

METRO NORTH
MENTAL HEALTH RESEARCH REVIEW

2016



Integrating RESEARCH and practice

Cover Image by **Cary Davies**.

Cary Davies paints and draws using various mediums including water colour, ink, acrylic and oils. Cary uses diverse techniques to translate complex experiences, landscapes and beauty into simple forms, symbols and images. Inspired by nature and the spirit of the land, Cary says her art 'links my soul to my physical world. Relationships, experiences and my emotional reaction to them, are released when I paint'. Cary explains that her childlike figures such as the one on the cover allude to innocence and the inner child in us all.



**Queensland
Government**

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Metro North Hospital and Health Service

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

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

MNHHS is unique in that two of its hospitals - The Royal Brisbane and Women's and The Prince Charles Hospitals are tertiary/quaternary referral facilities, providing advanced highly specialist care for people from across the state and further afield. Dedicated units provide Public Health and Aboriginal and Torres Strait Islander health services. Oral health and mental health services are governed and provided by district wide directorates.

MNHHS strategic and operational documents articulate commitment to grounding practice in a culture of research education, learning and innovation. MNHHS aspires to being patient centred in research, competitive in national and international research funding and to nurture the next generation of researchers. To enable and support achievement world-class research, the

service has invested in establishment of a robust infrastructure including the MNHHS Research Office and Metro North HHS Collaborative for Allied Health Research, Learning and Innovation (CAHRLI).

The MNHHS Research Office

The Metro North Office of Research was established, in 2016, to support research endeavours across Metro North by providing access to research resources and education and to establish a Research Strategy which will be supported by investment and commitment by the HHS leadership. Soon after, the Metro North Research Excellence Awards were launched as an annual recognition of the valuable contribution research and our researchers play in advancing healthcare. Metro North will launch their inaugural Research Strategy in 2017, further placing research to allow our patients the best access in Australia to novel diagnostics, innovative therapeutics and advanced health services.

Collaboration for Allied Health Research, Learning and Innovation: CAHRLI

Established in 2014, CAHRLI is a network of allied health clinicians and researchers working to link research, learning and patient care, capitalising on existing to enhance capacity and output. CAHRLI is underpinned by principles of innovation and translation of research into practice. Membership is multidisciplinary and

inclusive of representatives from all Metro North facilities and services. CAHRLI has strong links with various research units within the service and a range of external stakeholders. Research leadership is provided through a sub-committee - the Allied Health Research Committee. This committee, establishes strategic direction and supports development of inclusive, integrated and equitable allied health research agenda across the Metro North HHS Allied Health community. The specific objectives of the group are to:

- enhance the profile of allied health research
- build capacity for allied health research
- facilitate the application of research into practice.

One of the mechanisms employed to achieve these objectives is provision of scholarships to support allied health clinicians to prepare for, and undertake research higher degrees. Three of these merit based scholarships have been awarded to MNMH clinicians (Carmel Fleming, Kathy Prentice and Lisa Wright - see pages 32 and 15).

Further information can be found in the Website: <https://www.health.qld.gov.au/metronorth>, Email: cahrl@health.qld.gov.au.

Metro North Mental Health

Metro North Mental Health (MNMH), a Clinical Directorate formed 1 July 2014, is accountable for provision of mental health services across the MNHHS catchment. With annual expenditure of \$172 million, MNMH employs 1130 full time equivalent staff. Around 3400 people are receiving services at any given time. During 2016 the service provided 413,303 occasions of service to 21,296 unique individuals; 3549 people had a total of 4990 admissions to inpatient units.

MNMH service employs a balanced model of care encompassing community, inpatient and support services, addressing needs across the lifespan. Assessment and treatment are provided through three area based services: The Inner North Brisbane Mental Health Services (INBMHS), The Prince Charles Hospital Mental Health Service (TPCHMHS) and Redcliffe-Caboolture Mental Health Service (RCMHS). While the mix and composition of teams varies, the three services encompass acute, continuing care and older persons' teams, and specialist consultation liaison teams which support medical units. INBMHS and TPCHMHS also have Mobile Intensive Rehabilitation Teams and dedicated Early Psychosis Services.

Community services are provided by multi-disciplinary teams based at Brisbane City, Fortitude Valley, Herston, Nundah, Chermside, Pine Rivers, Caboolture and Redcliffe, with outreach services to Kilcoy. Dedicated, specialised teams provide a range of interventions to target groups, including people needing short term intensive care and people with complex needs related to severe and enduring mental illness. A Perinatal Mental Health Team provides services to pregnant women and mothers across the HHS and the Homeless Health Outreach Team delivers care in the community to people who are homeless and experience mental illness.

Community services are linked to 334 inpatient beds comprising: 182 acute adult, 12 adolescent, 40 Secure Mental Health Rehabilitation, 60 Community Care, 24 long stay nursing home psycho-geriatric and 16 state-wide alcohol and drug

detoxification beds. Admissions to acute care inpatient units are made by consultant psychiatrists at The Royal Brisbane and Women's Hospital, The Prince Charles Hospital and Caboolture Hospital.

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

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

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

MNMH has invested substantially over the last decade in human and technological resources, building a robust research infrastructure, expertise and capacity. Research is increasingly integrated in the fabric of services. MNMH supports conjoint clinical academic appointments with various universities, actively encourage and support clinicians to

undertake post-graduate study and collaborate effectively with a range of stakeholders, locally, nationally and internationally. Staff across disciplines and service lines are working collaboratively to design and conduct research and support translation of evidence to practice.

The combined efforts and substantial expertise of researchers in dedicated and clinical positions have supported continuous increases in research and related activities within the service. Publications doubled in number 2009-2012 and have increased incrementally since, with an impressive 77, 79, 103, 106 and 132 peer-reviewed papers (along with multiple books/chapters) and 2012-2016. Conference presentations have risen exponentially from 25 in 2013 to 88 and 90 in 2015-16. Demonstrating increased engagement of staff in evaluation and dissemination of their work, many of these presentations are by clinicians and managers. In 2016, 36 staff were enrolled in post-graduate studies, MNMH researchers supervised 35 RHD students, 70 research/evaluation projects were being undertaken and grants held totalled more than \$35 million. Each year MNMH hosts research students and academics from universities across the world. The multiple robust collaborations, with universities, non-government agencies and consumers established by team members will ensure research within MNMH continues to flourish.

This review includes information about research performance indicators including publications, grants awarded, enrolment of staff in post graduate degrees and supervision of higher degrees by staff; it also includes stories of researchers and clinicians describing the various ways research can be integrated in practice and the experience of conducting research within the service. The purpose of the review is to give you a sense of the breadth and depth of research with which the service is involved, the creativity and motivation of staff and some insight into the experience of undertaking research related to mental health.

Foreword

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

Welcome to the fourth annual Metro North Mental Health Research Review. This review provides an opportunity to celebrate the commitment of staff across the service to embedding research in practice and practice in research and recognise the valuable contributions made to developing the evidence needed to improve care and outcomes for people affected by mental illness.



A/ Prof Brett Emmerson AM
(Executive Director MNMH)



Prof Michael Breakspear
(Chair MNMH Research Collaborative Committee)

As Executive Director of MNMH, and Chairperson of the MNMH Research Collaborative committee we are delighted to showcase the world-class work of clinicians and researchers working with MNMH. As evidenced by the impressive lists of publications other dissemination activities and grants 2016 has been yet another full and rewarding year for the service; research capability and capacity continue to grow.

We have noted previously the depth and breadth of research, evaluation and quality improvement activities in mental health. As you'll read in the review these activities range from 'bench' - (basic or discovery science) through translational research - at the 'bedside' - to population health; from brain systems to individuals, to families and society. Research within the service addresses mental health and physical and emotional wellbeing across the life span, from perinatal to older person's mental health. MNMH researchers are concerned with BIG data and individual experiences, with the process and outcomes of care and the structure and function of services. Some studies are exploratory or observational, using various methods to examine routine practice or implementation of a new service model, others involve testing cutting-edge interventions using sophisticated randomised controlled trial designs. Some studies are funded by prestigious grants – many are conducted by dedicated clinicians who go the extra mile to integrate research in practice, with in-kind support of the service. Whatever the method or topic, the activities are designed to contribute to the evidence needed to improve the services and outcomes for people affected by problems related to mental health.

A brief review of the stark statistics and impact of mental illness shows just why research in mental health is so important. (see opposite page) While figures and 'facts' such as these are shocking and quantify the economic costs they do not convey the immeasurable human suffering associated with mental illness. We are proud that our researchers and staff make the issue personal and work to reduce this suffering.

Given the diversity and ever increasing extent of activities, this review is necessarily an incomplete representation of activities and people involved in research and related activities across the service. In compiling the content we have focused on illustrating the importance of partnerships in development and implementation of the evidence needed to improve practice and the various ways research can be integrated in practice. We recognise that not all MNMH staff want to **be** researchers and the multiple demands on their time, but research is everybody's business; engagement in research of some kind in some way - as a critical consumer, participant or investigator is essential to improving the safety and quality of services and outcomes.

With warm thanks to all who have contributed, we commend this review to you and encourage you to get in touch with any of our researchers if you have any questions or ideas.

A handwritten signature in blue ink, appearing to read "Brett Emmerson".

Associate Professor Brett Emmerson AM

A handwritten signature in black ink, appearing to read "Michael Breakspear".

Professor Michael Breakspear

Prevalence, costs and impact of mental disorder

- In each 12 month period, one in five adults and almost 1 in 7 (14% or 560,000) 4–17 year old Australians experience a mental disorder
- Anxiety disorders are the most common conditions affecting around 14% of Australians annually
- Substance use disorders will be experienced by around 5% of Australians in any 12 month period; substance disorders are common among people experiencing other mental disorders
- Two in every hundred Australians will experience an eating disorder during their lifetime; incidence is 9 times more likely in girls and women, but rates are increasing among boys and men
- Around 3% of Australians are affected by disorders involving psychosis
- People with severe mental illness (psychotic disorders and major depression) are likely to die prematurely; estimates vary but lifespan is curtailed by around 20% or up to 32 years. The cost of comorbidities associated with premature death in those with serious mental illness is estimated at over A\$45.4 billion annually
- Estimated annual costs of psychosis for the Australian population in 2014 were approximately \$10.1 billion: of this A\$3.9 billion was government expenditure – the balance - A\$6.2 billion -was incurred by individuals and non-government organisations.
- Suicide accounted for 35% of deaths of females aged 15-24 in 2014
- Enduring mental disorder is associated with substantial impairment in social and occupational function, self-care and quality of life. People with severe mental disorder generally have fewer educational qualifications than the general population, are over represented in the unemployed, tend to be socio-economically disadvantaged, are more likely to be homeless and have increased risk of involvement with the criminal justice system.
- In Australia nearly three quarters (75%) homeless adults have a mental illness with around one third (approximately 29,000 people) affected by severe disorders. Around 40% of people in prison have a diagnosable disorder with 10–20% affected by psychotic disorders.
- The complex problems associated with psychotic disorders means people with these conditions often need many services, over a long period, consuming around 80% of Australia's spending on mental health care.
- The cost of the burden of serious mental illness, including opioid dependence, in 2014 Australia is estimated at A\$98.8 billion (6% of Australian GDP)

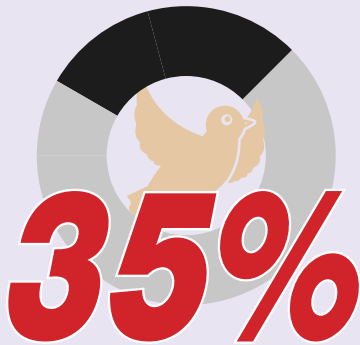
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In Australia nearly three quarters

(75%)

of homeless adults

have a mental illness.



of deaths of females aged 15-24 are suicide



one in five adults experience a mental disorder



Mental disorders:

3rd

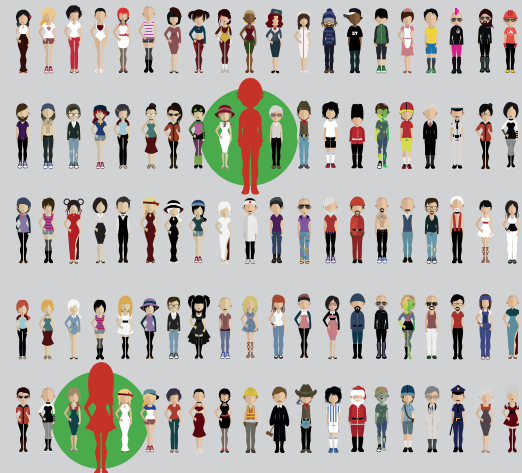
leading cause of disability burden in Australia.

Psychosis

affects **3%** of Australians

\$98.8 billion

The cost burden of serious mental illness



TWO IN EVERY HUNDRED AUSTRALIANS WILL EXPERIENCE AN EATING DISORDER

At a Glance



From the desk of the Principal Research Fellow – Mental Health

Sue Patterson

I've now been working as 'principal research fellow' with MNMH for over five years. Each of these years has been rewarding professionally and personally. I came to the role with wide-ranging experience of mental health services and systems (my life and career could be called well rounded or haphazard depending on perspective). My personal 'journey' had not been without its struggles; I had experience of 'hanging on in quiet desperation'¹ and close relationships with people affected in various ways by mental illness.

Trained as a psychologist I worked clinically and later in management of mental health services for many years. Having begun to critically question why things were done the way they were I found myself butting heads with bureaucracy and decided on change of direction. I moved to the UK and began researching the ways these complex systems work, how people interact within and with systems, and more particularly the divergent impacts treatment in mental health services has on people's lives. I came to appreciate Paul Batalden's observation that, "Every system is perfectly designed to get the results it gets" and that despite the rhetoric of evidence based medicine, that the nexus of research, policy and practice was anything but linear and that evidence is at best partial.

I developed an interest in the production and application of evidence and completed a PhD examining the complex socio-political factors shaping the conduct of research in mental health care before managing research for a national UK Charity. Wanting to return to Aus for family reasons I was delighted to get the job at Metro North. It has been a real privilege to work in various ways with consumers, clinicians, students, academics and a range of agencies and organisations to design and deliver research across the HHS and further afield.

I have learned much in my time with MNMH - most importantly, that there is always more to learn, for me personally and in relation to mental health and services. Today's 'evidence-based' answer is tomorrow's question. I've deepened my appreciation of the importance of multiple perspectives to research. Working within MNMH and with various stakeholders has highlighted the diversity of ways of knowing and the need for different types of 'knowledge' dependent on who is using it, to what end. I aim to approach my work with the view that there is no single 'truth' or right approach to addressing the diverse questions facing researchers and clinicians working in mental health – this is reflected in the scope, depth and breadth of research and related activities going on in MNMH.

The diversity and complexities of mental health services and research make my job both very interesting and difficult to describe. According to my job description my work is to 'promote a multidisciplinary research culture and a shared vision for quality service provision across the Metro North Mental Health (MNMH). To lead, support, encourage and coordinate service improvement activities including quality activities and research.' Brett says 'it's anything to do with research'. I know my work days are full (to overflowing) and I believe that what I do is contributing, in some small way to improvement in mental health care but because much of my 'product' is intangible and achieved through various social processes, I find it hard to articulate a clear answer to the question 'what do you do?'

Reflecting on this prompted me to record activities over the course of a week. Adopting what might loosely be described as an observational approach I collected data, (scrawls on bits of paper, notes in my outlook calendar) without a protocol. Reporting of activity is selective and limitations inherent in the method oblige caution in interpreting findings – reliability and generalisability are uncertain. Further research, using rigorous methods, is needed to develop a deeper and more comprehensive understanding of the role of principal fellows! Nonetheless should you wonder 'what does a principal research fellow do?' – or more particularly what does a particular research fellow do?, the account below may provide some insight.

Attend to emails

I receive around 100 a day, of various types. Several are phishing type invitations from editors of obscure journals unrelated to mental health who seek esteemed colleagues to submit their latest work for publication for a fee. (press delete) Others are messages of varying relevance from within the organisation, or from government advising of various events and opportunities, flagging new strategic directions or celebrating success. (read, press delete). A few are from marketing agencies – my email address is on some data base that's been sold (clearly, I didn't read the fine print) and a few more from various agencies advertising conferences or seminars. Occasionally emails advise of the acceptance or rejection of a paper submitted – the acceptances help me feel good about what I do, the rejections are mostly well justified and part of being a researcher is learning to live with critique – sometimes, however it seems unjust and I wander round feeling indignant for a while. The majority of emails are from colleagues about planned or ongoing studies or from people seeking advice or to make a time to explore

¹ Pink Floyd 'Dark Side of the Moon'

research ideas. Some bring particularly good news – today I receive advice that four of six applications for funding submitted to the RBWH Foundation in 2016 are successful. Congratulations to Niall Higgins, Dylan Flaws, Michael Breakspear and Chris Randall. Grants are formally awarded February 2017.

Peer review an article submitted to an International Nursing Journal.

Peer review generally, involves evaluation of scholarly work, research, or ideas by others who are considered peers or experts in the same field. Peer review is regarded as a critical process in the development and dissemination of 'evidence'. While reviews are inherently subjective in that they are informed by the opinions, experiences, knowledge and values of the 'peer' it provides some degree of quality assurance.

In my view, the article I was invited to review was generally well written, providing a comprehensive account a qualitative study of the experiences of mental health nurses working to deliver care consistent with the recovery paradigm with 'high risk' populations. The researchers identified a range of challenging situations within which nurses were challenged to promote personal responsibility and autonomy of people inclined to engage in behaviours commonly regarded as socially inappropriate. I recommend a minor revision – enhancing the explanation of the process of analysis and inclusion of critical reflection on the transferability of findings to other settings. I will receive a copy of the response sent to the authors including comments by other reviewers.

Peer review is a great way to learn about research and to become research active – Journals are always looking for reviewers –if you're interested check out the website of journals you like to read and make contact with the editor.

Work with a colleague to revise a paper on the basis of reviewers' comments. This is the other side of the coin. Imani Gunasekara, James Scott and I submitted a manuscript reporting a qualitative study designed to answer the question 'What makes an excellent mental health doctor?' (see page 10) for publication and were asked to consider reviewers' feedback and prepare a revision. This really innovative study was conceived and led by Imani who works as a consumer consultant within MNMH.

The paper is novel in that it represents a conversation between people who use services and psychiatrists, about the kinds of care received and desired. While a growing literature describes problems in relationships and communication between Doctors and consumers, and therapeutic alliance is widely recognised as critical to best outcomes, this is the first time that Doctors and Consumers have collaboratively contributed to development of a model of excellent practice. Consumer participants were recruited from inpatient and community settings within MNMH.

The reviewer has asked us to 'explain how the potential vulnerability of participants (consumers) was addressed – how they were assessed for capacity to participate and well enough to participate?

I feel conflicted about this. It's unlikely that a similar question would be asked if the participants had been health professionals – indeed the reviewer did not ask how we protected psychiatrists' from exploitation. I wonder why a different standard should apply – nonetheless it's important to choose 'battles' and getting the message of the paper out there is important. Rather than engage in a potentially extended debate with the reviewer about the ethical conduct of research and respect for autonomy, we respond by including a description of the process in the paper. We explain in research terms that Imani 'used her interpersonal skills, experience and common sense to gauge whether people were willing to engage in conversation at all and then whether they were able to make an informed decision about participation – we report that 'capacity to consent was assessed by checking understanding as the information sheet was reviewed and by asking participants to describe in their own words what they were being asked to do and why before formally inviting them to participate.

