IMPROVING PUBLIC MENTAL HEALTH SERVICE: IS GROUP THERAPY THE ANSWER?

A Thesis by Publication submitted by

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ABSTRACT

Several psychotherapeutic varieties exist and can be delivered either individually or in a group format. Group Therapy is an effective treatment modality however, there is limited evidence related to the implementation and sustainability of a Therapeutic Group Program (TGP) in an Australian public mental health service setting. The aim of this work-based study was to identify and understand critical elements contributing to the sustainability of a TGP and to enable scaling of implementation in other services. A retrospective analysis of a TGP provided the opportunity to conduct a retrospective analysis of implementation. The TGP consisted of a variety of group therapies for example Dialectical Behaviour Therapy, Cognitive Remediation, Cognitive Behaviour Therapies. Case managers, consumers (patients) and management's perceptions of the barriers and facilitators of TGP implementation were collected via 14 semi-structured interviews. Michie's Behaviour Change Wheel characterising behaviour change interventions through Capability, Motivation, Opportunity, and Behaviour (COM-B) was utilised for the thematic analyses of the qualitative data. The findings identified the following: Capability: a shift in focus from case management towards therapeutic intervention and specific training programs leading towards participation in the TGP leads to improved staff capability; Motivation: a clear well defined structured evidence-based approach is required as well as opportunities for staff to participate in the TGP as this facilitate enhanced work satisfaction due to staff working to their full scope of practice; and Opportunity: management support, allocated staff, allotted time for staff, adequate resourcing including a specific budget and clear governance structures are required to sustain the TGP. Strategies identified to facilitate the implementation of evidence-based practice included behaviour change interventions and clarity in statements of policy requirements and governance processes related to TGP in policy documents. These strategies would enable to implementation of a TGP within a public mental health setting and provide consumers access to group therapy through a public service.

Keywords: group therapy, psychotherapy, mental health, implementation

CERTIFICATION OF THESIS

I, Zonia Weideman declare that the Master Thesis entitled Retrospective process evaluation of a therapeutic group program in a public mental health service is not more than 40,000 words in length including quotes and exclusive of tables, figures, appendices, bibliography, references, and footnotes. The thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work.

Date:9 September 2022

Endorsed by:

Professor Karen Trimmer
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Student and supervisors' signatures of endorsement are held at the University.

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STATEMENT OF CONTRIBUTION

Paper 1: Improving Public Mental Health Services. Is Group Therapy an answer?

The student contributed 80 % to this paper. Collectively Karen Trimmer, Amanda Hensen and Tracy L Kolbe-Alexander contributed to the remainder. The paper was submitted to the Cognitive and Behavioral Practice Journal on 19 August 2022 (Appendix V).

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CAS	Community and Acute Services
CBT	Cognitive behavioural therapy
CCT	Community Care Team
CCU	Community Care Unit
CIMHA	Consumer Integrated Mental Health Application
DBT	Dialectical behaviour therapy
HoNOS	Health of Nation Outcomes Scale
HHS	Hospital and Health Service
LSP – 16	Life Skills Profile 16
MHI	Mental Health Inventory
MHSS	Mental Health and Specialised Services
NGO	Non-Government Organisation
PIS	Participant Information Sheets
RRPT	Recovery, Rehabilitation and Partnership Team
TGP	Therapeutic Groups Program
TNA	Training Needs Analysis
WMHS	West Moreton Hospital and Health Services

Glossary

Bipolar Disorder

"Bipolar disorders are brain disorders that cause changes in a person's mood, energy and ability to function. Bipolar disorder is a category that includes three different conditions — bipolar I, bipolar II and cyclothymic disorder. People with bipolar disorders have extreme and intense emotional states that occur at distinct times, called mood episodes. These mood episodes are categorised as manic, hypomanic or depressive. People with bipolar disorders generally have periods of normal mood as well. Bipolar disorders can be treated, and people with these illnesses can lead full and productive lives." (American Psychiatric Association, 2020)

Case Management

Mental Health Case management is a specific approach to the coordination of community mental health services (Dieterich, 2017).

Consumers

"People with mental illnesses and/or chemical dependency who receive services in settings where it is not customary to use the term "patient" (England, 2015, p. xxiv).

Dialectical Behaviour Therapy (DBT)

DBT teaches skills in mindfulness, interpersonal effectiveness, distress tolerance and emotion regulation. This group consists of a weekly skills group, weekly meetings with a DBT therapist and out of session phone coaching (Pasieczny, 2011).

Group Therapy

"A special form of therapy in which a small number of people meet together under the guidance of a professionally trained therapist to help themselves or one another" (Price, Hescheles, & Price, 1999, p. 170).

Peer Support

"Services delivered by individuals who share life experiences with the people they are serving. These individuals offer informational, emotional, and intentional support to their peers, which allows for personal growth, wellness promotion, and recovery." (England, 2015, p. xxviii).

Personality Disorder

"Personality is the way of thinking, feeling and behaving that makes a person different from other people. An individual's personality is influenced by experiences, environment (surroundings, life situations) and inherited characteristics. A person's personality typically stays the same over time. A personality disorder is a way of thinking, feeling and behaving that deviates from the expectations of the culture, causes distress or problems functioning, and lasts over time." ((Association, 2013).

Psychosocial Interventions

"For mental health and substance use disorders are interpersonal or informational activities, techniques, or strategies that target biological, behavioral, cognitive, emotional, interpersonal, social, or environmental factors with the aim of improving health functioning and well-being." (England, 2015, p. 31).

Recovery

"A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. The four major dimensions that support a life in recovery are overcoming or managing one's diseases or symptoms, having a stable and safe place to live, engaging in meaningful daily activities, and developing relationships and social networks." (England, 2015, p. xxix).

Schizophrenia

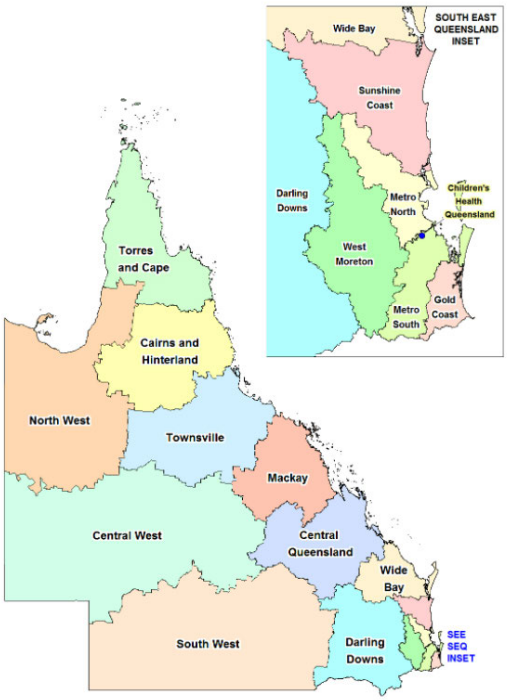
"Schizophrenia is a chronic brain disorder that affects less than one percent of the U.S. population. When schizophrenia is active, symptoms can include delusions, hallucinations, trouble with thinking and concentration, and lack of motivation. However, with treatment, most symptoms of schizophrenia will greatly improve." (Association, 2013.).

Substance Use Disorder

"The essential feature of a substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems" (Association, 2013).

West Moreton Health Services

"West Moreton Health provides health and wellbeing services to more than 320,000 people across the Somerset, Scenic Rim, Lockyer Valley and Ipswich communities. Its borders stretch to the north of Esk, west of Gatton, east of Ipswich and Springfield, and south of Boonah. We provide preventative and primary healthcare services, ambulatory services, acute care, sub-acute care, and oral health, mental health and other specialised services (including prison health services and alcohol and other drugs services) to the region. West Moreton is the fastest growing region in Queensland in relative terms with a population that is expected to almost double to 588,000 by 2036." (Health).



