Metro North Hospital and Health Service

Putting people first

Metro North Mental Health

Celebrating Research

Queensland Government

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

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

Interpreter Services Statement

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

Design and typesetting by Clinical Multimedia,
Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service

Clinical Multimedia_Oct '16 0783_ss

Contents

About Metro North Hospital and Health Service

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

MNHHS Strategic Priorities: Mental Health, Research and consumer and community engagement

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

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

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

About Metro North Mental Health

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

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

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

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

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

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

Foreword

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

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

Professor Michael Breakspear
(Chair Metro North Research Collaborative Committee)

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

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

THANK YOU
Dr Anna Praskova

Dear Anna,

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

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

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

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

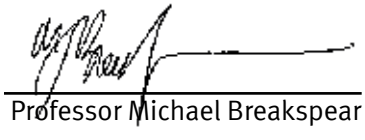
With kind regards

Brett Emmerson, Sue Patterson, Michael Breakspear

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

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

Associate Professor Brett Emmerson



Professor Michael Breakspear

At a Glance

Celebrating Success

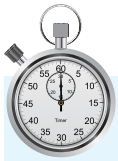
Metro North Mental Health researchers recognised at Metro North HHS Research Excellence Awards

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

Dr Dylan Flaws

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

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



90 SECONDS with Dylan

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

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

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

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

How did you get started?
When I finished my undergrad I had no idea what I wanted to do. I took a job as a research assistant in DEM with Dr Martin Than, and loved it. My first

job was just to call up enrolled patients and ask them follow-up questions. It was through that job that I first got interested in medicine. I was slowly given increasingly challenging tasks, eventually in Singapore collaborating on a multinational chest pain trial.

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

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

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

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

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

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

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

What's in the future for mental health research?
The future of mental health research is very exciting. It's one of the reasons I chose to specialise in psychiatry. One day I hope terms like "schizophrenia", which describe symptom clusters will be replaced by new definitions, based on the underlying aetiology for these symptoms. This will be the start of a paradigm shift in how we diagnose and treat mental illness. I'd love to see that in my lifetime.

Dr James Scott

James was awarded the Promoting Health Minds and Bodies Award for his work dedicated to improving the mental health of Australian youth.

He says,

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

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

James's research is concerned with preventing the onset of mental disorders, identifying the underlying causes of schizophrenia and improving treatment and outcomes for young people with early psychosis. His work has been nationally and internationally recognised as having the potential to improve the mental health of young people across the world.

Professor
Michael Breakspear

Michael undertakes research into the neurobiology of psychiatric disorders, particularly major depression, bipolar disorder, schizophrenia and dementia. His work is grounded in brain network theory, which models the brain as a complex network of regions and their connections - the "google map of the brain". Michael leads a team of researchers using sophisticated functional and structural brain imaging studies to look at the way different parts of the brain mis-connect in people with mental health disorders, or who are are at high risk of future illness. His recent studies have demonstrated brain networks disturbances involving key regions required for decision making and emotional regulation in young people at risk of bipolar disorder.

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

Michael explains the work further:

What is Systems Neuroscience?

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

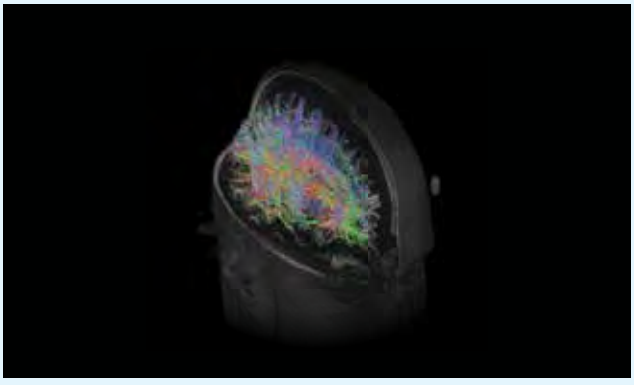
What do you and your team do and how?

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

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

What is the purpose of your research?

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



Local study adds to evidence related to Childhood trauma in patients with early psychosis.

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

Abstract

The prevalence and correlates of childhood trauma in patients with early psychosis.

Michael Duhig, Sue Patterson, Melissa Connell, Sharon Foley, Carina Capra, Frances Dark, Anne Gordon, Saveena Singh, Leanne Hides, John McGrath, James Scott.
Aust N Z J Psychiatry. 2015 Jul;49(7):651-9. doi: 10.1177/0004867415575379. Epub 2015 Feb 26.

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

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

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

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

Metro North Mental Health Researcher completes Chairman's Scholarship.

A/Prof Sue Patterson

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

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

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

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

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

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

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

CCQI: Evaluation of e-Lester: a multiple case study, with mixed methods used to describe process and impact of four pilot programs designed to support improvement in the care provided to people with severe mental illness, specifically in relation to cardiovascular health in NHS Mental Health Trusts. See http://www.rcpsych.ac.uk/pdf/eLester%20final%20report%2016.03.16.pdf

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

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

CLAHRC Oxford: Development of a standardised approach to monitoring and evaluation of PPI in social care, health, education and research across The Thames Valley and Milton Keynes.

In collaboration with A/Prof Weaver, Modelling the process and impact of service user involvement in mental health services research: Comparative case studies to develop a theory of involvement. This ongoing work is a multinational qualitative study of user involvement in research.

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

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

Consumer and carer engagement:

Nothing about us without us.....

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

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

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

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

Imani Gunasekara

The Accidental Researcher, collaboration and co-production

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

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

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

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

When I was well again and back at work I was curious about the experiences of people hospitalized in our mental health service at the RBWH. I collated and analysed feedback from the suggestion boxes on the wards and found that the experience of care from the nurses was variable. I decided to develop a training package for nurses at the RBWH to assist them to work with people in a way that was person-centred and supported recovery. Because I wanted it to be relevant here at the RBWH and really reflect the views of people admitted to hospital I started talking to people on the wards, asking them what they thought made an excellent mental health nurse and what could be done to improve the practices.

When approaching people I introduced myself as a consumer and assured people that their feedback would be anonymous. I encouraged them to be open and people pulled no punches in expressing what they wanted and didn't want from an excellent mental health nurse. I wondered whether they would have been so open with someone who wasn't a consumer, who hadn't been in a similar position to theirs.

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

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

The second work, a work in progress, is the research project "What Makes an Excellent Mental Health Doctor". We obtained ethical approval for this research project. There was support at all leadership levels from the Executive Director to the Principal Research Fellow to my direct line manager. I was supported to dedicate a substantial portion of my time to conducting the research work so long as I met the other basic needs of my job.
Sue and I worked together to develop the qualitative approach that we used in this research, based on the approach taken in the previous project. The research questions were developed collaboratively. I conducted the interviews with Sue providing guidance and coaching to enable me to delve deeper into the consumers' responses to questions.
We worked together to analyse the data and make sense of what people were saying to us. An important part of this study was getting feedback from doctors about consumers' views and expectations – we wanted to understand what the doctors needed to work in the way valued by consumers. Sue has taken the lead in writing the article, in collaboration with Dr James Scott but we always discuss what is to be written and critique it together. The paper reporting the study is soon to be submitted.

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

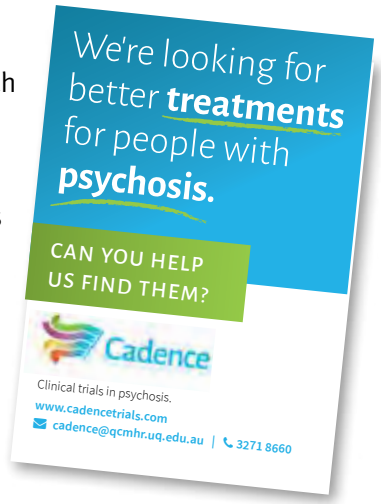
In conclusion I would urge academic and clinician researchers to consider conducting a collaborative research project with service users. It is not an easy path and positive outcomes are fundamentally dependent on mutual respect. It involves a shift in focus from being experts to becoming partners, supporters,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

CADENCE – building research capability

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

Cadence by Prof John McGrath

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



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

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

For more information on Cadence, visit www.cadencetrials.com

Sam Bicker, Professional Lead for occupational therapy reflects on the importance of research for

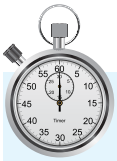
How Occupational Therapists can set sail on a research journey

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

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

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

As the professional lead for OT within MH at RBWH I remain passionate that if viewed as part of professional practice research skills can and will be developed. By actively promoting research within mental health OT's there will be a natural movement towards OT's learning more about research within the entire organisation, increasing their confidence in talking about research, develop their understanding of the research process and ultimately become an active part of the research community.



90 SECONDS with Bjorn Burgher... Psychiatric Registrar and Research Fellow

Bjorn Burgher, a psychiatric registrar and Research Fellow at the RBWH, began work on his PhD in 2015 with UQ and QIMR Berghofer. His PhD research involves using diffusion and functional MRI to learn how brain network connectivity dynamics are altered by neuroinflammation in early psychosis. Bjorn is also working with A/Prof James Scott to establish a multi-institutional collective of clinicians, researchers and scientists to systematically collect phenotypic and biological data longitudinally on an early psychosis cohort. These data could be used to address critical questions prognosis and prediction of outcome for young people who experience psychosis.

Please tell us about your research in a 'text message' (160 characters or less)
Inflammation impairs cognitive refinement in early psychosis. I use MRI to study how brain networks become faulty when inflammation occurs.

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

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

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

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

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

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

How can we make mental health research more attractive to clinicians?
Research can be integrated into clinical practice in such a way that it adds value and promotes improvement in clinical skills. If clinicians feel that research is adding value rather than being a burden it will promote engagement.

What would your internet search history tell us about you?
I watch streamers on Twitch and Youtube; generally videos games and other geek culture.

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

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

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

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

Recovery oriented care

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

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

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

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

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

Lucianne Palmquist, mother, wife, daughter, PhD candidate and practicing psychologist.

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

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

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

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

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

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

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

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

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

Physical health and mental health

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

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

Psychiatrists' follow up of metabolic abnormalities and influences on practice

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

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

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

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

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

Homeless Health: Taking Metabolic Monitoring to the Street

Changing clinical practice is notoriously difficult but evaluations have shown that various interventions, including introduction of specialist positions, scheduling monitoring at service rather than individual level, and formalisation of service policy and procedures can improve rates of monitoring, identification, and follow up of cardiovascular risk factors among patients who attend clinics. Evidence is limited, however, in relation to care for more marginalised populations, such as people who experience homelessness and may avoid services.

As part of ongoing service development, The MNMH Homeless Health Outreach Team (HHOT) implemented a multi-faceted quality improvement initiative designed to improve rates of metabolic monitoring among people receiving support from the team. Central to the initiative was provision of a portable metabolic monitoring kit that enabled clinicians to undertake monitoring 'on the street' and in other public spaces where they usually provide services.