The paper was accepted for publication (see abstract on page 9) CONGRATULATIONS Imani!! For a copy of the paper please contact me or Imani on Imani.gunasekara@health.qld.gov.au

Draft a protocol for an evaluation of implementation of single session family work to enable provision of support to family and carers of people admitted to hospital for treatment of mental illness.

National Standards for Mental Health Services in Australia oblige services to recognise, respect, value and support the importance of carers to the wellbeing, treatment, and recovery of people with a mental illness, in various ways. Nonetheless, and despite evidence that carer-focused interventions can improve the experience of care and outcomes, attention to the needs and rights of carers is inconsistent and often ad-hoc across jurisdictions and within MNMH. Research, advocacy groups and personal accounts highlight the difficulties carers experience engaging with services and dissatisfaction with process and outcomes of engagement. Improving the ways services engage with carers has been identified as a priority for mental health services in Australia.

Because the proposed intervention – single-session family work is – well supported by evidence of effectiveness – that is we know it can work – the evaluation is concerned with finding out whether it can be delivered and is acceptable to people who might use the service in the MNMH setting. The protocol and supporting documents will be submitted to the Ethics committee for review before the study commences. Findings will inform decisions about implementation of the intervention beyond the pilot.

Discussion with colleagues about the linkages/ disjunctions between different components of the health and social care services/police and impact on patients. We draw on personal experiences and observations of the workings of the systems. If it's hard for clinicians and managers who 'know the system and language' to negotiate the politics and bureaucracy, we

wonder what it's like for consumers. We speculate about potential for a study into the interface between services and consumers' experiences of inter-agency working but there are so many studies of this already - whatever the services concerned, the same challenges to continuity of care and integration are identified. Internationally, policies advocate bringing together the fragmented services but political and funding cycles and vested interests in maintaining the status quo mitigate against the fundamental shifts required.

Review an application for ethical approval of a study examining communication within multi-disciplinary teams.

I joined the RBWH HREC early in 2012. Membership involves reviewing proposed studies according to the principles set out in the National Statement on Ethical Conduct in Research published by the NHMRC for monthly meetings at which studies are discussed. The RBWH

committee also offers an expedited – between meeting - review for studies involving low and negligible risk. Review involves first forming an opinion about the level of risk. Risk is considered negligible if there is no foreseeable risk of discomfort or harm and if there is any foreseeable risk, it will not be of more than inconvenience, for example completing a survey about non-sensitive topics such as how you travel to work. Risk is considered low when the only foreseeable risk is one of discomfort, such as that experienced in everyday life. The review also involves considering the values of respect, research merit and integrity, justice, and beneficence which underpin the National Statement. My review goes to the Chairperson who will consider my views, along with those of other reviewers and provide feedback to the researchers. It is worth noting that HRECs generally and the RBWH HREC in



particular exist to enable research – to work collaboratively with researchers. The RBWH committee welcomes contact from researchers planning studies and will support you to negotiate ethical and procedural issues.

In response to a request from the Exec Director, scan literature to answer the question 'Are people with mental illness more likely than the general population to receive treatment for traumatic injury?'

The short answer is 'probably'.... but it depends on how mental illness and traumatic injury are defined and inconsistency in coding of presentations obliges caution in interpretation of figures. The conclusion is 'more research is needed' – and that studies should be designed to enable understanding of the different types of trauma associated with mental illness and the circumstances leading to treatment.

Enter and analyse responses to questionnaires examining Psychiatrists' views regarding implementation of the Queensland Health Smoking Cessation Pathway in the service.

I learn that around 10% of 43 psychiatrists who responded to the survey smoke cigarettes and two of those want to quit. Psychiatrists agree that MH Services should ask, advise, assist consumers admitted to hospital to quit, that effective management of withdrawal during admission is important to getting the best outcomes, and that management of smoking and encouraging quitting is part of their role. They acknowledge some patients are interested in quitting. They disagree, however about whether MH services should confiscate cigarettes and the appropriateness of encouraging quitting during admission to a mental health ward.

Following ethical review, revise documents related to a study of work engagement and wellbeing of administrative and operational staff working in mental health. Specifically insert appropriate footers so that documents can be adapted for different sites and version control maintained. I'm excited about this study – while non-clinical staff are commonly exposed to the challenges associated with working in sometimes volatile mental health settings and are the face of the service, there has been very little work examining their experiences and needs. The study is designed to develop information that can be used to improve the work experiences and wellbeing of staff. We hope to extend the study to encompass clinicians and managers across MNMH>

Collate the Metro North Mental Health Research Review.

One of the many highlights of each of year is compiling the Mental Health Research Review – I am always impressed both by the depth and breadth of the work and the willingness of managers, clinicians and researcher to make time to provide information and share their stories. This year has been no exception – indeed it has been very difficult to contain the review – there is just so much happening in research.

My sincere thanks go to all who have contributed in various ways to this publication and to development of a flourishing research culture!

Thank You

Invitation

If you have any questions, would like more information about any of the research reported in the review or would like to get involved in research

please feel free to contact me on

susan.patterson@health.qld.gov.au

Translating evidence to practice

National standards for mental health services 2010

Standard 10 Delivery of care

10.5 Treatment and support The MHS provides access to a range of evidence based treatments and facilitates access to rehabilitation and support programs which address the specific needs of consumers and promotes their recovery.

Whilst medication is the mainstay of medical treatment of mental illness, it is not a panacea. Research suggests that any given anti-psychotic medication will 'work' for just one in four people to whom it is prescribed and often for a limited period of time. Even when medications ameliorate some symptoms, others may continue and side effects can be highly problematic. Just as in the general population, many people prescribed medication for mental illness do not take it as intended and a substantial proportion of those who do, experience difficulties in multiple life domains. The complexity of problems associated mental illness means a spectrum of care may be required at a given time or over time. Services are thus required to provide access to a various psychosocial interventions including psychological and occupational therapies to address the specific needs of consumers and promote their recovery. National standards for mental health services 2010 specifies that the interventions provided should be evidenced based. A range of interventions are supported by evidence and included in clinical guidelines but studies internationally demonstrate that evidence based interventions such as psychological therapies are inconsistently provided in public mental health services. Moreover, new interventions are likely to languish for 15–20 years before being incorporated into usual care. Bridging this 'translational' gap is a high priority internationally and locally.

THE CASE OF GROUP BASED PSYCHOTHERAPIES

Used broadly the term psychotherapy encompasses an array of interpersonal interventions aiming "to modify feelings, thought patterns, attitudes and behaviour". Psychological treatments is a more specific term applied to treatments employing particular strategies and techniques to address specific conditions or symptoms consistent with the goals of health services (Barlow, 2006).

Psychological treatments are distinguished, by three characteristics:

- Delivery by a trained professional to a person seeking help;
- Self-containment - a discrete intervention separable from other components of care; and
- Employment of theoretical model of human psychology or psychopathology as a framework to support application of specific techniques with the purpose of achieving desired goals.

Psychological treatments may be delivered to individuals or groups of people with a common 'interest'. Some psychological treatments are designed specifically as group interventions with 'the group' and interaction among members integral to the interventions and achievement of outcome. Group formats may also be selected pragmatically – it is generally considered more efficient to deliver interventions to groups than several individuals.

Despite evidence of effectiveness of a range of groups based psychological treatments and promotion, little research has been conducted into delivery in 'real world' mental health context. The limited research evidence available supports practice based knowledge that implementation is problematic. There is, it has been argued a lack of knowledge internationally about the utilisation of group based interventions of various types in mental health services and a pressing need to understand delivery of these interventions in real clinical situations.

Against this background researchers and clinicians from MNMH and Griffith University teamed up to examine the delivery of groups locally. First a mapping exercise was undertaken to enable a description of group therapies being provided in the service. This laid the foundation for a qualitative study of implementation of groups, examining factors perceived to enable or hinder use in the services.

A STUDY OF GROUP BASED PSYCHOTHERAPIES IN PUBLIC MENTAL HEALTH SERVICES

The qualitative study was conducted by Lucien Lloyd-West a Griffith University Psychology student for his honours thesis. Jointly supervised by A/Prof Sue Patterson (MNMH), and Prof Analise O'Donovan (Griffith), Lucien interviewed 18 management and clinical staff involved with the implementation of group-based psychological therapies within the service.

Analysis of interview data was informed by the Consolidated Framework for Implementation Research (CFIR). The CFIR (as described by developers³) “provides a menu of constructs that can be used in a range of applications – as a practical guide for systematically assessing potential barriers and facilitators in preparation for implementing an innovation, to providing theory-based constructs for developing context-specific logic models or generalizable middle-range theories”.

Two key barriers to implementation were identified: the predominance of the ‘medical model’ within services and the lack of structured processes to support planning and implementation. With any psychotherapy considered an ‘optional extra’ and ‘not core business’ the organisational culture was perceived as minimally supportive of group-based psychotherapies.

Psychologists in generic ‘case management’ roles reported that their capacity to apply discipline specific skills was constrained by high case loads and demands to manage risk and discharge consumers as quickly as possible.

‘In case management roles, it’s not always supported for clinicians to run groups, for time to be released, a bit of a cultural thing’

Many other clinicians reported similar challenges. Along with psychologists they noted that delivery of group psychotherapies required specialist skills not incorporated in most qualifying degrees. Engaging consumers in groups was commonly described as challenging for various reasons. To engage consumers needed to see the intervention as valuable to them, some needed practical (such as transport) or emotional support to interact with peers. When participants could be recruited, maintaining group numbers, particularly when interventions ran for several weeks was also seen as a barrier to effectiveness of groups. As described by one participant

‘I’m quite reluctant to run a group if we don’t have good numbers. If we have below four people I’d be thinking about whether that’s going to run partly because there’s a high chance that half the people won’t turn up.’

Managers were committed to providing the best care possible, generally supportive of groups and encouraged innovation but acknowledged that psychotherapies were not prioritised.

Nonetheless, 18 formal group based psychotherapy programs were provided in MNMH over 2015. These groups that were commonly initiated and led by highly motivated staff who believed in the interventions and made time (sometimes by working extra hours) to plan and deliver groups. Being persistent, feeling confident and having support from colleagues were regarded as critical to success. Clinicians spoke of needing to be prepared - in terms of not just the content but who’s going to say what... and to have a flexible approach to delivery:

‘I may have to change it, rather than do something that might require a higher level of ability or participation, I can shift it down a notch and try and engage people in a different, more appropriate way.’

With governance and evaluation of these groups informal and ad-hoc, little was known about outcomes and impact. Consensus was that a framework including governance processes and tools to support assessment of need, design and evaluation of groups would be helpful but it was emphasised that the processes should not be burdensome.

Findings are being disseminated in various ways. In addition to submission of the thesis (which received a high distinction), a report has been submitted to the MNMH executive, a summary of findings has been provided to participants and two papers are soon to be submitted to peer reviewed journals.



Lucien Lloyd-West

We asked Lucien about his experience conducting the study:

What was it like conducting a research project within Metro North Mental Health Service?

I was a research novice and entering a new environment so initially somewhat daunting. However, once I met Sue, the lead investigator, and she introduced me to colleagues, I quickly felt part of the research team. Everyone was welcoming and helpful and showed interest in what I was doing I learned how complex the mental health system is with so many different professionals working to provide care in what can be challenging circumstances. Sue's support and insider knowledge were important in getting the project going. She knew who I should talk to and facilitated contact so I could recruit participants. Her guidance about how the system works and the politics of mental health care was critical to my understanding what clinicians were telling me in interviews.

What worked well while you conducted this research?

Robust supervision and mentoring, and the helpfulness of all the people I interviewed. I literally knew nothing about qualitative research at the outset so Sue's qualitative research knowledge and skills, and ability to join the theoretical and practical elements of psychological science were important - she encouraged me to think critically about what I was doing and why, and to make sense of the different perspectives people brought to the study. She reminded me that this was real world research with potential to influence services and improve outcomes. This made it very much more than a study to get my degree completed. Analise's input was essential in keeping me on track with the process and enabling me to develop the interviewing skills and analytic skills I needed to complete the study. When I encountered substantial hurdles I was able to talk about them and both Sue and Analise gently guided me over or around them.

What did you find challenging about conducting this research?

Frankly, everything but it has been great for developing new skills.

Upon reflection I've realised that the biggest hurdles were the ones I constructed in my own mind each time I had to learn new skills. For example, I initially doubted my ability to conduct the qualitative interviews well – I was concerned about needing to be a 'good researcher' - and that got in the way of attending to the interview and participant.

The analysis of the qualitative data was really nothing like I had anticipated. I was worried about whether I would be able to do it but having a structured method and permission to think creatively helped. I remember finally 'getting over' my self-doubt when writing the discussion, more or less independently. I remember thinking well I'm just going to do the best I can, that will be enough.

Another challenging thing about conducting research in practical 'real world' settings with people doing their jobs is the need for consistent, critical thought in light of the research questions posed. (Is this where I talk about Sue's famous "So what" – meaning what difference would it make if we knew that information?).

I was challenged by the need to make significant research decisions because I was aware that the quality of my investigation might have a direct influence on the delivery of healthcare services.

What would you like to have known at the beginning of the project?

That it really wouldn't be as hard as I thought. Research is difficult; to make out otherwise would be wrong. I have a tendency to over think things, especially when doing something new and this meant I perhaps put excessive pressure on myself at times. I would have like to have known more about what I was searching for, but perhaps ambiguity and not knowing are needed for an exploratory qualitative study.

Do you have any advice for someone beginning a similar journey?

Yes! give yourself more time than you think you need. Begin tasks sooner rather than later. Look after your mental and physical health, be kind to yourself - Meditate, if you don't like meditation find an activity that takes you away from the research project periodically (for example cooking, exercise, singing, listening to music, making art). Do the very best you can and take pride in your work.

I would say to anyone who has the opportunity to work on a project within Metro North – Do it! You certainly will not regret the decision.

THE CASE OF SENSORY MODULATION

Humans are constantly receiving and processing information from within and from the environment through the five 'main' senses (touch, sight, hearing, taste, and smell) and two 'hidden' senses – proprioception (body awareness), and vestibular (movement and balance).

Management of sensory input involves both 'processing' and 'modulation'. Sensory processing refers to the way the nervous system receives messages from the senses, integrates them and turns them into appropriate motor and behavioural responses. Sensory modulation describes the processes involved in regulating and organising the degree, intensity and nature of responses to sensory input. An individual's capacity to modulate sensory input influences experience, behaviour and ability adapt to challenges in daily life. Generally, sensory modulation occurs outside awareness as people go about their day to day activities. Attention is typically paid when stimulation is 'too much' or 'too little' and if modulation strategies are inadequate, distress may result.

Research associates difficulties in sensory modulation and use of particular strategies to manage sensory input with a range of mental health conditions/ disorders including anorexia nervosa (over responsiveness to stimuli), bi polar disorder and schizophrenia (avoidance of sensory input and restricted sensory registration). Increasing evidence of the centrality of sensory integration and modulation in adaptive function and sensory problems among people with mental illness has supported development and deployment of a range of 'sensory' interventions in mental health care. Commonly managed and delivered by occupational therapists who have advanced training, these interventions might be designed to support/enable an individual to modulate experiences at a given time (for example in response to a distressing situation) and/or to develop self-understanding and strategies to regulate exposure and responses to stimuli, optimising sensory experiences in the short as well as longer term. Additionally or alternately clinicians working with people with mental health problems/illnesses may adopt a 'sensory approach' employing a sensory lens when undertaking assessment, case formulation and planning care.

For more information: Brand-Gothelf A et al (2016) Sensory modulation disorder symptoms in anorexia nervosa and bulimia nervosa: a pilot study. *Int J Eat Dis.* 49(1), 59-68; Brown C et al (2002) Sensory processing in schizophrenia: missing and avoiding information. *Schiz Res.* 55, 187-195; Champagne T (2011) Sensory Modulation and Environment: Essential Elements of Occupation. 3rd Ed, Pearson Clinical and Talent Assessment, Sydney.

Lisa Wright an occupational therapist working at TPCB has been awarded a CAHRLI scholarship to support her studies into implementation of evidence based medicine in mental health care. Specifically her mixed methods research will support development of a framework to implement Sensory Modulation approaches in mental health to support changes in clinical practice and better outcomes for consumers.

Lisa's project title is: Sensory Modulation in Mental Health Care: translation of knowledge into clinical practice in inpatient mental health units.

The purpose of this study is to explore the factors that influence the translation of knowledge of Sensory Modulation approaches into clinical practice Mental Health inpatient units. This study will use a mixed methodology of both qualitative focus groups and quantitative survey using the Theoretical Domain Framework to explore implementation factors. The results of this study will be used to develop an implementation framework for Sensory Modulation approaches in mental health inpatient units.

Aims of the study

- To explore staff's experiences of using sensory modulation as a clinical intervention
- To explore the factors, knowledge, attitudes of mental health clinicians that enable or hinder the translation of Sensory Modulation knowledge into clinical practice
- To identify the enablers and barriers at a service level to implementing Sensory Modulation in an inpatient Mental Health Units

We asked Lisa about her motivation and experiences.

What motivated you to undertake embark on this study?

I am fascinated by the culture of practice in mental health. In my current role, as an Allied Health Educator I became interested in how training and education could change clinical practice in mental health care. I wanted to research how to embed evidence based practices in mental health care.

Where are you up to with your studies?

I have been accepted into Master of Philosophy at University of Queensland.

What challenges have you overcome to be at this stage?

The enrolment process.

What has been most rewarding?

Meetings with my UQ Advisors, their wealth of knowledge is truly amazing.

What do you hope to achieve in the next 12 months?

I hope to complete my systematic review of literature and conduct my survey and hopefully a small focus group.

What advice would you give clinicians in a position similar to where you were 12 months ago?

Find university advisors who are interested in your area of research.

How can we make research more attractive to clinicians?

Provide training like the Research Education Development (RED) program held at Griffith University to clinicians, it was a wonderful way to introduce clinicians to health care research.

Sam Bicker, Occupational therapy professional lead works closely with other discipline seniors and occupational therapists to promote integration of evidence based practices in routine care. She observes that translation of evidence to practice in OT is challenged by the barriers identified across health care and some specific issues. She describes lack of time due to conflicting demands of a high pressured environment and service delivery as the key issue. More specifically Sam notes that limited knowledge and understanding of OT evidence base means the potential contribution of the profession is not appreciated. The case management model used in mental health services means OTs are often employed in generic roles – while their practice is informed by theories of occupation, scope for discipline specific interventions is limited. Sam considers investment – in allied health education and OT specific researcher roles essential to enabling full integration of OT evidence-based in multi-disciplinary team work.

Sam is working with colleagues to enable access to sensory modulation interventions in inpatient units. She and Eleanor Vallelonga presented a paper on this at the NT / QLD OT conference 'Practitioners for the Future' on Friday October 28th 2016.



Sam Bicker



Eleanor Vallelonga

ABSTRACT

A proposed clinical pathway for delivering sensory modulation within an acute inpatient mental health unit.

Background: Disruption to occupational participation is a characteristic of mental health problems and the MOHO model theorizes how disability will influence participation through not only the direct consequences of impairment but from other influences such as the environment. The use of sensory approaches in mental health can assist consumers in managing or adapting to functional limitations and emerging research supports the benefits of using sensory approaches in acute inpatient mental health settings. Often due to time pressures and other service inefficiencies a therapist is unable to follow a clinical pathway that helps support evidence based assessment and interventions using these approaches. Within one of our acute inpatient wards there is work being done to trial and develop a rigorous clinical pathway for the delivery of sensory interventions that have also been highlighted through the use of evidence based Occupational Therapy assessments within MOHO.