Last updated: 21 January 2021

CHAPTER 1: INTRODUCTION

1.1 Context/Background

The National Study of Mental Health and Wellbeing conducted in 2021 found that 2 in 5 Australians have experienced a mental disorder in their lifetime (Statistics, 2020-21). The Productivity Commission Inquiry Report of 2020 into Mental Health found that Australians with a mental illness struggle to find services that are right for them and recommended that gaps within community health care be addressed (Commission, 2020). Embedded within Recommendation 12 of the report is the provision of more group therapies.

The West Moreton Region faces a population growth of 113% by 2036 and therefore an increase in the need of mental health resourcing can be assumed (State of Queensland Annual Report 2017–18). With this growth in mind, West Moreton Hospital and Health Service (WMHS) needed to look at new and innovative ways to deliver care to consumers experiencing a mental illness and ways to utilise resources as effectively as possible (*The State of Queensland (Queensland Health) Department of Health Annual Report* 2017-2018).

The gap between research and evidence-based practice still exists, especially pertaining to group therapy. Effective, innovative practice implementation in complex systems, for example public health services, takes time, effort and requires high levels of support (Burns 2011). These resources are limited within a system that is already stretched due to the increase in number of consumers and the increase in complexity faced by clinicians. "It is well recognized that the use of evidence-based practices (EBPs) is critical to improving service outcomes for those receiving behavioral health services. However, EBPs are not easily implemented in behavioral health settings, and there are many challenges to supporting these services over time" (Vroom, 2022, p. 106)

Why then the focus on group therapy? Both individual therapy and group therapy demonstrate different advantages and disadvantages. Some advantages of group therapy are that it is more cost-effective and time efficient and facilitates more peer learnings and social connection. However, disadvantages of group therapy include being less flexible for the consumer and individual therapy allows better therapist patient relationships (Aguilera-Martín, 2022, Burlingame, 2003).

The objective of group therapy is to optimise service delivery for consumers of the mental health service and enhance the delivery of interventions. Offering different modalities of psychosocial intervention assists consumers on their recovery journey (J. Scott Rutan, 2021). Drum et al., (2011) stated that "One of the least tapped reservoirs of health care assistance is employing the power of group interventions to treat those who are trying to adjust to challenging health conditions" (p. 247). This work-based study will focus on the gap that still exists between what has been proven to be effective and embedding therapeutic group delivery in clinical care. Thus the research is not based on how to facilitate groups, but rather on the factors that inform the implementation of therapeutic groups.

This study investigated group therapy in one public health mental health service. Interviewees were clinicians facilitating the program, public health service managers and consumers that had previously participated in group therapy. The emphasis was on obtaining an understanding of elements that are required to implement and sustain group therapy.

Section 2 of this chapter outlines the background to the research, defining the research problem and provides the background of the researcher as practitioner. The literature review (section 3) provides

detailed information related to barriers and facilitators of implementing group therapy as well as the implementation science with behaviour change as the focus. Section 3 also includes the scope of the research to provide clarity to the study and identify the gap in the literature. Section 4 offers an understanding of the conceptual model and outlines the purpose of this research.

Chapter 2 provides a detailed overview of the methodology including ethical considerations. Chapter 3 includes the final version of the peer-reviewed journal article submitted for consideration for publication in Cognitive and Behavioural Practice. The conclusions, contributions and the researcher's lessons learned are presented in Chapter 4.

1.2 Problem/Issue

In 2016, West Moreton Health Service (WMHS), Mental Health and Specialised Services (MHSS) identified a need for a service-based framework to initiate the delivery of community Therapeutic Group Programs (TGPs). At the time, their management requested the establishment of TGP for the following reasons:

1. Evidence based treatment of specific diagnostic presentations and symptomology was not occurring due to an over emphasis on case management.
2. Case management was generic and did not support discipline specific practice and therefore clinicians were not working towards their full scope of practice.
3. Due to the generic nature of case management and the focus on case management for a number of years, clinicians were de-skilling.

4. Cost effective and efficient treatment options needed to be explored within a landscape with increased demand and stagnant funding.

I am the Therapy Lead of WMHS and was responsible for the implementation and subsequent sustainability of the TGP. I am an Occupational Therapist with over 20 years of experience within the mental health sector. At the time (2016), there was limited guidance in the literature on how to establish TGPs within a public mental health sector. To assist in establishing the TGP, and due to the lack of literature, a governance group was created with the Therapy Lead, Team Leaders, Discipline Specific Leaders, Allied Health Director, Nursing Director and Clinical Director of the Community and Acute Mental Health Services to guide the establishment process.

Benchmarking was completed with other Hospital and Health Services to establish what TPGs were being offered. There was very little consistency across health services and only Darling Downs Hospital and Health Service had an overarching plan in place that incorporated evidence-based care specific to their population.

The decision was made to analyse aggregated data related to diagnostic population groups within WMHS CAS. Data from Queensland Health's mental health information management system CIMHA (Consumer Integrated Mental Health Application) were collected on diagnostic groups (Appendix A). To ensure evidence-based practice, the governance group made the decision that Level I and II clinical treatment evidence would inform the development during the initial roll out of the TGP (see Table 1). It was generally accepted that this level of evidence is the most reliable evidence of whether a treatment is effective (Merlin et al., 2009). The population cohorts according to diagnostic DSM-V criteria and Level I and II evidence-based therapeutic groups are included in Attachment I. Priority

was given to therapeutic groups that were identified across two or more diagnostic cohorts, for example, DBT is identified for both substance use disorder and Personality Disorders. This also became the inclusion criteria for the therapeutic groups: to access DBT, consumers required a diagnosis of either personality disorder or of substance use disorder.

Table 1: Levels of Evidence for Prognostic Studies

Level	Type of evidence
I	High quality prospective cohort study with adequate power or systematic review of these studies
II	Lesser quality prospective cohort, retrospective cohort study, untreated controls from an RCT, or systematic review of these studies
III	Case-control study or systematic review of these studies
IV	Case series
V	Expert opinion; case report or clinical example; or evidence-based on physiology, bench research, or "first principles"

Once the therapeutic groups were identified, the next step was to locate existing skill sets. After discussions within the Governance group, it became clear that a Training Needs Analysis (TNA) among staff was required in order to deliver the prioritised therapeutic groups. The TNA was required to identify staff skill deficits pertaining to the priority therapeutic groups to establish training requirements. A Therapy Capability Survey was undertaken in 2017 with staff from the various practice areas to identify their level of training, expertise and willingness to train in the

various therapeutic modalities (Appendix C). The survey provided an indication of what training was required to offer the identified therapeutic groups. It also provided an opportunity for case managers to be involved in the design of a training program which facilitated more interest in the TGP (Dark, 2018) Several external content experts in their various fields, were sourced to provide training to staff. After the completion of training, an expression of interest was sought from clinicians to coordinate the individual groups and a Group Coordinator was employed to oversee the overall logistics of the TGP. Coordinators were required to complete a Group Outline, and this was presented to the Governance committee (Appendix D).

The establishment of an interdisciplinary TGP occurred in 2017 in MHSS (Appendix E). Each group within the TGP had Outcome Measures specific to that group determined by the individual group planner and supervision or consult group. For example, DBT Outcome Measures include Borderline Symptom List – BLS 23, Depression Anxiety Stress Scales (DASS) 21. Other outcome measures include Emergency Department Presentations and Mental Health Unit admissions. Outcome Measures of each group are quarterly reported to the TGP Governance Group.