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

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

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

The roles of Psychologists in physical health

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

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

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

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

Metro North Hospital and Health Service

Physical health care in mental health services: The experiences and expectations of consumers

Sarah Young, Anna Praskova, & Sue Patterson Metro North Mental Health

THE PHYSICAL HEALTH OF PEOPLE WITH SEVERE MENTAL ILLNESS

Lifespan curtailed by

13 to 32 years

60% OF PREMATURE MORTALITY DUE TO PHYSICAL ILLNESS

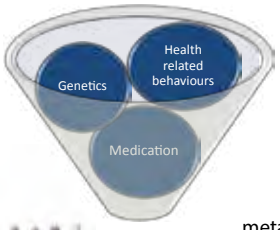
Compared to the general population people with SMI are:

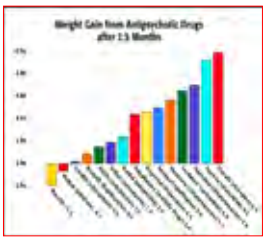
TWICE as likely to be obese

3X more likely to have diabetes

of people with SMI smoke tobacco

Causation is complex





Antipsychotic medications cause metabolic dysfunction and weight gain

Barriers to health care access and suboptimal care

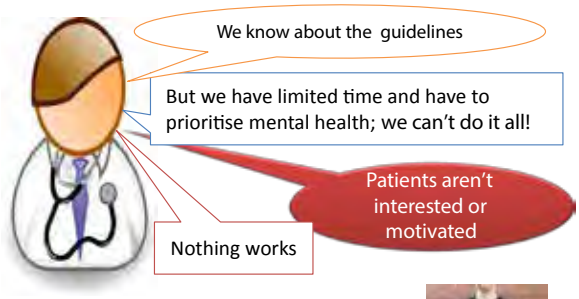
Cardiovascular disease:
Leading cause of premature death in people with SMI

Heart Foundation

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

Therapeutic guidelines:
Don't just screen, intervene

RESEARCH: practice is variable internationally, typically suboptimal WHY?



BUT, Nobody asked me!

THIS STUDY

To add consumers' voice to discussion, we conducted a qualitative study, interviewing a convenience sample of people with SMI recruited from across Metro North Mental Health Services. We asked 'what does the service do for your physical health and what would you like?' Data were analysed thematically.

The 40 Participants (including 23 men) were

21 to 80 years old – mean 47 years

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

Half live with chronic illness or injury

FINDINGS

Consumers' **primary concerns were weight/body shape and fitness**. They were concerned about how they looked and being judged for something that was commonly considered beyond their control (**weight gain was commonly attributed to psychotropic medication**). Being overweight was described as undermining confidence and hindering social engagement. Most participants reported smoking cigarettes but no -one identified this as a health concern.

THEY SAID

- You weigh and measure us but don't tell us why or what you find. Please feedback results and tell us what they mean
- Motivation to attend to physical health is affected by mental health; sometimes just getting by is all we can do
- We do care about our physical health, we just don't know how to change
- We need you to be assertive and proactive, especially when we're unwell
- Support access to structured physical activity and provide information about healthy eating and refer for specialist help when needed
- Make hospital healthier (food is stodgy and we can't exercise)
- Care should be holistic

HELP us HELP OURSELVES

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

SELECTED REFERENCES
Crawford M et al (2014). Assessment and treatment of physical health problems among people with schizophrenia: national cross-sectional study. BJP DOI:10.1192/bjp.bp.113.142521
De Hert M et al (2011). Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care World Psychiatry, 10(1): 52–77.
Lawn, S. (2012). In it together: Physical health and well-being for people with mental illness. ANZJ Psychiatry 46 (1) 14-17.
Mitchell AJ et al (2012). Guideline concordant monitoring of metabolic risk in people treated with antipsychotic medication: systematic review and meta-analysis of screening practices. Psychol Med, 42:125-147.
http://www.heartfoundation.org.au/sitecollectiondocuments/hf-shifting_burden-cvd-accecons-2005-may.Pdf

We are grateful to the clinicians across the service who interviewed consumers and supported the study. Particular thanks go to the people who generously gave their time and shared their views. This study was funded in part by CHIRP (the Caboolture Hospital Innovation and Research Program) and conducted with support of Metro North Mental Health. For further information contact Susan.patterson@health.qld.gov.au

Queensland Government

Nursing Research

by Niall Higgins Senior Research Fellow

NURSING RESEARCH

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

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

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

Violence towards health-care workers, especially in areas such as mental health, has become increasingly common, with nursing staff suggesting that a fear of violence from their patients may affect the quality of care they provide. Following from this, the nursing research team decided to implement the Safewards program, developed by Professor Len Bowers, Kings College London. The nursing leadership team followed the recommended evaluation approach with the added view to understand how this would be translated to the context of mental health nursing practice in their wards (Dart, 2015). Their work was presented at the ACMHN annual conference. Throughout the Safewards project,

several one day training events were conducted for staff to receive education support (Higgins, 2015). Additional supervision was provided at unit level to support the program, and the majority of components of the program were successfully implemented. Consumer Consultants, who have a lived experience with mental health issues participated in ward meetings and activities where appropriate. Carer Consultants also attended regular meetings to represent Carer views. The introduction of the Safewards program has become a positive group activity. It appears to engage consumers with a positive experience and staff are beginning to notice small changes to their language during interactions with consumers (Hiscox, 2015). The contribution to research from nursing education and clinicians in the ward areas include education, training and support to assist nurses to develop and maintain therapeutic relationships within inpatient mental health units in Metro North HHS (Hatch, 2015).

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

Nursing workforce

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

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

Successful strategies for building student confidence in mental health care

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

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

Significantly, after placement, this confidence increased to at least 96% ('completely confident' or 'mostly confident').

The survey identifies what students felt helpful and interesting on their mental health placement. It is encouraging to see how 'beneficial' the students see the mental health placement and that the stigma surrounding the consumers and staff is greatly reduced and in some cases appears to be completely removed – particularly their perceptions about Electro Convulsive Therapy. Feedback indicates that some wish to commence a career in mental health nursing, stating their experience has 'completely changed my mind about mental health'.

The survey is ongoing and is routinely delivered by the Nurse Educators and Clinical Facilitators. The data gathered help highlight and ensure positive learning experiences continue for future undergraduate nursing students undertaking mental health clinical placements.

Medication Safety Committee
"Primum non nocere" or "To Do no Harm"

Bruce Collyer1 RN, Louise Hawhiks1 RN, Diane Burrows1 RN
1Metro North Mental Health, Royal Brisbane and Women's Hospital

Introduction

Medication Safety has been listed as Number 4 of the "National Safety and Quality Standards", an it is every clinicians concern to act and practice in a safe manner. In 2010 Metro North Mental Health RBWH initiated a multidisciplinary Medication Safety Committee with representatives from Nursing, Pharmacy and Medicine. What grew out of a working party set up to examine issues with the prescribing of Clozapine, involved into a committee that is responsible for the monitoring of all aspects of medication safety for the Mental Health service line here at the RBWH. It was the first Queensland public hospital committee of its kind that was specific to Mental Health.

Method

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

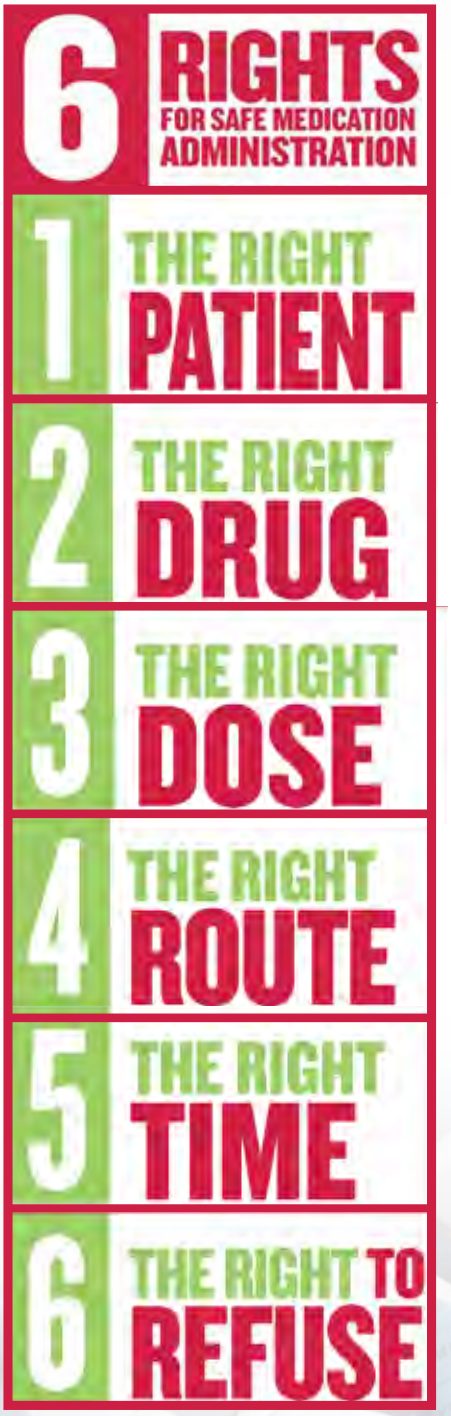
Results

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

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

Conclusion

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



Queensland Government

The Queensland Forensic Mental Health Service

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

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

Research in 2015 focussed on:

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

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

Researcher Profile

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

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

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

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

Abstract

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

Susanna Every-Palmer, Justin Barry-Walsh and Michele Pathé. Australian and New Zealand Journal of Psychiatry (2015) 49(7) 634-41. doi: 10.1177/0004867415583700.

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

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

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

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

Abstract

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

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

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

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

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

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

On being a clinician researcher

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

Sarah Young
Clinical Psychologist
and researcher

Sarah Young, clinical psychologist and researcher.

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

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

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

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

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

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

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

Natalie Avery
Primary Care
Liaison Officer

Natalie Avery, primary care liaison officer, TPCH MHS completed a qualitative study for her masters' thesis while working full time.

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

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

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

I then used the break between university semesters over Summer 2015/2016 to focus on piecing together the findings and drafting the write up.

I submitted my thesis early in 2016 and am writing up a paper for publication. I have begun sharing the findings with colleagues and services across Metro North, and hope to disseminate them more widely to other Mental Health Services, and possibly present at conferences or other forums.

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

Since starting my own research project, I have had the opportunity to assist others in developing research ideas, and have also been involved in a number of collaborative projects with other partner organisations interested in improving physical health outcomes of consumers, as part of my role. I have also made a number of really useful contacts – both for future research, and projects regarding physical health needs of people with severe mental illness.

Anne Gordon
Psychologist

Anne Gordon, psychologist early psychosis service, RBWH.

Anne's work running a wait-list controlled trial of Social Cognition and Interaction Training in routine care has been described in part in the 2013 and 2014 MNMH Research Reviews. This year we are delighted to have Anne round out the story of the study and share her experiences. Anne writes:

Schizophrenia is frequently associated with impaired social functioning that undermines quality of life. Because of this, various psychological interventions have been designed to improve social functioning. One such intervention is Social Cognition and Interaction Training (SCIT), a manualised group-based intervention informed by cognitive-behaviour therapy. SCIT is delivered over 20 x one hour sessions and is designed to support participants to develop improved emotion perception, ways of thinking and skills that promote effective social behaviour.

To make sessions fun and engaging tools such as DVDs, games, photos, and role plays are used to help participants learn theory and practise new skills.

Working as a psychologist and case manager in mental health I was often seeing people who experienced social difficulties and wanted to find ways to help. I read about and had training in delivering SCIT. My experiences and the evidence available suggested it would be helpful for the people accessing community mental health services. However most of the research had been conducted in specialised settings and no studies had been completed in community settings. I had to complete a research study as part of my clinical doctorate and decided studying SCIT with folk living with psychosis or schizophrenia would help develop evidence needed to improve care and outcomes.

I developed a protocol for a randomised wait-list controlled trial and set about getting organisational support to run the SCIT program in the service and ethical approval to run the study. In 2013 my colleagues (Jess Alum, Eleanor O'Sullivan and Paul Crampton) and I started co-facilitating the weekly Social Cognition and Interaction Training (SCIT) group program in the MNMHS. My role entailed recruiting participants (to the group and research), facilitating the program, and doing assessments and analysing data for my study.

Recruitment into the program was challenging and time consuming. Getting enough people to run a total of six groups entailed attending many clinical team meetings to encourage clinicians to refer consumers to the program and research. I had to persist in my efforts and continue to try and promote the program among all clinical staff using various means, such as providing them with written information about SCIT and the study, as well as advertising flyers for clients. I also contacted clients who wanted more information about the group before enrolling, and who wanted further information about the study and what would be required of them if participating. Another part of conducting the research (and my clinical practice) was to co-facilitate the SCIT groups and ensuring high retention rates throughout. Reminders to participants to attend each session, and managing any barriers they may have faced in attending needed to be addressed and problem-solved. All in all, this part of the research involved lots of persuasion on my part! It also involved me working out of usual hours to make it all possible.