Method: In this presentation, an overview will be provided of the proposed clinical pathway which would include:

- Assessment/screening
- Intervention strategies
- Documentation
- Use of recommendations

Discussion/Outcomes: It is hypothesized that the sensory pathway will enable the OT to deliver sensory approaches that are evidence-based and best practice through following a methodical process and will continue to support further integrating sensory-informed practice within acute inpatient mental health units.

Conclusion: The proposal and development of a clinical pathway will help provide a process for effective service delivery, with the means to complete robust evaluation of this service provision.

Anneliese Russell, Occupational Therapist, Assistant Director Occupational Therapy at TPCMHHS is also working to promote delivery of evidence based practices within mental health. Working with OTs and educators, Anneliese is establishing a student resourced clinic to both enhance students' experiences with the service and increase access to OT interventions. Anneliese presented a paper describing experiences at the OT Australia Qld/NT State conference held at the Brisbane Convention and Exhibition Centre on 28th Oct 2016.

ABSTRACT

Developing Student Resourced Services within Adult Mental Health: How we got started

Background: As part of Occupational Therapy student placements within adult mental health services, a project was completed as an important and innovative model to develop resources for student resourced services. This formed part of a long-term vision to offer additional Occupational Therapy services to consumers and provide ongoing student placements within mental health.

Method: A working party was established to develop a project plan, in response to clinical education and service needs. Student placements were offered and feedback was obtained from stakeholders as part of the process to develop future student resourced services.

Discussion/outcomes: Following a literature review, considerations when developing student resourced services; benefits and limitations were identified. Several outcomes have already been achieved within the project. This has included increasing our capacity to meet demand for student placements, thus facilitating greater exposure and interest as future practitioners within mental health. This supports the long-term vision for future placements and improving consumer access to Occupational Therapy assessments and interventions through Student Resourced Services.

Conclusion: Students benefited from a peer learning approach, while also contributing to ongoing service development. Students provided insight into how to effectively provide support and structure for project placement. Student also raised awareness about the learning styles of generation Y with important considerations for supporting our Practitioners for the future. Ongoing completion of consumer, staff and student surveys will provide further details regarding effectiveness and inform future sustainable clinical education and research opportunities

THE MENTAL HEALTH CLINICAL COLLABORATIVE (MHCC).

To support ongoing quality improvement and translation of evidence to practice MNMH actively participates, with services from across the state in the Mental Health Clinical Collaborative (MHCC). Hosted by MNMH, the MHCC is led strategically by a Clinical Chair (currently Dr Brett Emmerson) and the statewide Steering Committee. A manager and data analyst lead operational activity.

The MHCC was established in 2005 to foster environments that support continuous quality improvement in services statewide. Clinicians and managers from across the state are brought together every six months for peer group discussion, to showcase local service improvement initiatives and hear about best practice from leading experts. The MHCC also provides regular reports on clinical and practice indicators. These reports are designed to be clinician friendly, clinically meaningful, and to enable monitoring of practice at both an individual service and at a statewide level.

Work of the collaborative has focused in recent years on improving practice in relation to the physical health of mental health consumers. Despite evidence to indicate that early identification, lifestyle interventions and treatment may reduce these risks, the monitoring of physical health has not traditionally been part of routine clinical care in mental health services. Consequently, MHCC members have been directing efforts towards two key initiatives.

1. Embedding physical health assessment and monitoring in care provided to people diagnosed with Schizophrenia.
2. Promoting the provision of brief smoking cessation interventions to QH inpatient mental health consumers, through the offering of the QH Smoking Cessation Clinical Pathway.

In 2017 the collaborative will continue to promote routine assessment and monitoring of physical health in mental health services and the delivery of smoke free healthcare in inpatient mental health services. New work will focus on extending smoke free health care with implementation of the QH Smoking Cessation Clinical Pathway to QH mental health community based services.

The MHCC has published work on improvement in practice regarding physical health and presented work related to smoking at international conferences. For more information please see references below or visit the MHCC intranet page at <http://qhheps.health.qld.gov.au/mentalhealth/govperf/amhcc.htm> or contact Sally Plever (sally.plever@health.qld.gov.au) or Irene McCarthy (irene.mccarthy@health.qld.gov.au).

See: Plever S, et al., (2010). Queensland Mental Health Clinical Collaborative. *Aust Psychiatry*, 18, 106-114; Plever, S et al., (2012). Clinical Practice Improvement Payments: incentives for delivery of quality care. *Aust Psychiatry*, 20, 407-412; Plever S (2016). A collaborative approach to improve the assessment of physical health in adult consumers with schizophrenia in Queensland mental health services. *Aust Psychiatry*, 24(1), 55-61.

PSYCHOLOGISTS AND RESEARCH IN MENTAL HEALTH

Anthony Bligh, who brings substantial experience working clinically and in management in a range of areas has recently been appointed Director of Psychology, MNMH. With experience in various research and clinical roles, he is keen to ensure psychologists are enabled to use the research knowledge and skills that are central to training. He is particularly keen to build capacity and opportunity around assessment of outcomes and evaluation of the implementation of psychological therapies in routine practice. Anthony says...



Anthony Bligh

Research is fundamental in any field where positive outcomes are the goal. In mental health, it is important to be sure we are doing all we can to help our consumers achieve the best possible outcomes in their recovery. The goal of clinical research in mental health is to guide clinicians in the choice of what is best practice for a particular condition or situation, in order to achieve the maximum benefit for the consumer.

All Psychologists are extensively trained in the application, design, and completion of research through formal training and are encouraged to continue consuming and generating research throughout their careers. The combination of clinical utilisation of evidence to inform practice, while also generating and adding to the clinical research knowledge base through involvement in research projects is referred to as the “Scientist-Practitioner Model”. This model is considered the ‘gold standard’ for Psychologists in order to maintain the evidence based approach to clinical work.

In MNMH we have a number of Psychologists actively involved in research projects, from smaller individual studies, to large-scale, multi-site investigations. It is my goal to see MNMH Psychologists involved in even more projects through 2017 and into the future, involving local universities in research collaborations when available, but also working with teams of researchers from across MNMH to develop interesting multi-disciplinary research projects and ultimately contributing to even better outcomes for MNMH consumers.



Let's Get Physical: Oral Health

Physical health has been a high priority within MNMH for five years. The Let's Get physical Initiative instigated by Brett in 2012 has supported substantial and sustained improvement in assessment and management of cardiovascular health of consumers. (see poster page 20).

As part of this program MNMH has been working closely with University of Queensland School of Dentistry for over four years to develop understanding of the challenges facing people with mental illness in relation to oral health and to improve access to care, and outcomes for consumers. The reciprocal collaboration involves

- MNMH hosting final year dentistry students undertaking research projects related to oral health
- MNMH clinicians and consumers delivering a mental health literacy education session for dentistry students, describing major mental illnesses and the individual, social and systemic factors that hinder access to services¹.
- UQ dentistry students providing educational seminars for mental health clinicians
- UQ delivering oral health clinics for consumers in community mental health services.

In 2016, three students worked with Leslie Le, Germaine Lee and Anthony Chung worked with mental health clinicians and consumer consultants to develop an oral health video and brochure as part of their final year evidence-based practice project. The 'Healthy Mouth, Happy Smile' project uses every day, non-technical language and visual elements to effectively provide information and show people how to care for teeth and gums, dentures and share tips on mouth-friendly food and drinks.

This project built on findings of a study completed by 2015 students Alison Cheah and Ram Pandey exploring the acceptability of incorporating oral health promotion in inpatient units (see abstract)

ABSTRACT

Social factors, health behaviours and the direct effects of substances contribute to the poor oral health and restricted access to dental services experienced by people who are dependent on drugs and/or alcohol. Admission for inpatient withdrawal management provides an opportunity for intervention to promote oral health but to be effective it must be acceptable to patients. To support intervention design, we examined patients' views about oral health, practices and treatment access, and appropriateness of health-promoting intervention in this context. Given paucity of knowledge in the area we employed a qualitative approach, data were collected in semi-structured interviews with inpatients of a public specialist alcohol and drug unit in Australia in September 2014. Analysis employed the framework approach. All 14 participants wanted 'good teeth' but few diligently attended to oral healthcare; most sought assistance only in emergencies. Participants' knowledge of services was limited and practical and affective barriers hindered access. With none recalling attention to oral health during admission, support was strong for incorporation of oral health in inpatient assessments. Participants wanted information about the impact of substances on oral health and oral hygiene practices provided in various formats, and facilitated referral to non-judgemental, affordable treatment. Patients regarded promotion of oral health in the inpatient context as important, relevant and acceptable. Support should respect the different knowledge, practices and motivations for oral health and recovery, of patients. Addressing practical and affective barriers to dental services will require collaboration between drug and alcohol and dental services, and this should be the focus of further research.

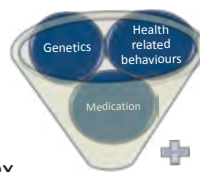
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1 Patterson S & Ford P Dentistry Students' knowledge and views about mental disorder and oral health and the impact of a targeted mental health session on attitudes. *Mental Health Education, Training and Practice*; 9(3) 190-202.

PHYSICAL HEALTH OF PEOPLE WITH SEVERE MENTAL ILLNESS is



METRO NORTH MENTAL HEALTH



Lifespan curtailed by **13 TO 32 YEARS**

EXCESS MORTALITY DUE TO PHYSICAL ILLNESS 60%

Causation is complex

Barriers to health care and suboptimal practice

Mental health services have obligation and opportunity to screen and intervene to reduce cardiovascular risk

LET'S GET PHYSICAL:

interlinked service development, evaluation and research (2011 ongoing)

Aims

- develop a detailed, multi-perspective understanding of the role of mental health & drug and alcohol services in management of the physical and oral health of people who access services and describe factors shaping practice.
- describe the process and impact of quality improvement initiatives from various perspectives
- provide information to support service improvement so that people with SMI receive appropriate physical and oral health care in a timely and efficient way
- Improve experience of services and health outcomes

Integrate attention to physical health in routine practice

Metabolic monitoring scheduled at service level - designated physical health months
 Education and training
 Performance targets and monitoring
 GP surgery in outpatient department ,
 Dental and nutrition clinics
 Wellbeing centres and consumer held records
 Community based healthy living programs
 Implementation of Smoking Cessation Pathway

Collaborate in service development & research

UQ- dentistry and dietetics (MNMH provides education re mental health and hosts student projects ; students deliver clinics)
 Physicians (deliver education and training)
 Primary Health Networks and PCYC (partners in delivery of community programs)
 Collaborations for Leadership in Applied Health Research and Care (NWL, UK)
 Royal College of Psychiatrists (UK)

Study process & outcomes

Rates of monitoring and follow up
 Consumer cardiovascular health
 Contextual factors shaping practice
 Psychiatrists 's views about practice
 Psychologists' views about practice
 Consumer experiences and expectations of services
 Clinicians' & consumers' knowledge & expectations re oral health
 Acceptability and impact of community programs

Achievements

Substantial, sustained improvement in screening and follow up
 7 publications & multiple conference presentations
 Development of clinical guidelines
 Robust, sustained partnerships
 Culture change re physical health
 Enhanced research capacity

Ongoing service improvement - Expanding scope and reach
 RCTs of interventions
 Investigation of consumer outcomes

What's Next?

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ACKNOWLEDGEMENTS: we are grateful to all the MNMH staff and consumers who have enabled service improvement & contributed to research and evaluation in many ways

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



Alison describes her experience of coming to research in mental health as a final year dentistry student.



Alison Cheah

Research. What an alien and inaccessible term. The notion of publishing a paper at the time seemed so far-fetched, even ludicrous to a couple of dentists. What made it all the more daunting, was that the paper was to be written on a completely different subject; mental health. What drew me to the topic was just that; the fact that from one specialty to another, I could reach out and make a connection, independent of the current dental psyche.

We worked closely with A/Prof Sue Patterson over a period of two years, to transform a 5th year compulsory research task into a publishable document. Finding the right tone and dynamic of the article was difficult, as there were multiple authors with varying voices and opinions. Periods of busy research were also met with long lulls between communication, and it became increasingly painful to focus once our main researchers moved to the UK and Canberra to pursue alternate activities.

As students, it was incredibly challenging to undertake qualitative research, as there was always a particular emphasis in the field to focus on quantitative studies. I had to re-wire parts of my brain to think objectively, critically and most importantly emotively. What I learnt was that healthcare required a holistic frame of mind, and that no two specialities can be separated when there is a unified goal.

Working with patients at the RBWH inpatient drug and alcohol treatment facility was a step into a world outside my cosy bubble. The harsh realities of life were met with the most incredible personalities who were eager to share; you could not help but feel compelled to listen to their stories. You laughed, you cried but most of all, you began to connect with those who you may have never thought of reaching out a hand to.

Our research has followed me onto a job with Queensland Health. I currently work as a senior dentist within multiple correctional facilities in South East Queensland. In other words, I am a prison dentist, although few believe me when I tell them. In many ways, I have been so successful in my career to date through the skills that I learnt during this project. The ability to empathise and to understand patients coming from a drug-dependent background, has allowed me to fine tune my treatment plans. By this, I mean that I am able to more accurately manage patient expectations and tailor my advice to reflect each person's educational needs.

I believe that a strong relationship between current clinical practice and ongoing research is crucial in achieving unified healthcare goals. This collaboration should be encouraged in its infancy, by integrating compulsory research into all health science fields prior to graduation.

Despite multiple rejections, hair pulling and litres of blood and sweat sacrificed to the research gods, I now invite you to pull up a chair and read our article. Give thought to each hand-picked word, each carefully crafted sentence, each captivating idea... and know that even though I may not be the most academically gifted, nor the most awe-inspiring dentist that you will ever meet, have faith that we are the tiny levers that are moving the world.



Seconds with James Scott

Consultant Psychiatrist & Conjoint Associate Professor

UQ Centre for Clinical Research and Metro North Mental Health – RBWH.

James is a child and adolescent psychiatrist working clinically at the RBWH and in private practice. He holds conjoint appointments with the University of Queensland.

James has extensive clinical and research experience, and has published widely in areas of child and adolescent mental health.



Dr James Scott

We asked him to tell us about his work.

What motivated you to become a clinician/researcher?

I was motivated to become a clinician researcher as I listened to the stories of the patients whom I cared for. I was first really intrigued by seeing young people with hallucinations who clearly did not have schizophrenia. But all the text books said because they have hallucinations, they must be psychotic. That set me on a quest to understand why what I saw in my clinical practice was different to the dogma of the day. Once I read the literature, I realised that there were a lot of unanswered questions and I was hooked. I set about trying to answer them through clinical research.

Please tell us a bit about your research interests and activities

My research falls into two broad related categories (i) child and adolescent mental health and (ii) early psychosis. In relation to child and adolescent mental health, I work with a range of collaborators in Australia and internationally exploring the prevalence, causes, correlates and treatment of depression, anxiety, aggression, self harm and developmental disorders. I'm very interested in bullying and its devastating effects on mental health. My interests in relation to early psychosis are broad including prevention, phenomenology and treatment options. I'm also working closely with Prof John McGrath on work funded by the John Cade Fellowship – we're running three trials of interventions we hope can improve outcomes for people with psychosis.

Can you be a bit more specific about your work on antibodies, the brain and psychosis

We don't know what causes schizophrenia. However, the recent discovery of syndromes like anti-N-Methyl-D-Aspartase Receptor (anti-NMDAR) Encephalitis has opened up the possibility that some of the patients whom we are treating for schizophrenia in fact have an autoimmune disorder requiring immunotherapy. In collaboration with immunologists and neurologists, we examined the prevalence of autoimmune encephalitis in patients with first episode psychosis. To our surprise, five of 113 patients admitted for first episode psychosis had autoimmune syndromes which was causing their psychosis. They recovered with immunotherapy rather than psychiatric care. This work has already resulted in the Australian clinical guidelines for the treatment of psychosis being amended to recommend that all patients with first episode psychosis should be tested for autoimmune encephalitis.

What is the greatest challenge to integration of research in practice?

Lack of translation. Human behaviour is hard to modify and although we now know a lot about who to prevent mental disorders, the common causative risk factors such as maltreatment in childhood, substance abuse in adolescence and bullying in schools remain highly prevalent. Until we can as a society support people to improve parenting skills, address both parental and adolescent substance misuse and make our schools safer, there will continue to be unacceptable high rates of mental illness. Changing societal attitudes and behaviours is the greatest challenge to improving the health of our nation.

ABSTRACT

Cognitive and Social Functioning Deficits after Anti-N-Methyl-DAspartate Receptor Encephalitis: An Exploratory Case Series

Gemma L. McKeon, James G. Scott, Donna M. Spooner, Alexander E. Ryan, Stefan Blum, David Gillis, Daman Langguth & Gail A. Robinson.

Background: Anti-N-methyl-D-aspartate receptor (NMDAR) encephalitis is a recently described life-threatening autoimmune disorder associated with a characteristic multi-stage neuropsychiatric syndrome. Although it is known that the majority of patients experience neuropsychological disturbance post-treatment, some aspects of the cognitive profile remain unclear.

Methods: This study sought to investigate patterns of cognitive functioning in a sample of anti-NMDAR encephalitis patients. Seven (6F:1M; mean age, 26.4 years; range, 16–37 years) treated patients completed a comprehensive set of neurocognitive and social functioning measures. Performance was analyzed using normative data (where available), and comparison with matched controls (10F:4M; mean age, 25.8 years; range, 16–38 years). Results: Individual cognitive profiles ranged from within normal limits to extensive dysfunction. Relative to controls, the patient group's performance was affected in the domains of verbal/visual memory, working memory, attention, processing speed, executive functioning, and social cognition. The patient group also reported significantly higher levels of anxiety compared to controls.

Conclusions: These results add to the accumulating evidence that neurocognitive deficits, consistent with the distribution and functions of the NMDAR system can persist during recovery from anti-NMDAR encephalitis. This is the first study to provide evidence of performance decrements on measures of social cognition, including some involving theory of mind. (JINS, 2016, 22, 828–838)

Journal of the International Neuropsychological Society (2016), 22, 828–838. Copyright © INS. Published by Cambridge University Press, 2016. doi:10.1017/S1355617716000679

REVIEW

Long-Term Outcomes of Attention-Deficit/Hyperactivity Disorder and Conduct Disorder: A Systematic Review and Meta-Analysis

Holly E. Erskine, PhD, Rosana E. Norman, PhD, Alize J. Ferrari, PhD, Gary C.K. Chan, PhD, William E. Copeland, PhD, Harvey A. Whiteford, PhD, James G. Scott, PhD

Objective: Attention-deficit/hyperactivity disorder (ADHD) and conduct disorder (CD) are common externalizing disorders. Despite previous research demonstrating that both are longitudinally associated with adverse outcomes, there have been no systematic reviews examining all of the available evidence linking ADHD and CD with a range of health and psychosocial outcomes.

Method: Electronic databases (EMBASE, Medline, and PsycINFO) were searched for studies published from 1980 up to March 2015. Published cohort and case-control studies were included if they reported a longitudinal association between ADHD or CD and adverse outcomes with a minimum follow-up of 2 years. Outcomes with sufficient data were pooled in a random effects meta-analysis to give overall odds ratios (ORs) with corresponding 95% CIs.