Management requested the enhancement of the TGP once the effectiveness and clinician interest of the TGP became evident in CAS. A diagnostic population analysis and an evidence-based data review was repeated in 2018 and the TGP was amended to meet the needs of the 2018 consumer cohort. Changes in the population data from 2016 -2018 included a decrease in the diagnoses of general psychiatric examination, not elsewhere classified. However, the top five diagnostic groups remained relatively stable:

F20 – F29: Schizophrenia, Schizotypal and delusional disorders;

F30 – F39: Mood (Affective disorders);

F40 – F48: Neurotic, stress-related and somatoform disorder;

F60 – F69: Disorders of adult personality and behaviour; and

F10 – F19: Mental and behavioural disorders due to psychoactive substance disorders.

Outcome measure data was also collated to ensure that both the diagnoses and symptomology were considered. Queensland Health mandates the use of the Life Skills Profile 16 (LSP-16), Mental Health Inventory (MHI) and the Health of the Nation Outcome Scale (HoNOS). Even though mandated, the MHI is not regularly completed, and data was not reliable and could not be used. Data from the LSP-16 and HoNOS indicated a gap in the TGP program (Attachment F). The top four problems identified within the HoNOS data were: item number 7: Problems with depressed mood, item number 8: Sleep, item number: 3: Problem drinking or drug-taking and item number 9: Problems with relationships. The top three problems identified within the LSP-16 were: number 16: capable of fulltime work, number 3: show warmth to others, number 8: Make and/or keep friendships. Except for work, all other identified areas of need were addressed within the TGP. Vocational Rehabilitation is still a gap in service delivery. However, external providers and Non-Government Agencies (NGO) have been sourced to address this gap.

Since then, the TGP has been enhanced in 2019 and again in 2020 (Appendix G). Moreover, the ongoing sustainability of the TGP has been identified as a priority for WMHS. Other public health services have also been in contact with WMHS to request guidance on establishing their own TGPs. This work-based study will therefore examine the critical experiences and influences of public mental health staff involved in the development of

the TGP. The information obtained during this study will be disseminated to inform other Health Services within the public health system on the enablers and barriers of commencing a TGP and with the goal that the WMHS TGP can be sustained in the long term.

1.3 Literature Review and Gap Analysis

Any proposed change in service delivery within the public health care sector needs to ensure that all stakeholders concerns are addressed (González-Valderrama, 2015). Slade (2009) recommended identifying all relevant stakeholders at the commencement of change management and communicating the relevance, and viability of practice changes to them as soon as possible. Slade also noted that it is important to identify outcomes that will indicate successful implementation from the commencement of the change management process and continually measure progress against these outcomes whilst always placing the patient at the centre of all change (Slade, 2009).

A review of literature related to psychiatric rehabilitation, mental health, group therapy, therapeutics, psychosocial intervention, community psychiatry, staff training, and change management has been used to inform this study. The literature review, which focusses on addressing stakeholder concerns, includes the following overarching themes:

- Mental health disorders are a serious health concern;
- Effectiveness of therapeutic group intervention;
- Current practice in offering therapeutic group interventions;
- Skills gap;
- Cost-effectiveness;
- Other barriers to implementation; and
- Implementation science provides models, theory and framework for successful implementation and sustainability of evidence-based care.

1.3.1 Mental Health Disorders Are a Serious Health Concern

The 2007 National Survey of Mental Health and Wellbeing indicated that 45.5% of Australians will experience a Mental Health Disorder within their lifetime (Health Service Research and Development). Australia's estimated resident population on 30 June 2017 of 24.6 million people is projected to increase to between 37.4 and 49.2 million people by 2066 (Australian Bureau of Statistics 2016). With the increase in population, and assuming the current prevalence of Australians experiencing Mental Health Disorders remains consistent, an expected growth of demand on the public mental health system is predicted (Allison & Bastiampillai, 2015).

Public mental health sector service delivery will face a substantial increase in demand with limited growth and therefore new cost effective and efficient methods of service delivery need to be considered. It is encouraging that there has been a shift in funding focus to community services as this is where group therapy occurs (Hickie, 2015; Perkins, 2016).

1.3.2 Therapeutic Group Intervention is Effective

A group can comprise of distinct clientele or deliver a particular model of therapy, for example, Dialectical Behaviour Therapy (DBT) is recommended for people diagnosed with Borderline Personality Disorder (Burns et al., 1999; Koerner, 2013). The effectiveness of group therapy as a mental health intervention is well researched (Burlingame, 2003. Naik, 2013. Dark, 2015. Burlingame, 2016. J. Scott Rutan, 2021. Kocijan Lovko, 2021.). The evidence base relates to each separate group therapy, for example the effectiveness of DBT, Cognitive Behaviour Therapy (CBT) and Psychoeducation has been proven through a meta-analysis to be effective forms of psychological intervention (Australian Psychological Society, 2018, p. 16). The effectiveness of each separate group therapy is summarised

in the "Evidence-based psychological interventions in the treatment of mental disorders: A review of literature" (Australian Psychological Society, 2018) (Appendix H). Ongoing effectiveness after the delivery of a group has been researched and verified. For example, a reduction in social anxiety disorder; a decrease in depression and anxiety after a CBT group up to 4.6 years after the delivery (Fogarty, et al., 2019). Group therapy is effective for several reasons, examples include:

- Group therapists come from many professions and bring their professional experience and knowledge which makes group therapy a multidisciplinary intervention modality (Lorentzen, 2014).
- Curative factors can be facilitated within a group that cannot be facilitated within individual therapy for example cohesion, universality and altruism (Yalom, 2021).
- A group can comprise of distinct clientele or deliver a particular model of therapy for example DBT for people diagnosed with Borderline Personality Disorder (Koerner, 2013).

1.3.3 Therapeutic Group Interventions Are Not Routinely Offered

A chasm exists between the evidence and the implementation of group therapy in the public mental health service. Despite the evidence on the effectiveness of group therapies it is not available to consumers within all Hospital and Health Services in Queensland, Australia (Drum et al., 2011; Lorentzen & Ruud, 2014). The Mental Health of Australians 2: report on the 2007 National Survey of Mental Health and Wellbeing stated that even the implementation of effective and efficient innovative evidence-based practices in a public setting is complex due to the diversity of tasks, the diversity of patients and diversity of staff. (Deloitte, May 2017).

A Queensland Health internal web-based search was completed in June 2022 to determine which of the health services offer group therapy

within the community adult service and six out of fifteen Health services offer a TGP (see Table 2).

Table 2: Queensland Health Services Offering TGP

Health service	Offers TGP
Cairns and Hinterland	N
Central Queensland	N
Central West	N
Darling Downs	Y
Gold Coast	Y
Mackay	N
Metro North	Y
Metro South	Y
Northwest	N
Southwest	N
Sunshine Coast	Y
Torres and Cape	N
Townsville	N
West Moreton	Y
Wide Bay	N

1.3.4 A Skill Gap Exists

Recent evidence suggest that clinicians are not sufficiently skilled to deliver group therapy if they have not received specialised training (Martyn Whittingham et al., 2021). Reasons include: individual therapy continues to be valued above group therapy; variability and a decrease in group therapy training in undergraduate training across multidisciplinary professions; lack of work experience or clinician competency; developments in pharmacological treatments; economic reasons, limited research on group therapy in mental health public services in Australia; and a lack of research (knowledge) in the utilisation of group therapy at a local level (Fairburn & Cooper, 2011; Khawaja et al., 2011; Martyn Whittingham et al., 2021). Shay (2021) also notes psychological barriers as clinicians are reluctant to facilitate Group Therapy due to a lack of confidence and they may fear feelings of "inadequacy, shame and humiliation" (p. 72). Clinicians and management's beliefs and opinions about the use of Group therapy leads to prioritisation, or a lack thereof, and lack of prioritisation widens the skills gap (Taylor et al., 2001).