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

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

Wherever possible I would recommend clinicians being involved in research in their clinic setting, including helping others carry out their research, as it's a great way to learn, and importantly helps clients access better clinical treatment and care. Getting SCIT off the ground and delivering the program as well as doing my research required a lot of energy and enthusiasm, but was well worth the effort. I am continuing my involvement with research, working with a team of researchers and clinicians on a large randomised controlled study of SCIT for people with psychosis or schizophrenia.

Charana Perera,
Psychiatric Registrar

Qualification as a psychiatrist involves an extensive program of education and clinical training. To achieve the competencies required for Fellowship of the Australia and New Zealand College of Psychiatrists, trainees must generally complete a Scholarly Project involving novel research. Project topics and methods can be selected by the trainee to suit their research interests but must enable them to demonstrate they are able to

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

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

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

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

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

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

TPCH Psychology

by Lee Beames, Director Psychology

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

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

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

Evaluation: worth the effort? We think so – here's why!

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

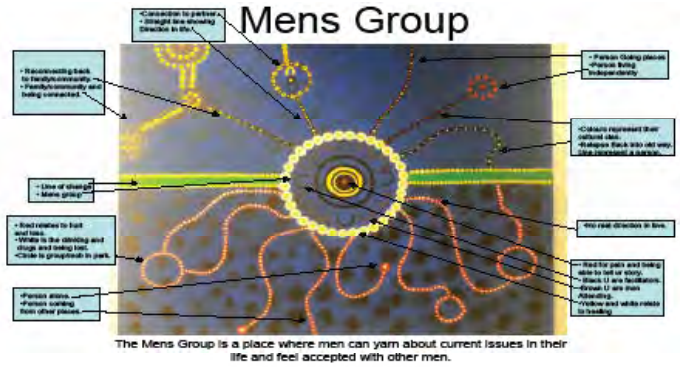
(from Osborne D & Gaebler, T. 1992. Reinventing Government: How the Entrepreneurial Spirit Is Transforming the Public Sector. Reading, MA: Addison-Wesley.)

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

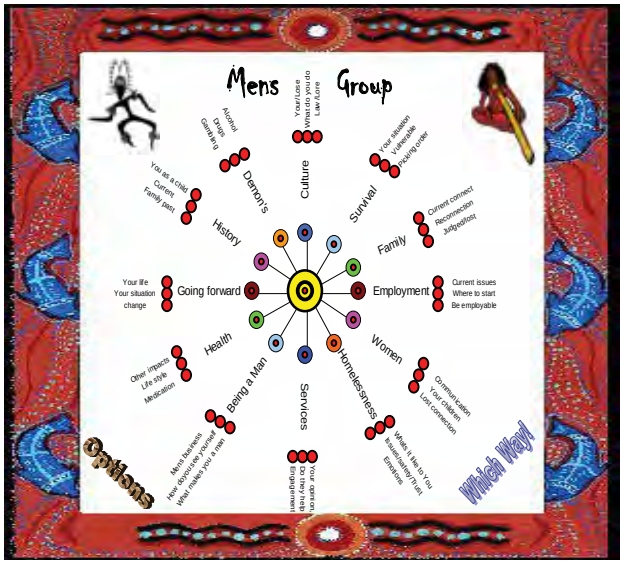
As described by evaluation theorist, Donald Kirkpatrick evaluations can be designed to measure reactions (what the participant thought and felt), learning (change in attitude, knowledge or capability), behaviour (change - implementation/application of learning) and results (the effects of behaviour change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

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

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



The Mens Group is a place where men can yarn about current issues in their life and feel accepted with other men.



The Valley Mens Group

Andrew Cummins

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

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

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

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

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

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

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

Outcomes from the Men's Group.

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

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

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

Cannabis and Psychosis

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

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

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

Abstract

Natural Recovery From Cannabis Use in People With Psychosis: A Qualitative Study

Shane Rebgetz, Leanne Hides, David Kavanagh and Anand Choudhary

Journal of Dual Diagnosis. 201511179-83. doi: 0.1080/15504263.2015.1100472.

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

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

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

Ten evidence based reasons for embedding health care in values-based enabling environments

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

1. EEs improve quality of care and thus measurable patient outcomes

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

2. EEs promote wellbeing of patients, optimising conditions for recovery

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

3. EEs enhance workforce engagement

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

4. EEs reduce staff sick leave

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

5. EEs are good for the organisation's bottom line

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

6. EEs support positive mood; positive mood promotes more flexible problem solving, robust decision making and enhanced analytic precision

- Interviews with CEOs and senior leaders of 35 U.S. health services known for their patient experience improvement initiatives linked compassionate care to lower staff turnover, higher retention, recruitment of more highly qualified staff, and reduced costs from shorter lengths of stay, lower rates of rehospitalisation, better health outcomes, and fewer costly procedures. http://www.theschwartzcenter.org/media/Building-Compassion- into-the-Bottom-Line.pdf

7. EEs reduce the risk of adverse outcomes

- Work stress reduces standards of patient care and increases mistakes (Firth-Cozens & Greenhalgh, 1997)
- Dissatisfied doctors have riskier prescribing profiles, less adherent patients and less satisfied patients (Williams & Skinner, 2003)

8. EEs are good for the organisation's reputation

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

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

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

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

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

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

References

Department of Health. *NHS Health and Well-being. Final Report*. Crown copyright, 2009. (www.nhshealthandwellbeing.org/FinalReport.html)

Dromey J. (2014) *Meeting the Challenge: Successful Employee Engagement in the NHS* www.ipa-involve.com

Firth-Cozens J & Greenhalgh J. (1997) Doctors' perceptions of the links between stress and lowered clinical care*, Social Science & Medicine*, Vol. 44, pp. 1017-22.

Haas J, Cook F, Puopolo A., Burstin HR & Clearly P (2000) Is the professional satisfaction of general internists associated with patient satisfaction? *Journal of general internal medicine*, 15, 122-128.

Laschinger HK, Leiter MP (2006). The impact of nursing work environments on patient safety outcomes: the mediating role of burnout/ engagement. *Journal of Nursing Administration*, vol 5, pp 259–67.

Maben J, Peccei R, Adams M, Robert G, Richardson A, Murrells T. and Morrow E. (2012) *Patients' experiences of care and the influence of staff motivation, affect and wellbeing. Final report.* NIHR Service Delivery and Organisation programme. http://www.netscc.ac.uk/hsdr/projdetails.php?ref=08-1819-213

Machin, T and Goh, H. E. and Patrick, J. and Jury, C. (2010) *Establishing links between organisational climate, employee well-being and historical patient outcomes*. In: 27th International Congress of Applied Psychology, 11-16 Jul 2010, Melbourne, Australia.

Manser T (2009) Teamwork and patient safety in dynamic domains of healthcare: a review of the literature *Acta Anaesthesiologica Scandinavica*, 53, 2 1 143-151

Mazzocco K, Petitti DB, Fong KT, et al. 2009. Surgical team behaviors and patient outcomes. *American. J. Surgery* 197(5):678–85

Medland J, Howard-Ruben J, Whitaker E. (2004) Fostering psychosocial wellness in oncology nurses. *Oncol Nurs Forum* 31(1):47–54

NHS Employers Staff experience and patient outcomes: What do we know? http://www.nhsemployers.org/~/media/Employers/Publications/Research%20Report%20%Staff%20experience%20and%20patient%20outcomes.pdf

Powell M, DawsonJ, Topakas A, Durose J and Fewtrell C. Staff satisfaction and organisational performance: evidence from a longitudinal secondary analysis of the NHS staff survey and outcome data. *Health Serv Deliv Res* 2014;2(50). DOI: 10.3310/hsdr02500

Robinson D, Perryman S, Hayday S (2004). *The Drivers of Employee Engagement,* Institute for Employment Studies, Report 408

Rondeau, K., & Wagar, T. (2012). *Employee high-involvement work practices and voluntary turnover: does human capital accumulation or an employee empowerment culture mediate the process? Examining the evidence in Canadian healthcare organisations.* Paper presented at the Organisations Proceedings of the European Conference on Intellectual Capital.

Royal College of Physicians (2012) *Implementing NICE public health guidance for the workplace: Overcoming barriers and sharing success.* www.rcplondon.ac.uk/sites/default/files/documents/shipreport.pdf

Shanafelt TD, West C, Zhao X, Novotny P, Kolars J, Habermann T, Sloan J. (2005) Relationship between increased personal well–being and enhanced empathy among internal medicine residents. *J Gen Intern Med.* 20(7):559–564.

Topakas A., Admasachew L., and Dawson J. *NHS staff survey scores as predictors of trust outcomes a multi-method longitudinal analysis.* Birmingham: Aston Business School, n.d.

West M, and Dawson J (2012). *Employee Engagement and NHS Performance,* The Kings Fund

For further information please contact Sue Patterson, Principal Research Fellow Mental Health MNHHS, 3646 1153.

http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/enablingenvironments.aspx

The role of geometry in determining the connectome's network properties

James A. Roberts[1], Alistair Perry[1,2,3], Anton R. Lord[1,4], Gloria Roberts[3,5], Philip B. Mitchell[3,5], Robert E. Smith[6], Fernando Calamante[6,7,8], Michael Breakspear[1,9]

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

Introduction

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

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

Data Acquisition and Tractography

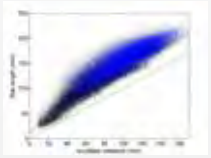
Diffusion MRI scans were recorded from 75 healthy subjects on a Philips 3T Achieva Quasar Dual MRI scanner: single-shot EPI sequence (TR = 7767 ms, TE = 68 ms), 32 gradient directions (b = 1000 s/mm²), reconstructed to yield 1 mm x 1 mm x 2.5 mm voxels.

Using probabilistic tractography, we derived estimates of whole brain structural connectivity. The fiber orientation distribution (FOD) within each voxel was estimated using *MRtrix* by performing constrained spherical deconvolution. Our connectivity matrices were reconstructed from densely seeded tractography (100×10^6 streamlines/subject) and parcellated into a relatively fine representation of 513 uniformly sized cortical and subcortical regions.

Weights were determined by counting the number of streamlines joining each region. Weights were divided by the corresponding fiber lengths to reduce the effect of distance biases. The resulting weighted, undirected matrices were nearly fully connected in each subject; we analyzed the connectivity matrix averaged across subjects.

Spatial properties

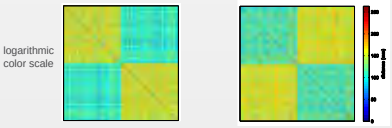
To measure connection lengths we calculated both the Euclidean distances and the curved fiber tract lengths:

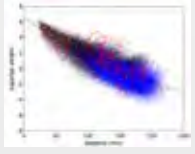


Fiber length vs Euclidean distance
Black: intrahemispheric
Blue: interhemispheric

The connectome is fully described by two matrices:

Weighted connectivity | Distance matrix

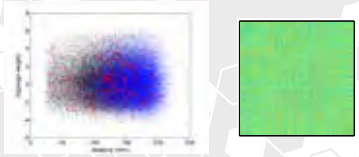




Connection strengths between nodes decrease as a function of fiber length slightly slower than exponentially.