Results: Of the 278 studies assessed, 114 met inclusion criteria and 98 were used in subsequent meta-analyses. ADHD was associated with adverse outcomes including academic achievement (e.g. failure to complete high

school; odds ratio [OR] = 3.7, 95% CIs 2.0–7.0), other mental and substance use disorders (e.g. depression; OR = 2.3, 1.5–3.7), criminality (e.g. arrest; OR = 1.5–3.8), and employment (e.g., unemployment; OR = 2.0, 1.0–3.9). CD was associated with outcomes relating to academic achievement (e.g. failure to complete high school; OR = 2.7, 1.5–4.7), other mental and substance use disorders (e.g. illicit drug use; OR = 2.1, 1.7–2.6), and criminality (e.g. violence; OR = 3.5, 2.3–5.3).

Conclusion: This study demonstrated that ADHD and CD are associated with disability beyond immediate health loss. Although the analyses could not determine the mechanisms behind these longitudinal associations, they demonstrate the importance of addressing ADHD and CD early in life so as to potentially avert a wide range of future adverse outcomes.

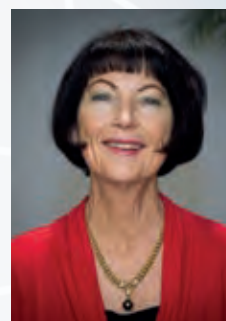
Key words: attention-deficit/hyperactivity disorder, conduct disorder, outcomes, longitudinal, epidemiology

J Am Acad Child Adolesc Psychiatry 2016;55(10):841–850.

Partnerships Are Essential

Partnerships among stakeholders with diverse interests are critical to achievement of the ambition of integration of research and practice. Partnerships bring multiple benefits to all involved.

Here Dr Jeanie Sheffield, Senior Lecturer from the University of Queensland School of Psychology writes of the benefits of research collaborations between universities and MNMH.



Dr Jeanie Sheffield

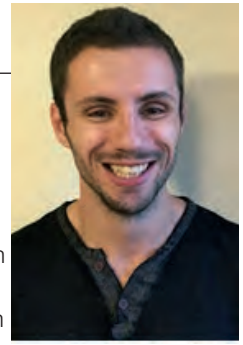
Research that is well designed, thoughtful, and seeks to answer important and relevant questions can provide significant benefits to service providers, service users, and also to the researchers undertaking the study. Having researchers external to the service who are and not invested in the outcomes of the studies supports generation of impartial evidence.

Since 2012, researchers from the School of Psychology at The University of Queensland have undertaken a range of research projects within MNMH, principally with the Eating Disorder Outreach Service (EDOS). These projects have been conducted by postgraduate students under the supervision of UQ academic staff and service clinicians. Studies have involved examining the process and outcomes of care for people receiving services from EDOS using a range of methods. The ongoing collaboration was formalised in 2016 with the establishment of a research collaboration between A/Prof Sue Patterson, MNMH, and Dr Jeanie Sheffield, The University of Queensland. Sue and Jeannie are working together to establish infrastructure to support research within the service.

Beginning early 2016, research has been conducted by a master's student in clinical psychology who has used a qualitative research approach to examine the implementation of a new treatment program at EDOS, the 3-month Intensive Outpatient Program (IOP). This research was designed to talk to both EDOS staff and individuals who were referred for treatment through the IOP program to hear about their experiences as either a deliverer or participant in the IOP program.

This research has already provided positive benefits in relation to building effective partnerships between health and education, to assisting EDOS to have an external evaluation of its services, in facilitating consumers of a service to have a voice, and in providing clinical students with research and training experiences that increase their knowledge and understanding of mental health conditions. Given that evidence-based practice is the framework through which treatments should be selected and implemented, then collaborative research such as this can contribute in a coordinated manner to make a difference. The sharing of knowledge and experience between health and education has been a worthwhile enterprise that has the potential to be ongoing and to continue to contribute meaningfully to effective service delivery and the improvement of patient experience and outcome.

John Van Beusekom, a Provisional Psychologist and Master of Clinical Psychology Candidate (UQ) writes of his experiences



John Van Beusekom

Across 2016 I have been part of a research team evaluating the implementation of the Intensive Outpatient Program (IOP), within the Eating Disorders Outreach Service (EDOS). The team is being led by collaborators from the University of Queensland (UQ) and Metro North Hospital and Health Service (MNHHS). A mixed-methods design is being employed to support collection of qualitative and quantitative data pertaining to the experiences of both service providers and service users and the outcomes of participation in the program. I'm really pleased to have been asked to write about my experiences.

As a provisional psychologist usually working in a clinical role, it has been rewarding to experience and evaluate the development of a service designed to meet the needs of this population. Through interviewing service users and service providers, I have heard rich descriptions of the passion clinicians and management bring to their roles, and the impact this passion has had on the lives of those experiencing disordered eating. Evaluating the process of implementation has also given me a new lens through which to view clinical services and research projects. I look forward to using these newly developed skills in future roles.

As a post-graduate psychology student, there were various challenges that arose throughout this research project. As I have limited experience conducting research, it was initially difficult to conceptualise and establish the evaluation process, especially surrounding qualitative research methods. However, by drawing on the partnership that has been formed between UQ and MNHHS, supervision around this process has strengthened my research knowledge and skills. Also, entering a well-established clinical service initially evoked some apprehension. However, the supportive culture EDOS embodies gave me confidence to collaborate with staff at all levels of the service.

In the future, it would be rewarding to see this research partnership carry on. By continuing to evaluate the sustainability of the IOP over time, a rich description of this program can be communicated with other services developing an eating disorder day program. Further, because we are using a theoretical model to describe the implementation the findings of this study will be relevant more generally. It is encouraging to know that once I complete my work, another Masters student will be continuing with the study looking at sustainability of the service. Taking part in research provides a rewarding learning experience to complement a clinical skill-set.

Whilst contributing to my personal knowledge and skills surrounding the process of real-world research, this project will be used to inform and guide the ongoing development of the IOP, as well as the implementation of similar services across Australia.

Eating Disorders

Anorexia nervosa and bulimia nervosa are serious psychiatric disorders characterised by extreme emotions, attitudes, and behaviours related to weight and food. With complex physical, psychological and psychosocial symptoms and outcomes, these conditions can be life threatening. While eating disorders are diagnosed according to characteristic symptoms, the presentations and experiences of people with a given diagnosis are highly 'individual' and commonly vary over time; many people with eating disorders have other mental health problems.

The complexity of the conditions and the nature of symptoms complicate treatment. Evidence supports the view that treatment should be provided in the least restrictive environment possible (preferably in the community) but there is no 'one size fits all' approach and individuals may require a spectrum of care, encompassing medical, psychological and psychosocial treatments at a given time and a range of interventions may be appropriate dependent on the presentation, circumstances and course of the condition. In light of complexities and diversity of needs, the National Eating Disorders Collaboration developed National Standards recommending a stepped-care model for eating disorders (NEDC, 2012). The model incorporates six levels or types of support, interventions and treatment of varying intensity appropriate to the different presentations and stages of recovery.

Michelle Roberts is a Senior Social Worker working within the mental health service, in the Hospital Drug & Alcohol Service and in patient Eating Disorders Service. Her role within the eating disorders unit includes delivering a variety of groups aimed at recovery and discharge planning. She writes of her experiences working in partnership with The Eating Issues Centre (TEIC) to establish and evaluate a peer mentor program for people admitted for treatment of eating disorders.



Michelle Roberts

People seeking treatment for an eating disorder often report finding it difficult to believe they can recover because they haven't previously met anyone who has recovered. Hearing this message from people admitted locally motivated us to establish a peer program for the ward.

We worked with The Eating Issues Centre (TEIC), a non-government organisation, which was already running a successful mentoring program, linking trained mentors (with experience of eating disorders recovery) with people seeking support with their own recovery.

The mentor group runs on a monthly basis within the ward with two mentors attending each group. Mentors rotate to ensure that patients who have lengthy admissions are exposed to a range of experiences.

Twenty seven patients attended the twelve groups run in 2016, with several attending two or more sessions. Inspired by positive feedback from mentors and participants we set out to share the message with colleagues.

Midyear outcomes were presented to the Australian and New Zealand Academy of Eating Disorders annual conference in Christchurch in August 2016. This conference was attended by inpatient staff, TEIC staff and a senior mentor.

The early success of the inpatient program led to the inclusion of peer mentoring in an the Intensive Day Program run by the Eating Disorders Outreach program. We'll continue monthly groups on the wards through 2017 as well as looking at ways to further develop and promote the group. Our aim is to formalise the evaluation this year.

Michelle talks about her experience in establishing a partnership

How did you go about establishing the collaboration?

Many years ago I attempted to develop links with both non-government eating disorders organisations with a varying degree of success. I had always experienced some hesitation from one of the services and I wonder if it was because of the government/non-government divide that can often occur. I believe the collaboration finally came about due to a bit of persistence and passion about this development from my end, along with being in the right place at the right time to again plant the seed. We were also able to utilise an existing program within the non-government service as well as being able to attach a financial component for the speakers. Having the support of the Director and team members also showed the non-government service that we were serious about the collaboration

What worked well?

Having the support of the team definitely helped. Having shared goals with the non-government service about this program has helped to develop a good line of communication between myself and the coordinator of the mentor program. The development of this cohesive working relationship has helped both myself and the worker from TEIC to feel comfortable in raising difficult issues without it affecting the program. Talking about future promotion of the program and ways of sustaining the program long term has also help with the development of a good working relationship.

What did you learn that might be useful to others in similar situations?

Open communication is key, along with establishing shared goals. You need to have a clear aim, to know why you want to develop the group/partnership and what the purpose is. Developing these partnerships need time, to build trust and to work out different personalities and working styles. Be prepared for things to go slowly at first. Trying to go too soon/ too quickly can lead to miscommunication, loss of shared goals and the program possibly failing. Be prepared for many meetings in the initial stages.

I am really interested in research and enjoyed this component when studying for my Masters. I keep up to date with the literature relevant to my clinical work but it's just not practical to fit formal research into my work schedule. Working part time has also made it difficult to keep the momentum up. Because I think it's really important to reflect on what we do and share experiences in various ways I worked with collaborators to develop a poster to present at an Eating Disorders Conference.

A place at the table?

Valuing peer support in the treatment of Eating Issues.

A story of cross sector collaboration

Michelle Roberts, Senior Social Worker, Hospital Alcohol and Drug Service & Eating Disorders Service, Metro North Mental Health Service, Royal Brisbane and Women's Hospital, (QLD), Australia

Alee Lee, Eating Issues Practitioner and Peer Mentor Program Co-ordinator, The Eating Issues Centre (Qld), Australia

Tanya Kretschmann, Senior Peer Mentor and Recovery Speaker, The Eating Issues Centre (QLD), Australia

WHY

It is often the experience of people seeking treatment for their eating disorder, to have never met anyone that has recovered from an eating disorder. People who have recovered from an eating issue know better than anyone how difficult it can be to fully recover, and can provide tangible hope and reassurance that recovery is possible.

A joint project between the Royal Brisbane and Women's Hospital Eating Disorder Service (RBWH) and The Eating Issues Centre (TEIC) was established, to provide people currently receiving treatment in an inpatient setting for their eating disorder with access to recovered people. The aim of building this connection was to promote recovery, provide emotional support and psychoeducation, facilitate discharge planning, and aid in the reduction of readmission.

The program also provides community links, reduces actual and perceived social isolation, and increases hope in the possibility of recovery from eating issues. The speakers are also afforded the opportunity to utilise their lived experience in positive and meaningful ways, reframe their own inpatient experiences, and remain connected to the value of ongoing recovery.



WHAT

In January 2016, RBWH and TEIC initiated a collaborative program inviting speakers from the TEIC Peer Mentor Program (PMP) to work with acute patients receiving inpatient treatment. Whilst the group is facilitated by the RBWH Social Worker, the Recovery Speakers and patients equally drive the program. The group runs monthly and is attended by up to 5 patients at any one time, with 2 Recovery Speakers.

The group is an opportunity for inpatients to meet people who have encountered their own eating issues, have also experienced an inpatient admission, and have now moved into recovery and/or have recovered. The group allows patients to ask questions about recovery, and to see first-hand that recovery is not only possible, but worth the effort.

Recovery Speakers provide peer support to each other during and after the sessions, and also access TEIC staff and community members to review their experiences, develop new approaches and implement learnings from the project.

PROGRAM OUTCOMES

Recovery Speakers were able to share their own experiences with recovery from eating issues and encourage patients to ask relevant questions, so as to offer experiential-based suggestions and responses.

Patient Outcomes and Feedback:

- Reduced feelings of social isolation, and increased community connection for people living with and recovering from Eating Issues;
- Access to a support person outside of professional treatment team;
- Access to recovery orientated peer perspectives - to reduce distance between the health practitioner and patient (reduce practitioner-patient dissonance), and encourage adoption of health practitioner perspectives;

"Very inspiring"

"Made me realise that recovery was not an overnight process and that setbacks were not a failure"

"It was good to ask someone that has been there if it's worth it"

Recovery Speaker Outcomes and Feedback:

- Positive reframing of inpatient experiences;
- Reflection on those people and practices that were helpful in recovery, to encourage continued connection and/or reconnection with these activities;
- Greater acceptance of the eating disorder journey and experiences, and increased perception and understanding of the value of the lived experience;
- Increased confidence and wellbeing;

"Being a part of the hospital speaking program has definitely strengthened my own recovery. Witnessing the courage of the women who participate in the groups is inspiring. The women often ask us to speak about how to stay motivated during the process of recovering from eating issues. I am really proud to be a part of this movement by the RBWH for those in recovery to have their knowledge and lived experience valued."

"As a Recovery Speaker in the program, it has truly given me the opportunity to share that recovery from an Eating Disorder and Issues is possible. I am very spirited about recovery, coming from a personal lived experience, and the program has allowed us to share our passion with inpatients that may not have had the opportunity to have met or engage with those who have had personal experience before. It has been a privilege to be a part of the program and I feel it has been a gift to be involved".

ORGANIZATIONAL OUTCOMES

People in the acute phase of their eating disorder are linked with a community of recovered people, who are able to support and inform them from a lived experience. It is also an introduction to the recovery based practice of TEIC, facilitating referrals for counselling, therapeutic group work and peer mentoring post discharge.

Since commencing of the program all inpatients have attended at least one session (n=18). The feedback has been overwhelmingly positive.

The project has enhanced the already strong relationships and referral pathways between the RBWH and TEIC and enabled an extension of the program into the RBWH funded Intensive Outpatient Program run by the Eating Disorders Outreach Service. Initial feedback has been positive, which highlights the importance of peer mentors in service development.

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Two MNMH clinicians awarded PhDs in 2016.

Congratulations to Doctors Shane Rebgetz and Ed Heffernan

Shane Rebgetz, Team leader of Child and Youth Mental Health

Shane, a psychologist who has been working in Child and youth mental health services for 10 years began his PhD studies in 2009. The program of research that underpinned his thesis grew from observations in clinical practice – Shane noticed that some people presenting with psychosis who used cannabis were stopping or reducing use without formal treatment. With a view to informing practice and improving outcomes, Shane set about understanding ‘this Natural Recovery’.



Dr Shane Rebgetz

Shane describes commencing a PhD in 2009 as ‘daunting’, and the processes around getting research running in the service as time consuming. “Navigating the ethical approval and SSA approval processes takes time about 300% longer than first anticipated”, he said. Recruitment of participants, dependent on busy clinicians, was also challenging and slower than expected. Shane overcame recruitment and other challenges over the years by establishing relationships with clinicians and showing how the study could be useful to practice. Shane says support of service managers was very important and being able to access SARAS leave enabled him to complete his studies successfully. Reflecting on his experiences Shane noted a progressive openness to research across Metro North MH over recent years and commended managers and clinicians for embracing the challenge. His key ‘tip’ for others embarking on the research/Phd path is to align research with organisational direction and patient outcomes.

The research underpinning the PhD was published in seven papers in prestigious journals (below) over three years.

Rebgetz S et al, L. (2015). Can exploring natural recovery from substance misuse in psychosis assist with treatment? A review of current research. *Addictive Behaviors*, 46, 106-112. **Rebgetz Set al** (2015). Systematic analysis of changes in cannabis use among control conditions of randomised controlled trials. *Addictive Behaviors Reports*, 1, 76-80. **Rebgetz S et al** . Changes in cannabis use among psychotic clients without specialised substance use treatment. *Schizophrenia Research*. doi: 10.1016/j.schres.2016.03.030. **Rebgetz S et al** et al Predictors of substance use reduction in an epidemiological first-episode psychosis cohort. *Early Intervention in Psychiatry*, 8, 358-365. **Rebgetz, S et al** et al (2014). A prospective study of natural recovery from cannabis use in early psychosis. *European Journal of Psychiatry*, 28, 218-229; **Rebgetz, S et al** et al (2015). Natural recovery from cannabis use in people with psychosis: A qualitative study. *Journal of Dual Diagnosis*, 11, 179-183. **Rebgetz, S et al** et al (2016). Prospective recovery of cannabis use in a psychotic population: A qualitative analysis. *Addictive Behaviors Reports*. Accepted 16 July 2016.

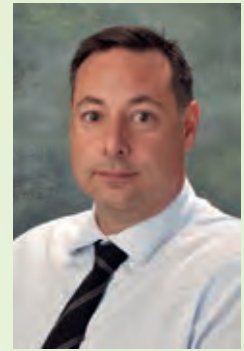
PhD ABSTRACT

Natural Recovery of People with Cannabis Use and Psychosis

People with psychosis who use cannabis have much worse outcomes, but treatments typically have only limited effects that are poorly sustained. This program of research explored how people with psychosis cease using cannabis without substantial assistance, to see if this shed light on how treatments could be improved. The studies suggested that greater focus on employment, separate accommodation, and social and emotional support for cessation would result in stronger outcomes than at present. Similar reasons were found for strategies to maintain a reduction in use; while relapse was associated with substance using peers, and problems with relationships and negative emotions.

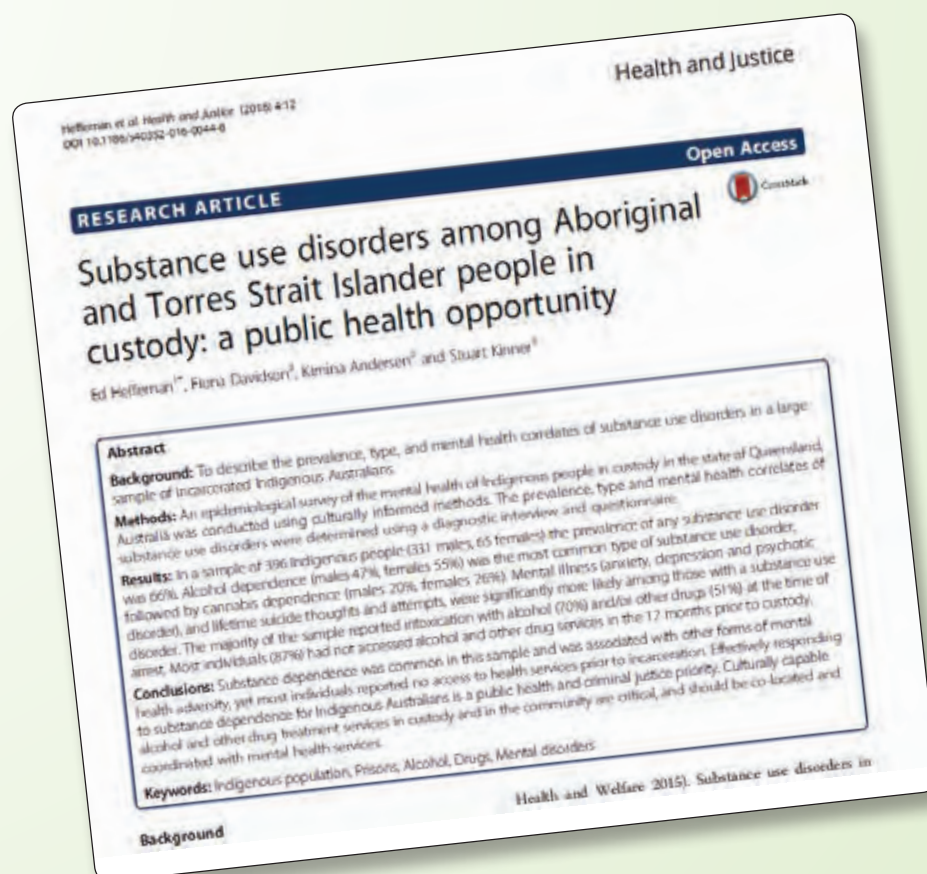
Ed Heffernan, Director of Queensland Forensic Mental Health Services.