1.35 Cost-effectiveness

Several perceived barriers to implementing Group Therapy are described in literature: high cost, limited research, ineffective organisational support, hesitation from consumers to join groups, structural issues and set model of services (Burlingame, 2003 and (McCarthy, 2011). Group therapy offers a range of benefits however administrators and management will require a reason l that speaks to the economic bottom line. Serving the needs of more than one person at a time provides motivation to administrators as resources are used optimally (Aguilera-Martín, 2022). Even though the use of resources in an optimal way might be evident, the affordability of groups will have to be proven to ensure health service managers buy into / invest in the establishment of group therapy.

According to McCarthy and Hart (2011) "Nonetheless, economic evidence is based mainly in cost-effectiveness studies regarding medications, with little attention given to psychosocial interventions. Still, there is data supporting the use of combined treatment (i.e., pharmacologic and psychosocial interventions) as a cost-effective intervention" (p. 353). Affordability will have to be proven to ensure Health service managers buy into the establishment of Therapeutic Groups. "It is therefore essential that researchers and practitioners collaborate in the development of effective groups to meet health care needs, and in providing evidence that such interventions are cost effective" (Drum et al., 2011, p. 364).

Once such study within the Australian Public Mental Health setting that demonstrated cost effectiveness as well as clinical effectiveness of DBT is the randomised controlled study conducted by Pasieczny and Connor in 2011. They note that DBT is more effective for consumers with Borderline Personality Disorder than 'treatment as usual', resulting in a reduction of emergency department visits, mental health unit admissions and bed days (Pasieczny & Connor, 2011). They calculated a total reduction in cost per consumer of $5927.00 over six months of treatment (Pasieczny & Connor, 2011).

1.3.6 Other Barriers to Implementation

Structural barriers to TGP include lack of sufficient space, insufficient consumer referrals, reputation of the TGP, clinician's confidence in group therapy, beliefs and culture or support from management and colleagues (Shay, 2021). Psychological barriers include a model of service where the case manager experiences gratification and positive feedback when they are a helpful sole therapist for the consumer and do not want to share this positive experience with their colleagues (Taylor et al., 2001) or other group facilitators.

Barriers to implementation can arise at any, or all of government levels such as individual, team and organisation (Barker, 2016). A further barrier to implementation to any evidence-based practice in public health is behaviour change. Evidence informed practise through necessary research is required to inform the design and evaluation of policies, organisational levers, and implementation/dissemination strategies that can improve the quality of psychosocial interventions and health outcomes (Drum et al.,2011).

It is important for strategists to address these barriers within organisations through investigating effective utilisation of finite resources, including optimum treatment and high productivity rates. This work-based research study provides the researcher the opportunity to fulfill the role of strategist and focused on the design around the implementation of a TGP. The focus is shifting to providing the right treatment at the right time by the right person (Pain et al., 2018).

1.3.7 Implementation Science

Even though the effectiveness of therapeutic groups within the health care sector is well supported (McCarthy & Hart, 2011), change management strategies to implement a TGP will have to be employed. The evaluation should examine the difficulties undermining change, select strategies to bridge the difficulties and frequently evaluate change strategies. Pingani (2013) summarised the implementation process as:

1) prepare well for change;

2) involve all stakeholders,

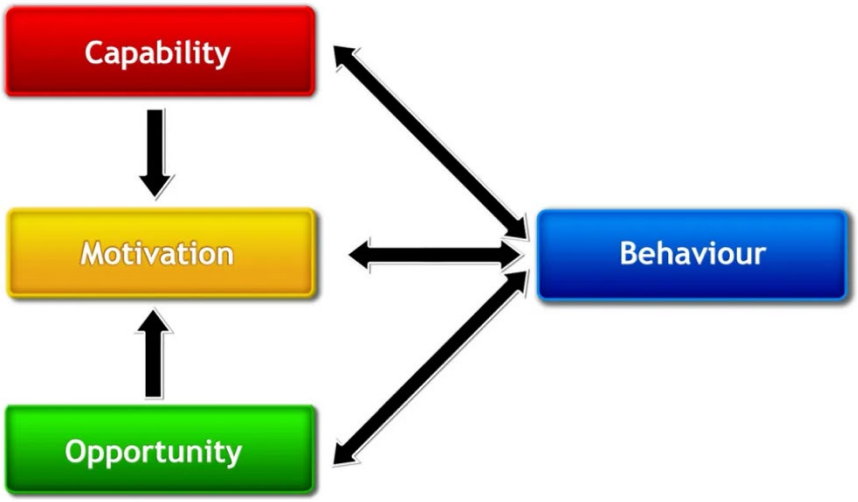
3) develop a proposal for change; and

4) make sure the proposal is evidence based, feasible and attractive to stakeholders and includes continuous evaluation of the implementation process.

This thorough process around change management will lead to sustained change. Michie explained that there are three essential components at the centre of behaviour change: capability, opportunity and motivation, (Figure 1) (S. Michie et al., 2011). The COM-B Framework provides a structure to describe factors and or determinants that influenced the implementation of TGP and barriers that exist that prevent change.

Figure 1

COM-B system – A Framework for Understanding Behaviour



From "The Behaviour Change Wheel: A new method for characterising and designing behaviour change interventions," by S. Michie, M. M. van Stralen, and R. West, 2011, *Implementation Science 6*(42), p. 4. (Copyright 2011 by Creative Commons Attribution 2.0 Generic.

Once this strategy is developed it will act as a bridge between the evidence and practice. Enabling the scaling of this strategy into other health services that will result in Therapeutic Groups being offered to consumers across Queensland. It is important that evidence-based group therapy is

available to consumers in rural areas as well as consumers in metropolitan areas as different modalities of clinical intervention enhances consumers recovery journey.

1.4 Conceptual Model

This work-based exploratory study supported theoretical knowledge by practically investigating the essential elements and challenges noted by clinicians and MHSS management. Both have been involved in the establishment of a TGP in a public community mental health setting. These factors will be used to develop a model of service that will benefit WMHS and enable implementation into other health services. Patients (consumers) and the lived experience workforce's opinions will ensure the model of service is consumer focused and meets both the needs of the organisation and its consumers.

This research identified what critical elements and challenges contributed to the implementation and sustainability of a community TGP in a community public mental health service. Following the above this research also aims to identify how the TGP framework can be scaled into other public health settings. Research questions and how it was incorporated into the qualitative study are stipulated in 2.3.8. To address the research question, a constructivist paradigm was adopted, using a qualitative approach. The study sought a deeper understanding of the barriers and enablers of the TGP in MHSS and aimed to understand the constructs from various perspectives.

CHAPTER 2: METHODS

2.1 Introduction

The previous chapter provided insight into the research and provided context around the gap analysis that informed this study. This chapter outlines the methodology of the study and the rationale for using selected research paradigm and methods.

2.2 Research Aim

The aim of this study was to identify critical elements in the establishment of a TGP. This includes what worked well during the implementation process, what challenges emerged, why clinicians became involved and referred to the TGP, when clinicians included TGP into care planning, how TGP sustainability can be ensured and what resources are required for establishment and sustainability. The findings will be used to develop a TGP framework that can be implemented in other health services.

2.3 Design

2.3.1 Research Paradigm

Constructivism was the paradigm selected as most appropriate for this work-based study due to its exploratory nature. Interpretivism was also considered as consumers, clinicians and managers were asked about their perceptions and experiences of participating and referring to the TGP. Constructivism, however, provides the opportunity to interpret interviewees' perceptions as this paradigm seeks to understand the world (Mills, 2006). This paradigm was used as the interviewees generated knowledge through the interaction. Within this research I sought to retrospectively analyse the barriers and facilitators to the implementation of TGP in a public health sector. Interviewees' experiences were studied to garner ideas on how TGP can be sustained. Semi-structured interviews

were chosen as the preferred method of data collection and this is justified through the importance of interactions, exchanges and negotiations of meaning which corresponds with the constructivist ontology (Mojtahed et al., 2014).