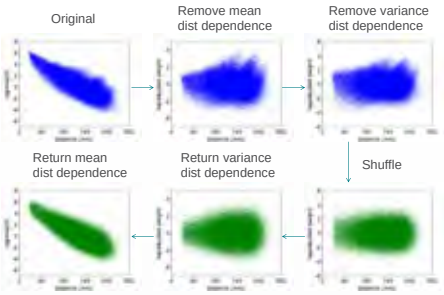
Black: intrahemispheric
Blue: interhemispheric
Red circles: homologous L-R
Black line: cubic fit over all

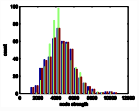
Randomized surrogate networks are widely used to determine whether a network feature is "expected" from simple assumptions. Typical randomization algorithms do not take spatial properties into account:



Geometric surrogates

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

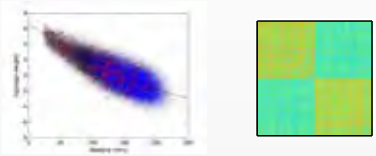




Preserves weight distribution, but alters node strength distribution → can stop here or obtain original strength distribution by slightly modifying the weight distribution

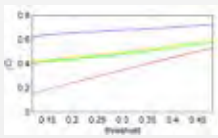
Two options for preserving strength distribution: original sequence (W_{SSP}) or random sequence (W_{SP}).

Geometric surrogates preserve cloud and some fine details:

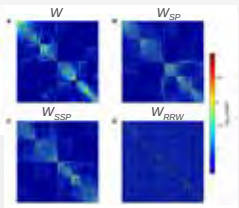


Network features and geometry

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

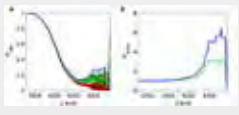


Mean clustering coefficient.
Blue: Data W
Yellow: Strength-preserving W_{SP}
Green: Strength-sequence-preserving W_{SSP}
Red: Random rewiring W_{RRW}

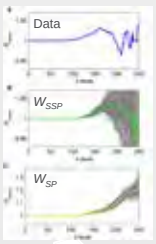


Q values: W=51, W_{SP}=46, W_{SSP}=48, W_{RRW}=14

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



Rich club by node strength
Blue: Data W
Green: Geometric surrogate W_{SSP}
Red: Shuffled surrogate W_{RS}

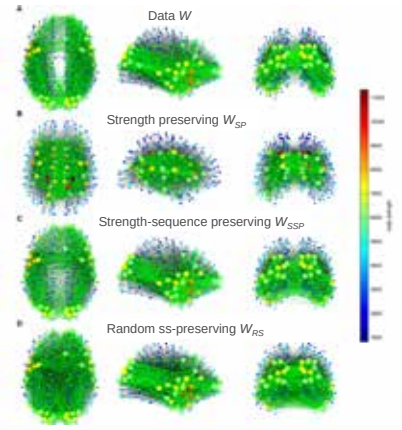


Rich club by node degree
Gray lines: ensemble of geometric surrogates, each normalized to their own degree-preserving surrogates

If geometry solely determined the rich club, the richest nodes would be far richer than the real brain. Preserving the original strength sequence yields a rich club of similar richness to the data

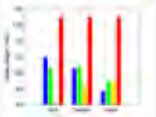
Rich club

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



If geometry solely determined the rich club, all the rich nodes would lie in a 'ball' near the center of the brain. Preserving the original strength sequence yields increased interhemispheric connectivity, particularly feeder connections between rich and non-rich.

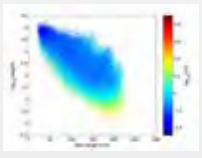
Fiber lengths within the rich club are longer than predicted by geometry. Usual geometry-ignoring random networks have a higher wiring cost than the brain, but geometric surrogates have lower cost – thus inter-hub wiring cost cannot have been the dominant consideration governing brain evolution, extra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

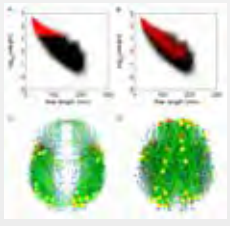


Blue: W Green: W_{SSP}
Yellow: W_{SP} Red: W_{RRW}

Consistency

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





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

Conclusions

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

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

References

[1] Henderson JA and Robinson PA, *PRL* **107**:01810 (2011); *Brain Connect* **3**:423 (2013); *Brain Connect* **4**:112 (2014).
[2] Samu D, et al., *PLOS Comput Biol* **10**:e1003557 (2014).

james.roberts@qimrberghofer.edu.au http://sng.org.au/
michael.breakspear@qimrberghofer.edu.au

MNMH staff enrolled in post graduate study

Graduate Certificate in Health (Mental Health)	
Ryan Zeppa-Cohen, INBMH CMHT	Graduate Cert Health (Mental Health) University of Southern Queensland
Tara Lane, Nurse HHOT	Grad Cert Suicide Prevention Studies, Griffith University
Grad Dip Nursing; Master of Mental Health Nursing	
Korpo Joanna Galakpai, RBWH	Central Queensland University
Jannette Newell, Nurse Educator RBWH	University of Southern Queensland
Maria Padilla Luque, INBMH CMHT	Central Queensland University
Natalie Allen, INBMH CMHT	Central Queensland University
Jasmin Hunter TPCH CCU	University of Newcastle
Matene Ackfun, TPCH inpatient unit	University of Southern Queensland
Sharen Duncan, Pine Rivers CMHT	University of Sunshine Coast
Benjamin Roper, Red/Cab SMHRU	University of Newcastle
Natasha Sutton, MNMH-Red Cab CCCU	Australian Catholic University
Rebecca Ashby, MNMH-TPCH Acute Care Team	University of Newcastle
Hannah Morecroft, MNMH-TPCH	
Jessy M Ngoma, MNMH-RBWH	University of Newcastle
Masters Degrees	
Annette Vasey Psychologist Community Forensic Outreach Service	M Mental Health Family Therapy The University of Queensland
Amy Strong, Nursing TPCH CMHT	M Counselling, University of Sunshine Coast
Jessica Waine, Occupational Therapy HHOT	M Mental Health Practice, Griffith University
Emma Ashe, Social Work RBWH CMHT	M Counselling, Queensland University of Technology Use of constructive therapies such as narrative therapy with mental health consumers.
Kylie Garrick, Director Allied Health, MNMH	M Psychology (organisational) Griffith University The Employee Experience of Peer Support in a Mental Health Context.
Natalie Avery, Psychology, MNMH-TPCH	M Psychology (clinical) Charles Sturt University The role of psychologists in addressing physical health needs of people with Severe Mental Illness
Patricia Bicevskis, TPCH Secure Mental Health Rehab Unit	M Forensic Mental Health, Griffith University
Doctor of Psychology (Clinical)	
Anne Gordon, Psychology INBMHS	Griffith University A randomised wait-list control community study of Social Cognition and Interaction Training (SCIT) for people with schizophrenia
Annette Vasey, Psychologist, CFOS	Annette Vasey, Psychologist, CFOS

PhD	
Fiona Davidson **Research and Evaluation Officer** **Queensland Forensic Mental Health Service**	The University of Queensland A comparison of court liaison and court diversion services throughout Australia for people with mental disorders.
Shane Rebgetz **Psychologist/Team Leader RedCab CYMHS**	Queensland University of Technology 'Natural Recovery of Cannabis Use and Psychosis' yes
Ed Heffernan, Director, **Queensland Forensic Mental Health Service**	The University of Queensland Mental health of Aboriginal and Torres Strait Islander people in custody
Melanie Mitchell, Psychologist, **Community Forensic Outreach Service**	The Queensland University of Technology Precursors to violence in people with a mental illness who threaten violence.
Lucianne Palmquist, Psychologist, Red/Cab CYMHS	Griffith University Recovery in young people using CYMHS.
Elke Perdacher, Co-ordinator Post Grad Program Qld Forensic Mental Health Service	The University of Queensland Utility of the Android tablet PC app. adaptation of the AIMHi Stay Strong Plan with Aboriginal and Torres Strait Islander women in custody.
Bjorn Burgher, Psychiatric Registrar	The University of Queensland Microglial activation in early onset psychotic disorders
Dylan Flaws, Psychiatric Registrar MNMH-TPCH	Decision aid derivation methods for the Acute Coronary Syndrome Pathway
Professional Doctorate	
Kimina Andersen, A & TSI Program Director, Mental Health	University of New South Wales Forensic Mental Health and Aboriginal and Torres Strait Islander people

Supervision of post graduate students by MNMH Staff

Sue Patterson	
Natalie Avery, Psychologist, TPCH	Charles Sturt University The role of psychologists in addressing physical health needs of people with Severe Mental Illness accessing public Mental Health Services
Lucianne Palmquist Psychologist Red/Cab CAMHS	Griffith University A grounded theory explanation of Adolescent 'Recovery': CYMHS consumer perspectives.
Lucien Lloyd-West	Griffith University Optimising the efficiency of groups in mental health care

Supervision of post graduate students by MNMH Staff con't

Ed Heffernan	
Fiona Davidson University of Queensland	A comparison of court liaison and court diversion services throughout Australia for people with mental disorders.
Niall Higgins	
Peter Carr **Co-Supervisors: Profs Claire Rickard & Marie Cooke**	Griffith University Risk Factors for peripheral intravenous cannula insertion failure in the Emergency Department: The VADER Study
Michael Breakspear	
Matt Hyett, University of New South Wales	Attention and inference in melancholic depression PhD conferred 2015
Kartik Iyer, The University of Queensland	Novel methods for predicting outcome in neonates from electroencephalographic recordings. PhD conferred 2015
Anton Lord, The University of Queensland	Biometric markers for affective disorders PhD conferred 2015
Phil Mosley, The University of Queensland	University of Queensland Neurobiology of impulsivity in Parkinson's Disease
Matt Aburn, The University of Queensland	Computational neuroscience
Justin Chapman, The University of Queensland	Physical activity in mental illness
Jonathon Robinson, Queensland University of Technology	Predictive coding errors in schizophrenia
Megan Campbell, The University Of Queensland	Functional anatomy of human mirror system
Saurabh Sonkusare, The University of Queensland	Interoception in depression
Mark Daglish, Jason Connor & Matt Gullo	
Bonnie Law	PhD / MBBS UQ, Interactions between mood, stress & alcohol dependence
James Scott	
Carina Capra PhD, Queensland University of Technology	Measuring, understanding and reducing psychotic-like experiences (PLEs) in young people (2011-2015)
Holly Erskine, The University of Queensland	The epidemiology of conduct disorder and implications for interventions (2013-2016)
Natalie Mills, The University of Queensland	The role of cytokines in depression and cognition in adolescents
Hannah Thomas, The University of Queensland	Beyond the classroom and into the cyber world, next generation research into adolescent bullying
Thy Meddick, The University of Queensland	Exploring family mental health as predictors of children's education and vocational outcomes across the lifespan
Rebecca Banney, The University of Queensland	Specific language impairment across the lifespan: A retrospective and prospective study

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

Dissemination activites

Peer Review Publications

1. Alexandrou E, Ray-Barruel G, Carr P, Frost S, Inwood S, Higgins N, Francis L, Alberto L, Mermel L & Rickard C (2015) International Prevalence of the Use of Peripheral Intravenous Catheters. *Journal of Hospital Medicine*, 10 (8): 530-533.

2. Andreasen N...Byrne G et al., , (2015) First Administration of the Fc-Attenuated Anti-beta Amyloid Antibody GSK933776 to Patients with Mild Alzheimer's Disease: A Randomized, Placebo-Controlled Study. *PLoS One*, 10 3:. doi:10.1371/journal.pone.0098153

3. Brunton G, Ward W (2015) A handbook for junior doctors on the medical management of eating disorders on an inpatient unit. *Journal of Eating Disorders* 2015, 3(S1):O5.

4. Barron L, Ward W (2015) Prevention of hypokalaemia in bulimia nervosa. *Journal of Eating Disorders* 2015, 3(S1):O61

5. Barron L, Barron R, Johnson J, Ward S, Wagner I, & Ward W (2015) Significant nutritional variables in patients with eating disorders. *Journal of Eating Disorders*, 3(S1):O62.