Ed Heffernan is a forensic psychiatrist who has worked in custodial settings for nearly twenty years. As Director of Queensland's Forensic Mental Health Services he played a central role in the establishment of mental health services for people in Queensland prisons, courts and watch houses. He is particularly interested in psychiatry in custodial settings and substance use disorders. The idea for his PhD grew from his experiences and observations in this context. Ed's PhD examines what is understood about the interaction between mental disorder and the criminal justice system and describes for the first time the prevalence of mental disorder in a systematic and culturally informed survey of Indigenous prisoners in Queensland.

**Dr Ed Heffernan****ABSTRACT**

Aboriginal and Torres Strait Islander people experience health inequality and social disadvantage when compared to non-Indigenous Australians, the later includes an incarceration rate 13 times that of non-Indigenous Australians. From a health perspective the most significant contributor to the burden of disease for Indigenous Australians in Queensland is mental disorder. Nearly twenty five years ago the Royal Commission into Aboriginal Deaths in Custody highlighted the over representation of Indigenous people in custody and also called for better understanding and treatment of the significant mental health challenges faced by this group. Despite this there had been no systematic research done to describe the prevalence of mental disorder for Indigenous Australians in custody.

This PhD thesis examines what is understood about the interaction between mental disorder and the criminal justice system and describes for the first time the prevalence of mental disorder in a systematic and culturally informed survey of Indigenous prisoners in Queensland. The clinical and policy implications of the findings are presented as are the translational activities that have been informed by these findings.



Social Workers and Research

Social work as a profession is concerned with enabling individuals, groups and communities to shape and change the conditions in which they live and addressing inequity and social disadvantage. Social workers usually work within human rights and social justice frameworks. While some research basics are included in social work degrees, social workers typically do not have advanced research skills upon graduation. When joining the workforce it can be difficult, particularly when workloads are heavy for new graduates to find opportunities to engage with research. However, contemporary practice standards make it clear that research is central to social work practice. Social workers are expected to “understand the role of research and evaluation in obtaining and generating new knowledge for practice.” (AASW 2013).

RedCab SOCIAL WORKERS building research capacity

Inspired by Dr Jack Bell who promotes the different ways clinicians can engage with research as *consumers*, *participants* or *producers* the Social Work network at Redcliffe Caboolture Mental Health and Alcohol and Drug Service, recognised that we can be involved in research even in our busy clinical lives.

We focussed on increasing the *consumption* of research in our social work meetings for 2016, becoming active “consumers of research” embedding a journal club in our monthly meetings during 2016. Staff took turns to bring an article for group review and we engaged in lively discussion focused on understanding how we could apply the research to improve our clinical practice. Whilst we regularly read research and journals for our own individual professional development, it was a great opportunity as a group to have this journal club.

Topics explored in 2016 have included Cultural competence in Social Work, Caring for Carers, Trauma informed Social Work, Family sensitive therapies and Social Work practice frameworks.

We also kept our eyes open for opportunities to participate in research activities, for example by being interviewed or completing surveys, via the Australian Association of Social Work and our other networks aimed at improving the knowledge base in Australia especially around being a Social Worker in Mental Health. THE AASW reminded us that participating in research projects like this also contributes to our CPD hours.

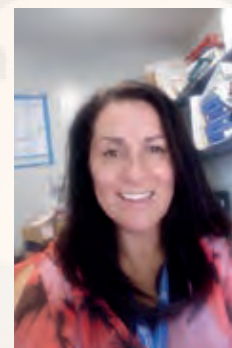
As a group we dipped our toes into participating in research by our involvement in the Caboolture Hospital Tribal Challenge Caring Together Project. We utilised our research brains by conducting literature reviews, exploring best practice and engaging informally with staff and consumers for their views. This led to the development of an Action plan for improving the experience of carers in our inpatient wards which has been endorsed by executive and will be evaluated in 2017. We also enthusiastically supported our colleague Judy Brown, who presented her paper at THEMHS conference in New Zealand during 2016.

As a result of these experiences we are all feeling more confident at continuing as consumers and participants but also becoming ‘producers’ of research. As a group we will be actively supporting our social work colleague Nadine McKenzie in her first brave venture into producing research! We will share this journey and learn with her along the way and hopefully more of us will also take the next step along the research continuum. As a group we will be actively supporting our social work colleague Nadine McKenzie in her first brave venture into producing research! We will share this journey and learn

with her along the way and hopefully more of us will also take the next step along the research continuum.

Enhancing cultural inclusive practice within acute mental health settings through the delivery of alcohol and drug groups

Judy Brown is a senior social worker working in the Alcohol and Drug Service at Caboolture.



Judy Brown

Judy completed her social work qualification in New Zealand and has worked within the mental health field for many years. With a longstanding interest in mental health/addiction, education and cultural diversity, she gained experience as a social work lecturer/Professional Lead and contributed to the creation of a Bi-cultural degree in social work.

After immigrating to Australia in 1997 she continued to enjoy working within the mental health and alcohol and drug sector based at Caboolture/Redcliffe Community Health Centres. She brought her passion for culturally inclusive practice to the service and has been applying a well-researched framework, to group sessions within an acute mental health inpatient unit. She presented a paper reporting her experiences at the THEMHS conference in Auckland, New Zealand in August 2016. It is worth noting that Judy invested personally in this – she worked outside business hours to craft the presentation, paid registration fees herself and attended the conference while on holiday.

1 Kemmis, S. (2010). Research for praxis: knowing doing. Pedagogy, Culture and Society, 18(1), 9–27.

We asked Judy to tell us about her work and the presentation.

What do I do on a day to day basis?

My current role incorporates alcohol and other drug counselling, with a strong emphasis on the psychosocial implications of mental health/addiction related to holistic health and wellbeing. Incorporating a cultural focus continues to be pertinent to my daily clinical practice with carers, groups and individuals across the spectrum of hospital, health and community services.

You recently presented at a conference in New Zealand, please tell us about the presentation?

The main focus of my presentation was applying a well-researched Maori framework, Te Whare Tapa Wha to alcohol and drug group sessions within an acute mental health inpatient unit. In conclusion, I found this model of practice to be easily applied and adaptable within group settings, which enable consumers to explore a more in-depth understanding of the various dimensions of health, promoting strategies to contribute to healing.

What motivated you to share this work?

By moving beyond traditional models of health care individuals are provided with opportunities to improve holistic, collective practices to support the journey towards health and wellbeing. Cultural models offer dynamic opportunities to meet future cultural needs and challenges within burdening health services.

What challenges did you overcome to present?

Balancing my work and home-life commitments and taking on this project was at times a real challenge. Thanks to the support from friends, family and work colleagues who gave me that extra push when I needed it.

What enabled you?

Special thanks to all group participants for sharing priceless lived experiences and inspiring hope of change for healthier futures. To the consumer companions who attend the weekly groups, your contributions and encouragement have made the group project a great learning experience and an awful lot of fun.

What would you say to a colleague considering presenting?

Developing ideas and sharing knowledge is motivating and you really don't have to be an academic.

So, just do it, presenting really is less confronting than you think!

ABSTRACT

Enhancing cultural inclusive practice within acute mental health settings through the delivery of alcohol and drug groups – Judy Brown

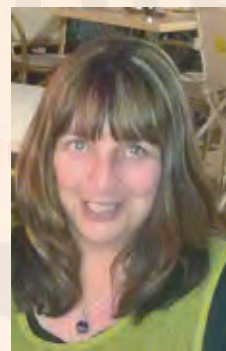
This paper identifies how a cultural framework Te Whare Tapa Wh'a can be interwoven in an alcohol and drug education group within an acute mental health setting. This cultural model offers a conceptual framework that supports recovery orientated practice in accordance with alcohol and drug best practice principles. Its implementation relies on developing a deeper understanding of the meaning of health towards restoring a balanced, holistic perspective which translates concepts in terms of cultural significance.

It enhances a philosophy of integration, which recognises the aim of shared healthcare, consumer ownership, active participation and drawing on the groups lived experiences. It promotes consumers as experts, encourages inclusion, shared ideas, and collective problem solving toward empowerment and recovery. These group strategies incorporate essential components; ensuring consumer representation and attendance to groups, as well as providing overall support with flexible content and collective delivery. Therefore, this paper utilises principles of the Te Whare Tapa Wh model to provide cultural diversity within a group environment, ultimately contributing a positive authentic learning experience.

Kathy Prentice, Senior Social Worker QHVSS

Kathy Prentice is a social worker with the Queensland Health Victim Support Service (QHVSS) she has worked since August 2015, as a Victim Support Coordinator. As

described more on page 42 QHVSS provides services to victims of crime committed by a person with a mental illness or intellectual disability. Kathy has a long standing commitment to practitioner research, an approach concerned with addressing important problems in thought and actions, in theory and practice ... in and for our communities.¹ Involvement in various programme evaluations and an enduring partnership with researchers from CQ University motivated Kathy to complete a research based MSc and Masters of Social work, and eventually to her position with QHVSS and to enrolment in a PhD, for which she secured a CAHRLI scholarship.



Kathy Prentice

Kathy writes of her research and experience with QHVSS:

Research has been part of my role at QHVSS since I started. During my first year I worked with two colleagues to review literature regarding the needs of violent crime committed by people diverted to into forensic mental health systems. A paper reporting the review- 'The forgotten party: What are the recovery needs and challenges of the victims of violent crime by offenders who are diverted into forensic mental health systems?' is under review with Journal of Forensic Psychology and Psychiatry. Reading papers for this review renewed my longstanding interest in restorative justice.

Restorative justice: a principles based practice used to guide repair of harm done by one person to another.

Surprisingly the practice has not been used widely within forensic mental health systems, and little is known about impact of restorative practice with forensic mental health populations.

The CHARLI scholarship is to support me to develop a proposal for a PhD I am currently applying to Griffith University to undertake a PhD to examine if restorative approaches can enhance the recovery of both victims and patients within forensic mental health systems following an act of violence. For example, where an offence has been committed against a family member, a restorative approach could assist in healing trauma and in re-establishing relationships with carers/ supports; where a staff member has been assaulted by a patient, a restorative approach could allow for repair of the care relationship. This will be the first Australian research within this specialty, and it will also add significantly to the limited evidence base globally.

This study is not without its challenges, and a number of key ethical considerations will be addressed. These will include the safety of all participants; the confidentiality of patients; the timing in relation to patient's mental health improving; capacity to consent; and, the avoidance of stigmatisation of patients.

The opportunity to access such funding as that granted by the CAHRLI pre-PhD scholarship is really important in in helping me to juggle a challenging clinical role and post graduate study. Having one day a week for six months to devote to my entry into university life, and to commence a Doctorate, will allow me to find some time to ensure I maintain a work-life balance. Having three Belgian Shepherd Dogs at home will also encourage me to get up and move rather than spend the next four to five years glued to a computer!

My early advice to anyone contemplating a PhD is firstly to ensure you have the right supervisors, who will provide you with encouragement, guidance, and will share their wealth of knowledge. Secondly, you need to very seriously consider if you are committed to living and breathing a research question for up to six years. It is not for those who are unwilling to make sacrifices, but ultimately having the luxury to immerse yourself in a subject totally is a privilege afforded to few.

Child and Youth Mental Health

In Australia approximately 14% of children and adolescents suffer from mental health issues in any 12 month period, with over one third experiencing more than one mental disorder. The importance of addressing the mental suffering of youth is paramount for the individual, their family and society. The most common mental disorders affecting youth aged 4-17 are ADHD, anxiety disorders, major depressive disorder and conduct disorder. Because circumstances and needs of individuals are highly variable, and range of interventions of varying intensity are required to ensure the best use of resources and outcomes. Services for young people with problems related to mental health are provided through a range of private, non-government and government agencies including education and health services. The 'mix' of services available in a given locality will depend on demographic and socio-political factors and resources available, but is likely to include some combination of generalist support and/or counselling services and specialist services. The very limited research available demonstrates that young people use a range of mental health services, commonly seeking services through the education sector with less than 15% using specialist services. There is a pressing need to ensure specialist services are acceptable and accessible to young people.

This need is appreciated by Redcliffe-Caboolture Child and Youth Mental Health Service (RCCYMHS) team leader, Shane Rebgetz and clinicians who are undertaking research designed to support quality improvement. Studies are examining access to services and the experience and expectations of young people and other agencies.

Research being undertaken by Lucianne Palmquist, a psychologist with Child and Youth Mental Health Services at RedCab is generating important new insights regarding experience of mental health problems and pathways to and through services. Importantly the study is developing an understanding of what young people aged 12-17 want from mental health services and what matters to them in relation to 'recovery'.

Lucianne is completing a PhD through Griffith University. As described in the MNMH Review, 2015 Lucianne's thesis (due early 2018) is grounded in a qualitative study of 'recovery' from mental illness among young people aged 12-17 years. Her study involves in-depth qualitative interviews with young

ABSTRACT

Roller coaster under construction:

Adolescent consumers' recovery in transition through Child & Youth Mental Health Services (CYMHS)

Recovery is like "the stereotypical roller coaster ... You have those ups and downs to start with... but then you're able to change what the rest of the journey is like... If you want to help yourself, then you'll continue to build the ride that goes up forever...." 'Anna', 17.

In an era in which 'Recovery-oriented' and 'Consumer focused' policies are promoted across Mental Health Services for all ages, adolescent Consumers' voices are under-represented in discussions of Recovery. Recovery policy has been informed almost exclusively by adults' experiences. As adolescents have substantively different life circumstances, developmental, psychosocial and mental health concerns, it is inappropriate to extrapolate the utility of adult Recovery frameworks for adolescents.

The aim of this longitudinal grounded theory study is to develop a comprehensive explanation of adolescents' Recovery processes as they transition into and through mental health services. Broader purposes of the study are to elevate the profile of adolescents' concerns in discussions on Recovery; to inform policy, service development and practice across sectors to enhance supports pertinent to adolescents' self-identified needs and aspirations.

Using sequential narrative interviews with current Queensland CYMHS consumers aged 12–17, this study explores the questions: What does 'Recovery' look like for Adolescents? How is the process supported by personal action, and how are these actions informed? What supports are identified as beneficial and in what ways?

Illustrated by young Consumers' own words, initial findings will be presented tracing adolescents' all-but straightforward and sometimes risky pathways to securing positive support for 'moving forward' into a recovered future. Some processes unique to young people will be highlighted, with implications for various systems within which young people live and operate. Considerations for research, policy and practice will be discussed.

This presentation will be of particular interest to parents, clinicians, educators and policy makers across (mental) health, education and youth development sectors.

Presented at: Asia Pacific International Mental Health Conference Recovered Futures: People Practice Partnership Policy Brisbane Queensland Australia 24, 25, 26 October 2016.

people at two times during their transition through CYMHS. Lucianne presented preliminary findings from first round of interviews at the Pacific International Mental Health Conference in October 2017. Lucianne is supervised by Prof Analise O'Donovan, A/Profs Graham Bradley and Sue Patterson.

Victoria Cullity, psychologist with Redcliffe Caboolture Child and Youth Mental Health is leading another study designed to improve responsiveness of the service to local need.

A descriptive study of referral, access and care pathways.

The study has been planned in response to feedback from within the service and external agencies regarding perceived inconsistency in eligibility criteria/access and lack of clarity about decision-making processes. Concerns have been expressed that the service may not, as it currently operates, be addressing the needs of the community. Eligibility issues and treatment outcomes of CYMH services are important for service delivery and policy making. Firstly, it is necessary to understand eligibility into services to match evidence based practice and to implement research-based practices in the community, as there is limited understanding about what treatment in these settings actually entails, who they are being applied to and how clinicians tailor such intervention and treatment to the

needs and clinical presentations of such consumers an in depth understanding of this process is required.

The study is part of an ongoing program of quality improvement work designed to improve the care provided to young people with severe mental illness at RCCYMHS. The interlinked aims of the study are to:

1. Describe referrals to RCCYMHS and outcomes of referrals.
2. Describe the cohort of young people offered services by RCCYMHS.
3. Describe the clinical pathway with reference to treatment offered, engagement in the offered treatment, duration of treatment and discharge plan.

The study is a retrospective chart review, involving collection and analysis of routinely collected data from records related to 100 randomly selected referrals to RCCYMHS from June 2016 to August 2016. Data extracted will be analysed descriptively. Quantitative data will be entered onto Excel and/or SPSS. Simple descriptive and frequency analyses will be conducted to enable responses to objectives.

Results will be disseminated in a range of ways to various stakeholders and be used to inform consultations around service development.

Systems Neuroscience

Led by Prof Michael Breakspear who holds a conjoint appointment with Metro North and QIMR Berghofer, the QIMR Program of Mental Health Research involves epidemiological, genetic, neurobiological and computational research into the major mental health disorders. The Program integrates the work of six different research groups across these areas. The research ranges from basic wet-lab research, to large population-based studies of genetic risk conducted with international consortia, through to the latest in computer modelling and brain imaging technologies. Research encompasses most major mental health disorders, including dementia, major depression, bipolar disorder, ADHD, OCD, post-natal depression and schizophrenia. Research covers many areas of direct relevance to patients and their families, including the nature of genetic and environmental risk factors for mental illness, examining their natural history and their causes. We are also developing imaging-based tests for better diagnosis and to monitor response to treatment. Our work in physical activity and mental health investigates and promotes the mental health benefits of physical exercise, particularly among people with severe mental illness.

In 2016, researchers from Metro North Mental Health, QIMR Berghofer Medical Research Institute, and the University of New South Wales (UNSW) made a breakthrough in understanding of bipolar affective disorder. The research involved making and comparing MRI scans of the brains of three different groups: people who had been diagnosed with bipolar disorder, people who had a first-degree relative with bipolar and who were therefore at high genetic risk themselves, and unaffected controls. Analysis showed differences in key brain structures and activities between unaffected controls and people who either have or are at high risk of bipolar disorder with disturbances in the connections responsible for regulating emotional and cognitive processes. The study team hope the findings will in future, lead to a way of identifying and managing those at risk before the onset of bipolar disorder and will also lead to an accurate way of diagnosing affected individuals.

Knowing who is likely to develop bipolar disorder can support provision of advice about how to minimise their risk of developing bipolar disorder, for example, by avoiding illicit drugs and minimising stress. Another possibility is commencing people on medication to prevent onset of the illness.

Impaired Network Controllability in Bipolar Disorder

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Introduction

Disturbances to large-scale brain networks have been implicated in many psychiatric disorders. A recent investigation into bipolar disorder and high-risk individuals revealed impaired connectivity in lateralized subnetworks involving key emotional and cognitive centres¹. In search of a mechanistic explanation for the link between dysconnectivity and brain dysfunction, we applied concepts from network control theory.

