised approach to patient recruitment was essential. There were many other research assistants who were vital to the success of particular projects.

Figure 19. Prof Nadeeka Dissanayaka (L), Prof Gerard Byrne (C), Prof Nancy Pachana (R)

Where to now?

After retiring from UQ and RBWH in May 2025 I plan to write forensic reports, travel and enjoy the grandchildren. I am not sure yet whether I have another book in me! Of course, none of this would have been possible without the strong support of my wife, Dr Donna O'Sullivan, who retired recently from her position as EDMS at TPCH. I thank Donna and all of my students and collaborators for their essential support and assistance.

>$40 million*
in research fundings

>200
journal articles

>40**
book chapters

4**
books

* including from industry sources as well as the NHMRC, MRFF, the Wicking Trust, the RBWH Foundation, the Rotary Foundation, and the U.S. Alzheimer's Association.

** Prof Byrne's most recent book, *Anxiety in Older People: Clinical and Research Perspectives* (Byrne & Pachana, Cambridge University Press, 2021) was co-edited with Prof Nancy Pachana. An older textbook, co-written with Professor Christine Neville, is still in print and remains recommended reading for old age psychiatry trainees: *Community Mental Health for Older People* (Byrne & Neville, Elsevier, 2009). Prof Byrne is also the author of the chapter on Anxiety Disorders in several editions of the *Oxford Textbook of Old Age Psychiatry.*

Highly cited journal articles include work on the Geriatric Anxiety Inventory, much of which was completed at RBWH:

1. Pachana NA, Byrne GJ, Siddle H, et al. (2007) Development and validation of the Geriatric Anxiety Inventory. *International Psychogeriatrics*, 19(1): 103-114.
2. Byrne GJ, Pachana NA. (2011) Development and validation of a short form of the Geriatric Anxiety Inventory – the GAI-SF. *International Psychogeriatrics*, 23(1): 125-131.

Well-cited systematic reviews include the following:

1. Sarris J, Byrne GJ. (2011) A systematic review of insomnia and complementary medicine. *Sleep Medicine Reviews,* 15(2): 99-106.
2. Goncalves DC, Byrne GJ. (2012) Interventions for generalized anxiety disorder in older adults: systematic review and meta-analysis. *Journal of Anxiety Disorders*, 26(1): 1-11.
3. Robins Wahlin TB, Byrne GJ. (2011) Personality changes in Alzheimer's disease: a systematic review. *International Journal of Geriatric Psychiatry,* 26(10): 1019-1029.

Publication: Rasch modelling of IQCODE scores in people with dementia

COMMENTARY

Rasch modeling of IQCODE scores in people with dementia

Gerard J. Byrne[1,2]

The Informant Questionnaire for Cognitive Decline in the Elderly (IQCODE; Jorm and Jacomb, 1989) is an informant-rated instrument which is useful in situations in which the person being assessed for cognitive impairment is unable or unwilling to undergo cognitive testing, or where there may be a question about the validity of cognitive testing. Its performance as a screening tool is comparable to that of cognitive screening tests such as the Mini-Mental State Examination). Limitations on face-to-face consultations during the COVID-19 pandemic have opened up another use for the IQCODE as an adjunct to telephone testing methods such as the Telephone Interview for Cognitive Status-Modified (Brandt *et al.*, 1993).

The IQCODE has been validated against other measures of cognitive change (Jorm *et al.*, 1996), clinical diagnosis (Jorm, 2004; van Nieuwkerk *et al.*, 2021), brain autopsy findings (Rockwood *et al.*, 1998), neuroimaging findings (Cordoliani-Markowiak *et al.*, 2003), incident dementia (Louis *et al.*, 1999), and mortality (Jorm, 2004). It has also been the subject of a Cochrane review (Quinn *et al.*, 2021).

The original IQCODE has 26 items, and the Short IQCODE (also known as IQCODE-16) has 16 items (Jorm, 1994). Each item is rated on a 5-point Likert scale from "Much improved" (1) to "Much worse" (5). For example, "Recalling conversations a few days later" is item 5 on the IQCODE and item 3 on the Short IQCODE. The informant is asked to rate how the person is now in comparison with how they were 10 years ago. Both major forms of the IQCODE are available in multiple languages and can be used without a licence fee. The Short IQCODE has been reported to be correlated 0.98 with the original version (Jorm, 2004), and it is now in widespread use.

In clinical use, the standard method of calculating a total score involves dividing the summed item scores by either 26 for the IQCODE or by 16 for the Short IQCODE. This method generates a score out of 5, with higher scores indicating greater cognitive decline over the previous 10 years. When screening for dementia, the developers have recommended using cutting points on the IQCODE of 3.27/3.30 and on the Short IQCODE of 3.31/3.38, whereas other researchers have proposed cutting points between 3.27 and 4.00 (Jorm, 2004). The thresholds for detecting clinically significant cognitive decline vary by the prior probability of cognitive impairment in the population under test (e.g., memory clinic attendees versus population samples), but are straightforward to apply.

The clinical utility of the IQCODE depends critically upon the availability of a suitable informant, who needs to have known the patient for the previous 10 years. It also relies upon truth telling by the informant, so is likely to have limitations in both civil and criminal medicolegal assessments. It may be influenced more generally by the response style of the informant and by the demand characteristics of the assessment situation, including social desirability. The IQCODE does not substitute for detailed clinical history-taking because it does not provide information about clinical course or trajectory, and it is silent as to etiology.

A potential problem with the IQCODE Likert scores is that the individual items may not be of equivalent "difficulty" and as a consequence the summed scores form an ordinal scale rather than a linear one (Boone, 2016). The Rasch model provides a mathematical method for dealing with this problem. Rasch analysis, named for Danish mathematician Georg Rasch, employs a statistical approach that is most often applied to categorical or ordinal data, including data from questionnaires. The Rasch model seeks to capture the trade-off between item difficulty and respondent ability and can be understood as a special case of item response theory (Raykov and Marcoulides, 2018). A polytomous Rasch model can be applied to Likert scales that measure a characteristic or ability using successive integers. Rasch models allow such nonlinear data to be converted into linear form, allowing interrogation using parametric statistics (Boone, 2016). Linear transformation has

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The Informant Questionnaire for Cognitive Decline in the Elderly (IQCODE) is an informant-rated instrument which is useful in situations in which the person being assessed for cognitive impairment is unable or unwilling to undergo cognitive testing, or where there may be a question about the validity of cognitive testing. Given some limitations when using the IQCODE-16 despite its widespread use, Gerard talks about how Rasch analysis can be utilized to convert ordinal data from assessments like the IQCODE-16 into interval-level measurements. This transformation accounts for varying item difficulties and respondent abilities, enabling more precise and meaningful comparisons. The commentary referenced a study in which the researchers applied Rasch modelling to the IQCODE-16, identifying a unidimensional scale with strong reliability, allowing for the conversion of ordinal scores into interval data.

The practical implication is that transforming IQCODE-16 scores into interval-level data enhances the precision of cognitive decline assessments. This improvement further facilitates more accurate tracking of changes over time and strengthens the tool's utility in both clinical and research settings. In summary, it highlights the benefits of applying Rasch modelling to the IQCODE-16, emphasizing that this approach has the potential to refine the assessment's accuracy and reliability in measuring cognitive decline among the elderly.

> *"This invited commentary discusses the clinical utility of a new scoring method of a scale sometimes used in memory clinics, particularly when the patient is unable to be tested. I based my analysis on my experience in clinical work and research at the RBWH/STARS memory clinic."*
>
> – Prof Gerard Byrne

PRIORITY 3 5

The Use of a Digital Well-Being App (Stay Strong App) With Indigenous People in Prison: Randomized Controlled Trial

JMIR MENTAL HEALTH Perdacher et al

Original Paper

The Use of a Digital Well-Being App (Stay Strong App) With Indigenous People in Prison: Randomized Controlled Trial

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Abstract

Background: Indigenous Australians in custody experience much greater rates of poor mental health and well-being than those of the general community, and these problems are not adequately addressed. Digital mental health strategies offer innovative opportunities to address the problems, but little is known about their feasibility in or impact on this population.

Objective: This study aims to conduct a pilot trial evaluating the impact of adding the Stay Strong app to mental health and well-being services for Indigenous women and men in custody. The trial compared immediate and 3-month delayed use of the app by the health service, assessing its effects on well-being, empowerment, and psychological distress at 3 and 6 months after the baseline.

Methods: Indigenous participants were recruited from 3 high-security Australian prisons from January 2017 to September 2019. The outcome measures assessed well-being (Warwick-Edinburgh Mental Wellbeing Scale), empowerment (Growth and Empowerment Measure [GEM]—giving total, 14-item Emotional Empowerment Scale, and 12 Scenarios scores), and psychological distress (Kessler Psychological Distress Scale). Intention-to-treat effects on these outcomes were analyzed using linear mixed models.

Results: Substantial challenges in obtaining ethical and institutional approval for the trial were encountered, as were difficulties in timely recruitment and retention due to staff shortages and the release of participants from prison before follow-up assessments and an inability to follow up with participants after release. A total of 132 prisoners (age: mean 33, SD 8 y) were randomized into either an immediate (n=82) or a delayed treatment (n=52) group. However, only 56 (42.4%) could be assessed at 3 months and 37 (28%) at 6 months, raising questions concerning the representativeness of the results. Linear improvements over time were seen in all outcomes (GEM total: Cohen d=0.99; GEM 14-item Emotional Empowerment Scale: Cohen d=0.94; GEM 12 Scenarios: Cohen d=0.87; Warwick-Edinburgh Mental Wellbeing Scale: Cohen d=0.76; Kessler Psychological Distress Scale: Cohen d=0.49), but no differential effects for group or the addition of the Stay Strong app were found.

Conclusions: We believe this to be Australia's first evaluation of a digital mental health app in prison and the first among Indigenous people in custody. While the study demonstrated that the use of a well-being app within a prison was feasible, staff shortages led to delayed recruitment and a consequent low retention, and significant beneficial effects of the app's use within a forensic mental health service were not seen. Additional staff resources and a longer intervention may be needed to allow a demonstration of satisfactory retention and impact in future research.

Trial Registration: ANZCTR ACTRN12624001261505; https://www.anzctr.org.au/ACTRN12624001261505.aspx

(JMIR Ment Health 2024;11:e53280) doi: 10.2196/53280

Authors: Elke Perdacher, David Kavanagh, Jeanie Sheffield,
Penny Dale, Edward Heffernan

Indigenous Australians in custody experience much greater rates of poor mental health and well-being than those of the general community, and these problems are not adequately addressed. Digital mental health strategies offer a more innovative, accessible, and cost-effective way to address these problems, but little is known about their feasibility in or impact on this population. While there is some evaluation of digital mental health strategies for the general Australian population, the evaluation of these strategies in prisons and for Aboriginal and Torres Strait Islander people in custody is near non-existent. This study aimed to investigate this gap and evaluate the impact of adding the Stay Strong App (SSA) to mental health and well-being services for Indigenous people in custody.

Researchers recruited participants from 3 high-security Australian prisons from January 2017 to September 2019. The immediate and 3-month delayed use of the SSA by the health service and its effects were assessed at 3- and 6-months follow-up after the baseline. Participants provided information about their levels of well-being (Warwick-Edinburgh Mental Wellbeing Scale), empowerment (Growth and Empowerment Measure [GEM]) and psychological distress (Kessler Psychological Distress Scale) across time points. However, there were substantial challenges in obtaining ethical and institutional approval for the trial, as were difficulties in timely recruitment and retention due to staff shortages and the release of participants from prison before follow-up assessments and an inability to follow up with participants after release. Even though a total of 132 prisoners were randomised into either an immediate (n=82) or a delayed treatment (n=52) group; only 56 (42.4%) could be assessed at 3 months and 37 (28%) at 6 months, raising questions concerning the representativeness of the results. Linear improvements over time were seen in all outcomes, but no differential effects for group or the addition of the SSA were found. This suggests that the app did not contribute to any measurable effects or benefits beyond existing forensic mental health services. Nonetheless, this was Australia's first evaluation of a digital mental health app in prison, emphasising its feasibility of use within prisons. Furthermore, a previous qualitative study emphasised the SSA as a culturally validated assessment and intervention tool, as evidenced in the level of engagement and positive feedback of both clients and practitioners (Perdacher et al., 2022). Therefore, while this paper was not able to demonstrate a statistically significant benefit for the use of the App due to limitations within the study, they were able to demonstrate the identification and resolution of a number of significant administrative and research challenges, and provide support for further investigation, given the feasibility of the research approach and the positive feedback received from both clients and practitioners. To improve retention and overall impact, future research could include additional staff resources with longer interventions.

Figure 20. The Stay Strong App.

Citations: Perdacher, E., Kavanagh, D., Sheffield, J., Healy, K., Dale, P., & Heffernan, E. (2022). Using the Stay Strong App for the Well-being of Indigenous Australian Prisoners: Feasibility Study. *JMIR formative research, 6*(4), e32157. https://doi.org/10.2196/32157

Priority 4: Health systems research

MNMH Guidelines for Partnering with Lived Experience

Partnering with people with lived and living experience, their families, carers and support people.

> “Co-design goes beyond traditional methods of consultation by forming authentic partnerships with consumers, carers, service providers and key stakeholders. It utilises their knowledge and experience in the design, delivery and evaluation of mental health policies. The methodology is underpinned by principles of early engagement, inclusivity, transparency, shared power and equity of knowledge and responsibility.”
>
> THE CO-DESIGN INITIATIVE, 2016

MNMH is committed to the imperative “Nothing about us without us” (Bell et al., 2023). We actively work to value and respect the voices and experiences of people who have lived or living experience of mental illness and/or problematic alcohol and other drug use and those of the family, carers and support people who love and support them.