2.3.2 Research Design

A qualitative method was used to examine the critical experiences during both the process of development, implementation of therapeutic groups within WMHS and the impacts it has had on staff and consumers. The qualitative approach is consistent with a constructivist research philosophy.

A Logic Model was developed by the insider researcher prior to this study being done and then updated with the results of the interviews Appendix K: Preliminary Logic Model. The Logic Model graphically explains the connection between inputs, outputs, objectives and outcomes (Savaya & Waysman, 2005). The logic model describes the logical chain of how outputs and outcomes relate to each other. The logic model also describes the relationships between what resources are used (financial and human), what will be produced (outputs), and what will be achieved (outcomes) (Hayes, 2011). Inputs are a list of resources and constraints, outputs are the deliverables of the project, outcome indicators are the objectives that can be observed and measured and determine the success of the program (Hayes et al., 2011). The Logic Model is included as it provides a snapshot of the requirements of factors influencing the implementation and sustainability of a TGP.

2.3.3 Participants and Recruitment

Both purposive sampling and snowballing were used during recruitment of clinicians participating in the research. Expert purposive

sampling was used as this provides the opportunity to identify participants that have a knowledge around the implementation of TPG (expert group) (Mojtahed et al., 2014). To eliminate researcher bias, interviewees were asked to identify other participants that might have perceptions around the implementation process: 'snowballing'. Snowball sampling is when the interviewee identifies further interviewees. This process is repetitive, hence the 'snowball' effect (Noy, 2008). 15 WMHS staff were identified through this process and 11 were interviewed and five consumers were identified by their case managers, and three consumers were interviewed.

Table 3: Participants and Recruitment to study

Participants	Eligibility	Approached	Consented	Actually Interviewed
Clinicians and Management	15	12	11	11
Lived Experience	0			0
Consumers	5	4	3	3

2.3.4 Clinicians and Management

This study included staff from Goodna Continuing Care Team (CCT), Ipswich Rural CCT, Gailes Community Care Unit (CCU) and the Recovery, Resource and Partnership Team (RRPT) as the focus population for the therapeutic groups in these teams is on adults within the community. The researcher was also the Team Leader for the RRPT and therefore excluded from this study. The researcher obtained support from the Director of Operations CAS and approval from the Executive Director, Mental Health and Specialised Services prior to commencing this project.

Fifteen interviews were conducted, and all clinician and WMHS management interviewees were provided with the right to withdraw at any point during the research without any adverse impact on their employment or relationship with other staff or the health service. Interviewees needed to inform the researcher of their intent to withdraw by contacting the researcher either in writing or by phone. None of the clinicians or managers decided to withdraw.

2.3.5 Consumers

Case Managers were asked to review their current consumer caseload and identify consumers who met the inclusion criteria. Five consumers were identified. Case Managers contacted these consumers and invited them to participate in the study. Consumers who expressed interest gave permission to their case manager to pass on their contact details to the interviewer for follow up. The interviewer contacted the consumers directly and provided them with an information sheet outlining requirements for participating in the study and a consent form. Participants were given an opportunity to ask questions related to the study. Consumers had the right to decline to participate and this decision was respected. Any decision to decline participation did not adversely affect any current or future care they may receive or require from the health service.

For consumers who agreed to participate, arrangements were made to conduct the interview at a suitable time. The interviewer confirmed with the consumer whether they would like a support person with them during the interview. If yes, the consumer could nominate a support person and the interviewer contacted them and provided information around participation. In the case where the consumers wanted a support person, but were unable to nominate one, a WMHS peer worker was offered. None of the consumers chose to have a peer worker present, however, two chose

to have their nominated support person present. Three consumers were interviewed for this study.

The Lived Experience workforce was identified as eligible participants early in the study as their unique perspective will have provided a useful insight into the use of group therapy. However, none could be identified that has participated either as a pervious consumer or as a facilitator or co-facilitator and so did not meet the inclusion criteria. This was disappointing but provided an opportunity for service development. A separate quality improvement activity was conducted to enhance the involvement of the Lived Experience workforce within the TGP. At the time of writing this Exegesis the Lived Experience workforce is involved in the following group therapies: DBT, Wise Choices (Acceptance Based Therapy), Social Cognition Interaction Therapy (SCIT) and have commenced Peer Groups in the Living Well Team and in the Alcohol and Other Drugs Team.

Participation was voluntary and consumers who wished to participate completed and signed a consent form (Appendix P: Consent Form – Consumers and Appendix Q: Consent Form – Clinician and Management). This form asked consumers to indicate their consent in relation to specific elements of the study, allowing consumers to vary or change their level of participation according to their preferences and wishes. For example, a consumer may have preferred to participate in an interview but may not want / consent to the research team having access to their medical record. All the participants agreed for their consent to be recorded into their health records. A copy of the completed consent form was provided to the consumer for their records.

All consumer interviewees were given the option to withdraw from the study at any time without providing a reason. Consumer interviewees could also withdraw from the study on clinical advice from their treating

team or case manager. This would have been the case if a consumer's mental state had deteriorated to such an extent that they are unable to meet the study participation requirements, or they were no longer under the care of a case manager.

2.3.6 Ethical Considerations

Interviewees provided written informed consent following approval of the research protocol by both the West Moreton Health Research Ethics Committee (Approval HREC/2020/QWMS/62557) (Appendix T: Ethics Approval WM) and The University of Southern Queensland Ethics Committee. A Research Collaboration Agreement was drafted and signed by delegates from both WMH and USQ (Appendix U: Standard Research Collaboration Agreement). No direct benefits for taking part in this study were offered to interviewees.

Because the researcher established the TGP, and unbiased information was sought during the interviews, she could not conduct the interviews due to a conflict of interest. As a result, an experienced Clinical Psychologist (Group Coordinator): completed the interviews. Biases were minimised as she commenced within Queensland Health approximately two months prior to the interviews and had minimal exposure and experience of the TGP. The interviewer conducted the interviews inquisitively with the purpose of gaining a more in-depth knowledge related to the TGP. This matched the research paradigm of constructivism well with interviews rich in information.

There are always real and perceived risks with qualitative interviews as part of research. The World Health Organisation's Ethics Research Committee describe some possible risks as: psychological trauma by discussing opinions or experiences that the interviewees might not wish to

discuss, breach of confidentiality and privacy, stigmatisation, increased vulnerability of the interviewee through inadequate attention to confidentiality and privacy issues (Olayiwola, 2008). Other potential risks that have been identified included: possible coercion of consumers to complete the interviews and selection bias when recruiting consumers. To address the above risks the interviewer abided by the following guidelines:

- Participant Information Sheets (PIS) were developed by the researcher with clear information about the study, privacy, risks and potential benefits for the service, clinicians and the researcher (Appendix N: Participation Information Form Consumer and Appendix O: Participation Information Form Case Managers and Management). A complaints or escalation process was described in detail. Complaints or escalation could be made to the Director of Operations CAS or to the clinician's own Team Leader or Discipline Lead (three options). A Participant Information Sheet was provided to the interviewee prior to the interviews commencing.
- Information storage, publication, and reporting of findings, contact details of researcher / interviewer were included in the information sheet.
- Participation in this study was completely voluntarily and consent could be withdrawn at any time.
- Case Managers were informed of the study and requested to discuss the study with consumers who met the selection criteria. There was no benefit for Case Manager to recruit consumers.
- Once Case Managers provided names to the Interviewer, consumers were again asked if they consented to participate. The Interviewer is the Groups Coordinator and has no input into the consumers care outside of group therapy. This was done to minimise the impact of a possible power imbalance.
- The interviews were conducted in private to ensure confidentiality.