6. Baxter AJ, Brugha TS, Erskine HE, Scheurer RW, Vos T & Scott JG (2015) The epidemiology and global burden of autism spectrum disorders. Psychol Med ; 45(3):601-13

7. Boonstra TW, Danna-Dos-Santos A, Xie HB, Roerdink M, Stins JF, Breakspear M (2015) Muscle networks: Connectivity analysis of EMG activity during postural control. *Scientific Reports* 5: 17830.

8. Breakspear M, Roberts G, Green MJ, Nguyen VT, Frankland A, Levy F, Lenroot R, Mitchell PB (2015). Network dysfunction of emotional and cognitive processes in those at genetic risk of bipolar disorder. *Brain*, 138: 3427-3439.

9. Capra C, Kavanagh DJ, Hides L, & Scott JG (2015) Subtypes of psychotic-like experiences are differentially associated with suicidal ideation, plans and attempts in young adults. *Psychiatry Res,* 228(3), 894-898.

10. Capra C, Kavanagh DJ, Hides L, & Scott JG (2015) The Current CAPE-15: A measure of recent psychotic-like experiences and associated distress. *Early Interventions in Psychiatry* doi:10.1111/eip.12245.

11. Cheah SY, Lawford BR, Young RM, Morris CP, Voisey J (2015) Dysbindin (DTNBP1) variants are associated with hallucinations in schizophrenia. *European Psychiatry*, 30:486-491. doi:10.1016/j.eurpsy.2015.01.008. PMID: 25697573

12. Cheah SY, Lawford BR, Young RM, Morris CP, & Voisey J (2015) Association of NOS1AP variants and depression phenotypes in schizophrenia. *Journal of Affective Disorders*, 188:263-269. doi:10.1016/j.jad.2015.08.069

13. Cocchi, L, Sale MV, Lord A, Zalesky A, Breakspear M, Mattingley JB (2015) Dissociable effects of local inhibitory and excitatory theta-burst stimulation on large-scale brain dynamics. *Journal of Neurophysiology*, 113: 3375-3385.

14. Creed PA, Hood M, Praskova A & Makransky G (2015) The Career Distress Scale: Using Rasch Measurement Theory to Evaluate a Brief Measure of Career Distress. *Journal of Career Assessment*, doi:10.1177/1069072715616126

15. Davidson F (2015) Mental Health Liaison and Diversion: Court Liaison Services and Mental Health Court Programs in Australia. NHMRC Centre for Research Excellence in Offender Health. www.offenderhealth.net.au/sites/default/files/Mental%20Health%20and%20Diversion%20National%20Report.pdf

16. Dissanayaka, N White E, O'Sullivan E ... Byrne G (2015) Characteristics and Treatment of Anxiety Disorders in Parkinson's Disease. *Movement Disorders Clinical Practice*, 22: 155-162. doi:10.1002/mdc3.12157

17. Duhig M, Patterson S, Connell M, Foley S, Capra C, Dark F, Gordon A, Singh S, Hides L, McGrath JJ, & Scott JG (2015). The prevalence and correlates of childhood trauma in patients with early psychosis. *Australian and New Zealand Journal of Psychiatry*, 49: 651-9. doi:10.1177/0004867415575379

18. Erskine D, Baumgartner B & Patterson S (2015) Implementation and impact of an Extended Hours Service in Mental Health Care: Lessons Learned from a mixed-methods evaluation. Australian Health Review,. doi. org/10.1071/AH15007

19. Erskine HE, Moffitt TE, Copeland WE… & Scott JG (2015). A heavy burden on young minds: the global burden of mental and substance use disorders in children and youth. *Psychological Medicine*, 45(7):1551-1563.

20. Every-Palmer S, Barry-Walsh J, Pathe M (2015) Harassment, stalking, threats and attacks targeting New Zealand politicians: a mental health issue. *Australian and New Zealand Journal of Psychiatry*, 49: 634-641. doi: 10.1177/0004867415583700

21. Ferro MA, Boyle MH, Alati R, Scott JG & Dingle K (2015) Maternal psychological distress mediates the relationship between asthma and physician visits in a population-based sample of adolescents. *The Journal of asthma* : official journal of the Association for the Care of Asthma. 2015;52(2):170-5.

22. Fornito A, Zalesky A, Breakspear M (2015) The connectomics of brain disorders. *Nature Reviews Neuroscience*, 16: 159-172.

23. Forouzanfar MH, Alexander L, Anderson HR, Bachman VF, Biryukov S, Brauer M, Scott JG et al., (2015) Global, regional, and national comparative risk assessment of 79 behavioural, environmental and occupational, and metabolic risks or clusters of risks in 188 countries, 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. Lancet (London, England); 386(10010):2287-323.

24. Gardiner P, Byrne G, Mitchell L & Pachana N (2015) Financial capacity in older adults: a growing concern for clinicians. *Medical Journal of Australia*, 202 2: 82-85. doi:10.5694/mja14.00201

25. Gladman B, Waghorn G, Wishart L & Dias S (2015) Reliability of Health Professionals Perceptions of Employment for People with Severe Mental Illness. *Journal of Rehabilitation*, 81: http://www.readperiodicals.com/201501/3653060651.html

26. Gollo LL, Zalesky A, Hutchinson, RM, van den Heuvel M & Breakspear M. (2015) Dwelling quietly in the rich club: Brain network determinants of slow cortical fluctuations. *Philosophical Transactions of the Royal Society* B. 370: 20140165.

27. Goulter N, Gardner G & Kavanagh D (2015) What keeps nurses busy in the mental health setting? *Journal of Psychiatric and Mental Health Nursing*, 22: 449-456.

28. Graham RK, Parker GB, Breakspear M & Mitchell PB (2015) Clinical characteristics and temperament Influences on euphoric and irritable bipolar hypo/manic mood states. *Journal of Affective Disorders*, 174: 144–149.

29. Guo, CC, Hyett MP, Nguyen VT, Parker G & Breakspear M (2015) Out-of-sync: Disrupted neural activity in emotional circuitry during film viewing in melancholic depression. *Scientific Reports*, 5: 11605.

30. HanleyD (2015) The journey. *Schizophrenia Bulletin* doi:10.1093/schbul/sbu145

31. Harding IH, Harrison BJ, Pantelis C, Yücel M& Breakspear M (2015) Effective connectivity within the frontoparietal control network differentiates cognitive control and working memory. *NeuroImage*, 106: 144-153.

32. Hay P, Galletly C, Carter G, …& Ward W (2015) The 2014 RANZCP clinical practice guidelines for eating disorders. *Australian and New Zealand Journal of Psychiatry*, 48(S1):30-31.

33. Heffernan E, Davidson F, Andersen K & Kinner S (2015) PTSD among Aboriginal and Torres Strait Islander people in custody in Australia: prevalence and correlates. *Journal of Traumatic Stress*, 28(6):523-30. doi: 10.1002/jts.22051

34. Heffernan E, Andersen K & Kinner S (2015) Enhancing research quality through cultural competence: a case study in Queensland Prisons. *Australasian Psychiatry*, 23(6):654-7. doi: 10.1177/1039856215609763

35. Heitmann S, Boonstra TW, Gong P, Breakspear M & Ermentrout B (2015) The rhythms of steady posture: Motor commands as spatially organized oscillation patterns. *Neurocomputing*, 170:3-14.

36. Henderson S ...Byrne G, ... & Malhi G (2015) Why academic psychiatry is endangered. *Australian and New Zealand Journal of Psychiatry*, 49 1: 9-12. doi:10.1177/0004867414563453

37. Henry JD, Moses E, Castellini J, & Scott J (2015) Mental health problems in adolescence and the interpretation of unambiguous threat. *PloS One*, 10(6), doi:10.1371/journal.pone.0127167

38. Hides L, Limbong J, Vallmuur K, Barker R, Daglish M, & Young R (2015) Alcohol-related emergency department injury presentations in Queensland adolescents and young adults over a 13-year period. *Drug and Alcohol Review*, 34:177-184. doi:10.1111/dar.12218

39. Higgins N, Keogh S, & Rickard C (2015) Evaluation of a pilot educational program on safe and effective insertion and management of peripheral intravenous catheters. *Journal of the Association for Vascular Access*, 20: 37-42. doi:10.1016/j.java.2014.12.001

40. Hyett MP, Breakspear M, Friston KJ, Guo, CC & Parker G (2015) Disrupted effective connectivity of cortical systems supporting attention and interoception in melancholia. *JAMA Psychiatry*, 72: 350-358.

41. Hyett MP, Breakspear M, Friston KJ, Guo, CC, & Parker G (2015) The insula state of melancholia: Disconnection of interoceptive and attentional networks. *JAMA Psychiatry*.

42. Iyer KK, Roberts JA, Hellström-Westas L, Wikström S, Hansen-Pupp I, Ley D, Vanhatalo S, Breakspear M (2015) Cortical burst dynamics predict clinical outcome early in extremely preterm infants. *Brain*, 138: 2206-2218.

43. Iyer KK, Roberts JA, Hellström-Westas L, Wikström S, Hansen-Pupp I, Ley D, Breakspear M & Vanhatalo S. (2015) Early detection of preterm intraventricular hemorrhage from clinical electroencephalography. *Critical Care Medicine* 43: 2217-2227.

44. Liu, X... Byrne G, Martin J, & Whiteford H (2015) The effects of Tai Chi in centrally obese adults with depression symptoms. Evidence-Based *Complementary and Alternative Medicine*, doi:10.1155/2015/879712

45. Lowry T, Pathe M, Phillips J, Haworth D, Mulder M & Briggs C (2015) Harassment and other problematic behaviours experienced by the staff of public office holders. *Journal of Threat Assessment and Management*, 2: 1-10.

46. McGrath J, Alati R, Clavarino A, Williams G, Bor W, Najman J, Connell M, Scott JG (2015) Age at first tobacco use and risk of subsequent psychosis-related outcomes: A birth cohort study. *Australian and New Zealand Journal of Psychiatry* doi: 10.1177/0004867415587341

47. Malhi G ... Ward W, Zepf F, Gray C, & Fagermo N. (2015) The 2014 RANZCP clinical practice guideline project and CPG for eating disorders. *Australian and New Zealand Journal of Psychiatry*, 48(S1):29-30.

48. Martin G, Thomas H, Andrews T, Hasking P & Scott JG (2015) Psychotic experiences and psychological distress predict contemporaneous and future non-suicidal self-injury and suicide attempts in a sample of Australian school-based adolescents. *Psychol Med*. 2015;45(2):429-37.

49. Mills NT...Scott JG, Martin NG, Montgomery GW, Wray NR & Vinkhuyzen, AA (2015) Heritability of Transforming Growth Factor-beta1 and Tumor Necrosis Factor-Receptor Type 1 Expression and Vitamin D Levels in Healthy Adolescent Twins. *Twin Res Hum Genetics*, 18: 28-35.

50. Miloyan, Beyon, Byrne, Gerard J. and Pachana, Nancy A. (2015) Threshold and subthreshold generalized anxiety disorder in later life. *American Journal of Geriatric Psychiatry*, 23 6: 633-641. doi:10.1016/j.jagp.2014.08.010

51. Moore S, Scott JG, Ferrari A, et al., (2015) Burden attributable to child maltreatment in Australia. *Child Abuse and Neglect*, 48: 208-220.

52. Moore S, Scott JG, Thomas HT, et al. (2015) Impact of adolescent peer aggression on educational achievement and employment in an Australian Cohort. *Journal of Adolescence*, 43: 39-49.

53. Murray CJ, Barber RM, Foreman KJ, Abbasoglu Ozgoren A, Abd-Allah F, Abera SF, Scott JG et al., (2015) Global, regional, and national disability-adjusted life years (DALYs) for 306 diseases and injuries and healthy life expectancy (HALE) for 188 countries, 1990-2013: quantifying the epidemiological transition. *Lancet* (London, England). 386(10009):2145-91.