> “The foundational premise of participatory research methods is the value placed on genuine and meaningful participation – methods that offer “the ability to speak up, to participate, to experience oneself and be experienced as a person with the right to express yourself and to have the expression.”
>
> (ABMA ET AL., 2019)

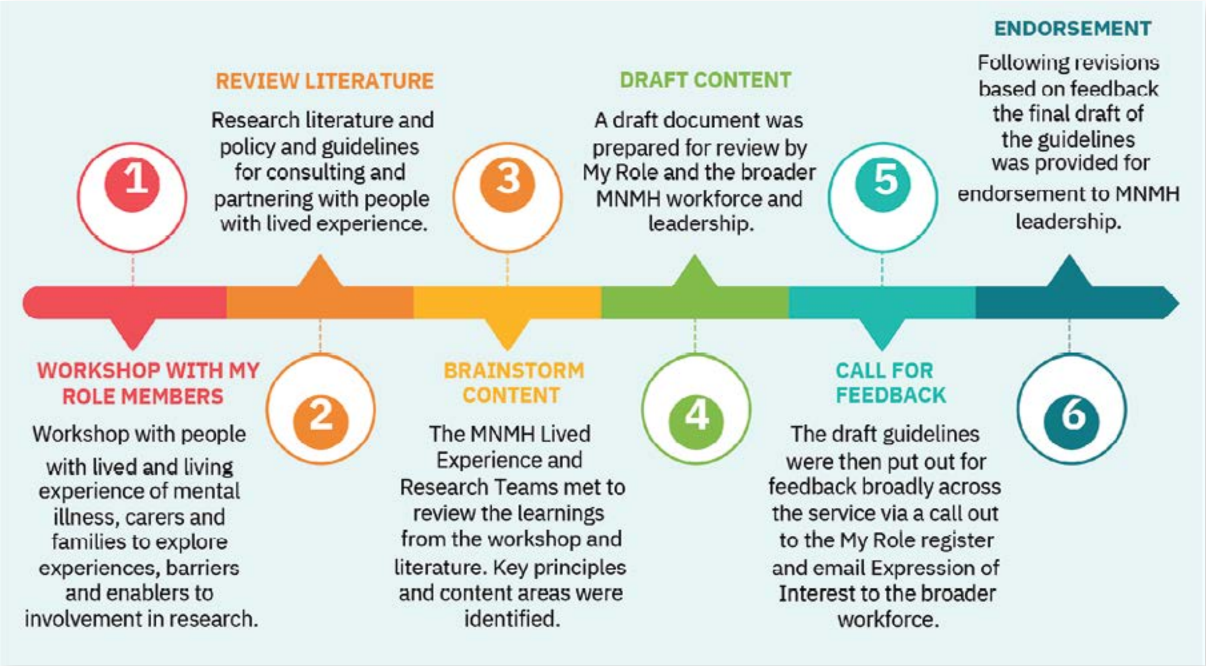
People with lived experience have experienced the mental health system first hand as either a person who has accessed mental health services for themselves or as a family member, carer or support person. This unique expertise and insight adds to planning and delivery of research that is likely to be relevant, meaningful and of benefit. Active involvement of people with lived experience in mental health research helps us to ask the right questions, overcome recruitment challenges, and aids the interpretation of findings (Happell et al., 2020).

While co-design has been acknowledged as the best practice approach for guiding policy, practice and research, true co-design is not always feasible, practicable or the most appropriate model. Co-design is one of many forms of participatory research that emphasises partnership, equality and respectful engagement to design, plan and implement work that will meet the needs of the research and those who are involved in it. These choices might lead to highly participatory strategies for some steps in the research process, and more researcher driven strategies at others (Vaughn & Jacquez, 2020).

The type of partnering should fit the purpose and resources of the question or project being undertaken, however principles and learnings from the co-design literature can be used to facilitate more robust, inclusive and meaningful partnerships and outcomes. At Metro North Mental Health involvement in research can come in many forms and must be “fit for purpose”. Opportunities can vary from membership on committees, providing feedback on written documents or via surveys, participating in a study, being a named investigator on a project or initiating and leading a project from commencement to completion.

Developing MNMH’s guidelines for partnering

We are committed to ensuring that all people who come into contact with our services have the opportunity to engage in research related activities. With this in mind, the MNMH Lived Experience and Research teams jointly developed guidelines that aim to shape meaningful, genuine engagement and participation. These guidelines are aligned with Metro North Mental Health’s “Consumer and Carer Participation and Engagement within Metro North Mental Health 003633” and Metro North Health’s policies and frameworks such as “Partnering with consumers policy 005163” “creating better healthcare together through co-design (Metro North Health, 2022)”. Co-design is expressed as a priority in Queensland Health’s “Better Care Together” plan for Queensland’s state-funded mental health, alcohol and other drug services.



1 **WORKSHOP WITH MY ROLE MEMBERS**
Workshop with people with lived and living experience of mental illness, carers and families to explore experiences, barriers and enablers to involvement in research.

2 **REVIEW LITERATURE**
Research literature and policy and guidelines for consulting and partnering with people with lived experience.

3 **BRAINSTORM CONTENT**
The MNMH Lived Experience and Research Teams met to review the learnings from the workshop and literature. Key principles and content areas were identified.

4 **DRAFT CONTENT**
A draft document was prepared for review by My Role and the broader MNMH workforce and leadership.

5 **CALL FOR FEEDBACK**
The draft guidelines were then put out for feedback broadly across the service via a call out to the My Role register and email Expression of Interest to the broader workforce.

6 **ENDORSEMENT**
Following revisions based on feedback the final draft of the guidelines was provided for endorsement to MNMH leadership.

Principles for partnering with people with lived and living experience

Genuine

- Contributions of all project members are valued
- Input is validated and encouraged
- Not tokenistic or exploitative

Mutal Trust and Respect

- Is earned as the team members work together
- Is based on building relationships and shared understanding

Clear Expectations

- What is the scope/type of involvement?
- What is the time commitment?
- Where and when will involvement take place?

Appropriately Compensated

- Build funding for lived experience positions and time into project grants and requests
- Link to MNMH reimbursement procedure

Clear Communication

- Respectful
- Non-judgmental
- Clear and understandable
- Free of jargon
- Sincere
- Strengths-based
- Trauma-informed

Seeking Diversity of Views via Broad Representation

Seek engagement of all people who have an interest or stake including:

- People from a diverse background (e.g. Aboriginal and Torres Strait Islander, culturally and linguistically diverse
- Gender and LGBTQIA+ representation professional and lived experience
- Age range and levels of experience
- People with a range of disabilities

Training and Mentoring

- Experienced researchers move from the "expert" role to trainers, mentors and supporters
- Create educational and/or mentoring opportunities for people who are novices in research
- Training and mentoring opportunities are aimed at building research skills AND on working

My ROLE Reinvigoration Project

Imani Gunasekara
Senior Peer Coordinator

An interview with Imani Gunasekara

My ROLE is a registry of independent consumers and carers who are interested in improving mental health services through lived experience. What began as a registry is in the process of transforming into a dynamic community through the My ROLE Reinvigoration Project (MRP). We spoke with the project lead, Imani Gunasekara about My ROLE and MRP which is a co-designed, Lived Experience led initiative that began in 2023/24.

Can you tell us about what My ROLE is and how it started?

My ROLE stands for My Registry of Lived Experience. It's a collective of independent consumers and carers who have an interest in using their Lived Experience to improve the service offered by Metro North Mental Health. My ROLE is a database of people who can be contacted when opportunities arise to engage independent consumers in giving feedback for improving the service. Historically, there was a Consumer and Carer Engagement group (CCEG) right up until 2018, and there was about 15 members that would meet once a month. They would meet for 5 hours and they would provide feedback on compliments, comments and complaints, but also come together to provide feedback on other things. Shelley Kulperger undertook a codesign project to work out if there were other ways that we could engage people that had lived in living experience. Through several workshops, the idea of a collective called My ROLE was born. My ROLE was then established in 2020 and has since grown from having 44 members to over 100+ people.

> *But what we want to do is invigorate My ROLE so that it's more than just a register. We envision a dynamic and supportive community resource.*

Tell me about the My ROLE Reinvigoration Project (MRP)

For the reinvigoration of My ROLE, we wanted to achieve several things. To connect independent consumers and carers with opportunities for representation, networking, education, facilitation and sharing experiences. We wanted to actively engage people with lived experience and their carers in the planning, design, delivery and evaluation of the mental health service, and we want to support their personal recovery journeys. That's what My ROLE is aspiring to be.

To achieve this, in late 2023 and in 2024, we gathered information from stakeholders to shape what My ROLE might look like. And so having done that, we're starting to get a clear picture of recommendations that we want to make to the service about how to progress My ROLE, to make the most of those independent consumers and to give back to them.

Gathering this information has been a process over several activities and focus groups. We started with a survey for My ROLE members just to find out why they joined My ROLE, what they'd like to get out of it and what they would like to contribute to it. And based on feedback from that survey, we had a planning workshop. Later we met with PPIMS (Peer Participation in Mental Health Services) for two focus groups. We held a Metro North Mental Health Stakeholder's Workshop in 2024, which brought together over 80 participants from various backgrounds—clinicians, NGOs, Aboriginal and Torres Strait Islander groups, culturally and linguistically diverse people (CALD), LGBTQIA+ communities, neurodivergent people, carers, people with alcohol and other drug challenges and lived experience with mental health challenges, and people with disabilities. *"That workshop was my favourite. We explored what My ROLE should look like, and what meaningful partnering looks like. Everyone had a voice - young people, older adults, different cultural groups."*

We started to get a better understanding of what it really means to engage in meaningful partnering. Through this process, we've also identified some of the barriers that can prevent meaningful partnering and identify what the future of My ROLE should look like.

Can you tell us a bit about the Team and how you work together?

At the initial My ROLE planning workshop, we met Dr. Alex Cook (independent Lived Experience representative, and retired palaeontologist and geologist) and we later appointed Alex soon very soon afterwards as a co-investigator on the project. The other project team members include Dr. Tessa Clarkson and Associate Professor Kylie Burke who are from the Research Team. The project is entirely co-designed where we all work together. I've really enjoyed the thematic analysis because we've all worked equally to come up with the themes. This process really helped us think clearly, about what the themes were and how the things interacted with each other. One element of co-design in research is that academic researchers should move from the role of an expert to being mentors and supporters. Kylie did that really beautifully in giving us feedback on data collection and helping us with the workshops.

What are your hopes for the future of My ROLE?

I would like to see every department across Metro North mental health using My ROLE to partner with independent consumers. In their research and quality improvement projects. So everybody who is conducting a project -- make a budget for somebody on My ROLE to participate. *Meaningfully – not tokenistically.*

Audit of the use of clinical tools to monitor response to ECT and cognition of patients diagnosed with Major Depressive Disorder pre-and post-implementation of an Electroconvulsive Therapy Monitoring Guideline

Authors: **Dr Kalyani Terli**

Electro-convulsive therapy (ECT) is one of the most effective treatments available for mood and psychotic disorders. The Electroconvulsive therapy professional practice guideline (RANZCP) supports evidence on the effectiveness of ECT in relieving psychiatric disorders, by documenting that ECT is effective 70-90% of the time, with an especially high success rate when used to treat severe depression. However, there is limited evidence on the mechanism behind cognitive side effects occurring during and after ECT. Few recent studies support the hypothesis that hippocampus enlargement during ECT was associated with worse cognitive outcomes, and this result was generalisable across two independent cohorts with different diagnoses, different electrode placements, and a different number of ECT sessions. Due to the complexity and nature of ECT, there is a consensus among clinicians that close monitoring of patients receiving ECT should include assessment of the efficacy and side effects of ECT. The results of this monitoring should inform decision-making regarding further ECT prescription. Despite the acknowledged importance of patient monitoring, there is no consensus on its nature and frequency.

The aim of this project was to design and implement a guideline for monitoring the cognition and the response to ECT of patients diagnosed with Major Depressive Disorder based on the RANZCP Professional Practice Guideline for the administration of ECT. The ECT monitoring guideline was formulated, based on the recommendations of the RANZCP professional practice guidelines for ECT, to provide recommendations on the tools and frequency of their use and monitor the cognition and response to ECT of patients diagnosed with a Major Depressive Disorder. *Figure 21* shows the course monitoring procedure.

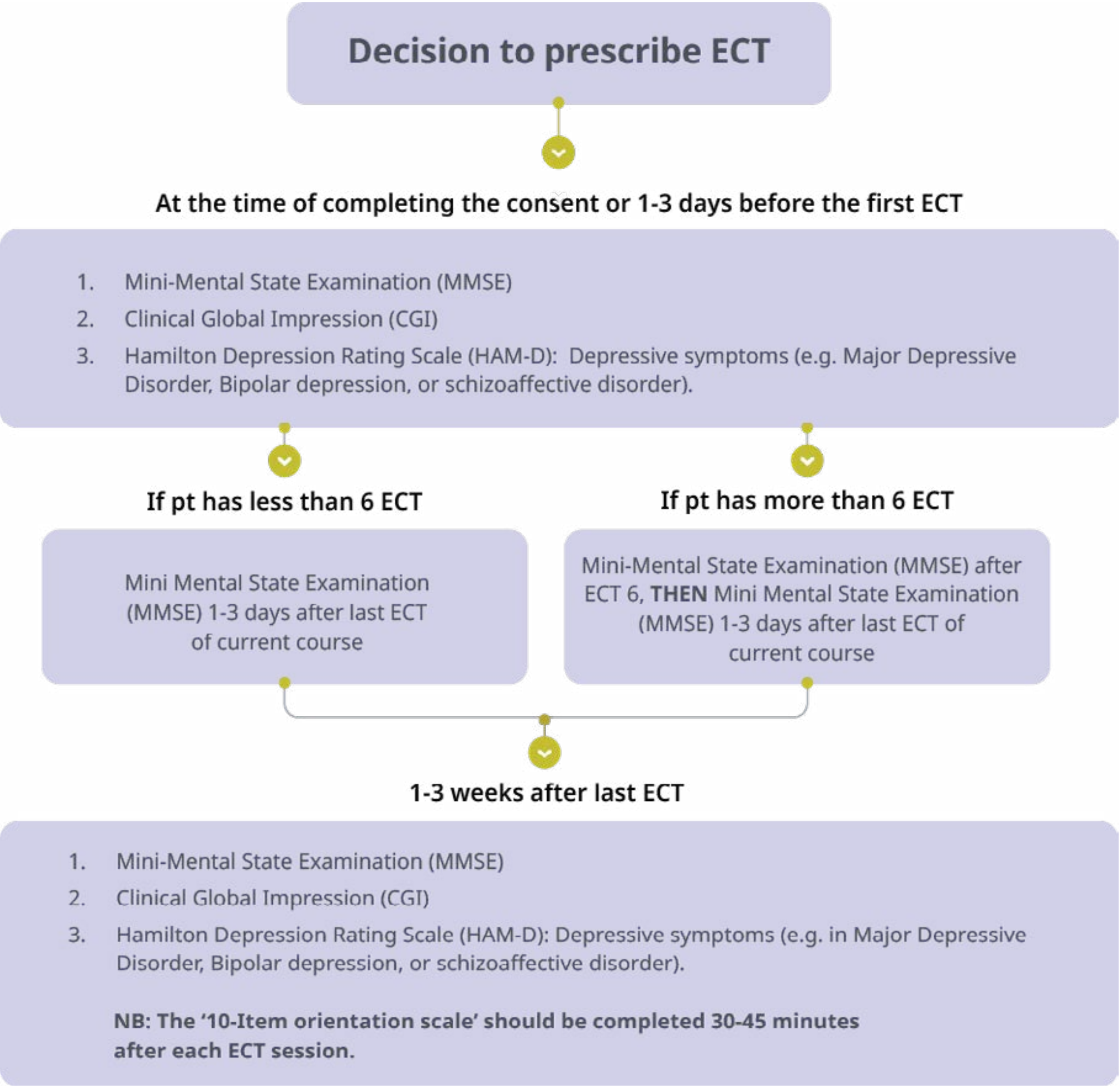


Figure 21. Monitoring during a course of ECT

We collected data both pre and post implementation. A chart audit of all patients who completed an acute course of ECT in the three months before the implementation of the ECT guideline was completed to determine the tools used to monitor their clinical response, and cognition during treatment and post-ECT course. The same was done 3 months after implementation to determine the tools used to monitor their clinical response, and cognition during treatment post-ECT course, as per the ECT pathway recommended.