Subjects

218 participants aged 12-30 years comprising three age- and gender-matched groups (Table 1)
 1) 38 bipolar disorder (BD)
 2) 84 high-risk (HR): first-degree relatives of BD patients
 3) 96 controls (CN)

Table 1. Demographic data across population groups

Demographic data	CN (n=96)	HR (n=84)	BD (n=38)	p
Females, n (%)	53 (55.2)	45 (53.6)	23 (60.5)	.77
Males, n (%)	43 (44.8)	39 (46.4)	15 (39.5)	.77
Intelligence Quotient (SD)	117.7 (10.3)	116.3 (10.7)	117.60 (11.6)	.65
Age (SD)	22.6 (3.8)	22.4 (4.7)	23.9 (3.3)	.15

Diffusion MRI & Tractography

DWI data were acquired using a 3T Philips Achieva X MRI scanner; 32 gradient directions ($b = 1000 \text{ s/mm}^2$), reconstructed to yield $1 \text{ mm} \times 1 \text{ mm} \times 2.5 \text{ mm}$ voxels. Within MRtrix3, constrained spherical deconvolution (CSD) (Fig 1b) was then employed with probabilistic tractography (iFOD2) to generate 5 million high-resolution whole-brain streamlines (Fig 1c).

The standard AAL template was subdivided into 512 cortical and sub-cortical parcellation regions (Fig 1d). Parcellations (in subject space) were combined with streamline maps to generate weighted structural networks (Fig 1e).

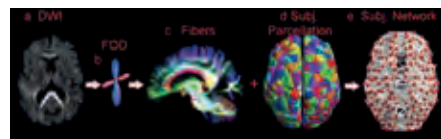


Figure 1. Steps involved in structural network construction

Controllability Metrics

Networks were normalised by the largest eigenvalue among all subjects to ensure linear stability. The linear system evolves according to

$$x(t+1) = Ax(t) + Bu(t)$$

where $x(t)$ is the state at time t , A is the structural adjacency matrix, and $u(t)$ is the time-varying energy applied to input nodes B .

Average controllability is the average energy needed to steer the system to any target state from an input node or subnetwork. Modal controllability identifies regions that drive the brain to difficult-to-reach states.

$$\text{Average controllability of node } n = \sum_j \frac{v_{nj}}{1 - \mu_j^2}$$

$$\text{Modal controllability of node } n = \sum_j v_{nj} (1 - \mu_j^2)$$

where n is a node, v_{nj} is the n th component of the j th eigenvector, and μ_j is the j th eigenvalue.

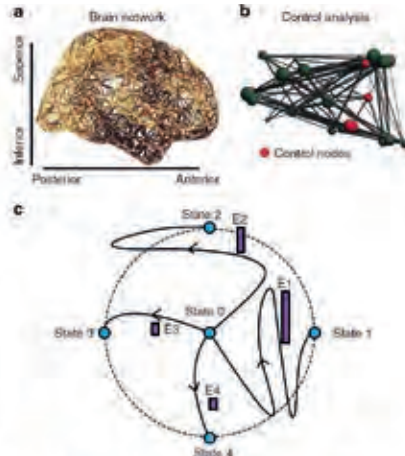


Figure 2. From the structural connectome (a), we examine the input to control nodes (b) required to move the brain to target cognitive states (c). Trajectories can have varying energy costs (purple bars)³.

Correlates of controllability

Node strength correlated positively with average controllability ($R = 0.81$) and negatively with modal controllability ($R = -0.86$). Controllability was compared before/after strength-preserving randomization to assess the relative contributions of strength distribution and network topology. Coefficients of variation were calculated as square of Spearman's correlation. Topology accounts for 33% of variation in average controllability and 15% in modal controllability.

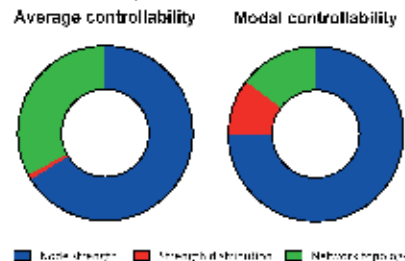
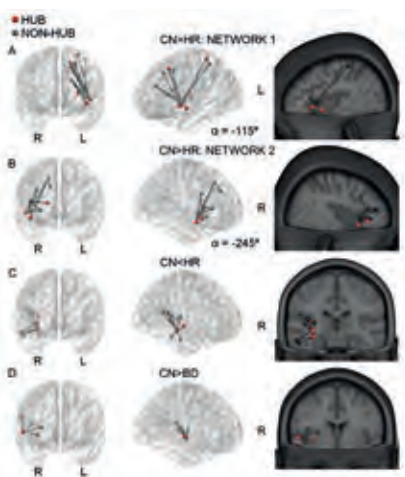


Figure 3. Components of controllability metrics

Sub-network differences

Previous work identified 4 subnetworks significantly different between CN, HR and BD groups¹ (Fig 3).



Functional modules

We next considered controllability in 7 functional modules of the brain². N-way ANOVA with Tukey-Kramer FDR correction was applied to find groupwise differences in mean node strength and controllability.

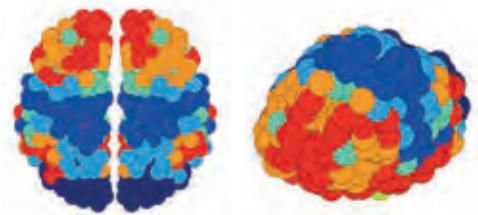


Figure 5. Brain modules derived from intrinsic functional connectivity²

BD subjects had significantly raised nodal average controllability in the frontoparietal module in spite of decreased node strength across all modules. Based on our prior analysis of correlates of controllability, this result implicates abnormal frontoparietal network topology.

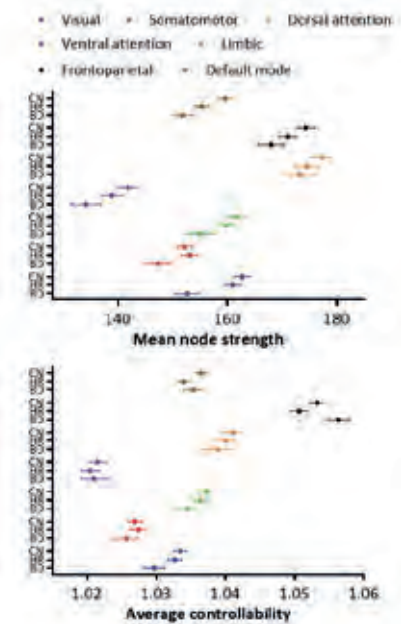


Figure 6. Mean node strength and average controllability in each group and each module

Conclusions

Structural dysconnectivity in HR individuals impairs signal amplification in affected lateralized circuits. This may have far-reaching implications on distant cortical regions by means of impaired control.

We also demonstrated increased controllability in BD reflecting aberrant frontoparietal network topology. This presumably gives rise to abnormal brain transitions in BD resulting in dysregulated emotional processing.

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Functional Dysconnection of the Inferior Frontal Gyrus in Young People With Bipolar Disorder or at Genetic High Risk

Gloria Roberts, Anton Lord, Andrew Frankland, Adam Wright, Phoebe Lau, Florence Levy, Rhoshel K. Lenroot, Philip B. Mitchell, and Michael Breakspear

ABSTRACT

BACKGROUND: Bipolar disorder (BD) is characterized by a dysregulation of affect and impaired integration of emotion with cognition. These traits are also expressed in probands at high genetic risk of BD. The inferior frontal gyrus (IFG) is a key cortical hub in the circuits of emotion and cognitive control, and it has been frequently associated with BD. Here, we studied resting-state functional connectivity of the left IFG in participants with BD and in those at increased genetic risk.

METHODS: Using resting-state functional magnetic resonance imaging we compared 49 young BD participants, 71 individuals with at least one first-degree relative with BD (at-risk), and 80 control subjects. We performed between-group analyses of the functional connectivity of the left IFG and used graph theory to study its local functional network topology. We also used machine learning to study classification based solely on the functional connectivity of the IFG.

RESULTS: In BD, the left IFG was functionally disconnected from a network of regions, including bilateral insulae, ventrolateral prefrontal gyri, superior temporal gyri, and the putamen ($p < .001$). A small network incorporating neighboring insular regions and the anterior cingulate cortex showed weaker functional connectivity in at-risk than control participants ($p < .006$). These constellations of regions overlapped with frontolimbic regions that a machine learning classifier selected as predicting group membership with an accuracy significantly greater than chance.

CONCLUSIONS: Functional dysconnectivity of the IFG from regions involved in emotional regulation may represent a trait abnormality for BD and could potentially aid clinical diagnosis.

Keywords: Bipolar disorder, Genetic risk, Graph theory, Inferior frontal gyrus, Network-based statistics, Resting-state functional connectivity

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ORIGINAL ARTICLE

Structural dysconnectivity of key cognitive and emotional hubs in young people at high genetic risk for bipolar disorder

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Emerging evidence suggests that psychiatric disorders are associated with disturbances in structural brain networks. Little is known, however, about brain networks in those at high risk (HR) of bipolar disorder (BD), with such disturbances carrying substantial predictive and etiological value. Whole-brain tractography was performed on diffusion-weighted images acquired from 84 unaffected HR individuals with at least one first-degree relative with BD, 38 young patients with BD and 96 matched controls (CNs) with no family history of mental illness. We studied structural connectivity differences between these groups, with a focus on highly connected hubs and networks involving emotional centres. HR participants showed lower structural connectivity in two lateralised limbic sub-networks centred on bilateral inferior frontal gyri and left insular cortex, as well as increased connectivity in a right lateralised sub-network compared with CN subjects. BD was associated with weaker connectivity in a small right-sided sub-network involving connections between fronto-temporal and temporal areas. Although these sub-networks preferentially involved structural hubs, the integrity of the highly connected structural backbone was preserved in both groups. Weaker structural brain networks involving key emotional centres occur in young people at genetic risk of BD and those with established BD. In contrast to other psychiatric disorders such as schizophrenia, the structural core of the brain remains intact, despite the local involvement of network hubs. These results add to our understanding of the neurobiological correlates of BD and provide predictions for outcomes in young people at high genetic risk for BD.

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INTRODUCTION

Large-scale brain networks arise from white matter (WM) tracts

that pre-empt the development of BD, as well as factors associated with resilience. This objective is particularly pertinent

Hosting research

is another way in which MNMH services are integrating research in practice.

Jason Dalla Lana Nurse Unit Manager of the Methadone Clinic at Biala City Community Centre – MNMH Alcohol and Drug Service describes the experience of supporting externally led studies.

It's fair to say that the Metro North Mental Health Alcohol and Drug Service is not a dynamic market leader in initiating research. But we don't mind dipping our toes in the water when it comes to hosting externally led projects. The Biala Acute Care Service (BACS), Needle and Syringe Program (NSP) and Roma Street Clinic (RSC) facilitated three research projects during 2016, all of which were based at the Biala City Community Health Centre.

The Healthy Liver Campaign or 'Liverlife' was conducted by the Kirby Institute to examine the impact of a targeted campaign on liver disease knowledge, assessment and treatment. Participation in this study involved an initial survey, liver fibroscan, liver health nursing assessment and education and blood tests including a Point Of Care test for Hepatitis C. This was followed up with a repeat survey to examine treatment adoption rates and improvement in client knowledge regarding HCV related liver disease. Liverlife was conducted in September, with the follow up surveys finalised by December. Participants were given a voucher as a thank you for their contribution.

Coordinating the conduct of this study was an exercise in herding cats. A target of fifty clients was set for the 4 day capture period. The tight timeframe and multiple interventions to be delivered on the single occasion meant a lot of pressure on our limited built environment. Kirby Institute provided researchers, an ultrasonographer and a lab scientist. MNMH-ADS provided two clinical nurses for assessment and phlebotomy and two operational officers, all organised over three separate work areas resulting in a production line format with clients escorted between eight separate stations. The study was advertised for two weeks prior and a tight booking system was managed by NSP staff. The study was also promoted to Metro South A&D for suitable clients. Core service delivery was decreased during this period due to the resources absorbed, and the nursing staff involved also needed offline time to later conduct the follow up surveys. As intense as it was, in both planning and delivery, I think most staff involved found the process quite refreshing and stimulating. Participation certainly gave our services a jump start into delivering the newly approved treatments for Hepatitis C, and motivated a number of contemplative clients to take charge of their disease management. The study also formed part of product validation for a point of care Hepatitis C test, with the client's blood samples being tested both on site and sent for serology for comparison.

The Australian Needle and Syringe Program Survey (ANSPS) is an annual survey which provides serial point prevalence estimates of human immunodeficiency virus (HIV) and Hepatitis C virus (HCV) antibodies, and sexual and injecting risk behaviour among people who inject drugs. This study is conducted annually over a two week period each October and is led by the Kirby Institute. All NSP clients were invited to complete a brief, anonymous questionnaire and provide a capillary blood sample for HIV and HCV antibody testing. This long standing study is bread and butter for our service and contributes directly to epidemiological trend analysis regarding health needs of the injecting drug using population. The ANSPS is well patronised by the clients of Biala NSP. Given that no reimbursement for client time is offered, the willingness to participate is an indicator of the great rapport that exists between our NSP staff and the client base. Extra staffing is utilised from our casual pool staffing during the capture period, and this is funded by our service. One hundred and nine clients were recruited, a lower number than is generally attained due to a shortage of available staff as a result of unplanned leave and cover required by other sites.

The Feasibility and Outcomes of Hepatitis C Treatment for people who use drugs study was commenced in October, and is led by the Queensland Alcohol and Drug Research and Education Centre (QADREC). This study seeks to examine the feasibility and outcomes of treating Hepatitis C infections among people who inject drugs using direct anti-viral therapy via a community-based treatment model, focusing on uptake, client retention, quality of life and substance use behaviour. Recruitment was from the Biala NSP client base, and interviews were carried out by the research team, and NSP OO4 staff who were funded by the study. The baseline interviews have been completed on two hundred and fifty clients, with follow up interviews in another six months. The sample size achieved in a relatively small time was impressive given that the study was commenced shortly after the ANSPS, so the team did well to prevent research fatigue amongst the clientele.

In all, the activities provided a demonstration of the challenges and benefits associated with hosting research. Ultimately the grand reward of facilitating research should perhaps be improved service design, delivery and client outcomes. More locally though, we benefit from the upskilling of staff and the opportunity for some short term project work to provide variety. I feel that the process also fosters an increased sense of inclusion and engagement for our clients. When our clients feel valued, respected and listened to, the service as a whole benefits regardless of the research outcome. Big thanks from me go out to the Medical, Nursing, Operational and Administrative staff of Biala. Special mentions to Peter Cochrane the CNC of BACS, Sue Shin CN of BACS and Massud Hasan CN of RSC for going the extra mile with the Liverlife study.

Nursing Research

The Mental Health Nursing Research Office has a range of active service-based research programs initiated by the nursing leadership group. They aim to support nursing research across Metro North Mental Health and also help develop our academic partnership with the School of Nursing at Queensland University of Technology. Major initiatives such as development and implementation of Police and Ambulance Intervention Plans (PaAIP) as well as the Acute Management Plan (AMP) fostered collaboration between Mental Health Services and the Queensland Police and Ambulance Services this year (Cartwright, 2016). A consumer's recovery is supported by a diverse group of people including: family, friends and a host of service providers including the local community nurse, ambulance and police officers. The Safewards trial implementation was concluded later in the year. The Safewards program aims to improve teamwork, communication and collaboration among mental health staff and consumers so that they will feel part of a cohesive and caring group. Initial evaluation of staff perceptions indicate there are important considerations to be made regarding the level of commitment that staff will have and this is directly related to supervision of this from nursing leaders (Fawcett et al., 2016). Within the Safewards program, Mutual Help meetings conducted in collaboration with Music Therapy were shown to facilitate a social community and build toward an energetic interactive hopeful mood experienced by consumers (Newell et al., 2016).

Support from the Perinatal Mental Health Service, provides ongoing education within the hospital and community to identify mothers who require comprehensive care across different services (Bennett & Whitford, 2016). Other more diverse work looked at the possibility of using technological devices for peripheral vein location to assist with insertion of IV catheters for those who require Electro Convulsive Therapy (Higgins, 2016). The integration of nursing research and education has helped highlight learning needs for clinicians and informed ward based education approaches. For example, nurses continue to find new ways to support consumers with their efforts to stop smoking who are just as likely to try to quit as the general population (Newell et al., 2016). Nurse Educators at the Royal Brisbane & Women's Hospital also explored potential distractors when administering medication that nursing staff encounter in an acute adult mental health unit on a daily basis (Collyer et al., 2016).

This year we also examined the impact of a large recruitment intake of novice practitioners into the mental health nursing workforce. An emphasis was placed on investing in the careers of these staff to integrate successfully with the workforce and provide for long term succession planning within the speciality of mental health nursing (Hall et al., 2016). The contribution to research from nursing education in collaboration with The Prince Charles Hospital also included training to support the exposure of next generation of mental health nurses to consumer and carer involvement in educational sessions. This can lead the change needed to decrease stigma and tackle disparity within our current healthcare system (Hall & Boyle, 2016). The outcomes of this evaluation work continue to attract and retain new nursing graduates into the speciality of mental health.



Metro North Hospital and Health Service *Putting people first*

Is removing the rights of consumers to smoke justified? Tobacco Free Wards in Mental Health

Newell, J.,¹ Sargent, O.³ and Snoswell, C.²
¹Royal Brisbane and Women's Hospital, Metro North Mental Health, Herston, Australia



STOP

WHY DO ANYTHING?

Quitting is the single most important health intervention for smokers.

Smoking is prevalent, lethal and undertreated in the mentally ill population.

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

WE KNOW

There is an existing procedure, and supporting documents including a clinical pathway and pre-printed medication chart, which see tobacco and related items, prohibited in all inpatient mental health units in this HHS. NRT is freely available for staff to provide to patients. We have the lowest completion rate for completing the pathways and many staff are unaware of NRT dosing guidelines.

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

ENGAGEMENT STAFF

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

To successfully implement this policy it was essential for clinicians to understand the day to day procedural requirements in order to minimise resistance to the initiative. This included guidance on how to undertake a smoking cessation intervention guided by the clinical pathway and explain the varying changes to patients. This was in tandem with the adequate provision of NRT to patients whilst they are inpatients and are unable to smoke.

Monthly education at staff meetings on troubleshooting NRT management.

So how do you dispel Ancient Myths?

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

We developed and implemented the procedure

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

CONSUMER AND CARERS:

- External support from the dietitians coordinator for the twice weekly consumer smoking cessation groups.
- Provision of consumer information, others and procedures.

OUTCOMES FOR PRACTICE:

- Clinicians are surprised to learn that their patients are just as likely to try to quit as the general population but less likely to succeed, and that they as health professionals play a role in this negative feedback cycle.
- Using a set of evidence based principles clinicians can recognise nicotine addiction as a serious condition that can be treated as a routine part of mental health care.
- Clinicians are dispensing more NRT and documenting in pathways.
- A consistent approach to this procedure provides an environment in which the risk of uptake and relapse of smoking is no longer a concern for consumers.

ROAD CLOSED AHEAD

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

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

OUTCOMES:

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



Installation of Quitline phones in inpatient wards and community areas

Quitline 13 7848

References: Australian National Survey of Mental Health and Wellbeing, ABS 2000; Australian Drug Strategy Household Survey, Cooper, J. Aust NZ J Psychiatry 2012; Szabovnik L, Alcotive Tok Rep 2004, Le Coad (MVA) 2014; Bowden JH, NZJ Psychiatry 2011; Loxton K, JAMA 2009; British Medical Association 2010

<http://www.mentalhealth.org.au>

Embedding research in MNMH

Health policies and strategic documents world-wide, endorse high quality research evidence as critical to improving the quality and efficiency of health care. The World Health Organization considers research an essential component of robust health systems and contends that policy makers, commissioners and practitioners should develop and apply robust research evidence to health care decision making. Successful conduct of randomised controlled trials (RCTs), regarded as the most robust method for testing the efficacy and effectiveness of interventions, is critical to improving the efficiency and quality of health services.