54. Naghavi, M …. Scott JG et al., (2015) Global, regional, and national incidence, prevalence, and years lived with disability for 301 acute and chronic diseases and injuries in 188 countries, 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. *Lancet* (London, England) ;386(9995):743-800.

55. Naghavi M,…Scott JG,… et al. (2015) Global, regional, and national age-sex specific all-cause and cause-specific mortality for 240 causes of death, 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. *The Lancet*, 385, 117-171. doi:org/10.1016/S0140-6736(14)61682-2

56. Najman JM, Alati R, Bor W, Clavarino A, Mamun A, McGrath JJ, McIntyre D, O'Callaghan M, Scott J, Shuttlewood G, Williams, GM, & Wray N (2015) Cohort Profile Update: The Mater-University of Queensland Study of Pregnancy (MUSP). *International Journal of Epidemiology* 2015, 44, 78-78f.

57. Nguyen VT, Breakspear M, Hu X & Guo CC (2015) The integration of the internal and external milieu in the insula during dynamic emotional experiences. *NeuroImage* 124: 455-463.

58. Patel V… Scott J, Shidhaye R, Vijayakumar L, Thornicroft G, Whiteford H (2015) Addressing the burden of mental, neurological, and substance use disorders: key messages from Disease Control Priorities, 3rd edition. *The Lancet*. doi.10.1016/S0140-6736(15)00390-6

59. Pathé M, Haworth D, Lowry T, et al., (2015). Assessing and managing the threat posed by fixated persons in Australia. *Australian and New Zealand Journal of Psychiatry*, 26: 425-438. doi: 10.1177/0004867415581033.

60. Pathé M, Haworth D, Lowry T, Webster D, Winterbourne P, Mulder M, Emmerson B (2015) A model for managing the mentally ill fixated person at major events. *Australian and New Zealand Journal of Psychiatry*, 49: 610-615. doi:10.1177/0004867415581022

61. Patterson S, Darbyshire C, Counsel R, Duhig M, Higgins N, & Williams I (2015) Implementing music therapy on an adolescent inpatient unit: A mixed-methods evaluation of acceptability, experience of participation and perceived impact. *Australasian Psychiatry* 23(5, 556-560.

62. Patterson S & Goulter N (2015) A critical reflection on process of a collaborative inquiry in a mental health service. *Action Research*, 13(2): 141-153. doi:10.1177/1476750314555437

63. Patterson S, Waller D, Killaspy H & Crawford MJ (2015) Riding the wake: Detailing the art therapy delivered in the MATISSE study. *International Journal of Art Therapy*, 20:28-38. doi:10.1080/17454832.2014.993666

64. Paynter JM, Riley EP, Beamish W, Scott JG, Heussler HS (2015) Brief Report: An evaluation of an Australian autism-specific, early intervention programme. *International Journal of Special Education*, 30(2) 1-7.

65. Perry A, Wen W, Lord A, Thalamuthu A, Roberts G, Mitchell M, Sachdev P, Breakspear M (2015) The organisation of the elderly connectome. *NeuroImage*, 114: 414–426.

66. Peusschers E, Twine J, Wheeler A, Moudgil V & Patterson S (2015) Documentation of medication changes in inpatient clinical notes: an audit to support quality improvement. *Australasian Psychiatry*, 23: 142-146. doi:10.1177/1039856214568215

67. Praskova A, Creed PA & Hood M (2015) The development and initial validation of a career calling scale for emerging adults. *Journal of Career Assessment*, 23:91-106. doi:10.1177/1069072714523089

68. Praskova A, Creed PA & Hood M (2015) Self-regulatory processes mediating between career calling and perceived employability and life satisfaction in Australian emerging adults. *Journal Career Development*. , doi:10.1177/0894845314541517

69. Praskova, A, Creed PA, & Hood M (2015) Career identity and the complex mediating relationships between career preparatory actions and career progress markers. *Journal of Vocational Behavior*, 87: 145-153. doi:10.1016/j.jvb.2015.01.001

70. Qi Y, & Breakspear M, Gong P (2015) Subdiffusive dynamics of bump attractors: Mechanisms and functional roles. *Neural Computation*, 27: 255-280. doi: 10.1162/NECO_a_00698

71. Rebgetz S, Hides L, & Kavanagh DJ (2015) Systematic analysis of changes in cannabis use among participants in control conditions of randomised controlled trials. *Addictive Behaviors Reports*, 1:76-80. doi:10.1016/j.abrep.2015.06.001

72. Rebgetz S, Hides L, Kavanagh DJ, & Choudhary A (2015) Natural recovery from cannabis use in people with psychosis: a qualitative study. *Journal of Dual Diagnosis*, 11:179-183. doi:10.1080/15504263.2015.1100472

73. Rebgetz S, Kavanagh DJ, & Hides L (2015) Can exploring natural recovery from substance misuse in psychosis assist with treatment? A review of current research. *Addictive Behaviors*, 46: 106-112. doi:10.1016/j.addbeh.2015.03.006

74. Roberts JA, Boonstra TW & Breakspear M (2015) The heavy tail of the human brain. *Current Opinion in Neurobiology*, 31: 164–172.

75. Sanders S, Flaws D, Than M, Pickering J, Doust J, Glasziou P (2015) Simplification of a scoring system maintained overall accuracy but decreased the proportion classified as low risk. *Journal of Clinical Epidemiology*, doi: 10.1016/j.jclinepi.2015.05.006

76. Sarris J... Byrne G, Ng C& Mischoulon D (2015) An adjunctive antidepressant nutraceutical combination in treating major depression: study protocol, and clinical considerations. Advances in Integrative Medicine, 2: 49-55. doi:10.1016/j.aimed.2015.02.001

77. Savage K, Stough C, Byrne G, et al., (2015) Kava for the treatment of generalised anxiety disorder (K-GAD): study protocol for a randomised controlled trial. Trials, 16: 1-13. doi:10.1186/s13063-015-0986-5

78. Scanlan JN, Argent S, Ayling B, Mouawad A & Woodward M (2015) The development and pilot testing of an occupational therapy group participation rating scale for inpatient mental health settings. Australian Occupational Therapy Journal, 62 333-340.

79. Sinclair B, Hansell N, Blokland G, Martin N, Thompson PM, Breakspear M, ..., McMahon K (2015) Heritability of the network architecture of intrinsic brain functional connectivity. NeuroImage, 121: 243-252.

80. Thomas E, Spittal M, Heffernan E, Taxman F, Alati R & Kinner S (2015) Trajectories of psychological distress after prison release: implications for mental health service need in ex-prisoners. Psychological Medicine, 46:611-21. doi: 10.1017/S0033291715002123

81. Thomas HJ, Connor JP, Scott JG. (2015) Integrating Traditional Bullying and Cyberbullying: Challenges of Definition and Measurement in Adolescents – a Review. Educational Psychology Review, 27:135-152.

82. Valenzuela MJ, Turner AJF, Kochan N, Wen W, Suo C., Hallock H, McIntosh AR, Sachdev P, & Breakspear M (2015) Posterior compensatory network engagement in cognitively intact elders with hippocampal atrophy. Hippocampus, 25: 581-593. doi: 10.1002/hipo.22395

83. Vos T, Barber R, Bell B,....Scott JG et al., (2015) Global, regional, and national age-sex specific all-cause and cause-specific mortality for 240 causes of death, 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. Lancet (London, England);385(9963):117-71.

84. Ward W, Silburn P, Marsh R, Randall C, & Mosley P (2015) Establishing a deep brain stimulation trial for patients with anorexia nervosa. Australian and New Zealand Journal of Psychiatry, 48(S1):14-15.

85. Wockner LF, Morris CP, Noble EP, Lawford B, Whitehall VL, Young RM, & Voisey J (2015) Brain-specific epigenetic markers of schizophrenia. Translational Psychiatry, 5:e680. doi:10.1038/tp.2015.177

86. Zalesky, A, Breakspear, M (2015) Towards a statistical test for functional connectivity dynamics. NeuroImage, 114: 466-470.

87. Zepf F, Hay P, Touyz S, Ward W (2015) Eating disorders bench to bedside: new findings and novel directions. Australian and New Zealand Journal of Psychiatry, 48(S1):13.

Books

1. *Heffernan E, Andersen K, Davidson F, Kinner S (2015) The Family Business - Improving the understanding and treatment of Post Traumatic Stress Disorder among incarcerated Aboriginal and Torres Strait Islander Women. Melbourne, AUS: Beyond Blue.*

Book chapters

1. Lingford-Hughes A & Daglish M (2015) Drugs of Abuse. In Anderson I & McAllister-Williams H (Eds.), *Fundamentals of Clinical Psychopharmacology* (Fourth Edition), CRC Press.

2. Patel V, Chisholm D, Parikh R, Charlson F, Degenhardt D, Dua T, Ferrari A, Hyman S, Laxminarayan R, Levin C, Lund C, Medina-Mora ME, Petersen I, Scott J, Shidhaye R, Vijayakumar L, Thornicroft G, & Whiteford H (2015) Chapter 1 in In Disease Control Priorities (third edition): Volume 4, Mental, Neurological, and Substance Use Disorders, edited by V. Patel, D. Chisholm, T. Dua, R. Laxminarayan, and M. E. Medina-Mora. Conference edition. Washington, DC: World Bank.

3. Pathé MT (2015) Stalking Public Figures: The Fixated Loner. In Petherick & Sinnamon (Eds.), *The Psychology of Crime and Antisocial behaviour.* Elsevier Science. (In press).

4. Robinson PA, Postnova S, Abeysuriya RG, Kim JW, Roberts JA, McKenzie-Sell L, Karanjai A, Kerr CC, Fung F, Anderson R, Breakspear MJ, Drysdale PM, Fulcher B, Phillips AJK, Rennie CJ, Yin G. (2015) A Multiscale "Working Brain" Model. "Validating Neuro-Computational Models of Neurological and Psychiatric Disorders", B. S. Bhattacharya and F. N. Chowdhury, eds. New York: Springer. Springer Series in Computational Neuroscience vol. 14, pp. 107-140.

5. Scott JG, Mihalopoulos C, Erskine HE, Roberts J, & Rahman A (2015) Child Developmental and Mental Disorders. Chapter 8 in "Disease Control Priorities (third edition): Volume 4, Mental, Neurological, and Substance Use Disorders," edited by V. Patel, D. Chisholm, T. Dua, R. Laxminarayan, and M. E. Medina-Mora. Conference edition. Washington, DC: World Bank.

6. Scott JG, Ross C, Dorahy M, Read J & Schäfer I (2015) Childhood Trauma in Psychotic and Dissociative Disorders, in Psychosis, *Trauma and Dissociation*. Moskowitz A, Schafer I & Dorahy M (Eds.). Wiley- Blackwell, West Sussex

Published peer reviewed abstracts

1. Bowler, B. and Boyle, C., (2015) 'Mental Health Nurses - empowering consumers to manage chronic disease: a motivational interviewing approach'. International Journal of Mental Health Nursing, 24 (S1): p2.

2. Collyer, B., (2015) '"Primum non nocere" or "To Do no Harm"'. International Journal of Mental Health Nursing, 24 (S1): p9.

3. Dalton, J. (2015) 'Successful strategies for building confidence in mental health care.' International Journal of Mental Health Nursing, 24 (S1): p12.

4. Dart, N., Fawcett, L., Kilshaw, M. and Meehan, T., (2015) 'Safewards Queensland: Back to the Future!!'. International Journal of Mental Health Nursing, 24 (S1): p13.

5. Fawcett, L., Dart, N. and Haworth, S., (2015) Deconstructing aggression with in Mental Health Services. Who will care?. International Journal of Mental Health Nursing, 24 (S1): p13.