We used logistic regression to estimate the odds of cognitive screening before and after the guideline implementation. The logistic regression analysis showed that the implementation of the guideline significantly increased the likelihood of baseline cognitive screening for the MMSE. The odds ratio (OR) for cognitive screening post-guideline implementation was 104 OR = 104 [CI 8.46 – 1279.12], indicating that patients were 104 times more likely to be screened for cognitive impairment after the guideline was implemented compared to pre-protocol for baseline measures *(see Figure 22)*. For baseline HAM-D17, the results showed that under the protocol, participants were 30 times more likely to receive baseline HAM-D17 testing (OR = 30 [CI 4.296 – 209.51]; *see Figure 23)*. However, the same increases in cognitive screening rates were not found at follow up time points. While cognitive screening rates numerically increased, these did not reach statistical significance.

Orientation Scale screening rates also went up post-protocol. Results of a negative binomial regression showed that the protocol was a significant predictor of orientation scale testing, β= -2.63, SE = .60, p < .001, 95% CI [.980, 129.437], while controlling for the number of total treatments received. Total treatments alone was not significantly predictive of orientation scale testing, β = -.011, SE = .11, p = .922, 95% CI [-.801, 1.22] *(see Figure 24)*.

From this project, we conclude that there was an increase in the use of clinical tools to monitor patient response to ECT and cognition for those diagnosed with Major Depressive Disorder after the implementation of the ECT Monitoring Guideline. The increase in monitoring was evident at baseline testing for both MMSE and HAM-D, and the results were statistically significant. More research is needed to monitor the provision of cognitive screening at follow-up time points and to evaluate the long-term impact of the ECT Monitoring Guideline on patient outcomes.

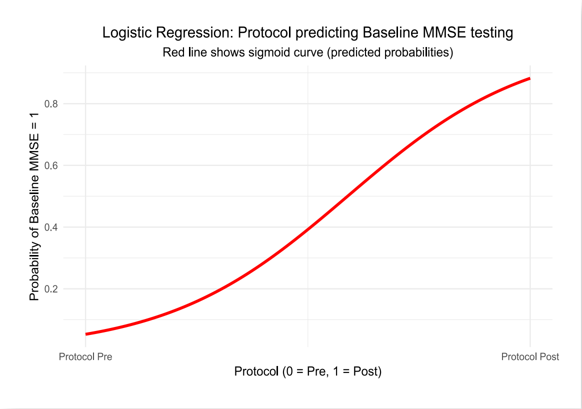


Figure 22.

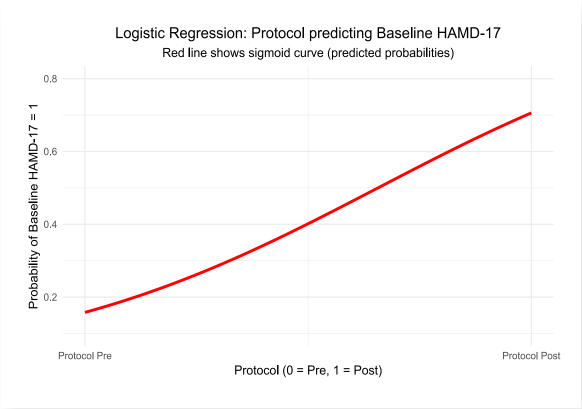


Figure 23.

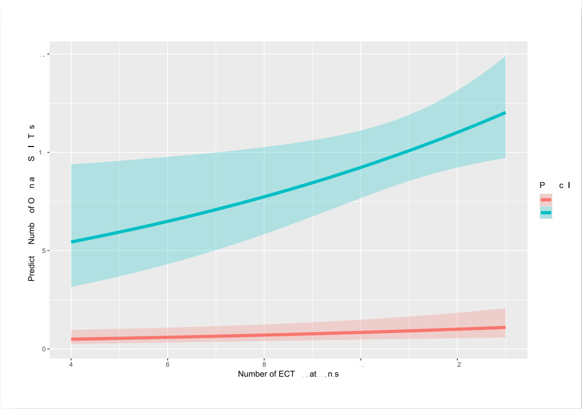


Figure 24.

Protocol: The effect of restorative justice interventions for young people on offending and reoffending: A systematic review


PROTOCOLS
Crime and Justice

Protocol: The effect of restorative justice interventions for young people on offending and reoffending: A systematic review

Hannah Gaffney[1,2] | Darrick Jolliffe[3] | Elizabeth Eggins[4] | Joana Gomes Ferreira[5] | Guy Skinner[6] | Barak Ariel[2] | Heather Strang[2]

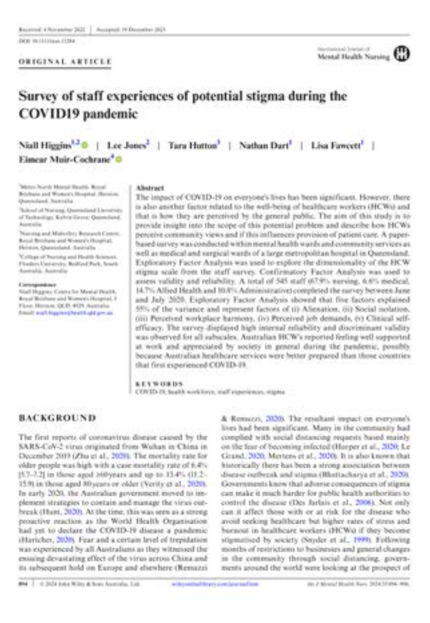
Abstract

Authors: Hannah Gaffney, Darrick Jolliffe, **Elizabeth Eggins**, Joana Gomes Ferreira, Guy Skinner, Barak Ariel, Heather Strang

Preventing and responding to the involvement of children and young people in crime and violence is a global public health concern. Restorative Justice (RJ) is a unique approach for preventing and responding to crimes and other harms despite which aims to [see intervention section for a definition]. However, there is no universally accepted definition of RJ and there are varying approaches/practices in the field. The overarching aim of this review is to better understand RJ by systematically reviewing the current forms of RJ that are used with children and young people and to synthesise its effectiveness for reducing offending and reoffending. The review will also examine whether the effectiveness of RJ interventions vary by the characteristics of youth, and/or intervention characteristics (e.g., setting, duration). An important additional contribution of this review will be synthesis of qualitative data relating to the barriers and facilitators of implementing RJ with youth, including perspectives of young offenders and other affected parties (e.g., victims). The review is funded by the Youth Endowment Foundation in the United Kingdom, and will be published in *Campbell Systematic Reviews*, a journal led by the Campbell Collaboration who are the sister organisation to the Cochrane Collaboration and oversee gold standard systematic reviews across a range of social science disciplines. This review will inform future implementation, evaluation, and generalisability of RJ interventions with children and young people. It will be particularly useful for both practitioners and policymakers worldwide, ultimately helping to understand whether RJ can meaningfully impact young offenders' lives. The review is almost completed and due to be published in late 2025.

PRIORITY 1 4 5

Survey of staff experiences of potential stigma during the COVID-19 pandemic



ORIGINAL ARTICLE

Mental Health Nursing

Survey of staff experiences of potential stigma during the COVID19 pandemic

Niall Higgins[1,2] | Lee Jones[2] | Tara Hutton[1] | Nathan Dart[1] | Lisa Fawcett[1] | Eimear Muir-Cochrane[4]

Authors: **Niall Higgins**, Lee Jones, Tara Hutton, **Nathan Dart**, Lisa Fawcett, Eimear Muir-Cochrane

The impact of COVID-19 on everyone's lives has been significant, but an emerging phenomenon was the subsequent increased stigma of healthcare workers (HCW) and its' possible effect on staff well-being. The aim of this study was to provide insight into the potential stigma during the COVID-19 pandemic and explore how HCWs perceived community views and whether this influenced provision of patient care. A paper-based survey was conducted within mental health wards and community services as well as medical and surgical wards of a large metropolitan hospital in Queensland. From the staff survey, researchers explored dimensions of the HCW stigma scale using Exploratory Factor Analysis (EFA). A total of 545 staff (67.9% nursing, 6.6% medical, 14.7% Allied Health and 10.8% Administrative) completed the survey between June and July 2020. The results showed that 55% of the variance was explained by five factors: (1) *Alienation,* (2) *Social isolation,* (3) *Perceived workplace harmony,* (4) *Perceived job demands, and* (5) *Clinical self-efficacy.* Contrary to previous research, participants reported not feeling *alienated or socially isolated* from their family and friends in the fear of contacting the virus or due to the nature of their work respectively. Participants felt safe and supported in the workplace *(Perceived workplace harmony)* but feelings of being overworked *(Perceived job demands)* were reported. Finally, participants felt confident in their clinical environment to perform their duties *(self-efficacy).*

These findings show that despite global concerns about HCW stigma, participants felt well-supported at work and appreciated by society. This suggests that staff with higher perceived organisational and social support are likely to demonstrate resilience and experience lower stress in times of crisis. Furthermore, the positive experience of Queensland HCWs could be attributed to the state's effective pandemic preparedness. The HCW stigma scale has potential for use by health and training organisations to make group-based and individual decisions for HCWs wellbeing during time of crisis in future.

PRIORITY 4

Life is better but not without challenges: experiences following discharge from community-based residential mental health rehabilitation-a qualitative content analysis

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RESEARCH

Life is better but not without challenges: experiences following discharge from community-based residential mental health rehabilitation–a qualitative content analysis

Stephen Parker[1,2,3,5] · Maddison Chapman[1] · Marianne Wyder[1] · Matthew Pommeranz[1] · Rebecca Walgers[1] · Frances Dark[1,2] · Carla Meurk[4]

Received: 17 January 2024 / Accepted: 24 June 2024 / Published online: 16 July 2024

Abstract
Purpose Community-based residential mental health rehabilitation units for people experiencing severe and persistent mental illness are increasingly available in Australia. Research completed 20 years ago suggested that people leaving these services often experienced impoverished social lives and other challenges in the community. It is unclear whether contemporary consumers experience similar difficulties. This qualitative study explored contemporary consumers' experiences after leaving community-based residential services.
Methods An inductive qualitative content analysis of individual interviews was completed with consumers 12–18 months following discharge from three community care units (CCUs) in Queensland, Australia. The interview schedule explored three questions: (1) What does life look like after leaving the CCU, (2) Has the CCU impacted their life, and (3) How could the CCU experience be improved? A convenience sample was used, with sampling continuing until thematic saturation was achieved. A member of the research team who had relevant lived experience actively supported the analysis and interpretation.
Results Seventeen interviews were completed. Three themes were identified: 'life is better but not without challenges', 'the CCU helps you get ready to go out into the world', and 'strict rules are important but rigid expectations can be hard; things could be better'.
Conclusion Consumers reflected positively on their lives post-discharge from a community-based residential rehabilitation unit and viewed the service as having supported improvements in their lives. The findings suggest the appropriateness of optimism about the possibility of sustained improvements in quality of life after leaving community-based transitional residential rehabilitation support.

Keywords Psychiatric rehabilitation · Residential services · Consumer experiences · Qualitative research

Introduction

There has been considerable expansion in publicly funded community-based residential mental health rehabilitation service capacity in Australia over the past two decades [1]. This trend contrasts with the shift from transitional residential treatment services to 'choose-get-keep' permanent housing initiatives like Housing First in countries such as the United States of America and Canada [2–4]. Some authors have argued that transitional residential treatment services are inappropriate and that permanent housing solutions are preferable [5, 6]. However, research considering optimal approaches to meet the accommodation and support needs of people affected by severe and persisting mental illness (SPMI) in the community remains limited [7, 8].

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Springer

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Community-based residential mental health rehabilitation units for people experiencing severe and persistent mental illness are increasingly available in Australia. This trend contrasts with the shift from transitional residential treatment services to 'choose-get-keep' permanent housing initiatives like *Housing First* in countries like the United States of America and Canada. Some research has argued that transitional residential treatment services are inappropriate and that permanent housing solutions are preferable. However, research considering optimal approaches to meet the accommodation and support needs of people affected by severe and persisting mental illness (SPMI) remains limited.

This qualitative study aimed to explore people's experiences 12-to-18 months after leaving a community care unit (CCU) based on three questions: (1) *what does life look like after leaving the CCU,* (2) *has the CCU impacted their life, and* (3) *how could the CCU experience be improved?* The knowledge arising through this research was expected to guide an understanding of these services' real-world impact (or lack thereof) from the lived-experience perspective. Researchers explored the experiences of 17 people (70.6% male) 12–18 months following discharge from three CCUs in Queensland, Australia through in-person and/or phone interviews.

> *I look back and*
> *I realise quite a bit of it was delusional...*
> *just I went there with the understanding that*
> *I could spend some time in this introspective way*
> *figuring out what I was going through...*
> *[the CCU] promotes self-confidence*
> *and esteem.* [INT116]

> *[T]hey improved on my*
> *medication taking, like how to*
> *take medication... [I]t made me be able to deal*
> *with crises that I'd have by myself... it helped me deal with*
> *things when I'm by myself – if I have a psychotic episode*
> *by myself, I'm able to deal with it.*
> [CLIN136]

The results showed that people generally reflected positively on their life experiences over the 12 to 18 months following discharge from a community-based residential mental health rehabilitation unit. They described improvements in their levels of community participation, health and wellbeing, and living situation. The CCU was described as having an instrumental role in supporting their readiness to go out into the world through the support provided by staff and co-residents, and opportunities for living skills development. While sentiment about the CCU was generally positive, most people acknowledged both the value and challenges of residing under 'strict rules' and rigid expectations. Most people also described experiencing ongoing struggles in the community and limitations in opportunities, including loss of professional and social supports attributable to the CCU environment. Meaningful differences between participants who were, or were not, supported under the clinical and integrated staffing models did not emerge; however, most participants who were supported described specifically valuing the availability of peer support workers. In conclusion, some people living with mental illnesses valued and viewed these services as an enabling step to increase independence, highlighting the significant need for caution in policy advocacy to abandon residential treatment in favour of exclusively funding permanent supportive housing solutions.