- Any other expectations around further privacy and confidentiality were addressed prior to the commencement of the interview.
- The Interviewer took a non-judgemental stance whilst listening and encouraging participation in a safe way.

On receipt of a signed consent form, each participant was assigned an ID code to ensure anonymity and confidentiality of data. Identifying codes were recorded on a master sheet which was stored in a separate secure location to that of the study data. Only the interviewer had access to the Master ID sheet and updated the sheet as required. Direct quotations from the transcripts have been used within the final report and other publications. In these instances, quotes have been de-identified and used in such a way as to ensure participant anonymity. Data collected has been stored in line with the Privacy Act 2009. Recordings of interviews were transcribed verbatim, and then deleted.

2.3.7 Resources

Resourcing for this project was provided through in-kind contributions by Queensland Health employees and a one-off funded contribution by the University of Southern Queensland. Initially funding was set aside for transcription costs, publication costs and dissemination of results at conferences, however all funding was used for transcription costs. Queensland Health contributed in-kind support from the WMHS librarians, access to printing, support through the Community of Practice, and support through the department of Research and Innovation. CIMHA (Consumer Integrated Mental Health Application) data have been provided by the Mental Health Clinical Improvement Team, Clinical Systems, Collections and Performance Unit, Mental Health Alcohol and Other Drugs Branch.

2.3.8 Data Collection: Individual Interviews

Semi-structured interviews were conducted in a public health service centre and aimed to investigate staff and consumer perceptions on the current TGP model implementation process and ongoing sustainability. Consumer interviews lasted approximately 30 - 60 minutes depending on the time consumers required to express their views and perceptions. Staff interviews continued on average for 45 minutes.

Before commencing each interview, the interviewer established rapport with interviewees by explaining the interview format and re-confirming capacity/consent to participate. An interview guide was developed to ensure all critically identified topics were discussed (Appendix R: Interview Guide). The guide included the research questions and objectives, however the interviewer was encouraged to seek clarification, investigate themes, and generally assist the interviewees to provide their honest opinions and feedback around the implementation and sustainability of the TGP. Guiding questions provided to the interviewer were:

- Q 1: What are MHSS staff's perceptions of the critical elements that contribute to the development of a community TGP in MHSS?
- Q 1 was supported by asking the following sub-Qs:
    - Sub Q 1: What worked well in the development of a community TGP?
    - Sub Q 2: What challenges emerged in the development of a community TGP?
    - Sub Q 3: Why did the MHSS staff member get involved in the delivering of TGP?
    - Sub Q 4: Why did the MHSS staff member refer consumers to the TGP?
    - Sub Q 5: When in the consumer journey did the MHSS staff member refer to the TGP?

- Sub Q 6: What are the key elements that contribute to the sustainability of the TGP and how might they be implemented?

- Q 2: What did the framework for implementing TGP look like in the context of WMHS and how can the TGP framework incorporate scalability into other public health areas?
- Q 3: What resources were required to develop a community TGP in West Moreton Hospital and Health Service?
- Q 3 was supported by asking the following sub-Qs:
  - Sub 1: What physical resources are required?
  - Sub 2: What staff resources are required?
  - Sub Q 3: Identify possible strategies to address any issues identified.

The aim was addressed by the following interview questions for consumers:

- Q 1: Assess consumer's perceptions for attending the TGP
- Q 1 was supported by asking the following sub-Qs:
  - Sub Q 1: Why did the consumer attend the TGP?
  - Sub Q 2: What were their perceptions around the physical resources for example the room, noise levels etc?
- Q 2: Assess consumer's perceptions of the treatment received.
- Q 2 was supported by asking the following sub-Qs:
  - Sub Q 1: What treatment was provided?
  - Sub Q 2: Did they receive the treatment they were expecting?
  - Sub Q 3: Could they have received the same care via individual treatment?
  - Sub Q 4: Did their perceptions around TGP change from pre to post treatment?
- Q 3: Identify possible strategies to address any issues identified.

Eleven MHSS staff and three consumers were interviewed, all of whom either were involved in the implementation or currently involved in the TGP. Interviews were concluded with clinicianss and consumers until

information saturation was achieved. Saturation was determined by lack of new information presented to the interviewer and the importance of the new information during the interview (Guest et al., 2020). Due the COVID pandemic interviews were mostly conducted online.

2.3.9 Data Analysis

Interview trends differed between clinicians, management, and consumers as involvement in the implementation of therapeutic groups differed.

Interviews were transcribed verbatim by an independent transcriber. De-identified handwritten notes and transcribed interviews were imported into NVivo 10. NVivo was used to develop a structured coding system for thematic analysis of data. Analysis of the provisional codes occurred to generate primary codes. Continual reflection of the codes occurred to ensure accuracy and validity. This is confirmed by Braun and Clarke (2014, p. 2): analysis is not a linear process and that the analyser needs to take the time to move back and forth as needed. In saying that, Braun and Clarke (2006, p. 16) developed six phases to guide the analysis process: 1: familiarising yourself with the data; 2: generate initial codes; 3: searching for themes; 4: reviewing themes; 5: defining and naming themes; and 6: producing the report.

The researcher became immersed in the data prior to coding when checking accuracy of transcribing, initial codes were then generated, and codes were collated into common themes. Themes were identified and reviewed according to Michie's COM-B system, that guided the analysis and ensured that themes were not missed. For example a theme was identified from clinicians that they require the Team Leaders to provide protective time to facilitate group therapy, which met the definition criteria of Social

Opportunity. The COM-B system guided the analysis and ensured that themes were not missed and so fulfill the criteria of a deductive thematic analysis. Following this, meta-themes and subthemes were defined and named by the researcher and supervisors (Susan Michie et al., 2011). A logic model was included based on the researcher's prior experiences of planning and developing the TGP. This model was constantly reviewed and finalised once the data from the interviews had been analysed and themes identified (Appendix K). This model will be provided to other health services to assist in establishing and evaluation of a TGP.

Conducting a thematic analysis has both advantages and disadvantages. Braun and Clarke (2006, p. 16) describes that thematic analysis provides a flexible approach whilst providing rich and detailed account of data. They further note that thematic analysis provides a more accessible form of qualitative research as other forms, like Phenomenological studies and Ethnographic Studies, are quite complex especially for the novice researcher. The disadvantages of thematic analysis are that whilst flexible this may lead to inconsistency and a lack of coherence when developing the themes. For this reason, Michie's COM-B system was useful to add coherence.

Limitations of this explorative qualitative study are the small study numbers for consumers, individual participant factors and enablers or barriers identified that are Hospital and Health specific. The small study size especially influenced the consumer sample as information saturation was not achieved. Obtaining the consumer perspective is important as noted by Dark (2018, p6) and a future research study is recommended with a focus on the consumer perspective of the TGP. Other individual participant factors that were considered were personality, professional constructs and operational management views that might transpose onto clinicians. As described earlier, thematic analysis has both advantages and disadvantages, some limitation around this method of qualitative analysis

is the lack of an substantial evidence base compared to that of other theories for example grounded theory, ethnography and phenomenology and this may effect the rigor of novice research (Braun, 2014).

2.4 Techniques to Enhance Trustworthiness

To ensure that the findings of this study were considered trustworthy and transparent the following components of trustworthiness were considered: credibility, dependability, confirmability, transferability, and authenticity (Connelly, 2016). Member checking through ongoing collaboration with the interviewer, occurred throughout the study to check and recheck interpretations of the data. This provided an opportunity to check the interpretations and obtain multiple perspectives which aligned with constructivism's paradigm: to seek to understand and explain (Mills et al., 2006).