6. Hatch, K., (2015) Too Busy to Be There? Supporting therapeutic relationships in the modern mental health unit'. International Journal of Mental Health Nursing, 24 (S1): p21.

7. Hall, K., (2015) 'An innovative approach to supporting undergraduate nursing students toward a career in mental health'. International Journal of Mental Health Nursing, 24 (S1): p19.

8. Higgins, N., Dart, N., Fawcett, L., Kilshaw, M. and Meehan, T., (2015) 'Introduction of the Safewards program in Queensland public hospital acute mental health settings'. International Journal of Mental Health Nursing, 24 (S1): p23.

9. Hiscox, C. and Higgins, N.' (2015) 'Embracing Safewards - Our experiences from the ward. ' International Journal of Mental Health Nursing, 24 (S1): p23.

10. Signorini R, Sheffield J, Rhodes N, Fleming C, Ward W: (2015) The effectiveness of enhanced cognitive behavioural therapy in an outpatient setting. *Journal of Eating Disorders*, 3(Suppl 1):O3.

11. Zalesky A, Fornito A, Cocci L, Gollo LL, & Breakspear M 2014, Time-resolved resting-state brain networks. *Proceedings of the National Academy of Sciences*, USA 11, pp.10341-10346.

Presentations at Conferences, Seminars, Workshops

1. Andersen K & Heffernan E (2015) The mental health of Indigenous Australians in custody: a public health challenge, Creating Futures, May 13, Cairns, 2015.

2. Black F, Fleming M, Keller S, Nugent T, Whitehead C, Craig-Jones C, & Heath A (2015) Mindfulness and madness: a Dialectical Behaviour Therapy (DBT) skills group in a secure mental rehabilitation unit. Presented at Australian and New Zealand Association for Psychiatry, Psychology and Law Conference, Canberra, 26 Nov 2015.

3. Breakspear M (2015) Hierarchical dynamics in prefrontal cortex. Systems and Computational Neuroscience Down Under. Brisbane, Australia

4. Breakspear M (2015) Network dysfunction of emotional and cognitive processes in those at genetic risk of bipolar disorder. Society for Mental Health Research. Brisbane, Australia

5. Breakspear M. (2015) Brain Waves. Keynote address. Organization for Human Brain Mapping. Hawaii, USA.

6. Dalton J (2015) Successful strategies for building confidence in mental health care. Presented at the ACMHN 41st International Mental Health Nursing Conference; Brisbane Convention Centre, October 7-9.

7. Darbyshire C (2015) Evaluating a music therapy program on an adolescent inpatient unit. Oral presentation at the 41st National Australian Music Therapy Association 2015 Conference, Sydney, 18-19 September.

8. Dart N. (2015) Safewards Queensland: Back to the Future!!. Presented at the ACMHN 41st International Mental Health Nursing Conference; Brisbane Convention Centre, October 7-9.

9. Denaro D, Watt B, & Hasan T (2015) The characteristics of targeted aggression in young people with co-occuring mental health and offending behavior. Presented at the Australian and New Zealand Association for Psychiatry, Psychology and Law Conference, Canberra, 26 Nov 2015.

10. Erskine D, Baumgartner B, & Ball B (2015) You Want to do What??? Community Commencement of Clozapine Treatment for a Person who is Homeless and Alcohol Dependent – Rising to the Challenge. Presented at The MHS Conference 2015, August, Canberra, Australia.

11. Flaws D (2015) Sensitivity, Specificity and receiver operator curves. Presented at The Prince Charles Hospital Psychiatry Statistics Workshop.

12. Green T & Gordon C (2015) From custody to community – developing culturally competent mental health services for Indigenous people in custody, May 13, Cairns, 2015.

13. Green B & Heffernan E (2015) Drug driven psychoses and legal responsibility in six Western Pacific Nations, Australia and New Zealand Association for Psychiatry, Psychology and Law Conference, 27 November, Canberra, 2015.

14. Hall K (2015) An innovative approach to supporting undergraduate nursing students toward a career in mental health. Presented at the ACMHN 41st International Mental Health Nursing Conference; Brisbane Convention Centre, October 7-9.

15. Hatch K (2015) Too Busy to Be There? Supporting therapeutic relationships in the modern mental health unit. Presented at the ACMHN 41st International Mental Health Nursing Conference; Brisbane Convention Centre, October 7-9.

16. Heffernan E, Clugston B, Perrin M, & Waterson E (2015) Rights, ethics, and system stress: the risks of involuntary care in Australian prisons, Australia and New Zealand Association for Psychiatry, Psychology and Law Conference, 26 November, Canberra, 2015.

17. Heffernan E, Waterson E, Orschulok S, & Erskine D (2015) Mental health meets policing: the importance of communication, Australia and New Zealand Association for Psychiatry, Psychology and Law Conference, 27 November, Canberra, 2015.

18. Heffernan E & Andersen K (2015) Understanding trauma and PTSD from a mental health SEWB and cultural perspective, Creating Futures, May 13, Cairns, 2015.

19. Heffernan E (2015) Custody to community, Integrity and Integration in Healthcare Delivery. The 24th Annual RBWH Healthcare Symposium, 14 October, Brisbane, 2015.

20. Higgins N, Dart N, Kilshaw M, Meehan T (2015) Introduction of the Safewards program in Queensland public hospital acute mental health settings. Presented to: ACMHN 41st International Mental Health Nursing Conference; Brisbane Convention Centre, October 7-9.

21. Hiscox C & Higgins N (2015) Embracing Safewards - Our experiences from the ward. Presented at the ACMHN 41st International Mental Health Nursing Conference; Brisbane Convention Centre, October 7-9.

22. Iyer KK, Roberts JA, Hellström-Westas L, Wikström S, Pupp IH, Ley D, Vanhatalo S, Breakspear M (2015) Early statistical measures of EEG bursts indicate clinical outcomes in extremely preterm infants. 9th International Conference for Brain Monitoring and Neuroprotection in the Newborn, Cork, Ireland.

23. Jeffrey S (2015) RAVES – A Nutritional Management model for the eating disorders. Australia and New Zealand Academy for Eating Disorders (ANZAED) Conference: Riding the Waves to Recovery Surfers Paradise, Australia. 21-22 August 2015

24. Jeffrey S (2015) Friend or foe: food beliefs and weight management. Obesity, Personality and Psychiatric Illness (2015) Queensland Audit of Surgical Mortality (QASM) seminar – 'The OBESE Patient: every surgeon's dilemma! Making the best of this difficult situation', Brisbane.

25. Mitchell M (2015) Traversing the space between threats and violence, Australian Psychological Society Forensic Conference, April 18, Sydney, 2015.

26. Pathé M & Mulder M (2015) A joint police-mental health diversionary model for managing fixated persons at major events. European Network of Public Figure Threat Assessment Agencies, 29 June-1 July 2015. London, UK.

27. Pathé M (2015) Mental health practice in a terrorist age. Shifting Landscapes and New Horizons in Forensic Mental Health. 2015 Forensic Mental Health Forum, Brisbane.

28. Pathé M (2015) Fixation and Public Figure Harassment. A 1-day workshops in July and October 2015 (Perth, Canberra, and Melbourne).

29. Roberts JA (2015) Bursts in neonatal EEG as a marker of neurological outcome. Université d'Auvergne, France. 7 July 2015.

30. Roberts JA (2015) Cortical burst dynamics predict clinical outcome early in extremely preterm infants. QIMR Berghofer Scientific Retreat, Surfers Paradise, Australia. 4 Nov 2015 (Breakspear M)

31. Scott J, Mamun A, Najman J & McGrath JJ (2015) Increased maternal pre-pregnancy BMI is associated with offspring psychosis-related outcomes. 15th International Congress of Schizophrenia Research, Colorado Springs, Colorado. United States.

32. Scott J (2015) From consulting rooms to global research: Clinical psychiatrists who research. Royal Australian and New Zealand College of Psychiatrists (RANZCP) 2015 Congress, Brisbane Australia (Invited Keynote).

33. Scott J, Duhig M, Hides L (2015) The prevalence and correlates of childhood trauma in patients with early psychosis. Royal Australian and New Zealand College of Psychiatrists (RANZCP) 2015 Congress, Brisbane Australia (Oral Presentation).

34. Scott J (2015) Causes and Care of Anxiety in Adolescents. Association of Counsellors of Catholic Secondary Schools of Queensland (ACCSSQ) Annual Conference. (Invited Keynote)

35. Scott J (2015) Psychotic like experiences in the general community. Australasian Schizophrenia Research Conference (Invited Plenary Speaker)

36. Scott JG, Gillis D, Ryan A, Prain K, Newman M, Wong R, Blum S (2015) The prevalence of autoimmune encephalitis in patients presenting with first episode psychosis RBWH Health Care Symposium, Brisbane Australia.

37. Scott J (2015) Bullying in Australia, Prevention and Intervention Victorian State Branch Conference of the Royal Australian and New Zealand Colleage of Psychiatrists, Lorne, Victoria.(Keynote Speaker)

38. Scott J (2015) Barriers and Options in the Treatment of Schizophrenia in Australia, World Psychiatric Association International Congress, Taipei, Taiwan (Invited Speaker)

39. Scott J (2015) Preventing mental illness in Australian Children and Youth. Australasian Society for Mental Health Research, Brisbane Australia (Keynote Speaker)

40. Scott J, Mamun A, Najman J & McGrath JJ (2015). Increased maternal pre-pregnancy BMI is associated with offspring psychosis-related outcomes. Australasian Society for Mental Health Research, Brisbane Australia

41. Scott J (2015) Neural autoantibodies in psychosis. Lecture at the Lady Cilento Children's Hospital, Brisbane

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

43. Scott J (2015) Clinical Trials in Early Psychosis. Lecture at Prince Charles Hospital Grand Rounds, Brisbane (11/6/2015)

44. Scott J (2015) Clinical Trials in Early Psychosis. Lecture at Royal Brisbane & Women's Hospital Grand Rounds, Brisbane (23/6/2015)

45. Scott J (2015) Clinical Trials in Early Psychosis. Lecture at Lady Cilento Children's Hospital Grand Rounds, Brisbane (17/7/2015)

46. Scott J (2015) Auto immune encephalitis. A cause of psychosis. Secrets of your brain revealed: a research update. UQCCR Community Symposium, Brisbane (22/08/15)

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

48. Scott J (2015) Optimising recovery in persons with serious mental illness. Invited Workshop PsyAcademy II (Janssen Cilag), Sydney (24/10/15)

49. Scott J (2015) Psychotic like Experiences, Research and clinical applications UQCCR Seminar Series, Brisbane (29/10/15)

50. Scott J (2015) Psychosis – What is it and how is it treated? Unravelling Psychosis Consumer and Carer Conference, Brisbane (26/11/15)

51. Scott R (2015) GPS tracking devices – fear and loathing in the sunshine state. Presented at the Australian and New Zealand Association fir Psychiatry, Psychology and law Conference, Canberra, 27 Nov 2015.

52. Signorini R, Sheffield J, Rhodes N, Fleming F, & Ward W (2015) The effectiveness of enhanced cognitive behavioural therapy in an outpatient setting. Australia and New Zealand Academy for Eating Disorders (ANZAED) Conference: Riding the Waves to Recovery, Surfers Paradise, Australia. 21-22 August 2015.

53. Sonkusare S (2015) Probing the brain body interaction underlying natural emotional experience. QIMR Berghofer Annual Student Symposium, QIMR Berghofer, Brisbane, Australia. 10 July 2015 (Breakspear M)

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

55. Sonkusare S (2015) Probing the brain body interaction underlying natural emotional experience. QIMR Berghofer Annual Scientific Retreat, Marriott Surfer's Paradise Resort, Gold Coast, Australia. 4–5 November 2015 (Breakspear M)

56. Sonkusare S. (2015) Semantic Cognition: how we know what we know? The Early Career Researcher (ECR) seminar series, QIMR Berghofer Brisbane, Australia. 27 November 2015 (Breakspear M)

57. Sonkusare S. (2015) Contribution of posterior middle temporal gyrus and angular gyrus in semantic cognition. SCiNDU: Systems & Computational Neuroscience Down Under, Queensland Brain Institute (QBI), The University of Queensland, Brisbane, Australia. 15–17 December 2015 (Breakspear M)

58. Taylor M (2015) Sensory modulation for substance use disorders. Presented at the WOWS Drug and Alcohol Symposium, May.