PRIORITY ① ● ● ④ ⑤ ●

Police negotiators and suicide crisis situations: a mixed-methods examination of incident details, characteristics of individuals and precipitating factors

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Routledge

Police negotiators and suicide crisis situations: a mixed-methods examination of incident details, characteristics of individuals and precipitating factors

Megan L. Steele [a,b], Lisa Wittenhagena,b, Carla Meurka,b, Jane Phillipsc, Bobbie Clugston [a,b,d], Peter Hecke, Elissa Watersona,c and Ed Heffernana,b,c

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Police negotiators provide leadership and expertise in the de-escalation and resolution of critical incidents, including responding to individuals exhibiting suicidal behaviour. This study describes the frequency and characteristics of suicide-related negotiation incidents in Queensland, Australia as classified in the Queensland Police Service Negotiator
Deployment Database, between 2012 and 2014. Incidents were analysed to understand the individuals involved and precipitating factors including mental health problems and intoxication with alcohol or drugs. Police negotiators were deployed to 156 suicide intervention incidents over a 3-year period, half of which occurred at a residence. The cohort had a median age of 32 years and were predominantly male (82%). Four out of five individuals appeared to have a mental health problem, and at least half were intoxicated due to drugs or alcohol. Findings highlight the importance of strong linkages between police, health and social services and the need for innovative and comprehensive, cross-agency programmes.

Key words: alcohol and other drugs; crisis situation; mental health; mixed-methods research; police–mental health collaboration; police negotiation; suicide prevention.

Article History: Received 25 September 2022; Accepted 21 March 2023

Introduction

Police are often the first to respond to people experiencing mental health and psychosocial crises. These interactions occur in a wide range of contexts with the majority of instances being resolved by frontline police, without the need for specialised negotiation or tactical response, and often involve police acting as a gateway to health care and other support services (Queensland Mental Health Commission, 2017). Police negotiators are highly trained police officers who provide leadership and expertise in the de-escalation and resolution of critical incidents. Frequently these incidents involve people who are threatening violence, individuals threatening suicide, barricaded individuals and hostage-takers (Vecchi et al., 2005). These types of complex situations require more than a routine standard policing approach. Police negotiators resolve these

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Authors: Megan Steele, Lisa Wiitenhagen, Carla Meurk, **Jane Phillips, Bobbie Clugston**, Peter Hecke, **Elissa Waterson, Ed Heffernan**

Police are often the first to respond to people experiencing mental health and psychosocial crises. These interactions occur in a wide range of contexts with most instances being resolved by frontline police, without the need for specialised negotiation or tactical response, and often involve police acting as a gateway to health care and other support services. Police negotiators provide leadership and expertise in the de-escalation and resolution of critical incidents, including responding to individuals exhibiting suicidal behaviour. This study explores the role of police negotiators in managing negotiation incidents recorded as 'suicide interventions' by describing the frequency and situational characteristics of the incidents in Queensland, Australia.

Researchers examined data from the Queensland Police Service Negotiator Deployment Database, between 2012 and 2014. Incidents were analysed to understand the individuals involved, including demographic and clinical characteristics (e.g., mental health problems and intoxication with alcohol or drugs) and precipitating factors (e.g., relationship issues, involvement with justice system, homelessness). The results showed that police negotiators were deployed to 156 suicide intervention incidents over a 3-year period. Almost one third of incidents occurred in the Brisbane region (31%), followed by Central Queensland (27%) and Southeastern Queensland (18%). Individuals had an average age of 32 year, and they were predominantly male (82%). Four out of five individuals appeared to have a mental health problem, and at least half were intoxicated due to drugs or alcohol. The researchers found that approximately half of all incidents occurred at a personal residence, and that most incidents occurred between the hours of 10am and 7pm and were resolved in around one hour. Over one third of incidents involved an individual with a weapon, and nearly half occurred at an elevated location off which the individual was usually threatening to jump. Despite these high-risk variables, there were very few fatalities reported (≤4%), suggesting that intervention from police negotiators is highly effective at resolving such situations. The apparent high rates of mental health problems in our cohort suggest that police negotiators need to be supported by (a) mental health training, and (b) real-time mental health service support. The findings highlight the importance of strong linkages between police, health and social services and the need for innovative and comprehensive, cross-agency programmes in managing crises such as responding to individuals presenting suicidal behaviour.

PRIORITY 1 2 ● 4 ● ●

Police Communications Centre Mental Health Liaison Service: Enhancing outcomes for people in mental health crisis.

Research Paper

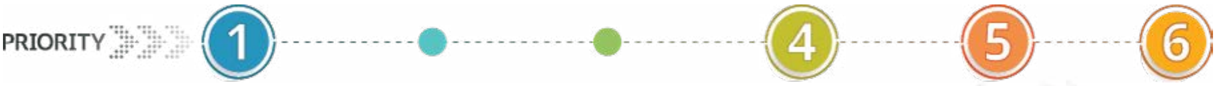
AUSTRALASIAN PSYCHIATRY

Police Communications Centre Mental Health Liaison Service: Enhancing outcomes for people in mental health crisis

Authors: **Leanne Payne**, Carla Meurk, **Elissa Waterson, Ed Heffernan**

As emergency departments face the ongoing challenges of access block (patients delayed from leaving the ED due to a lack of available inpatient beds) and increasing presentations related to mental health problems there is a clear need for cost efficient, innovative models of care that have capacity to respond in real time to a large volume of people over a large geographical area. A role the Police Communication Centre Mental Health Liaison Service (PCC MHLS) may be able to fill. The PCC MHLS is a clinician led state-wide service coordinated through the Queensland Forensic Mental Health Service (QFMHS), with clinicians embedded in a Queensland Police Service (QPS) communication centre. The PCC MHLS provides real-time mental health information and advice to police as first responders to people in mental health crisis. While there are other models which provide a high standard collaborative approach, such as co-responder models, the significant advantage of the PCC MHLS is its capacity to respond to multiple incidents during operations, it's not limited by geography, and may be less resource intensive than other models. The aim of this study was to explore this model of care and describe the consumer and service-episode characteristics and referral outcomes received by the PCC MHLS over a 12-month period.

The authors used a retrospective analysis of referrals received from 1st January 2023 to 31st December 2023. They described consumer and service episode characteristics and reported outcomes including suicide/self-harm using relevant descriptive statistics. The authors found that the service is well used receiving 3549 referrals, an average of 9.97 referrals per day. Referrals were characterised by an average age of 38.11 years (ranging from 6 to 102 years old), majority were male (60.4%), over a third (41%) did not have a current or historic psychiatric diagnosis and 28.1% were open to the public mental health service. The results showed that the highest reported presenting problem was suicide and self-harm (45.2%).
An Emergency Examination Authority, enabling involuntary assessment in a hospital setting, was enacted in 28.3% of cases, and 20.9% were referred to mental health services. These findings suggest some people may be experiencing psychological distress rather than a diagnosed mental illness. Therefore, the PCC MHLS is an important service as it can alleviate the burden on emergency departments by redirecting people to the most appropriate health service.



Restorative Practice in Mental Health at The Prince Charles Hospital (Stage 2)[1]

Authors: Catriona Harwood, Michael Power, Dr Tessa Clarkson, Imani Gunasekara,
Olivia Fisher, A/Prof Kylie Burke, Dr Senthil Muthuswamy

Restorative Practice (RP) is a relational approach to both prevent and proactively respond to harm. It involves those most directly impacted by the harm in having a say in the opportunity for repair. It is based on a belief that responses to wrongdoing need to involve more than imposing consequences for breaking rules and should address impacts within relationships. Restorative processes provide a reflective opportunity for acknowledgment of the impact of harm, exploration of the potential for repair, and moving on from the impact of the harm to the extent possible.

In a mental health service setting it is recognised that harm can be caused and experienced collectively and can result from systemic factors. The model of RP implemented in mental health services at The Prince Charles Hospital (TPCH) included a continuum of interventions from those that aimed to prevent conflict and harm, to those that are more formal responding to harm.

On a Restorative Practice continuum (Image below from Restorative Practice Continuum at TPCH), the informal practices can include affective statements ('I' statements) that communicate people's feelings, as well as affective questions that assist people to reflect on how their behaviour has affected others. Impromptu restorative conferences, groups and circles are more structured but do not require the detailed preparation needed for formal Restorative Meetings.

Restorative practice continuum

AFFECTIVE STATEMENTS
- Brief "I" statements inserting feeling and impact of behaviour into a statement, e.g. "I'm worried when you use that language that it is hurtful to others".
- Inserting feeling and impact of behaviour into statement e.g. 'I'm worried when you use that language that is hurtful for others'

AFFECTIVE QUESTIONS
- Asking who was affected and how
- Using the Restorative Questions card wiht the person who caused harm (Qs 1 on card), and separately with the person harmed if possible (Qs 2 on card)

IMPROMPTU RESTORATIVE MEETING
- If safe and consented to by both parties following use of the Restorative Questions, bringing those most directly impacted by an incident to communicate restoratively to help resolve the issue.

RESTORATIVE CIRCLE
- Group discussion allowing all participantsto have a say, Check in/ Check out circles can be used to support relationship building, goal setting, or to address a particular issue for example

RESTORATIVE MEETING (using external facilitator)
- Bringing the person who caused harm and the person who has been harmed (or a proxy/rep if appropriate) together to promote relationship repair, support repair of harm and promote healing
- Using Adult Restorative Justice Conferencing to facilitate
- Shuttle communication also possible if appropriate

Restorative Continuum from International Institute of restorative Practices (IIRP; Adapted from https://www.iirp.edu/defining-restorative/restorative-practices-continuum).

As per the continuum, the aim would be to use affective statements and questions to build relationships and remind about impact of behaviour. As language shift is critical to cultural shift, the use of affective statements and questions daily was encouraged staff and consumers.

The model was implemented in December 2019 in inpatient and community mental health services. This became known as Restorative Practice in Mental Health (RPMH1). It was implemented in response to violence and threats of violence by mental health consumers to other consumers, mental health staff, family, and others. This was the first time RP had been implemented in public mental health services in

Australia focused on harm resulting from violence and threats of violence. The external evaluation of the RPMH1 by Dr Diana Beere (2022) highlighted learnings and benefits over a 2.5-year year period of implementation of RP across TPCH Secure Mental Health Rehabilitation Unit (SMHRU) and the Nundah Adult Community Mental Health Team, Brisbane.

The implementation of RP was extended to other mental health services at TPCH (RPMH2). Building on the findings and recommendations of the external evaluation, a context mapping process was developed for the new teams to identify their priorities and needs for learning and support, and to support those teams who identify that RP can support meeting some of their priorities, such as responding to harm in the workplace.

We used an implementation science approach using an Exploration, Preparation, Implementation, Sustainability (EPIS) framework for context mapping with participants to improve the effectiveness to support the sustainability of change required to implement RP. The approach was iterative about learning to build restorative capacity within the service. It included the completion of a 2-day workshop for most staff in the additional services, as well as new staff in existing services implementing RP.

A Context Assessment Index tool was used to provide an evidence-based approach to understanding the priorities, opportunities, and readiness of teams for implementing change. In relation to the “Better Care Together” (Qld Health, 2022), priorities and Metro North Mental Health Priorities, the teams’ priorities were improving workforce capacity; strengthening quality to reduce harm and improve outcomes; and responding to mental health crisis and suicidality. The outcome of the assessment was that teams were considered in a medium-strong position for implementing change. Survey results provided extensive qualitative data collection on themes and sub-themes for staff. Of note regarding the issue of safety, 72% of survey participants thought more could be done to improve safety of staff, consumers, and others. This included personal, physical, psychological, and cultural safety within their everyday work. Whilst using a relatively small sample size, the context mapping process supported participants across the selected teams to voice their attitudes towards harm and violence in their setting, their barriers, strengths, and priorities.

Information gathered through the context assessment identified a strong collective voice that workforce and workload challenges were a continual challenge across all teams. Consistent with the external evaluation of RPMH1, the teams would value more extensive leadership engagement in restorative approaches, as well as resources, such as positions to support restorative responses in a meaningful way. The valuable outcome of this work has been that staff had confidence and could see the potential benefits of a restorative approach in their setting. The context assessment results from teams also supported giving the green light to the project team to proceed with developing and facilitating a learning package.