2.5 Timeline

Key milestones for this project included completion of research proposal, approval from West Moreton Health and University of Southern Queensland Ethics committees to complete the study, data collection and data analysis. Outputs included a publishable paper and a Project Logic model that will enable scalability into other health services and assist with sustainability of the TGP in WMHS. This study was conducted through self-directed research, coaxed by personal learning objectives and the methodological approach defined within the MPS program.

Below is the initial approximate timeline and the amended program. The timeline was amended due to the COVID-19 pandemic which caused a delay in consumer interviews, staff shortages and re-prioritisation of workload. The researcher is an insider researcher which has both benefits and challenges. The benefit is that completing the research is integral to

the researcher's main work function and so prioritisation occurred. The challenge was to be cognisant of any bias that this may create as the researcher was the driver for the establishment of the TGP.

Figure 2

Approximate Timeline for Completion of Program

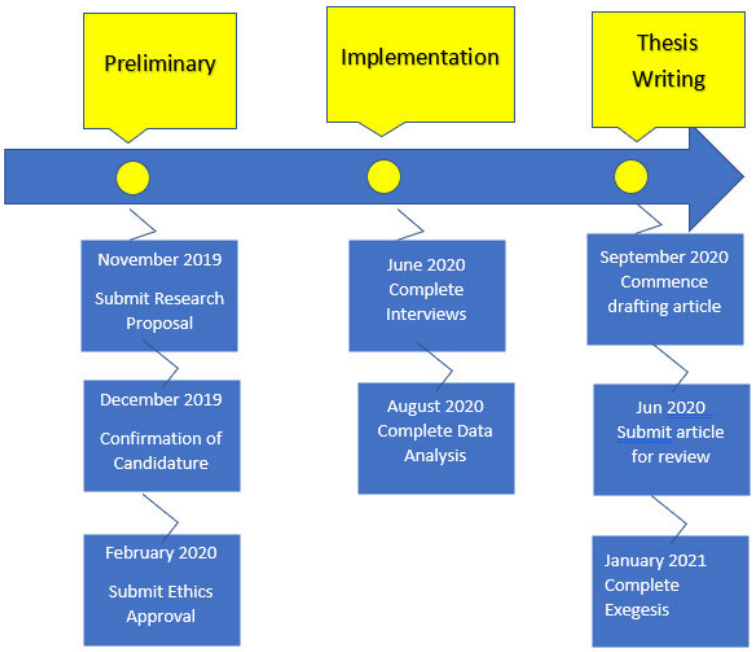
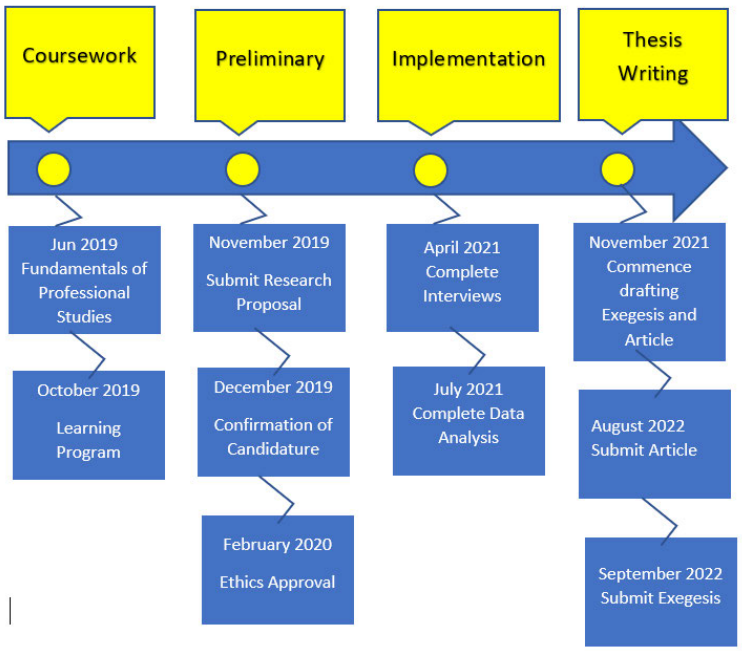


Figure 3

Actual Timeline for Completion of Program



CHAPTER 3: RESULTS

3.1 Introduction

Chapter 3 presents the thematic analysis of qualitative data collected via individual interviews and disseminated through the publishable article.

Working under a constructivism paradigm yielded rich data with themes emerging across a wide arena. To organise the themes thematic analysis was completed following Michie's COM-B behaviour change intervention (S. Michie et al., 2011). All the themes were relevant, however, through the coding process certain themes were more frequent and consistent across interviews. These themes are included in the publishable article. This document provides an opportunity to include other themes excluded from the article but will be used to enhance the TGP framework. These themes garnered some great discussion between the researchers and the Governance committee.

The WMHS staff identified different themes compared to the consumers. This difference in perspective from clinicians providing the therapy, and consumers participating in therapy is important in the evaluation and planning of future programs. Therefore, the COM-B analysis was conducted separately for the two groups, and then later merged to identify the behaviour change techniques (BCTs). This strategy assisted in developing the TGP framework in a well-defined and detailed way and identified the "mechanisms of action" as described by Michie (Michie, 2013).

3.2 Results: COM-B – WMHS Staff

3.2.1 Opportunity

Michie et al. (2011) distinguishes between Social Opportunity and Physical Opportunity, and both contribute towards change management. The Social Opportunity relates to the culture and the opinions held by the interviewees and how the culture contributed towards the establishment and sustainability of the TGP. The Physical Opportunity is what can be

achieved within a space, as well as identifying equipment required to facilitate the TGP.

3.2.1.1 Social Opportunity

The Team Leader's role within the TGP was a predominant theme, as well as themes around MHSS Management, time, governance, and staffing.

a. Team Leader

Both clinicians and MHSS management raised the role of the Team Leader. MHSS management voiced their beliefs around the effectiveness of the TGP and noted that the level of staff participation supported by the Team Leader contributes toward the sustainability of the TGP. Interviewees were very clear around specific attributes of a Team Leader (table 3) that support sustainability of the TGP and what attributes act as barriers:

> Then the senior roles as well there might be some expectations for them to contribute to group development and supervision. That might help to normalise the work that we do and potentially help with the long-term sustainability because now everyone is expected to do some. (Clinician)

Other interviewees noted that the emphasis placed on Key Performance Indicators (KPIs) by the Team Leader also plays a role. The clinician stated that the TGP will not be sustained if group facilitation is the first thing that the clinicians are asked to let go because it is not a KPI or not specified in their role description. Interviewees further noted that by focusing on KPIs the Team Leader does not acknowledge the work satisfaction and passion clinicians have for groups which mitigate the stress from meeting other KPIs.