While investigators design elegant scientifically sound studies, their implementation does not always go according to plan in the 'real world' in which service delivery is the key priority. Internationally, tens of billions of dollars are invested in trials each year but because trials are notoriously inefficient, return on investment is sub-optimal. Evidence is urgently needed to improve recruitment across health care domains.

To support ongoing improvement in the integration of research and practice, MNMH researchers are collaborating with researchers from Cancer Care at the RBWH in studying the influences on the conduct of research, particularly randomised controlled trials. Supported by funding from the RBWH Foundation, Sue Patterson, Ray Chan, James Scott and John McGrath are working with colleagues on a study titled 'Optimising Recruitment into Randomised Controlled Trials in Mental Health and Cancer Care'.

The study employs a comparative multiple-case study design, examining the implementation of RCT within mental health and cancer care services at the RBWH. The overarching aim of this study is to provide evidence which can be applied to inform the design and efficient conduct of randomised controlled trials in cancer care and mental health settings such that efficiency is improved. Data collected in 40 interviews with researchers and clinicians in both services are being analysed to answer four research questions:

The study will address the following research questions:

- What environmental, service and professional/personal factors influence recruitment to randomised controlled trials, particularly researcher access to potential participants?
- In what ways and in what contexts do these factors influence recruitment to randomised controlled trials
- How do various factors shape the process of randomised controlled trials and generation of evidence?
- In what ways are mental health and cancer care settings similar, and in what ways are they different with regard to recruitment to randomised controlled trials

Findings will underpin a strategic approach to developing the organisational and individual capabilities needed to support efficient conduct of studies such as those being implemented under the CADENCE program.

Cadence

Under a five year fellowship awarded by the National Health and Medical Research Council, Professor John McGrath and his team are undertaking research into modifiable risk factors for schizophrenia. In particular, the CADENCE team has established a clinical trials platform to improve clinical outcomes for people with psychosis, particularly early psychosis. CADENCE is currently running three trials within MNMH – Cadence BZ, testing whether adding a commonly used food preservative to regular treatments, assists with recovery from early psychosis; Cadence M, testing whether addition of an extract from the rind of the tropical fruit mangosteen to regular treatment improves symptoms in people with schizophrenia. The third trial - Cadence SCIT, led by Dr Frances Dark and A/Professor James Scott is examining the impact of a psychotherapeutic intervention on social function among people with schizophrenia. This trial builds on a pilot study undertaken by Anne Gordon, a psychologist with INBMHS which demonstrated that SCIT was valued by participants.

Cadence SCIT

Functional deficits (i.e., social skill, community functioning) are a core feature of schizophrenia. They represent key diagnostic criteria for the disorder that precede illness onset and are a strong predictor of outcome. These deficits are not always improved via medication, thus underscoring the need to develop psychosocial treatments to address functional impairments. In fact, improving psychosocial functioning is a critical yet so far elusive target of schizophrenia research. Older interventions, such as social skills training (SST), targeted the building blocks of broader domains of social functioning (i.e. social skills). Newer interventions, such as cognitive remediation, focus on the processes that support or underlie social functioning (i.e., cognitive deficits). Although both interventions improve the specific domains they target they have demonstrated limited generalization to broader psychosocial outcomes. This has led to the pursuit of other factors that contribute to functional impairments as potential treatment targets. One such factor is social cognition.

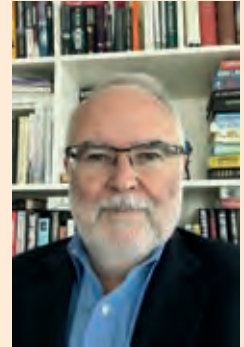
Social cognition is a set of cognitive processes applied to the recognition, understanding, accurate processing, and effective use of social cues in real-world situations. In schizophrenia research, it is generally comprised of the following domains: Emotion perception, Theory of Mind (ToM), and attributional style. Enthusiasm for the importance of social cognition in schizophrenia has grown as research has revealed that it is more strongly related to functional outcomes than neurocognition. This has encouraged the development of interventions aiming to improve social cognitive functioning in schizophrenia.

Using a randomised, controlled trial the primary aim in this study is to examine if Social Cognition and Interaction Training (SCIT) is a safe and effective treatment for those with schizophrenia.

For more information on any Cadence studies please email cadence@qcmhr.uq.edu.au

Older Person's Mental Health

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



Prof Gerard Byrne

As reflected in publication, 2016 has been a productive and rewarding year for OPMHS researchers, with team members leading the way in development and testing of measures and treatments for anxiety and depression among people diagnosed with Parkinson's.

Parkinson's Disease

Parkinson's is a progressive neurological condition affecting approximately 70,000 Australians from all walks of life. The average age of diagnosis is 65 years, but it can affect people as young as 30. Parkinson's is caused by a decline in the production of a brain chemical called dopamine. Lack of dopamine leads to difficulty controlling movements and moving freely (the primary 'motor' symptoms of Parkinson's) and can affect other body systems. Some people with Parkinson's have problems related to sense of smell and digestion; thinking and mood are often affected. Pain, depression and problems with memory and sleep can also occur and negatively impact day to day life.

ABSTRACT

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

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

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

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

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

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

Dissanayaka N, Mitchell L, Byrne G et al., (2016) <http://dx.doi.org/10.1080/07317115.2016.1240131>

Perinatal Mental Health

Perinatal mental health refers to the emotional, psychological and social aspects of health from preconception until two years post birth. This period is the highest risk time for women to develop mental health problems with a varying range of severity and impact upon functioning.

Perinatal depression, including major and minor depressive episodes, is one of the most common medical complications during pregnancy and in the 12 months after giving birth. Estimates suggest that up to 1 in 5 mothers will experience perinatal depression which can potentially affect the developing child, the mother-child relationship, paternal mental health, and relationships between parents.

Perinatal depression is undertreated, in part due to low rates of engagement by women with mental health services. Research overseas has linked various system, provider, family and patient factors with engagement. Key challenges identified for mothers are time constraints, logistical and financial considerations, and perceived stigma associated with attending mental health services. Research has also shown that mothers prefer psychotherapy over medication and to receive mental health care within an obstetric setting. While similar factors seem likely to shape engagement with services locally, no formal studies have been undertaken in Australia.

To address this knowledge gap and promote improvement in care, Alice and Renee are working on a study of influences on engagement with Perinatal Mental Health Services within MNMH.

Psychiatric Registrars Renee Chen and Alice Ayres are working with Consultant Psychiatrist George Bruxner and Consultant Obstetrician Alka Kothari on questionnaire based survey designed to identify influences on engagement with perinatal services in MNMH.



Renee Chen



Alice Ayres

During 2016, while working full time and studying for exams, Renee and Alice have completed a literature review, written a study protocol and completed research governance processes. Beginning early 2017 they will recruit participants from the Redcliffe Hospital Antenatal Clinic, The Perinatal mental health service and by letter to people who are referred but do not attend perinatal appointments. Participation in the study involves completing an on-line questionnaire, which takes about five minutes, either at the clinic or at home. Participants are asked to rate the extent to which various factors identified in the literature and in conversations with patients, influence engagement with peri-natal services.

We invited Alice and Renee to tell us a bit about perinatal mental health, themselves and describe their experiences getting their study to implementation stage.

What would your internet search histories tell us about you?

Alice: Either that I am frantically studying for the RANZCP exams, or I have an unusual interest pharmacokinetics and pharmacodynamics! It would also reveal that I love a great variety of nerdy things; most recently I have been indulging in the Star Wars Universe.

Renee: That I spend a lot of time planning my holidays and I order way too much take-away.

Please tell us about your research in a 'text message' (160 characters or less)

Our research aims to gain a preliminary understanding of the barriers and facilitators of women's engagement with perinatal mental health services in the Redcliffe area.

What motivated you to undertake embark on this study?

Mental health issues and disorders are commonly experienced by women during the perinatal period. However our data suggests only a small proportion of women who are offered Perinatal Mental Health Services engage. This gap in health care delivery motivated us to further our understanding of the barriers faced by women in accessing these services. After all, having an effective service is only useful if women can and want to attend.

Where do you see this work leading?

We hope our research will provide greater understanding of the factors that influence women's engagement with perinatal mental health services, which will hopefully guide improvements to health service delivery to this population in the future.

What challenges have you overcome to be at this stage?

A wide variety of challenges! Navigating the world of academia and research has been most educational - from completing mammoth ethics applications to the creation of meaningful questionnaires. Learning how best to present our research project to different audiences has been crucial – it is easy to forget that not everybody is a clinician, nor can one assume a baseline level of knowledge.

What do you hope to achieve in the next 12 months?

We hope to complete data collection and analysis, with the ultimate goal of publication. Somewhere along the way we also hope to pass exams, enjoy our clinical rotations and maintain sanity.

What advice would you give registrars in a position similar to where you were 12 months ago?

Try to take up any opportunities that are presented to you and pique your interest. Start planning early and allow plenty of time to accommodate unexpected delays and challenges while completing a project.

We would also suggest completing the scholarly project with, or embarking on one concurrently with a friend to make the journey more enjoyable.

How have you managed to fit research activity in while working full time as clinicians?

Fitting research in with clinical work is very achievable but requires active planning. We think that it's about working on things incrementally – setting aside some time every week and coordinating tasks between team members to ensure each stage is completed efficiently and no one team member is overwhelmed.

How can we make research more attractive to clinicians?

Research can seem like an intimidating and daunting task for clinicians who have not been exposed to it or are inexperienced. We were very fortunate to have passionate and helpful mentors who have provided plenty of guidance and support. We believe that by promoting the availability of resources and supervisors, this will encourage clinicians to enter into research.

The provision of dedicated research time within rotations would also be very attractive.

We would also encourage the formation of support groups to promote research. For example Alice regularly attends Breakfast Club meetings with fellow researchers, with guest speakers who provide inspiration and encouragement.



Queensland Health Victim Support Service – evidence supporting practice

The Queensland Health Victim Support Service (QHVSS) is a state-wide service assisting victims of personal violence crime in cases referred to the forensic mental health system. This includes people who are the direct victims of violence, or their families, when a person charged is referred to the Mental Health Court, or under the new Mental Health Act 2016 when a Magistrate makes a finding of a mental health defence and the charges no longer proceed.

Services are provided by experienced psychologists and social workers located in Brisbane, Townsville and commencing in Cairns in early 2017. The service is part of Metro North Mental Health, Metro North Hospital and Health Service.

The types of assistance provided to clients includes:

- counselling to respond to the impact of the offence to improve wellbeing and potential for recovery
- support for providing a statement to the Mental Health Court or the Mental Health Review Tribunal on the impact of the offence and safety concerns
- psycho-education is provided for victims and their families on the interaction between mental illness and intellectual disability and offending. This information is provided over time while the case progresses through the forensic mental health system
- informing clients about the option and process for applying for an Information Notice under the Mental Health Act 2016 which provides them with approved information about the forensic patient who harmed them and is placed on a Forensic Order or Treatment Support Order.

QHVSS staff also assist clients to access other specialist services. The service is available to frontline staff, such as mental health staff, police and ambulance officers impacted by violence and the case is referred to the forensic mental health system. QHVSS is a unique service in Australia and therefore evidence from comparable services within similar forensic mental health systems is not available. Over time the team has built an approach to practice drawing on evidence from research and other publications covering: impacts of violence for individuals and families; needs of victims of violence in justice systems; trauma and trauma informed practice; grief and loss; forensic mental health; specialist courts; homicide; occupational violence and domestic and family violence and stalking. In 2013 members of the team completed a literature review together with Victim Assist Queensland to contribute to the review of the Mental Health Act 2000. In 2016 an updated literature review was undertaken with the aim of gathering any existing research to further inform current service delivery and directions for future research.

In 2013 QHVSS revised its reporting information and over time some consistent themes have been present in service data. These include: most clients are female aged between 31 to 60 years of age. The main types of offences experienced by clients, or their families are: serious violent assault, homicide, attempted murder and other assaults. The largest group of clients are direct victim, with most known to the forensic patient, such as family members. This is consistent with research in this area.

Common presenting clinical issues include grief and loss, post-traumatic stress, acute and other chronic stressors, anxiety and depression. Common psychosocial issues include concerns about safety, perceived injustice, family conflict, physical health, trauma and financial issues

The year ahead is an exciting period for the service with a number of initiatives to further inform practice and service development over the coming years. This includes the commencement of a PhD by Kathryn Prentice in the QHVSS team focused on using a restorative approach in forensic mental health. The team is also undertaking a project on victims' services as part of implementing the forensic mental health sentinel event review. This includes brief reviews of literature in areas of referral pathways and services to assist carers who experience, or at risk of violence. Finally the Director of the service was successful in 2016 to receive a Churchill Fellowship to investigate the use of restorative justice in forensic mental health, and in mental health inpatient services as well as therapeutic approaches to families impacted by homicide.

INTEGRATING RESEARCH IN PRACTICE

Kylie Garrick, Director of Allied Health MNMH completed a research project as part of a Masters in Organisational Psychology. We invited her to tell us about the study and her experiences and provide some hints for others embarking on a study.



Kylie Garrick

To be honest I have put off writing this piece, feeling somewhat ambivalent about it, probably because that is also how I feel about research. I know how important and valuable research is, but I also know how challenging it can be, particularly trying to fit it in our very busy work and home lives. I recently returned to university to complete my Masters of Organisational Psychology and was required to undertake a research project to satisfy the dissertation requirements of the degree. The thought of this was somewhat scary particularly given I had not engaged in formal research since completing my honours degree (some 21 years ago). I was however also quite excited because for a long time I had wanted to evaluate the Peer Support Program (PSP) that we have in Redcliffe-Caboolture.

To say that undertaking this research was a challenge, is quite the understatement. Not only was I working full-time in a new role, undertaking placements for my degree and completing other course requirements, I was also supporting my mother who was dying of cancer, whilst trying to be a good mother and wife. I often wonder how the heck did I make it, but I guess I was motivated by the importance of the topic I was researching. The work we do as mental health providers is incredibly important yet can be incredibly stressful. Recognising this, myself and two colleagues Barb Bowler and Chris Dawber set out to ensure there were sufficient supports for staff to manage the stressors of working in mental health, by implementing a formalised Peer Support Program. This program will celebrate 10 years in 2017 so it was great timing to take a closer look at the employee experience of this program.

My qualitative research examined the role of peer support in supporting employees of Redcliffe-Caboolture Mental Health Service to respond to the job demands inherent in the mental health profession. Study participants who had accessed the organisation's PSP described peer support as a valued job resource that assisted them to respond to their occupational stressors. Participants valued the confidential and non-judgemental support of their peers that validated their experience and supported them to problem solve and link with support services for ongoing assistance. Study participants who had not accessed the PSP described barriers to accessing support and suggested improvements to facilitate broader employee access to peer support. The majority of participants, regardless of their experience of the PSP, agreed there was a need for peer support within the MHS and agreed the support of their peers supported employees to cope with both occupational and personal stressors. My study provided further evidence that the mental health profession is an occupation at high risk for stress. Findings also confirmed the workplace is a natural source of support and provided further evidence to inform the development and implementation of PSP in health settings and informs future training of peer support workers. I was excited to recently hear that Qld Health is looking to implement PSP across different HHS as part of the reducing Occupational Violence taskforce and I have been proud to share my research findings with the project officer.

For what it is worth, some tips that worked for me embarking on the research journey include:

- Set yourself realistic goals, including daily, weekly, monthly and yearly goals. It's great when you achieve one of your goals and it helps to keep you motivated to achieve the next milestone.
- Spend time on your research each day, even if it is only for 15 minutes.
- Connect with others who are also researching and use them as a sounding board to share lessons learnt from shared research experiences.
- Find a good supervisor and arrange regular supervision sessions to keep you on track.
- Engage the services of a critical friend who isn't afraid to tell you where you can improve.
- As hard as it can be to hear, feedback is good, particularly when it is constructive. Open your mind to hearing the alternative views of others.
- Compromise – through my research project I came across some ethical dilemmas which meant I was unable to conduct the research as originally intended. I was however able to compromise and adjust my research design to ensure the project could go ahead, even if a little different from what I had originally planned.

What I learnt most though through this process is that it is good to extend yourself and put yourself in situations that challenge you. I also learnt that I am probably not the best researcher and that's okay. I've never been someone driven to research or to publish but through this experience I am now more keen to participate in research activities, not so much as the lead investigator, but as a member of a research team where I can learn from others with more research experience than me. No doubt, as with many other things in life, the more you do it, the easier it gets.

Next Generation: Post Graduate Students and Supervision

Graduate Certificate

Robert Harrison

University and Degree

University of Queensland
Graduate Certificate of Public Health The

Graduate Diploma

Sue Adams

The University of Tasmania
Graduate Diploma of Nursing

Georgina Carter

Canberra University
Diploma of Mental Health Nursing

Bobbie Clugston

University of Queensland
Graduate Diploma of Psychology

Masters Degrees

Carrick Anderson

University of New South Wales
Master of FMH

Paula Arc

Australian Catholic University
Master of Social Work

Matteo Brunetti

University of New England
Master of Mental Health Practice

Leigh Couch

University of Southern Queensland
Master of Social Work

Sheila Gowlett

Griffith University
Masters in Mental Health Practice

Rebecca Mann

The University of Sheffield
Master in International Health Care Management and Leadership

Kline Oo

University of New South Wales
Master of FMH

Chrystal Van De Belt

University of New South Wales
Master of FMH

Annette Vasey

Master of Clinical Psychology

Rhonda Waterworth

The University of Queensland
Master of Law

PHD	University & Topic	Supervisor
Rebecca Armstrong	The University of Queensland Specific language impairment across the lifespan: A retrospective and prospective study.	James Scott
Elnike Brand	The University of Queensland Let's talk about sex - The development of a sexual knowledge base for Forensic Order patients with chronic psychotic illness.	Ed Heffernan, David Street & Graham Neilsen
Rachael Brimelow	The University of Queensland Management of affective and anxiety disorders in aged-care: identification, diagnosis and the impact on wellbeing through an e-health initiative for personal carers.	Nadeeka Dissanayaka, Gerard Byrne & Judy Wollin
Bjorn Burgher	The University of Queensland Neuroinflammation in schizophrenia	James Scott, Michael Breakspear & Gerard Byrne
Peter Carr	Griffith University Risk Factors for peripheral intravenous cannula insertion failure in the Emergency Department	Claire Rickard, Marie Cooke, Niall Higgins, James Rippey
Fiona Davidson	The University of Queensland Australian Mental Health Court Liaison Services, variation and common ground: performance measurement and evaluation.	Philip Burgess, Ed Heffernan, David Greenberg, Tony Butler
Emily Hielscher	The University of Queensland Non-accidental self-injury and suicidality in adolescents and young adults with psychotic experiences	James Scott
Jordan Laurie	Queensland University of Technology Non-contact vital signs assessment using robotic vision	Jonathan Roberts; Thierry Peynot, Oran Rigby, Niall Higgins
Elizabeth McVie	The University of Queensland An analysis of the decisions of the Queensland Mental Health Court	Gerard Byrne
Thy Meddick	The University of Queensland Exploring family mental health as predictors of children's education and vocational outcomes across the lifespan	James Scott

Melanie Mitchell	Queensland University of Technology Precursors to violence in people with mental illness who threaten violence.	Gavin Palk
Phil Mosely P	The University of Queensland Impulsivity and carer burden in Parkinson's Disease	James Scott & Michael Breakspear
Lucianne Palmquist	Griffith University A grounded theory explanation of adolescent "Recovery": CYMHS consumer perspectives	Analise O'Donovan, Sue Patterson & Graham Bradley
Elke Perdacher	The University of Queensland Stay Strong Custody Project	David Kavanagh, Jeanie Sheffield
Annaketurah Ralph	The University of Queensland Pathway from adverse childhood experiences (ACE) to problematic substance use (PSU) in young adults, specifically looking at the role of emotional dysregulation and rash impulsivity.	Matthew Gullo, Paul Harnett & Jason Connor
Suichi Suetani	The University of Queensland Physical activity and people with psychosis	James Scott, John McGrath, Harvey Whiteford
Hannah Thomas	The University of Queensland Beyond the classroom and into the cyber world, next generation research into adolescent bullying	James Scott
Amy Wong	Queensland University of Technology Does Cognitive functioning assist in distinguishing subjects with dissociative identity disorder from those with schizophrenia	James Scott
Ji Hyun (Julia) Yang	The University of Queensland Mindfulness and cognitive training in Parkinson's disease	Gerard Byrne

DISSEMINATION ACTIVITIES

Journal articles

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Book Chapters

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Scott JG, Mihalopoulos C, Erskine HE, Roberts J & Rahman A (2016). Childhood Mental and Developmental Disorders. In V. Patel, D. Chisholm, T. Dua, R. Laxminarayan & M. E. Medina-Mora (Eds.), Mental, Neurological, and Substance Use Disorders: Disease Control Priorities, Third Edition (Volume 4). Washington (DC): The International Bank for Reconstruction and Development / The World Bank

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Commissioned Reports

Davidson F. (2016) Key Performance Indicators for Australian Court Liaison Services, www.offenderhealth.net.au/sites/default/files/CLS%20Performance%20Framework%20and%20Measures%202016.pdf

Souza R, **Patterson S**, Gandesha A, McGeorge M, Quirk A, Crawford M (2016) Modelling the interface between primary care and specialist mental health services: A tool for commissioning. London: Royal College of Psychiatrists.