The workshops had high levels of satisfaction with the quality of the facilitators, the workshops, and the resources. The training resulted in building confidence in using RP as well as understanding the potential benefits of RP in a mental health setting. The training consistently received overwhelming positive feedback and an elevated level of participation. The top three take away topics reported by participants in the workshops the use of Circles, including the use of Fishbowls as a subset of Circles, understanding the impact of shame, and using a Relational Approach to work that included the concept of the Social Discipline Window, restorative questions, and responses to critical incidents. The responses suggest the main aims and content of the workshops had been received by the participants. Pre- and post-workshop survey results demonstrated increased confidence of staff in using restorative approaches in their setting, with staff and consumers to prevent and address conflict in the workplace *(see Figure 25).*

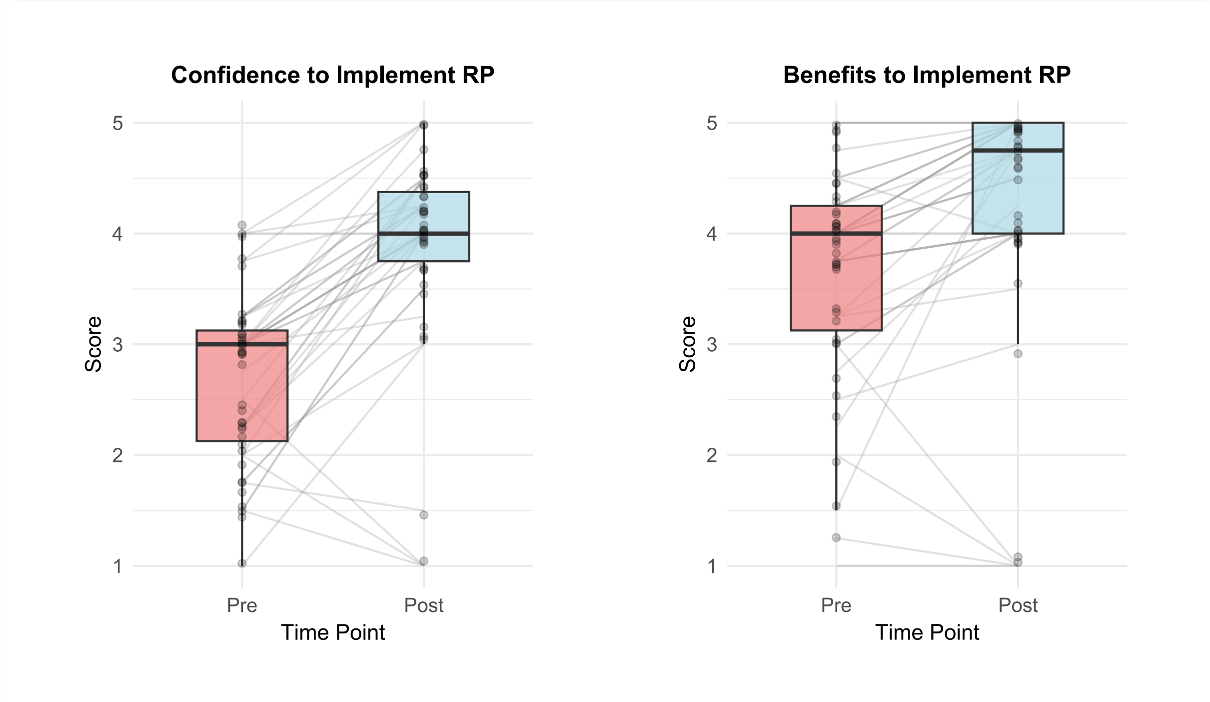


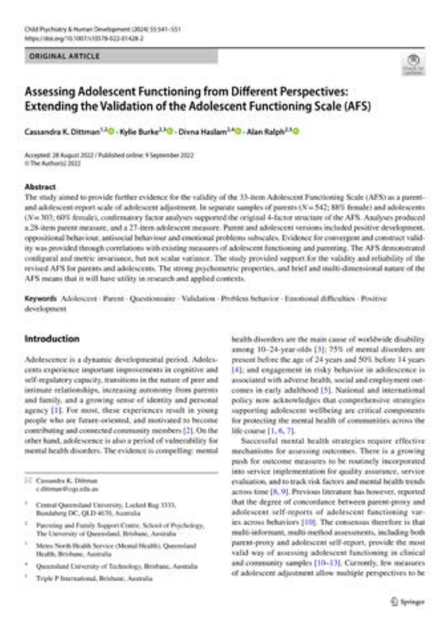
Figure 25. Pre- and post-training results. Individual participant scores are represented by points on the Y-axis, with grey lines indicating the direction of change between pre- *(Survey 2)* and post-intervention *(Survey 3)* time points on the X-axis. The distributions and boxplots illustrate the mean and variance of the scores.

The context assessment surveys and process, which included focus groups, developed for this work provide a valuable resource that can be used by other mental health services embarking on implementing RP in their service. We used Expert Recommendations for Implementing Change (ERIC) framework as a structure upon which specific strategies are identified to tailor and strengthen implementation of RP in mental health services. The findings of greater confidence in using RP could benefit from further measurements of confidence in what specific practice areas staff had been using it. Whilst there is not yet in Australia accreditation for restorative approaches organisationally, this work may benefit from further skillset measurement development.

The long-term benefits of a commitment to implementing restorative work in mental health services, whilst challenging, in the context of culture and capacity issues for services, has the long-term potential to bring significant gains to building relationships and responding to harm. Building staff capacity to respond restoratively can have the potential to encourage staff wellbeing, and provide the opportunity for healing by giving voice to those most directly impacted.

The project continues to connect with national and international stakeholders working in restorative approaches healthcare harm to support growth of restorative knowledge. Whilst continued funding is limited, future restorative work includes resource development and collaboration with learning providers to support introductory resources for healthcare staff across the service. In developing and implementing Restorative Practice in mental health services at TPCH, thank you to all the staff, consumers, lived experience, peer support staff, families, and Adult Restorative Justice Conferencing, Department of Justice and Queensland Health Victim Support Service staff, leadership by TPCH Team Leaders, and Nurse Educators who have supported this work since 2019.

Assessing Adolescent Functioning from Different Perspectives:
Extending the Validation of the Adolescent Functioning Scale (AFS)



Authors: Cassandra Dittman, **Kylie Burke**, Divna Haslam, Alan Ralph

Adolescence is a time of transformation: improvements in cognitive and self-regulatory capacity, shifts in the dynamics of peer and intimate relationships and increases in autonomy from parents and family, all while developing a sense of identity and personal agency. However, adolescence is also a period of vulnerability for mental health disorders. Successful mental health strategies require effective measurements for assessing mental health outcomes in young people. There is a growing push for outcome measures to be routinely incorporated into service implementation for quality assurance, service evaluation, and to track risk factors and mental health trends across time. The Adolescent Functioning Scale (AFS) is a multi-dimensional measure of both positive and negative aspects of adolescent mental health and wellbeing originally designed for completion by parents of adolescents.

The study aimed to build on the original validation of the AFS by providing further validation and refinement of the parent-report measure in a separate parent sample, alongside the validation of an adolescent-report version in a sample of adolescents aged 11–17 years. The researchers tested the AFS with a larger group of 542 parents (88% female) and 303 adolescents (60% female). The 33-item measure of adolescent functioning comprised of four subscales assessing oppositional defiant behaviour, antisocial behaviour, emotional difficulties and positive development. The results confirmed the original 4-factor structure of the AFS, including positive development, oppositional behaviour, antisocial behaviour and emotional problems domains. The scale was further reduced to a 28-item parent-report scale, and a 27-item adolescent-report scale. The findings provided support for the utility of a shorter version of the AFS as a multi-dimensional, multi-informant instrument to assess both positive development and problem behaviour in adolescence from both parent and adolescent perspectives. The AFS will have utility in research, intervention and applied contexts because of its brevity, strong psychometric properties, and capacity to be completed by parents and adolescents. Furthermore, because it has been designed specifically for adolescents and includes a positive development scale, the AFS provides a brief, yet comprehensive, measure of mental health problems and developmental competencies with this age group.

PRIORITY 5

Improving the Use of Sensory Approaches in an Acute Inpatient Mental Health Unit Using a Co-Designed Multifaceted Implementation Strategy


International Journal of Mental Health Nursing

WILEY

ORIGINAL ARTICLE

Improving the Use of Sensory Approaches in an Acute Inpatient Mental Health Unit Using a Co-Designed Multifaceted Implementation Strategy

ABSTRACT

1 | Introduction

Authors: **Lisa Wright**, Pamela Meredith, Sally Bennett, Emmah Doig

Sensory approaches in the mental healthcare context are clinical interventions that focus on the use of sensory experiences such as deep pressure, movement, touch, light, sound and smell to optimise physiological and emotional well- being. Despite the therapeutic benefits of sensory approaches being well documented, there are challenges in their implementation in acute mental health units. Some barriers can include lack of support from peers, clinician's not believing sensory approaches were part of their role, lack of sensory resources and equipment, lack of knowledge and training, concern about risks, lack of leadership from management, entrenched culture related to the use of restrictive practices, and fear of using sensory approaches as an alternative to seclusion and restraint. To address these barriers, this study aimed to evaluate the effect of a co-designed theory-informed multifaceted implementation strategy designed to improve the use of multiple sensory approaches in one acute inpatient mental health ward at The Prince Charles Hospital over a period of 11 months and investigated if sensory approaches affected the use of seclusion and restraint. Guided by Integrated Knowledge Translation (IKT) and informed by the Behaviour Change Wheel (BCW) approach, the Implementation strategies were co-designed and included provision of sensory materials/resources, education, prompts, modelling, audit and feedback, workplace coalition, and facilitation. Researchers gathered data through pre- and post-project questionnaires and routine clinical data.


CALM DOWN METHODS

IF YOU NOTICE YOU ARE BECOMING TENSE, ANXIOUS OR AGITATED, THEN WE OFFER THE FOLLOWING CALM DOWN METHODS IT MAY BE WORTH TRYING THEM BEFORE CONSIDERING PRN MEDICATION. PLEASE ASK STAFF TO ASSIST.

HERBAL TEAS
CHAI TEA
HOT CHOCOLATE
SOUR LOLLIES OR MINTS

MINDFUL COLOURING
WORD PUZZLES
SKETCH PAPER
WATERCOLOURS OR
COLOURED MARKER, PASTELS
OR PENCILS

STRESS BALLS
FIDGET ITEMS
THERAPY PUTTY
BOOKS FOR JOURNALLING
EAR PLUGS & SLEEP MASKS

CARD GAMES
ORIGAMI PAPER
JIGSAW PUZZLES
HAND BALLS

ASK THE STAFF TO USE THE COMFORT ROOM TO RELAX IN
OR
ASK TO FOR A REFERRAL TO BORROW A WEIGHTED BLANKET.

Among those who completed both pre- and post-survey (19 participants: multidisciplinary staff such as nurses, doctors, social workers, etc.), participants had higher levels of knowledge and confidence in using sensory approaches after the intervention period. There were also significant increases in the use of sensory kits, weighted modalities and sensory assessment/plans. While there was a numerical reduction in the use of restraint, seclusion and total time spent in seclusion, the number of events of seclusion and restraint pre–post intervention was too small to test for change statistically. Participants' open text recommendations to ensure the use of sensory approaches are sustained in their unit included ongoing training, funding, maintenance and supply of sensory equipment, increased staffing, and support from colleagues. This study demonstrates the importance of addressing a problem identified by knowledge users (clinicians, managers and peer support workers) and co- designing an implementation strategy to improve the use of sensory approaches in acute mental health units.

Finally, this is the first study to use the IKT and BCW to design, facilitate and evaluate a co-designed, theory-informed implementation strategy to improve the use of sensory approaches in acute mental health settings. Further research is required to investigate whether the strategies used can be sustained over time, and whether the steps used in this project can be used in other mental health units to improve the use of sensory approaches. The authors would like to acknowledge the TPCH Foundation, The Common Good, for funding the research and for MNMH-TPCH for supporting and participating in the research.

PRIORITY 4 5

Electroconvulsive therapy in a tertiary Australian mental health facility between 2009 and 2020

Research

ANZJP

Electroconvulsive therapy in a tertiary Australian mental health facility between 2009 and 2020

Emily Martin[1], Subramanian Purushothaman[1], Emma Ballard[2], Julie A Blake[2,4,5], Kylie Burke[1,6,7] and James G Scott[2,3,4,5]

Abstract

Background: Despite electroconvulsive therapy being one of the most effective treatments in psychiatry, few studies report trends in the provision of electroconvulsive therapy over time. This study aims to investigate the use of electroconvulsive therapy between 2009 and 2020 in an Australian public tertiary mental health facility, and to describe the electroconvulsive therapy patient population and change in courses of treatment.

Methods: Routinely collected data for 677 patients who received 1669 electroconvulsive therapy courses of treatment at an Australian public tertiary mental health facility between 2009 and 2020 were examined.

Results: The provision of acute electroconvulsive therapy was stable across the study period, however, the number of maintenance electroconvulsive therapy courses commenced declined over the study. Schizophrenia was the most common indication for index treatment (37.4%). The majority of patients (85.7%) received acute electroconvulsive therapy only. Voluntary provision of electroconvulsive therapy declined over the study period, reducing from 44.9% in 2009 to 16.3% in 2020.

Conclusion: Over the study period, there was a significant reduction in the number of maintenance electroconvulsive therapy courses commenced, and a large increase in involuntary treatment. The provision of electroconvulsive therapy was more likely to occur in males with a diagnosis of schizophrenia. Further studies are needed to generate a greater understanding of the factors influencing the provision of electroconvulsive therapy within differing geographical, social and healthcare landscapes.

Keywords

Mental disorders, schizophrenia, depression, neurostimulation

Introduction

Electroconvulsive therapy (ECT) is a safe and effective treatment for the management of affective, psychotic and neuropsychiatric disorders (Galletly et al., 2016; Malhi et al., 2015). There has been increased demand for admissions to mental health services within Australia in recent years (Royal Commission into Victoria's Mental Health System, 2019; Zhang et al., 2011) with a corresponding need to reduce the length of stay for acute admissions. Pharmacological advancements such as clozapine which reduces length of admissions (Leucht et al., 2013; Lin et al., 2020; Siskind et al., 2019) and long-acting injectable formulations of antipsychotic medications which prevent relapse of psychosis (Pacchiarotti et al., 2019) have changed the use of ECT. The stigma around ECT reduces its acceptability as a treatment by both those with mental illness and clinicians (Griffiths and O'Neill-Kerr, 2019;

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Australian & New Zealand Journal of Psychiatry, 58(8)

Authors: Emily Martin, Subramanian Purushothaman,
Emma Ballard, **Julie Blake, Kylie Burke**, James Scott

Despite electroconvulsive therapy (ECT) being one of the most effective treatments in psychiatry, few studies have reported trends in the provision of ECT over an extended timeframe. This study examined the provision of ECT and the changes in its use between 2009 and 2020 at the Royal Brisbane and Women's Hospital (RBWH). Researchers studied routinely collected data for 677 patients who received 1669 ECT courses of treatment across this time course. Schizophrenia was the most common indication for index treatment (37.4%) and the majority of patients (85.7%) received an acute course of ECT only.

Overall, between 2009 to 2020, the results showed that the provision of acute ECT was stable across the study period, however there was a significant reduction in the number of maintenance ECT courses over this period, reducing from 44.9% in 2009 to 16.3% in 2020. The authors hypothesised that the increase in involuntary ECT may have occurred with the introduction of the 2016 Mental Health Act and changes to consent processes. This study lays a crucial foundation for future research aimed at enhancing our understanding of the factors that may affect the provision of ECT across various geographical, social, and healthcare contexts.

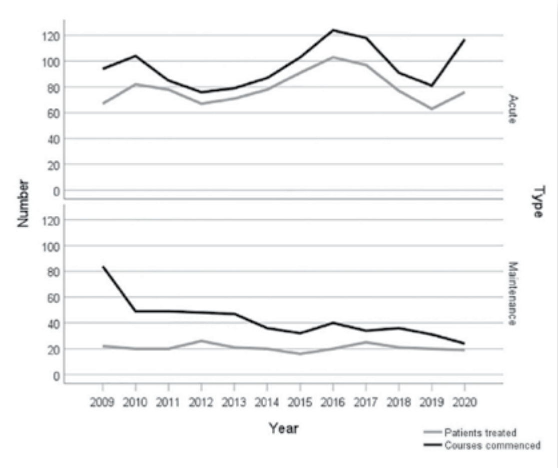


Figure 26. Trends in the number of patients and courses between 2009 and 2020 by acute and maintenance electroconvulsive therapy.