59. Taylor M & Meredith P (2015) Supporting consumer self-management through staff education: The sensory approaches eLearning project. Presented at the 16th International Mental Health Conference, August, Gold Coast (Aug)

60. Taylor M & Meredith P (2015) Supporting consumer self-management through staff education: The sensory approaches eLearning project. Presented at the Asia Pacific Occupational Therapy Congress, New Zealand.

61. Taylor M (2015) What's sensory modulation got to do with it? Presented at Least Restrictive Practice Statewide Forum, Brisbane 2015.

62. Taylor M, Fitzgibbon C & O'Sullivan J (2015) Adopting a sensory lens to enhance functional outcomes. Presented at workshop and webinar, Occupational Therapy Australia, Brisbane 2015.

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

64. Ward W (2015) Obesity, Personality and Psychiatric Illness. Queensland Audit of Surgical Mortality (QASM) seminar – 'The OBESE Patient: every surgeon's dilemma! Making the best of this difficult situation', Brisbane.

65. Ward W (2015) Medical management of eating disorders across the developmental spectrum (Workshop co-facilitated with Associate Professor Susan Moloney). The 13th Annual Conference of the Australian and New Zealand Association for Eating Disorders, Gold Coast.

66. Ward W (2015) Managing eating disorders in 2015. Australian Doctor Mental Health Seminar, Brisbane.

67. Ward W (2015) Diabetes and eating disorders. Directions in Diabetes Meeting (funded by Eli Lilly), Melbourne.

68. Ward W (2015) Eating disorders and diabetes: a practical guide. Queensland Diabetes Centre, Mater Hospital, Brisbane.

69. Ward W (2015) Recognising eating disorders /healthy body image promotion in secondary schools. Statewide School-based Youth Health Nurses Conference, Brisbane.

70. Ward W (2015) What's new in managing eating disorders in medical ward settings. Consultation Liaison Advanced Trainee Academic Session. Pre-Congress Workshop, RANZCP 2015 Congress, Brisbane.

71. Ward W (2015) Cairns eating disorders GP information dinner. National Eating Disorders Collaboration Forum, Cairns.

72. Ward W (2015) An Overview of the Medical Management of Eating Disorders. Inaugural Sunshine Coast Eating Disorders Network Meeting, Mental Health Professionals Network, Buderim.

73. Young S, Patterson S & Praskova A (2015) Physical Health in Mental Health: Driving Best Practice from the Consumer Perspective. The MHS Conference 2015 August, Canberra, Australia.

74. Young S, Praskova A & Patterson S (2015) Physical Health in Mental Health: Consumer and Carer Perspectives. Presented at the 16th International Mental Health Conference, August 2015, Gold Coast, Australia.

Poster Presentations

1. Collyer B (2015) "Primum non nocere" or "To Do no Harm". Poster presentation-poster award at the 41st ACMHN International Mental Health Nursing (IMHN) Conference, Brisbane, 7-9 October.

2. Fawcett L, Dart N & Haworth S (2015) Deconstructing aggression with in Mental Health Services. Who will care?. The ACMHN 41st International Mental Health Nursing Conference; Brisbane Convention Centre, October 7-9.

3. Frydman S, Breakspear M (2015) LabNeuro – a Modular Neuroscience Platform for the Acquisition of Multi-Modal Biometric Data Sources. Organisation for Human Brain Mapping – Honolulu, USA.

4. Frydman S, Breakspear M (2015) LabNeuro – a Modular Neuroscience Platform for the Acquisition of Multi-Modal Biometric Data Sources. Brain Connectivity Workshop – UC San Diego, USA.

5. Gollo LL, Roberts JA, Breakspear M (2015) A phase transition in human brain connectivity. SCiNDU: Systems & Computational Neuroscience Down Under, Brisbane, Australia. 15-17 December 2015

6. Gollo LL, Zalesky A, Hutchison RM, van den Heuvel M, Breakspear M. (2015) Core-periphery hierarchy of cortical time scales. Human Brain Mapping; Honolulu, USA. 14-18 June 2015.

7. Gollo LL, Zalesky A, Hutchison RM, van den Heuvel M, Breakspear M (2015) Dwelling quietly in the rich club: brain network determinants of slow cortical fluctuations. Brain Connectivity Workshop; San Diego, USA. 10-13 June 2015

8. Gollo LL, Zalesky A, Hutchison RM, van den Heuvel M, Breakspear M (2015) Are rich club regions masters or slaves of brain network dynamics? Computational Neuroscience Meeting; Prague, Czech Republic. 18–23 July 2015

9. Gollo LL, Copelli M, Roberts JA. (2015) Optimal signal detection with neuronal diversity: balancing the gullible and the prudent neurons. Computational Neuroscience Meeting; Prague, Czech Republic. 18–23 July 2015 (Breakspear M)

10. Matias F, Gollo LL, Carelli P, Copelli M, Mirasso C. (2015) Reconstructing the directionality of coupling between cortical populations with negative phase lag. Computational Neuroscience Meeting; Prague, Czech Republic. 18–23 July 2015 (Breakspear M)

11. Nguyen VT, Breakspear M, Guo CC. (2015) Hierarchical processing of the insula cortex during naturalistic emotional audition. Brain Connectivity Workshop, San Diego, USA. 10-13 June 2015

12. Nguyen VT, Breakspear M, Guo CC. (2015) Hierarchical processing of the insula cortex during naturalistic emotional audition. Human Brain Mapping Conference, Hawaii, 14-18 June 2015.

13. Nguyen VT, Sonkusare S, Breakspear M, Guo CC. (2015) The role of the cerebellum in predictive coding during dynamic mental processes. SCiNDU: Systems & Computational Neuroscience Down Under, Brisbane, Australia. 15-17 December 2015

14. Roberts JA, Breakspear M (2015) Consistency-based thresholding of the human connectome. OHBM 2015, 21st Annual Meeting of the Organization for Human Brain Mapping, Honolulu, USA. 14-18 June 2015.

15. Roberts JA, Gollo LL, Breakspear M (2015) Metastable wave patterns on the human connectome. SCiNDU: Systems & Computational Neuroscience Down Under, Brisbane, Australia. 15-17 December 2015

16. Roberts JA, Perry A, Lord AR, Roberts G, Mitchell PB, Smith RE, Calamante F, Breakspear M (2015) The role of geometry in determining the connectome's network properties. Brain Connectivity Workshop 2015, San Diego, USA. 10-13 June 2015

Research Grants, Awards, & Fellowships

1. Belavy D, Van Zundert A, & Higgins, N, A trial of a vessel finder vs standard technique for peripheral placement of intravenous catheters. *The University of Queensland Academic Title Holder Research Fund*, $57,311.19.

2. Berk M, McGrath J, Dean O, Lapau W, Dodds S, Scott J, & Dark F, The efficacy of adjunctive Garcinia mangostana Linn (mangosteen) pericarp for the treatment of Schizophrenia: A double-blind, randomized, placebo controlled trial (2015-2018). *Stanley Medical Research Institute*, US$899,398.

3. Breakspear M, Guo CC et al. Prospective imaging study of ageing: Genes, brain and behaviour. *NHMRC* $6,465,000 (2015-2020).

4. Breakspear M, Guo CC, Using advanced brain imaging to guide the surgical treatment of refractory epilepsy, *QIMR Berghofer-Clinician Research* Project grant, $28,000 (2015).

5. Breakspear M, Meinzer M, Improving brain function in healthy and stroke populations by non-invasive brain stimulation, QED (Queensland-Emory) Alliance Project grant, $204,604 (2015-2016).

6. Breakspear M, James McDonnell Collaborative Award, US$3 million (2011-2015).

7. Breakspear M, Guo CC, Using advanced brain imaging to guide the surgical treatment of refractory epilepsy, *QIMR Berghofer-Clinician Research Collaboration Award*, $28.000 (2015).

8. Breakspear M, Meinzer M, Improving brain function in healthy and stroke populations by non-invasive brain stimulation, QED (Queensland-Emory) Alliance, $204,604 (2015-2016).

9. Burgher B, QIMR Berghofer Queensland Mental Health Research Alliance Research Fellowship, $70,000 (2015).

10. Childs S & Patterson S, Using the WRAP to promote self-management and reduce service use for people with severe mental illness. *Metro North Hospital and Health Service Innovation Fund*, $98,160.

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

12. Fawcett L, Dart N, Goulter N, Haworth S Chelemeshatty R, Wilkinson N, Gunasekara I & Rodgers T, Does the introduction of a validated risk assessment tool impact clinical practice, ward atmosphere and patient outcomes? *Queensland Health Nursing and Midwifery Research Fellowship*, $100 ,000.

13. Flaws D, AusHSI top-up research scholarship, $30,000 (2013-2015).

14. Flaws D, Queensland Health Junior Research Fellowship, $250,000 (2015-2018).

15. Fleming C , Collaborative for Allied Health Research, Learning and Innovation MNHHS (CAHRLI) Innovation Fund 2015-2016. Eating Disorders Outreach Service Family LINK-ED Project, $10 255.

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

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

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

19. Heffernan E, The Family Business – Improving the Understanding and Treatment of Post Traumatic Stress Disorder among incarcerated Aboriginal and Torres Strait Islander Women, Beyond Blue competitive research grant, $255,000 (2014-2016).

20. Mihalopoulos C, Richardson J, Scott JG, Viney R, Brazier J, & Chen G, Determining the Best Outcome Measures for Assessing Cost-Effectiveness of Interventions for Childhood Mental Disorders, NHMRC Project grant, $473,837.

21. Patterson S, Chan R, Scott J & McGrath J, Recruitment to randomised controlled trials in cancer care and mental health: Comparative case studies. *Royal Brisbane and Women's Hospital Research Project Fund*, $40,000.

22. Sarris J, Stough C, Byrne GJ, Scholey A, & Bousman CA, Kava for the treatment of generalized anxiety disorder: a 16-week double-blind RCT. NHMRC ID 1063383. 2014-2016, $658,539.

23. Sarris J, Schweitzer I, Stough C, Bousman CA, Byrne GJ, The efficacy of adjunctive S-Adenosyl Methionine (SAMe) versus a combination nutraceutical in clinical depression: A double-blind, randomised, placebo-controlled trial. *NHMRC ID 1048222, 2013-2015,* $768,098.

24. Scott JG, Clinical Practitioner Fellowship Prevention and Management of Youth Mental Illness , NHMRC Project grant, $334,258.

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

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

27. Wagner I, Strodel E, Ward W, & Painter E, Supporting Carers of Sufferers of Long Standing Anorexia Nervosa: A capacity-building strategy to engage extended family in support and respite. *Queensland Centre for Social Science Intervention (QCSSI)*, $22,000.

Other dissemination activities

Catalyst:
Diagnosing Depression, Tuesday 6 October 2015, Producer: Adam Collins. http://www.abc.net.au/catalyst/stories/4322226.htm

EurekAlert:
Earthquakes – an unexpected help in interpreting the brain activity of premature babies, 25 May, 2015. Credit: University of Helsinki. http://www.eurekalert.org/pub_releases/2015-05/uoh-e-a052515.php

UQ News:
Scanning Centre to transform disease research and treatment, 14 December, 2015 https://www.uq.edu.au/news/article/2015/12/scanning-centre-transform-disease-research-and-treatment