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Scientific Correspondence

Johnson JC, Scott JG & Jess N. (2016). Assessing the effectiveness of pharmacotherapy for obsessive-compulsive disorder. *Lancet Psychiatry*, 3(11), e16.

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Presentations 2016

Avery N. A role for psychologists – improving health behaviour and physical health outcomes for people with Severe Mental Illness. RBWH Healthcare Symposium. Brisbane, September 2016.

Avery N. Physical Health in Public Mental Health Care: Qualitative study employing COM-B model to describe views and practices of Australian psychologists. CAHRLI Forum. Brisbane, June 2016.

Avery N. Physical Health in Public Mental Health Care: Qualitative study employing COM-B model to describe views and practices of Australian psychologists. TPC Research Forum. Brisbane, October 2016.

Bicker S. Model of Human Occupation in Mental Health; The model of human occupation - application within mental health, the model of human occupation screening tool(MOHOST), Volitional Questionnaire (VQ) & MOHO employment focussed assessments. Series of 4 webinars. OT Australia NT/QLD Division, April 26th - June 3rd 2016.

Bicker S & Vallelonga V. Sensory Modulation and MOHO. A proposed clinical pathway for delivering sensory modulation within an acute inpatient mental health unit. NT/QLD OT Conference, Brisbane, October 28th 2016.

Breakspear M. A Fokker Planck for the Brain. Cognitive Neuroscience Society (CNS). New York, USA, April 2nd -5th 2016.

Breakspear M. Brain Connectivity Workshop (BCW 2016). Marseille, France, June 22nd -24th 2016.

Breakspear M. Brain waves and chimera states: Mechanisms of cortical meta-stability. Yale Workshop on Brain Connectivity. Whistler, Canada, March 6th -9th 2016.

Breakspear M. Computational Models of Brain Activity. MatLab Conference. Brisbane, May 2016.

Breakspear M. From Simplicity to Complexity: Complex Systems Across Science. World Science Festival. Brisbane, March 9th - 13th 2016.

Breakspear M. Institute Of Neurology London Brain Meeting. London, UK, April 8th 2016.

Breakspear M. Nonlinear models of large-scale brain activity. Australasian Cognitive Neuroscience Society (ACNS 2016). Newcastle, Australia, January 24th -27th 2016.

Breakspear M. Organisation for Human Brain Mapping (OHBM 2016). Geneva, Switzerland, June 26th -30th 2016.

Breakspear M. Prospective Imaging Study of Ageing and Dementia. NHMRC National Institute for Dementia Research Inaugural meeting. Brisbane, May, 1st -3rd 2016.

Breakspear M. Sa2a Geometric constraints and dynamic consequences of the human connectome. 9th Dynamics Days Asia-Pacific (DDAP9). Hong Kong, China, December 14th -17th 2016.

Breakspear M. Structural, functional and effective connectivity in affective disorders. Brain & Mind Symposium. Helsinki, Finland, September 15th -16th 2016.

Breakspear M .Using neuroimaging to understand brain network disturbances in psychiatry. Biological Psychiatry Society. Newcastle, Australia, October 13th-14th 2016.

Brown J. Enhancing cultural inclusive practice within acute mental health settings through the delivery of alcohol and drug groups. THMHS Conference. Auckland, New Zealand, August 26th 2016.

Brunetti M. Early Psychosis Family Psychoeducation Program. Early Psychosis Family Psychoeducation Program. Brisbane, July 6th, 13th, 20th & 27th 2016.

Clugston B. Diversionary options under Queensland's new Mental Health Act. Griffith University Forensic Mental Health Forum. Brisbane, July 14th 2016.

Clugston B. Australian prison mental health services. RANZCP Faculty of Forensic Psychiatry 2016 Conference. Freemantle, September 9th 2016.

Coyne E...Higgins N & Massey D. Nursing students positively evaluate video exemplars of Objective Structured Clinical Assessments. 6th International Nurse Education Conference. Brisbane, April 3rd -6th 2016.

Dalton J. A hopeful and helpful letter. The Australian and New Zealand Academy of Eating Disorders Conference 2016 (ANZAED). Christchurch, New Zealand, August 26th 2016.

Dart N & Higgins N Safewards. Safety and Quality. Grand Rounds; RBWH Safety and Quality Committee. February 17th 2016.

Davidson F.Mental health diversion in Australia: The benefits of cross border collaboration for court based forensic mental health services. Griffith University Forensic Mental Health Forum. Brisbane, July 14th 2016.

Davidson F. The national court liaison services benchmarking project. NMHMR Centre of Research Excellence in Offender Health Symposium. Sydney, November 18th 2016.

Davidson F. Mental health diversion in Australia: How effective are court liaison services? RANZCP Faculty of Forensic Psychiatry 2016 Conference. Freemantle, September 9th 2016.

Davidson F & Morse M. The unique and evolving role of Australian mental health nurses in Courts. ACMHN's 42nd International Mental Health Nursing Conference. Adelaide, September 2016.

Flaws D. Developing and Implementation of the EDACS Chest Pain Protocol. HSRAANZ Symposium and AGM. Brisbane, December 1st 2016.

Fleming, C, (2016). Adult Psychopathology Clinical Psychology. School of Psychology and Counseling, Queensland University of Technology. Guest Lecture, Brisbane, 2016.

Fleming C. Child & Adolescent Psychopathology. Master of Educational and Developmental Psychology, School of Psychology and Counseling. Guest lecture, Brisbane, 2016.

Fleming C. Introduction to Eating Disorders. Annual Meeting of the National Eating Disorders Collaboration of Australia. Brisbane, July 17th 2016.

Fleming C. Skill-based training for professional utilizing a cognitive behavioural self help manual. Victorian Centre of Excellence in Eating Disorders. Guest lecture. Melbourne, 25th - 26th February 2016.

Fleming C. Working with Families Affected by Eating Disorders. Regional Forum for the National Eating Disorders Collaboration of Australia. Tasmania, February 11th 2016.

Green B. Belief and mass murder: An analysis of Anders Brevik's declaration. 36th ANZAPPL Annual Congress. Auckland, New Zealand, November 26th 2016.

Heffernan E. Mental illness, police and communications. Griffith University Forensic Mental Health Forum. Brisbane, July 14th 2016.

Heffernan E.The mentally ill and the criminal justice system: opportunities and challenges. 36th ANZAPPL Annual Congress. Auckland, New Zealand, November 26th 2016.

Heffernan E. The mentally ill in custody: An unnecessary recruitment of adversity. Improving Health and Social Outcomes for Prisoners and Young Offenders. Evidence and Partnerships, Brisbane, February 16th 2016.

Heffernan E & Davidson F. Trauma and PTSD among Aboriginal and Torres Strait Islander women in custody. RANZCP Faculty of Forensic Psychiatry 2016 Conference. Freemantle, 10th September 2016.

Higgins N & Meehan T. Safewards model – Collaborative research Metro North and West Moreton. Department of Health Occupational Violence Forum, Royal Brisbane and Women's Hospital. Brisbane, March 21st 2016.

- Keogh S... Higgins N, Davies K & Rickard C. A time and motion study of peripheral venous catheter flushing practice using manually prepared and pre-filled syringes. The Australian Vascular Access Society 1st Scientific Meeting. Brisbane, April 29th - 30th 2016.
- Moudgil V & Park M. An overview of the clinical, therapeutic and practice updates, new medicines, new indications for known medicines, safety updates, and upcoming medicines/devices for the area of Mental Health. QLD Annual Medicines Update 2016: Clinical and Practice Update - Mental Health. Brisbane, October 23rd 2016.
- Palmquist L. Roller Coaster Under Construction: A journey of adolescent recovery. Recovered Futures (2016 AsPac International Mental Health Conference. Brisbane, October 25th 2016.
- Pathé M. Fixation and grievance fuelled violence: Preventing the unpredictable. 36th ANZAPPL Annual Congress. Auckland, New Zealand, November 23rd 2016.
- Pathé M. Managing the fixated threat in Australia: Communication, co-ordination and collaboration. National Fixated Threat Assessment Conference. Brisbane, 28th April 2016.
- Pathé M Expanding the model: The emerging nexus between fixated loners and lone actor terrorists. National Fixated Threat Assessment Conference. Brisbane, 28th April 2016.
- Pathé M. Sovereign Citizens: Conspiracy, contagion and domestic terrorism. 36th ANZAPPL Annual Congress. Auckland New Zealand, November 24th 2016.
- Phillips J. Competency based training in forensic psychiatry. RANZCP Faculty of Forensic Psychiatry 2016 Conference. Freemantle, September 9th 2016.
- Prentice , K. The forgotten party: Victims of violent crime by offenders diverted to forensic mental health systems. North and South Queensland Social Work Conference. Brisbane, November 25th - 26th 2016.
- Roberts M, Lee A & Kretschmann T A Place at the Table? Valuing peer support in the treatment of eating issues. Australian and New Zealand Academy of Eating Disorders Annual Conference. Christchurch New Zealand, August 26th - 27th 2016.
- Russell A & Dark J. . OT Australia Qld/NT State conference held at the Brisbane Convention and Exhibition Centre on 28th Oct 2016.
- Scott J. Antipsychotic medication in the management of Early Psychosis. Queensland Branch of the RANZCP Faculty of Child and Adolescent Psychiatry Annual Conference. Invited Plenary. Gold Coast, 2016.
- Scott J, Auto immune encephalitis. A cause of psychosis. Grand Rounds: Top End Mental Health Services. Darwin, February 26th 2016.
- Scott J. Autoimmune Encephalitis: What Psychiatrists need to know. Psychiatry Education Day. Brisbane, August 13th 2016.
- Scott J. Bullying: A Modifiable Risk Factor for Mental Illness. PDN School Leaders Forum. Brisbane, March 9th 2016.
- Scott J. Hallucinations experienced by people living in the General Population. Queensland Hearing Voices Community Voices of Recovery Conference. Invited Keynote, Brisbane, July 12th 2016.
- Scott J. Psychopharmacology for children and adolescents. Australian Psychological Society (Qld Branch). Brisbane, May 27th 2016.
- Scott J. Queensland Research Update: Child and Youth Mental Health Update. BDHP Mental Health Research Update. Brisbane, May 27th 2016.
- Scott J. The Clinical Use of antipsychotics in young people with early psychosis. Child Psychiatry Grand Rounds, Health Promotion Board Singapore General Hospital. Singapore, November 29th 2016.
- Scott J. Use of antipsychotics in patients with early psychosis. Sunshine Coast Mental Health and Addiction Services Grand Rounds. Nambour, September 28th, 2016.
- Scott J. Use of LAI medication in managing early psychosis. Psychopharmacology in Schizophrenia. Canberra, February 17th 2016.
- Scott J, Connell M et al., Hallucinations in Adolescents and Risk for Mental Disorders in Adulthood: Prospective Evidence from the MUSP Birth Cohort Study. Royal Australian and New Zealand College of Psychiatrists (RANZCP) Congress. Hong Kong, May 8th – 12th 2016.
- Scott J et al., The Prevalence of Autoimmune Encephalitis in Patients Presenting with First Episode Psychosis. Royal Australian and New Zealand College of Psychiatrists (RANZCP) Congress. Hong Kong, May 8th – 12th 2016.
- Turner J. The lived experience of breast-cancer related lymphoedema. Clinical Oncology Society of Australia Annual Scientific Meeting. Gold Coast, November 16th - 18th 2016.
- Turner J.. Can you really “conquer” fear of cancer recurrence. Clinical Oncology Society of Australia Annual Scientific Meeting. Gold Coast, November 16th - 18th 2016.

Turner J. Supportive care for patients with advanced disease. Clinical Oncology Society of Australia Annual Scientific Meeting. Gold Coast, November 16th - 18th 2016.

Turner J. Can guidelines be adapted for low and middle-income countries? International Psycho-Oncology Society World Congress. Dublin Ireland, October 17th - 21st 2016.

Turner J. Helping parents with advanced cancer to talk with their children. International Psycho-Oncology Society World Congress. Dublin, Ireland, October 17th - 21st 2016.

Turner, J, (2016). A novel therapy for fear of cancer recurrence. International Psycho-Oncology Society World Congress, Dublin Ireland, 17th - 21st October

Turner J. Can you really “conquer” fear of cancer recurrence? International Psycho-Oncology Society World Congress. Dublin, Ireland, October 17th - 21st 2016.

Turner J. Coping with a diagnosis of secondary Breast Cancer. Breast Cancer Network of Australia Education Forum. Brisbane, August 23rd 2016.

Turner J.. Emotional impact of early breast cancer. Breast Cancer Network of Australia Education Forum. Brisbane, August 23rd 2016.

Turner J. Innovative approaches to psychosocial care. Cancer Institute NSW Innovations conference and Hospital Alliance for Research Collaboration forum. Sydney, August 14th - 16th 2016.

Turner J. Masterclass: addressing needs and innovative models of care. Cancer Institute NSW Innovations conference and Hospital Alliance for Research Collaboration forum. Sydney, August 14th - 16th 2016.

Turner, J, (2016). The value proposition of good psychosocial care. Cancer Institute NSW Innovations conference and Hospital Alliance for Research Collaboration forum. Sydney, August 14th - 16th 2016.

Turner, J, (2016). Cancer care for the whole patient: Contributions from psycho-oncology. UQCCR lecture series. Brisbane, August 9th 2016.

Turner J. Psychosocial aspects of cancer. RANZCP trainees. Tasmania, Hobart, July 20th 2016.

Turner J. Taking heart when your heart sinks: Communication challenges in the care of the patient with lymphoedema. Asia-Pacific Lymphology Conference. Darwin, May 27th 2016.

Turner J. Psychosocial aspects of care during treatment for breast cancer. Australian Institute of Radiography National Conference. Brisbane, April 22nd 2016.

Turner J. A matter of life and death: The spectrum of psychosocial care for those who survive and those who die from cancer. Cannan Institute Speaker Series. Brisbane, March 21st 2016.

Turner J. Health professionals and self-care. West Moreton and Health Service Social Work Forum. Ipswich, 16th March

Turner J. Coping with a diagnosis of prostate cancer. Prostate Cancer Support Group meeting. Brisbane, March 9th 2016.

Turner J. Depression – a modern epidemic. Centre for Palliative Care Research and Education Update program. Brisbane, March 11th 2016.

Ward W. Introduction to the medical management of eating disorders. Capitalising on the future. ANZAED Autumn Workshop Series. Canberra, March 11th -14th 2016.

Ward W. Reconfiguring general health services to meet the needs of adults with anorexia nervosa. 3rd Eating Disorders and Obesity Conference, Gold Coast, May 17th 2016.

Waterson E, Perrin M & Davidson F. The urgent versus the important: Complexities of prison mental health service delivery. RANZCP Faculty of Forensic Psychiatry 2016 Conference. Freemantle, September 9th 2016.

Willis K. A group base psychosocial intervention to support consumers in detoxification: Outcomes from pilot study. WOWS9 Conference. RBWH Brisbane, 13th May 2016.

Research Grants

Investigators (RBWH staff in bold)	Project Title	Granting Body	Amount
Breakspear M	Brain Connectomics in Psychiatry	NHMRC Principal Research Fellowship	\$763,845
Breakspear M	Researcher of the Year	Metro North Mental Health and Hospital Research	\$5,000
Breakspear M, Patterson S, Chapman J	Trialing the feasibility and acceptability of physical activity self-monitoring and supervised exercise interventions for adults with severe mental illness	RBWH Foundation Grant	\$39,000
Breakspear M, Martin N, Byrne G, et al.	Prospective Imaging Study of Ageing: Genes, Brain and Behaviour (PISA).	NHMRC Grant	\$6,465,047
Burgher B, Scott JG, Cumming P, Breakspear M.	Early Psychosis: Neuroinflammation and Neurodegeneration from Ultra High Risk to First Episode Psychosis	Herston Imaging Research Facility (HIRF) Seed Research Funding	\$100,000
Ferrari A, Charlson, F, Erskine, H, Leung J, Veerman L & Scott JG	Unpacking the Global Burden of Disease Study: How to use over 1 billion findings in your research and practice	MBS Collaborative Workshop grant	\$4,890
Sarris J, Ng, Byrne G et al.,	N-Acetyl Cysteine in the adjunctive treatment of obsessive compulsive disorder: A 16-week, double-blind, randomised, placebo-controlled study	NHMRC Grant	\$850,448
Scott JG	Anti-Neuronal Antibodies in patients with treatment refractory psychotic disorders	RBWH Foundation Grant	\$44,000
Scott JG et al.		Brisbane Diamantina Health Partners Brain and Mental Health Establishment Grant	\$70,000
Stafford L, Newman L, Mann B, Turner J et al.	EPIC. Enhancing parenting in cancer: Development and evaluation of a brief psychoeducational intervention to support parents with cancer who have young children	Victorian Cancer Agency	\$200,000
Randall C, Patterson S, Ward W & Sheffield J	Clinical outcomes and experience of a three month intensive outpatient program for people with Eating Disorders: A mixed methods study to inform systematic quality improvement.	RBWH Foundation	\$27,110
Fleming C	Collaborative for Allied Health Research - Eating Disorders Outreach Service Family LINK-ED Project	Learning and Innovation MNHHS (CAHRLI) Innovation Fund	\$10,255