PRIORITY 1 4 5

Priority 6: Digital solutions

Strengthening the Redcliffe Caboolture Secure Mental Health Rehabilitation Unit (SHMRU) Referral Decision Making Processes

Authors: **Darren Neillie, Kylie Burke, Allison Greenwood, Nadine Campbell, Bryce McMahon, Tessa Clarkson, Abbie Galloway (and the SMHRU clinicians)**

In 2021, the Redcliffe-Caboolture Mental Health Service’s (RedCab) Executive, in collaboration with the Secure Mental Health Rehabilitation Unit (SMHRU) team, undertook a review of their Model of Service. Initial consultations with staff and consumers indicated uncertainty, inconsistency, and dissatisfaction with multiple facets of the SMHRU environment which were impacting the workforce and the way in which care was provided.

One area that was identified to need evaluation and development are the processes for prioritisation of consumers and assessment of their needs for the purposes of referral and waitlist management. Needs assessment and prioritisation of consumers is a necessary process to make equitable decisions regarding admission based on need, risk, and potential benefit (Flynn et al., 2011). However, the decision-making process for the admission of referred consumers and prioritisation of those on the waitlist have not been clearly defined within RedCab SMHRU.

The RedCab SMHRU team therefore decided there was a need to improve the transparency of their referral, waitlist management and needs assessment processes such that decisions regarding admissions to the service are made using objective measures in addition to clinical opinion. Dr Darren Neillie (Consultant Psychiatrist, SHMRU Caboolture and TPCH) described the need for the project *“There has been awareness for some time that we could improve how we think about needs of consumers that are referred to SHMRU and improve how we mapped those needs to the SHMRU resource given the significance of being moved into a secure rehabilitation unit, but at the same time wanting to ensure that we were being least restrictive within the system and that we were as efficient as we could be with use of a limited resource.”*

Collaborating with MNMH’s Research Team, the SMHRU team have undertaken a project to review their internal processes and to develop a refined referral process that increases clarity for referrers and more efficient and effective access to pertinent information for the SMHRU clinical team to aide decision-making. Dr Neillie noted the benefits of this collaboration: *“we saw that there was really not a lot of existing literature that helps with decision making for admissions to SHMRU. This led to the coming together of the clinical team who had some ideas, but not that well-formed, other than we knew there was an issue, with the Research Team. in a way that has worked really well to get us to where we are now. And so I think it’s created an opportunity that has lots of benefits. One because it helps staff think through and answer the question what are we about? who are we here for? and what are we meant to be doing? You would think that everyone has answers to those questions, but they don’t. I think there’s been some confusion about the SMHRU model historically. in Queensland and there’s definitely confusion across jurisdictions because everyone has a slightly different secure hospital system.* A/Pro Kylie Burke (Director, Research Strategy and Evaluation) agreed with Dr Neillie, highlighting that *“the collaboration brings more resources to an important clinical challenge as well as combining the specific expertise of the clinicians and researchers to produce an innovative solution”.*

To make these improvements, the two teams commenced a project to review the referral decision-making processes (i.e., the factors taken into consideration and the processes used to make the decision). The project aimed to improve the processes and quality of information available to inform decisions about referrals and wait list prioritisation. Doing so will provide justification for decisions which can be passed on to referrers and will ensure that consumers most likely to benefit from the SMHRU environment and model of care are being admitted with priority.

Specifically, this project aims to evaluate and improve SMHRU's referral assessment and waitlist management processes by:

1. Articulating current decision-making processes and criteria for assessing referrals and prioritising the waitlist,
2. Identifying potential indicators of an appropriate, fair, and objective referral assessment outcome (i.e., a person who is suitable for admission to SMHRU), which includes the prioritisation of wait-listed consumers; and
3. Identifying a systematic approach to assessing and prioritising referrals, including by determining whether existing measures would be fit-for-purpose or if a new measure should be developed.

Collaborative Problem Solving processes 6 steps

(Shannon, 2021)

This project is a part of a broader continuous improvement initiative and will serve to inform subsequent steps towards an updated Model of Service for RedCab SMHRU. The project is utilising collaborative problem-solving processes and qualitative analysis.

The first two steps in the process were conducted via consultation and focus groups with staff from across the Redcliffe-Caboolture and TPCH SHMRU teams. A senior Lived Experience (Carer) was also involved in these activities.

Step 3 involved the use of the SEIPS framework as a continuous improvement process for developing a comprehensive understanding of the elements of the referral process and the interactions between these elements and how these impact the decision-making process. SEIPS is a framework for understanding outcomes within complex sociotechnical system such as healthcare (Carayon et al., 2014). Non-clinical members of the research team undertook the interactive observation tasks during a "in vivo" referral meeting with MDT members using retrospective referrals.

Steps 1-3 also explored the appropriateness of several previously validated measures however none were considered to fully meet the goals of the SMHRU referral process. Two of the three measures considered required extensive and costly training and licencing. Therefore, a bespoke SHMRU referral tool (Step 4) was developed to improve decision-making, increase effectiveness and efficiency of the referral process and that had potential to inform targeted treatment plans that could then be tracked throughout an admission.

The Metro North Mental Health SHMRU Referral Assessment Measure was developed with key members of the SHMRU team and was then introduced to the broader team for consideration. Once the team was happy with the proposed content the tool was piloted in a referral meeting (Step 5). Following the referral meeting the project team discussed the tool's utility, content, and ease of use with the MDT, refining it iteratively over successive meetings (Step 6).

The measure has now been developed into an online form using the Queensland Health endorsed RedCap survey platform *(see Figure 27).* This allows the tool to be used more efficiently, automatically totalling a person's strengths, vulnerabilities and rehabilitation potential as the clinicians review the referral information. The tool generates scores across these domains and presents the team with a recommendation of whether the person should be/should not be admitted to SMHRU or if other less restrictive methods should be used first before recommending an admission.

Dr Neillie hopes that the implementation of the measure will provide clarity for referring services and teams around the SMHRU model and particularly regarding *"the needs of consumers that are ideally addressed within a SMHRU setting as opposed to other less restrictive settings".* He also hopes that this will have benefits for consumers, families and staff in that people will *"have confidence in the system – if someone ends up in SMHRU they are there for the right reasons".*

The next steps in the development of the tool will be to further develop and test the scoring approach to ensure that this aligns with clinical judgement. To achieve this a retrospective analysis of past referrals will be repeated using the measure and then comparing the result to the initial referral decision. The tool will also continue to be used within referral meetings, primarily to guide discussion and clinical decision- making. Data collected will then be used to continue to develop the scoring matrix.

Figure 27. Clinicians using the tool.

Feasibility of Mental Health Triage Call Priority Prediction Using Machine Learning

nursing reports

MDPI

Article

Feasibility of Mental Health Triage Call Priority Prediction Using Machine Learning

Rajib Rana, Niall Higgins, Kazi Nazmul Haque, Kylie Burke, Kathryn Turner and Terry Stedman

Abstract: Background: Optimum efficiency and responsiveness to callers of mental health helplines can only be achieved if call priority is accurately identified. Currently, call operators making a triage assessment rely heavily on their clinical judgment and experience. Due to the significant morbidity and mortality associated with mental illness, there is an urgent need to identify callers to helplines who have a high level of distress and need to be seen by a clinician who can offer interventions for treatment. This study delves into the potential of using machine learning (ML) to estimate call priority from the properties of the callers' voices rather than evaluating the spoken words. Method: Phone callers' speech is first isolated using existing APIs, then features or representations are extracted from the raw speech. These are then fed into a series of deep learning neural networks to classify priority level from the audio representation. Results: Development of a deep learning neural network architecture that instantly determines positive and negative levels in the input speech segments. A total of 459 call records from a mental health helpline were investigated. The final ML model achieved a balanced accuracy of 92% correct identification of both positive and negative instances of call priority. Conclusions: The priority level provides an estimate of voice quality in terms of positive or negative demeanor that can be simultaneously displayed using a web interface on a computer or smartphone.

Keywords: artificial intelligence; automated distress screen; deep learning; distress; mental health; spontaneous speech; triage; voice computing

1. Introduction

Mental illness is multifactorial, and understanding it requires not only measurable biometric data but also consideration of the complex social and historical context that impacts a person's health outcomes [1]. Many psychiatric illnesses incorporate a voice component into their diagnostic criteria. For instance, disorganized speech is a key feature in diagnosing schizophrenia, while symptoms such as excessive talkativeness or pressure to keep talking characterize manic episodes in diseases such as Bipolar I and II [2]. Voice computing and machine learning (ML) hold significant promise for improving identification of those with high priority mental health needs by supporting clinicians in the assessment of callers' need for care [3].

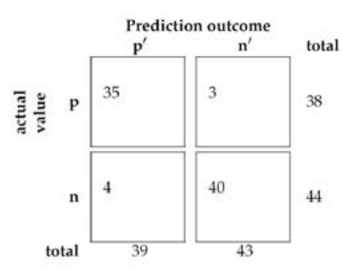
Authors: Rajib Rana, Niall Higgins, **Kazi Nazmul Haque, Kylie Burke, Kathryn Turner**, Terry Stedman

Mental illness is multifactorial, and understanding it requires not only measurable biometric data but also consideration of the complex social and historical context that impacts a person's health outcomes. Many psychiatric illnesses have a voice component in their diagnostic criteria. For instance, disorganised speech is a key feature in diagnosing schizophrenia, while symptoms like excessive talkativeness or pressure to keep talking characterise manic episodes in diseases, such as, Bipolar I and II. Voice computing and machine learning (ML) hold significant promise for improving identification of those with high priority mental health needs by supporting clinicians in the assessment of callers' need for care. Efficiency and responsiveness to callers of mental health helplines can only be achieved if call priority is accurate. Currently, call operators making a triage assessment rely heavily on their clinical judgment and experience with limited capacity in assessing other critical cues (e.g., callers' voice). This study explores the potential of using machine learning (ML) to estimate call priority from the properties of the callers' voices rather than only relying on the spoken word.

Using ML methods, phone callers' speech is first isolated using existing APIs, then features or representations are extracted from the raw speech. These are then fed into a series of deep learning neural networks to classify the priority level. The models were trained on a dataset of 459 historical call records from a mental health helpline. The model achieved a balanced accuracy of 92%, indicating that it performs well across both sensitivity (true positive rate) and specificity (true negative rate) without favouring one over the other. The priority level determined by ML provides an estimate of voice quality in terms of positive or negative demeanour displayed using a web interface on a computer or smartphone. While the prototype has limitations in providing a true interpretation of a caller's emotional state, the authors state the goal is not to replace mental health clinicians; instead, this prototype supports clinicians make their assessment on callers experiencing mental distress.

Future work should focus on refining the model, exploring additional data sources, and addressing implementation challenges. A comprehensive approach involving continuous monitoring and iterative improvements will be essential for successful deployment. While voice computing holds great promise as a clinically assistive tool, its target clinical applications are yet to be fully defined. When used judiciously and within appropriate boundaries, it can effectively support mental health services in understanding and interpreting callers' experiences without compromising equitable treatment.

Figure 28. App Interface



		Prediction outcome		
		p′	n′	total
actual value	p	35	3	38
	n	4	40	44
	total	39	43	

Figure 29. Confusion.

Telehealth Cognitive Behaviour Therapy to Reduce Anxiety in People Living with Cognitive Impairment: A Randomized Feasibility Pilot Study

Clinical Gerontologist

Routledge

ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/wcli20

Telehealth Cognitive Behavior Therapy to Reduce Anxiety in People Living with Cognitive Impairment: A Randomized Feasibility Pilot Study

Gabriela Pacas Fronza, Leander K. Mitchell, Nancy A. Pachana, Gerard J. Byrne, Jacki Liddle, Jihyun Yang, Deborah Brooks, Tiffany Au, Dana Pourzinal, Peter Worthy, Tracy Comans, Elizabeth Beattie, Sally Bennett, Trevor Russell & Nadeeka N. Dissanayaka

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Anxiety is commonly experienced by people living with cognitive impairment and dementia. Current clinical guidelines recommend psychotherapy as a treatment for anxiety in people living with cognitive impairment. This study examines the feasibility of a Cognitive Behavioural Therapy (CBT) intervention adapted for videoconferencing (Tele-CBT) to reduce anxiety in people living with cognitive impairment using a single-blind randomised feasibility pilot trial. Feasibility outcomes include recruitment and retention rates, acceptability, adherence, and ease of use. It also examines preliminary outcomes, i.e., reduced symptoms of anxiety (primary outcome), depression, and stress, and increased quality of life at post-intervention and compared to usual care.

People living with mild cognitive impairment or dementia experiencing anxiety were recruited and randomised to receive Tele-CBT (n = 5) or continue usual care (n = 5). Differences from pre- to post-intervention indicated that videoconferencing was feasible: minimal attrition, deems acceptable by participants and was easy to use. Additionally, the level of anxiety symptoms in both groups decreased; however, there was a larger reduction in anxiety observed in the intervention group compared to controls. While the treatment group experienced a decrease in depression symptoms, the control group did not. The Tele-CBT program is promising to reduce anxiety in people living with cognitive impairment. A RCT with a larger sample is required to determine the efficacy and implementation of the intervention in future. This pilot study further highlights the feasibility of digital solutions to address anxiety experienced by people living with cognitive impairment with minimal assistance from support persons.

PRIORITY ● 2 ● 4 ● 6

Delirium

Prof Andrew Teodorczuk
Director
Clinical Training, TPCH

An interview with Professor Andrew Teodorczuk

Delirium is a significant change in mental abilities that leads to confusion and reduced awareness of a person's environment. We sat down with Professor Andrew Teodorczuk to explore the syndrome in greater detail and the current research landscape.

Why is delirium research important?

Relative to its impact – reflected in high prevalence, poor outcomes, and an annual cost of nearly $9 billion in Australia – there remains a significant shortfall in delirium research. This is despite clear evidence that delirium is, at least in part, preventable.

Yet in routine care, delirium and its underlying causes are often missed, which compounds the associated mortality and morbidity. Importantly, most existing research has focused on prevention, while relatively little has been done to advance treatment – where the greatest clinical challenge lies.

Delirium research is also notoriously difficult to conduct, and as a result, it is often overlooked. To help address this gap in Australia, and with the support of the Australasian Delirium Association (ADA), we are conducting workshops to support research efforts spanning from bench to bedside.

Why have you chosen to focus on electronic tools to measure delirium?

While traditional methods of delirium assessment are theoretically effective, in practice they are underutilised. The increasing presence of early adopters of healthcare technology offers a unique opportunity to design digital tools that are more likely to be integrated into everyday clinical practice.

Delirium diagnosis and management can be considered a "wicked problem" – complex, multifaceted, and resistant to simple solutions. This makes it an ideal candidate for innovation, including the application of artificial intelligence. These challenges, and the potential to solve them, make delirium research particularly exciting.

What are the benefits of using these tools compared to other measures?

Digital tools offer several advantages over traditional pen-and-paper assessments. They allow for more ergonomic, accessible, and cognitively targeted approaches—such as the integration of distractors to test selective and divided attention, or the use of fluid tests to adapt to patient performance in real time.

Intelligent design features can also reduce test burden and accelerate diagnosis. In addition, these tools can more easily evolve alongside advances in technology, offering new efficiencies and possibilities not yet achievable through conventional means.

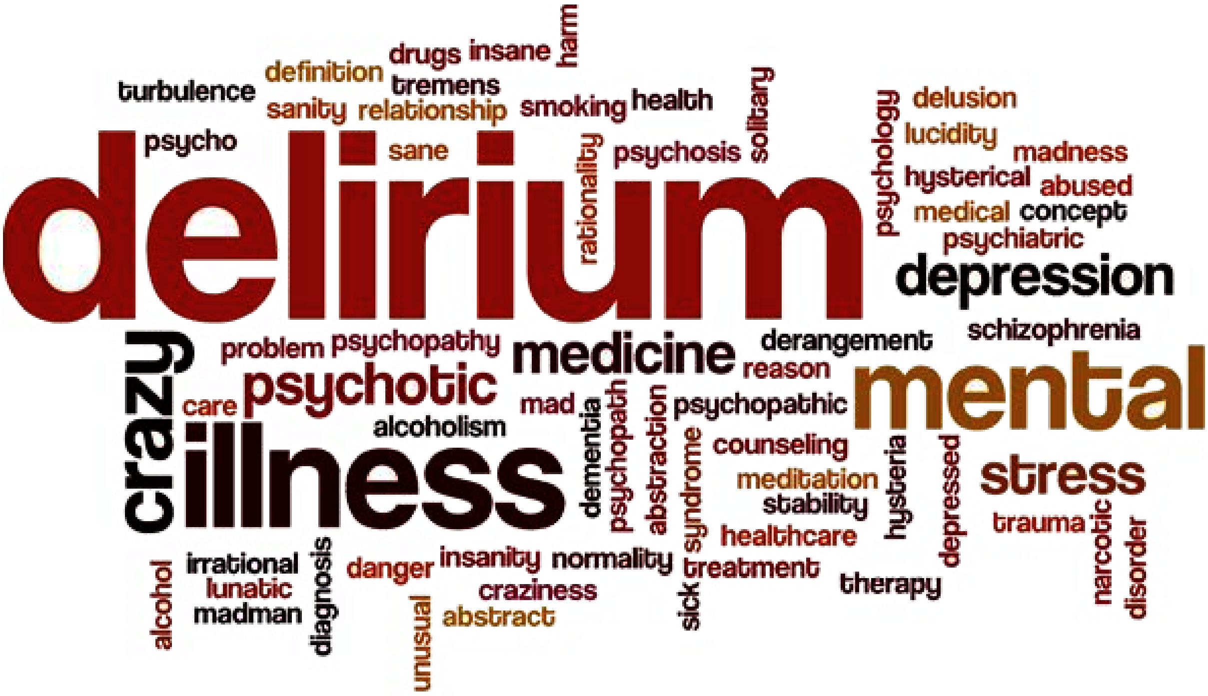
What does the future of these tools and delirium research look like?

We anticipate a paradigm shift in the care of older adults at risk of delirium – where the human-technology interface is harnessed to optimise the delivery of compassionate, patient-centred care. By reducing the burden of routine tasks through technology, clinicians can focus more on meaningful interactions with patients.

We have already developed and tested tools to help identify delirium and its causes using digital technologies. Moving forward, these tools will undergo further validation and wider implementation across Queensland Health and beyond.

The next phase will involve exploring digital management systems and co-developing bespoke tools for at-risk populations, including First Nations peoples, those from culturally and linguistically diverse backgrounds, and individuals with perceptual impairments.

More broadly, with the support of organisations such as the Australasian Delirium Association, we are committed to growing a national network of skilled delirium researchers. Our vision is a future where real-world, innovative solutions are developed to meet the complex clinical challenges of today's healthcare environments.



Published literature in 2024

Eamonn Eeles and colleagues published two significant articles documenting the development and refinement of an electronic delirium screening tool adapted for medical settings. The first article details a narrative review of electronic screening tools. The second article describes the content and face validity for the redesign of an adapted screening tool.

A narrative review of the development and performance characteristics of electronic delirium-screening tools

Contents lists available at ScienceDirect

Australian Critical Care

Review paper

A narrative review of the development and performance characteristics of electronic delirium-screening tools

Eamonn Eeles, MSc, David Duc Tran, HBsc, Jemima Boyd, BPhty, Oystein Tronstad, BPhty, Andrew Teodorczuk, MD, Dylan Flaws, PhD, John F Fraser, PhD, Nadeeka Dissanayaka, PhD

ARTICLE INFORMATION

ABSTRACT

Authors: Eamonn Eeles, David Duc Tran, Jemima Boyd, Oystein Tronstad, **Andrew Teodorczuk, Dylan Flaws**, John Fraser, Nadeeka Dissanayaka

Delirium is a serious and often underdiagnosed condition, particularly in hospitalised medical patients, where early detection is crucial for improving outcomes. Time is brain. Standard delirium-screening tools have variable uptake and may require intensive training. Using the same standard questions repeatedly every time the test is administered (as is universally the case) introduces possible retest bias. Electronic screening tools offer innovative solutions by incorporating features such as randomised test items to prevent bias, adaptive questioning to reduce patient burden, and automated scoring to minimise human error. This review examines five electronic delirium-screening tools developed between 2007-2023, identified through systematic searches of PubMed, Embase, and CINAHL.

Five tools were identified: two for general medical settings (DelApp and UB-CAM mobile app) and three for intensive care units (DelApp-ICU, eDIS-ICU, and iCAM-ICU). The review describes the tools based on their development process, validation studies, and performance characteristics.

The review highlights how these digital tools have unique capabilities. For example, UB-CAM's has an efficient two-step process (achieving screening in just 83 seconds), ICU-specific adaptations like DelApp-ICU's have perfect sensitivity and eDIS-ICU's randomised questions help prevent retest bias. While these tools show promise, limitations remain with only small validation samples and high financial implementation costs. The review emphasises the need for larger validation studies and greater emphasis on human-centered design principles. The risk is that care becomes instrumental and automatised when person centred care is needed to alleviate the distress of delirium. As this field evolves, collaboration between developers, clinicians, and patients will be crucial to transform these digital solutions from pilot concepts to routine clinical practice, potentially revolutionising delirium detection and improving outcomes for vulnerable patient populations. The future of electronic screening tools is exciting and could represent a transformational change management approach. Further consolidation of innovation and science in the spirit of collaboration between developers, researchers, clinicians, and people with lived experience will help lift these tools from pilot concepts to part of every-day practice, which has the potential to transform practice and delirium detection in the 21st century.

PRIORITY 5 6

Face and content validity of a mobile delirium screening tool adapted for use in the medical setting (eDIS-MED): Welcome to the machine

BRIEF REPORT

Australasian Journal on Ageing WILEY

Face and content validity of a mobile delirium screening tool adapted for use in the medical setting (eDIS-MED): Welcome to the machine

Eamonn Eeles[1,2,3] | **Oystein Tronstad**[4,5] | **Andrew Teodorczuk**[2,6,7,8,9] | **Dylan Flaws**[2,5,10,11] | **John F Fraser**[5] | **Nadeeka Dissanayaka**[3]

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Funding information
University of Queensland; Queensland Government through Queensland Health Clinical Research Fellowships program

Abstract

Objectives: Following a user-centred redesign and refinement process of an electronic delirium screening tool (eDIS-MED), further accuracy assessment was performed prior to anticipated testing in the clinical setting.

Methods: Content validity of each of the existing questions was evaluated by an expert group in the domains of clarity, relevance and importance. Questions with a Content Validity Index (CVI) <0.80 were reviewed by the development group for potential revision. Items with CVI <0.70 were discarded. Next, face validity of the entirety of the tests was conducted and readability measured.

Results: A panel of five clinical experts evaluated the test battery comprising eDIS-MED. The content validity process endorsed 61 items. The overall scale CVI was 0.92. Eighty-eight per cent of the responses with regard to question relevancy, usefulness and appropriateness were positive. The questions were deemed fifth grade level and very easy to read.

Conclusions: A revised electronic screening tool was shown to be accurate according to an expert group. A clinical validation study is planned.

Authors: Eamonn Eeles, Oystein Tronstad, **Andrew Teodorczuk, Dylan Flaws**, John Fraser, Nadeeka Dissanayaka

As identified in the above review, traditional screening methods for delirium can be time consuming, warranting the need for the development of an electronic Delirium Screening Tool for Intensive Care Units (eDIS-ICU). Recognising differences between ICU and medical patients — such as communication abilities, delirium subtypes, and underlying conditions — the researchers adapted the tool into eDIS-MED for general medical settings. Before clinical use, content validation is required to ensure its questions were clear, relevant, and appropriate. To evaluate eDIS-MED, the authors consulted with an expert panel of clinicians specialising in neurology, psychiatry, geriatrics, general medicine, and neuropsychology. They assessed content validity (whether questions aligned with delirium detection) using a Content Validity Index (CVI). They also evaluated face validity (whether the tool appeared effective) and readability (ensuring simplicity for cognitively impaired patients) using Flesch-Kincaid and SMOG tests.

Results showed 61 of 65 original questions were retained, with an overall CVI of 0.92, indicating strong validity, while 88% of responses rated the tool as relevant and useful. The refined eDIS-MED demonstrated high validity and usability for medical settings, with expert-endorsed questions and simple language. Next steps include clinical validation studies to evaluate effectiveness and colour accessibility improvements. If successful, eDIS-MED could revolutionise delirium screening, enabling faster, more accurate detection in hospitals. Given that delirium affects up to 30% of hospitalised older adults yet is frequently missed, tools like this could enhance early detection, improving patient care and reducing complications. This study highlights the importance of user-centred design and expert validation can refine digital health tools for better clinical outcomes.

Question	Example	Free-text comments
'Are you at a train station?'	 Are you at a train station? * ☐ Yes ☐ No ☐ unsure	*'Are you at a train station?'* 'Seems confusing. A patient might think the question refers to matching the question with the image, which is correct, as opposed to their own individual whereabouts'. Individual CVI = 0.8. Item modified.

Figure 30. Example of tool content and content expert feedback.

Dissemination Activities

Publications

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3. Brandenburg, C., Crilly, J., Thomas, S., Gardiner, P., Kinner, S. A., **Heffernan, E.,** Lincoln, C., Somerville, A., Davidson, P., Wilson, D., Green, D., & Byrnes, J. (2024). Police perspectives on the economic considerations of providing healthcare in short-term custodial settings in Australia. *Medicine, science, and the law*, *64*(3), 217–223. https://doi.org/10.1177/00258024231198915

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5. Brandenburg, C., Hilder, J., Noble, C., Liang, R., Forrest, K., **Joshi, H.,** Keijzers, G., Mickan, S., Pearson, D., Scott, I. A., Veysey, E., & Stehlik, P. (2024). "Luck of the draw really": a qualitative exploration of Australian trainee doctors' experiences of mandatory research. *BMC medical education*, *24*(1), 1021. https://doi.org/10.1186/s12909-024-05954-6

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Conference Presentations

1. **Brigg, N.,** & **Chaplain, A**. MIND the Longstay Gap: Intensive discharge support for MH consumers: Outcome implementation a mental health intensive discharge team (MIND). Presented by Amelia Grimmer at: *Occupational Therapy Australia Mental Health Forum, 2024*; Melbourne Convention and Exhibition Centre, Melbourne, Australia.

2. **Burke, K.** (August 2024). Parenting: A motivator or barrier to recovery from serious mental illness? [Oral presentation]. Presented at: *Metro North Mental Health Research Symposium 2024*; Caboolture Hospital, QLD, Australia.

3. **Burke, K., Eggins, E.,** Morawska, A., **Brennan, L., & McMahon, B.** (2024, August). *Considering parents with serious mental illness*. [Oral presentation]. Presented at: *Metro North Mental Health Research Symposium 2024*; Caboolture Hospital, QLD, Australia.

4. **Clark, S., Swan, T., Chatfield, A., McKenzie, E. S., Buckley, J., Hoey, J., & Li, H. K.** (August 2024). Growing with our learners: Developing education to meet the learning and professional development needs of a growing and diverse alcohol and drug nursing workforce. [Presentation session]. Presented at: *Drug and Alcohol Nurses of Australasia (DANA) Annual Conference and Symposia*; Adelaide: DANA; 2024.

5. **Clark, S., Swan, T., McKenzie E. S., Chatfield, A., & Li, H. K.** Indoctrinating into our tribe: Nurses reflections on the AO student nursing support program in Queensland. [Presentation session]. Presented at: *Drug and Alcohol Nurses of Australasia (DANA) Annual Conference and Symposia*; Adelaide: DANA; 2024.

6. **Durant, L., Eggins, E., Turner, K. & Burke, K.** (2024). *Approaching Mental Health Crisis Reform Within the Brisbane North Region*. [Poster session]. Presented at: 48th International Mental Health Nursing Conference; Perth, Australia.

7. **Eggins, E., Burke, K.**, Morawska, A., **Brennan, L., & McMahon, B.** (2024, August). *Considering parents with serious mental illness*. Invited presentation to the Parenting and Family Support Centre, University of Queensland, Brisbane, Australia.

8. **Eggins, E.**, Wilson, D. B., Betts, J., Roetman, S., Chandler-Mather, N., Theroux, B., & Dawe, S. (2024, September). *Psychosocial, pharmacological, and legal interventions for improving the psychosocial outcomes of children with substance misusing parents: A systematic review*. Poster presented at the Global Evidence Summit, Prague, Czech Republic.

9. **Eggins, E., Burke, K.,** Morawska, A., **Brennan, L., & McMahon, B.** (2024, August). *Considering parents with serious mental illness*. Poster presented at the Global Evidence Summit, Prague, Czech Republic.

10. **Eggins, E., Burke, K., Dittman, C., Clarkson, T.,** & Forbes, E. J. (2024, September). *The impact of parenting programs on adolescent mental health, positive development, and the parent-adolescent relationship*. Poster presented at the Global Evidence Summit, Prague, Czech Republic.

11. Eggins, E., Burke, K., Morawska, A., Brennan, L., & McMahon, B. (2024, August). Considering parents with serious mental illness. Paper presented at the Metro North Mental Health Research Symposium, Brisbane, Australia.

12. **Harwood, C.** (2024, August). Working in the With Box: A summary of the implementation of restorative approaches in a mental health setting (RPMH2) at The Prince Charles Hospital. Paper presented at *The Metro North Mental Health Research Symposium 2024*; Caboolture Hospital, QLD, Australia.

13. **Heffernan, E.** (2024). Understanding Psychotic Disorders: Garrison Health Education Series, Gallipoli Barracks, Brisbane [Invited Speaker].

14. **Heffernan, E.** (2024). The Insanity Defence and Fitness for Trial: RANZCP Tasmania Branch Training, Hobart, Tasmania.

15. **Heffernan, E.** (2024**).** Enhancing First responses to Mental Health Crisis: Innovations in Mental Health and Police Collaborations: Faculty of Forensic Psychiatry and Section of Child and Adolescent Psychiatry RANZCP Conference Future Forensic Practice Across the Lifespan: Science, Evidence and Risk, Gold Coast Queensland [Invited and Funded Keynote Presentation].

16. **Heffernan, E.** (2024). Enhancing First Responses to Mental Health Crisis, Australian Justice Health Seminar Series: Virtual, National Presentation [Invited Presentation].

17. **Heffernan, E.,** Meurk, C., & Lam, M. (2024). Understanding first responses to suicide crisis situations among current and ex-serving members of the Australian Defence Force: A Translational Data Linkage Project, International Conference of Military Medicine, Brisbane.

18. **Heffernan, E.** (2024). Lived Experience input to improve individual outcomes for people responded to by police: Learning from Harm Forum, Metro North HHS, Brisbane [Invited Presentation].

19. **Heffernan, E.** (2024). Police and Mental Health: Collaboration in the First response UNSW and Justice Health Network, Sydney [Invited Presentation].

20. **Heffernan, E.** (2024). Innovations in Police and Mental Health Collaboration: The role of mental health services: Office of the Chief Psychiatrist, Melbourne, Victoria [Invited Speaker].

21. Heffernan, E. (2024). Delusional Disorders: Queensland Prison Mental Health Symposium, Brisbane.

22. Hodges, B., Tipping, M., Hoey, J., Buckley, J., & Li, H. K. Let's get ready! The development of an organisational readiness toolkit to assist with embedding lived-living experience / peer workers into AOD services. [Practice-based/Service delivery presentation]. Presented at: Insight Centre for Alcohol and Other Drug Training; Brisbane, Australia.

23. **Hodges, B., Tipping, M., Hoey, J., Buckley, J., & Li, H. K.** (October 2024). When should we disclose our stores as an AOD peer worker? Development of a guide and reflective practice tool. [Poster Presentation: Winner Peoples' Choice Poster Prize]. Presented at: *Australasian Professional Society on Alcohol and Other Drugs 2024*; Melbourne, Australia.

24. **Hodges, B., Tipping, M., Hoey, J., & Li, H. K.** (August 2024). More than just extra seats at the table: Embedding lived experience into AOD training and workforce development. [Practice session presentation]. Presented at: *Australian Winter School AOD Conference, 2024*; Brisbane Convention & Exhibition Centre, Brisbane, Australia.

25. Holland, M. & **Parker, S.** (October 2024). Family Program Evaluation (MNMH Early Psychosis). [Invited Speaker]. Presented at: *Queensland Statewide Rehabilitation Forum, Metro South Addiction and Mental Health Service, 2024*; Online.

26. **Kelly, J. & Davis, C.** Recommendations to enhance AOD treatment for Lesbian, Gay, Bisexual and Transgender (LGBT) people: A Qualitative Study. (2024, August). [Oral Presentation]. Present at*: Metro North Mental Health Research Symposium 2024*; Caboolture Hospital, QLD, Australia.

27. **Ketheesan S**, Sarnyai Z, Lawford BR, Connor JP. Problem alcohol use, posttraumatic stress disorder and allostatic load in combat-exposed Vietnam veterans. Presented at: *International Society for Biomedical Research on Alcoholism 3rd World Congress on Alcohol and Addictions*; 2024; Melbourne Convention and Exhibition Centre, Melbourne, Australia.

28. **Ketheesan S**, Sarnyai Z, Lawford BR, Connor JP. Applying the allostatic load concept. Presented at: *The Metro North Mental Health Research Symposium*; 2024; Caboolture Hospital, Queensland, Australia.

29. **Lacis, K.** (March 2024). Use your Headdsss! Engaging and supporting adolescents and young adults. [Presentation session]. Presented at: *Sunshine Coast Youth Health Conference 2024*; Sunshine Coast Health Institute, Australia.

30. **Mercier, S., Bowman, D., Burke, K., Purushothaman, S., Giebels, E., Jones, L., Patrick, A., & Townley, J.** (August 2024). Working differently: Phases of care. [Oral Presentation]. Presented at: *Metro North Mental Health Research Symposium 2024*; Caboolture Hospital, QLD, Australia.

31. **Minchell, J. & Li, H. K.** (October 2024). Improving access to nicotine replacement (NRT) in inpatient wards: Establishment of Clinical Nurse Consultant/Tobacco Treatment Specialist roes in a public hospital service. [Merryl Caldwell-smith First Time presentation award]. Presented at: *Internation Nursing Conference*, ACMHN2024; Perth, Australia.

32. **Minchell, J. & Li, H. K.** (October 2024). Scope of Practice Credentials in Mental Health Nursing: Stepping up NRT on inpatient wards. Presented at: *International mental health nursing conference*, ACMHN2024; Perth, Australia.

33. **Moss, K., Heffernan, E., Meurk, C., & Steele, M.** (August 2024). Physical activity of inpatients under forensic mental health care: A mixed methods study of patient knowledge, preferences, practices and identified barriers. [Oral Presentation]. Presented at: *The Metro North Mental Health Research Symposium*; 2024; Caboolture Hospital, Queensland, Australia.

34. **Mounsey, R.** (November 2024). Equipping frontline workers to address youth vaping: The Vape Check initiative. [Presentation session]. Presented at: *Australian Association for Adolescent Health.*

35. **Mounsey, R., Petty, K., Lacis, K., & Li, H. K.** (October 2024). Equipping frontline workers to address youth vaping: The Vape Check. [Presentation Session]. Presented at: Oceania Tobacco Control Conference 2024; Gold Coast Convention & Exhibition Centre, QLD, Australia.

36. **Page, K.** Early trends in Hepatitis C testing and treatment at a Brisbane Needle and Syringe Program – The TEMPO Project (winner of the Rapid Presentation Prize). Presented at: *The Metro North Mental Health Research Symposium 2024*; Caboolture Hospital, QLD, Australia.

37. **Page, K**. Barrier and assistants to Hepatitis C treatment: Findings from the TEMPO study (in collaboration with the Kirby Institute, UNSW). Presented at: *Metro North Hepatitis C Treatment Forum 2024*; Beetson Hotel, Brisbane, Australia.

38. **Palmer, A**. Mental Health Alcohol and Other Drugs (MHAOD) Social Work scope of practice. Presented at: *State-wide MHAODS Social Work Day Conference, 2024*.

39. **Parker, S.** (March 2024). Multimorbidity and first episode psychosis (update). [Invited Speaker]. Presented at: Mental Health Alcohol and Other Drugs Branch, Multimorbidity Quality Improvement Strategy Forum, 2024.

40. **Parker, S.** (April 2024). RANZCP Centrally Administered assessments – Full day workshop. [Invited speaker and facilitator]. Tasmania Health, Hobart, Australia.

41. **Parker, S.** (April 2024). Integrating research into public mental health services, why it matters, how to do it. [Invited Speaker]. Presented at: *Mental Health, Launceston General Hospital*; Launceston, Tasmania, Australia.

42. **Parker, S.** (April 2024). The Queensland experience of developing psychiatry research at a public mental health service. [Invited Speaker – Online]. Presented at: *Research Planning Workshop, Mental Health, 2024*; Sydney Local Health District, Sydney, Australia.

43. **Parker, S.** (June 2024). Enhancing rehabilitation care through listening to and acting on lived experience: working towards co-design of residential services. [Invited Speaker]. Presented at: *MHCP Research Conference, 2024*; Central Adelaide Local Hospital Network, Adelaide, Australia.

44. **Parker, S.** (August 2024). Becoming and effective supervisor: Transition to Fellowship Component of 'Transition from trainee to consultant psychiatrist: adapting to a new role' webinar coordinated by the RANZCP for the section of Early Career Psychiatrists. [Invited Speaker]. Presented at: *RANZCP Webinar series*, Online event.

45. **Parker, S.** (October 2024). Predictors of rehabilitation engagement at Queensland's Community Care Units: Analysis of cross-sectional data from the 2023 CCU Benchmarking dataset. [Invited speaker]. Presented at: *Queensland Statewide Rehabilitation Forum, Metro South Addiction and Mental Health Service, 2024*; Online.

46. **Parker, S.** & Northwood, K. (October 2024). What happens after someone leaves a Community Care Unit? [Invited speaker]. Presented at: *Queensland Statewide Rehabilitation Forum, Metro South Addiction and Mental Health Service, 2024*; Online.

47. **Payne, L.** (August 2024). Supporting police as first responders to people in mental health crisis: Police Communications Centre mental Health Liaison Service. [Oral Presentation]. Presented at: *Metro North Mental Health Research Symposium 2024*; Caboolture Hospital, QLD, Australia.

48. **Petty, K**. Young people and alcohol and other drugs – Trends and laws. [Presentation session]. Presented at: *Central Queensland Youth Connect*; Rockhampton, Australia.

49. **Perdacher, E.** (2024, September). *Digital Mental Health in Prisons*. Workshop presented at Corrective Services NSW Psychology Conference, Paramatta, NSW.

50. **Perdacher, E.** (2024, November). *Digital Mental Health in Prisons.* Presentation presented at Qld Health and Griffith University's Forensic Mental Health Forum, Brisbane, Qld.

51. **Plever, S.** A system change intervention for sustained implementation of smoking cessation care in psychiatry settings. [Rapid fire presentation]. Presented at: *Oceania Tobacco Control Conference 2024*; Gold Coast, Australia.

52. **Plever, S.** Can a system change intervention, combined with a service incentive payment, overcome systemic barriers to treating tobacco dependence in publicly funded outpatient psychiatric settings? [Oral Presentation]. Presented at: *SRNT-Oceania 2024 Conference*; Brisbane, Australia.

53. Plever, S. "I want to quit. I wish I never smoked mate." Preliminary findings on the delivery and consumer experience of tobacco treatment in adult acute mental health units. (2024, August). [Free Paper Presentation]. Present at: Metro North Mental Health Research Symposium 2024; Caboolture Hospital, QLD, Australia.

54. **Plever, S.** System Change Intervention for Tobacco Treatment in Psychiatry Settings. [Poster presentation]. Presented at: *International Forum on Quality and Safety in Healthcare, 2024*; Brisbane, Australia.

55. **Plever, S.** System change intervention for implementing smoking cessation, at scale, in psychiatry services. [poster presentation]. Presented at: *2024 Herston Health Precinct Symposium*. Brisbane, Australia.

56. **Plever, S.** System change intervention for multi-site implementation of smoking cessation in public psychiatric settings. [Oral Presentation]. Presented at: *Society for Mental Health Research, 2024*; Sydney, Australia.

57. Postorivo, D., **Parker, S.**, Whiteford, H., Papinczak, Z., Rutherford, Z. (February 2024). Hospital-based crisis support spaces as alternatives to emergency departments. Presented at: *Emerging health policy and economics research conference 2024*; Sydney, Australia.

58. **Power, M.,** & **Harwood, C**. Restorative practice in mental health. Presented at: *10th International Conference on Social Work in Health and Mental Health, 2024*; Melbourne, Australia.

59. **Sidari, M.** (August 2024). All hands on deck: Database design in a specialist mental health service. [Oral Presentation]. Presented at: *Metro North Mental Health Research Symposium 2024*; Caboolture Hospital, QLD, Australia.

60. Teodorczuk, A. (May 2024). The role of AI and stimulation in geriatric education. [Invited speaker]. Presented at: British Geriatrics Society Spring Meeting, 2024; The Vox, Birmingham, United Kingdom.

61. **Terli, K.** (August 2024). Testing in Electroconvulsive Therapy. [Oral Presentation]. Presented at: *Metro North Mental Health Research Symposium 2024*; Caboolture Hospital, QLD, Australia.

62. **Uzabeaga, C., & Pickett, G**. MIND model of care. Presented at: *10th International Conference on Social Work in Health and Mental Health, 2024*; Melbourne, Australia.

63. Watson, K. (2024, October). Our Ways, Your Ways: Multidisciplinary mental health care for Indigenous Adolescents – A Case Presentation. Presentation at Forensic Faculty and Section of Child and Adolescent Forensic Psychiatry Conference, Gold Coast, Queensland.

64. Winten, C. G., Strodl, E., Ross, L. & Thomas J. J. (August 2024). A meta-analysis and systematic review of therapeutic treatments for ARFID in adolescents and adults. Presented at the Australia and New Zealand Academy for Eating Disorders Conference, Auckland, NZ.

65. Winten, C. G., Strodl, E., Paterson, J., Smith, E., Thomas J. J & Ross, L. (August 2024) The living experience of ARFID: the experience of treatment and diagnosis for those with ARFID and their loved ones and carers. Presented at the Australia and New Zealand Academy for Eating Disorders Conference, Auckland, NZ.

66. **Winten, C. G.**, Strodl, E., Paterson, J., Smith, E., Ross, L. & Thomas J. J. (August 2024). The clinical experience of ARFID: Health professionals experience of treating, managing and diagnoses ARFID. Presented at the Australia and New Zealand Academy for Eating Disorders Conference, Auckland, NZ

67. **Winten, C. G.**, Strodl, E., Eddy, K., Ross, L. & Thomas J. J. (August 2024) Dietetic-led Cognitive Behavioral Therapy - ARFID. Presented at the Dietitians Australia Conference, Brisbane, Australia.

68. Winten, C. G., Strodl, E., Paterson, J., Smith, E. & Ross, L. (August, 2024) Dietitian's experience of Avoidant/Restrictive Food Intake Disorder (ARFID). Presented at the Dietitians Australia Conference, Brisbane, Australia.

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A special thank you also to the exceedingly talented lived experience artist, Carolyn [Carrie] Davies, whose art is displayed on the front and back cover of this review.

Carrie has had a deep interest with art and nature and approaches her work with passion and energy even at her age of 77. She hopes through her painting to trap a sense of mood and create an emotional connection for herself and the viewer. Her pursuit of art as she once said;

> *"Is like chasing your dreams.*
> *It's always elusive and enticing at the same time,*
> *but very rewarding and each day there is a new and exciting*
> *project that drives me on to chosen pathway of life."*

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