Then of course if you go to management - if you talk about these issues, the group facilitation or the group management would be the first thing that is asked to be let go of because that's not in your KPIs - that's not in your role description, which unfortunately for many clinicians that is the things that they're more passionate to do. (Clinician)

Table 4: Attributes of a Team Leader Contributing Towards Sustainability, a case manager's perspective

Enablers of TGP	Barriers around TGP
TGP is part of Clinician's role	Not recruiting staff with group therapy experience
TGP is an opportunity to upskill	No explanation during recruitment that facilitation of TGP is expected as the norm
Arrange cover for clinicians whilst they are facilitating groups	Not understanding what is involved in facilitating a group
Endorse protective time so a clinician can develop group therapy content	Opportunities for clinicians to facilitate groups not discussed during operational supervision
Would encourage referrals to group therapy– consumer focused care	Not advocating for the groups in the team meetings
Would not support referral into group therapy if it was just to meet a KPI	Allocating caseloads reactively and not with good foreplanning
	Not supporting clinicians with workload management

	Not placing an expectation on senior roles within teams to contribute to the group programs or to offer supervision

b. MHSS Management

The role of MHSS Management was identified as a theme with interviewees noting the importance of management's role during the establishment and sustainability of the TGP. Ongoing requirements of MHSS Management is to write participation in the TGP into role descriptions (roles includes Case Managers, Psychiatric Registrars, consultants etc.) to set a clear expectation. MHSS Management need to set an expectation for seniors in teams to role model participation in the TGP. MHSS Management should provide operational supervision and include in the discussion when it is operationally convenient for the clinician to get involved rather than if clinicians should participate and set an expectation that facilitation off the TGP should be done by all CM as a skill enhancement program on a rotation basis. One clinician stated: "I think a lot of clinicians view it as being an extra on top of their role, which is a real shame because intervention and service delivery for clients is not just one-on-one." This was further supported by a clinician participating:

> When you are doing a community rotation, they (registrars) should be encouraged to participate in at least one therapeutic program for 10 weeks or something in delivering, in co-facilitating. You don't have to facilitate fully but co-facilitating. I think it would give them actually that nice feeling of like getting involved in therapy, it's a bit of a relaxation from your mundane work, day to day, that's from registrars and doctors point of view, and if the consultants,

> psychiatrists and the clinical director also supported continuously, then it will definitely be accepted and people will feel more free to ask, can I please do it? (Clinician)

Other roles of WMHS management as identified by interviewees were:

- participate in the TGP governance structure;
- ongoingly assess evaluation and outcome data and make recommendations;
- be aware of groups and the content;
- budgetary investment into groups and fund and support training programs;
- set KPIs for Team Leaders around their staff's referral and facilitation rates;
- monitor clinicians attending and providing training;
- ensure equitable contribution to TGP across sites and across disciplines for example Occupational Therapists are responsible for Cognitive Remediation Therapy and Psychology for Acceptance Commitment Therapy.

c. Time

The interviewees connected time and its effect on the sustainability of the TGP. Time is required to:

- train in the modality;
- participate in working groups;
- develop and plan for new groups;
- print consumer handouts;
- determine suitability of referrals;
- upskill Case Managers;
- book and set up rooms;
- facilitate TGP and reflect on group;
- maintain validity;

- reporting to the Multi-Disciplinary Team (MDT) and
- write clinical notes, and complete administration around each group.

Interviewees explained that clinicians with less experience required more time, which can be viewed as an investment as it upskills the workforce. Clinicians working in certain teams had more or less time based on the function of their teams, for example, clinicians working in the high paced mental health unit has less time than clinicians working at the Community Care Unit.

> So, for me as a manager, one of the easy components of it was certainly the model of service for the Community Care Unit - being a new program and a new model with an expectation that there would be group therapy (WMHS Manager).

Service pressure is the biggest barrier to having time to participate in the TGP. However, clinicians felt that the sustainability of the TGP is important for consumers care and therefore they continued to make time on top of their busy work loads. Interviewees noted that this leads to burnout of staff. Interviewees stated:

> Unless you actually invest in proper staffing that are more dedicated or have dedicated time for therapies, you can't just work off the smell of an oily rag and expect more with less of staffing. (Clinician)

> So if there is protected time but at the same time no decrease in their actual workload is not really a protected time. It's just shuffling things down the line. (Clinician)

> Like the last place I worked at if you were in the DBT program I think it was - for every DBT client you looked after that was - you

got three less case managed clients or something like that. So it was sort of an acknowledgement… (Clinician)

Also, if you are under - if the staff member is under significant strain and delivering therapy, it can't be done in isolation because it is a training process, and you will need to be in a good therapeutic space to deliver therapy (Clinician).

But overall, looking at things, I think it is still sustainable in our setting. If you look at it from a whole holistic perspective, running these groups is actually going to lessen the burden on the service (WMHS Manager).

From a general evidence perspective, we know that there's evidence that such programs really help in terms of improving / reducing burnout in staff as well as reducing the costs to the service as well (WMHS Manager).

d. Governance

Interviewees noted the importance of a clear governance structure to ensure the TGP is based on recent evidence, provide encouragement and validation of the TGP and ensure consumers' and clinicians' safety. The TGP Governance should focus on new programs that are needed, continuing research to investigate consumer benefits and what is needed for the service to expand. A governance committee also needs to consider equity across the service of staff delivering the TGP and ensure training and mentoring to deliver groups are provided. MHSS Management noted:

Basically, I think my overall view is a positive one because we started doing an organised therapeutic program only about three years,

maybe four years ago. Prior to that it was really haphazard and from here and there, different small parts of groups were depending on the clinicians' enthusiasm or the knowledge or the skill, but we never had a program as such for that which ran throughout the year and open for all the - whole of service really (WMHS Manager).

Another theme that was identified under social opportunity was to establish partnerships with research organisations. These partnerships could assist with training, sustainability, and ensure the focus continues to be on providing evidence-based care.

e. Staffing

Interviewees reflected on the sustainability of the TGP with two main themes emerging:

1. The TGP program may not be sustainable with the current staffing model due to staff burnout or losing their passion for groups due to other service demands / KPIs especially if management support is not present.
2. Current TGP model may be sustainable largely due to passionate staff. Upon further exploration some ideas around the two models emerged (table 4). The first model would be to have a dedicated therapies team and the second model would be the current model in which clinician's facilitate group therapy on an expression of interest basis.

Table 5: Staffing Model to Enhance TGP Sustainability – An Exploration

Have a dedicated therapies team	Continue with current model
Can be dedicated passionate and skilled clinicians	Passionate people put up their names to facilitate – staff choice
Small group facilitating a wide range of programs however staff are focused on group therapies	Staff only facilitate groups that they have an interest in. Leveraging off skilled and experiences clinicians already in service
Can still be supported by a working group – accumulative knowledge	Availability of staff with a broad range of interest and skills
More time to plan, implement and evaluate TGP	No protected time to plan, implement and evaluate the groups. Not all passionate clinicians are good group therapists and because they volunteer it is hard to say no to them assisting with the groups.
When 1 staff member leaves, skills are lost – no sustainability	High number of staff voluntary – 1 person leaving has less impact
Consistent offering of TGP	Sometimes no staff interest and so no groups
High workload for a small team of clinicians	Increase in workload for remaining clinicians within MDT

Team leader would prioritise group therapy	Team Leader prioritises KPIs and not group therapy – workload management not completed
Staff does not have the variety in their workload which may also lead to burnout	Staff burnout may occur due to extra work however can also prevent staff burnout due to the change in normal duties of CM

3.2.2.2 Physical Environment

Both MHSS staff and consumers could clearly articulate the physical requirements for a TGP. They identified three themes: rooms, resources, and budget:

a. Rooms

At the time of the interviews a limited number of large rooms were available to booked and host the TGP. These rooms where not specifically designed for group therapy. A specific, dedicated group room is required for TGP sustainability. Consistency is important, for example the same room should be available for the entire duration of a program, e.g. 8 weeks. This consistency will assist with time management as booking rooms, setting up and packing away takes time. The room size is important to make group participants feel comfortable and this aspect was especially emphasised during the COVID pandemic. It also must be a noise free and air-conditioned environment with easy access to amenities. One consumer commented, "The noise of the air conditioner in one room. That wasn't very helpful. The size of another room wasn't very helpful. It was a bit too tiny."

b. Resources

Interviewees identified the following resources to facilitate the substantivity of TGP:

- Professional printing of consumer booklets as this saves clinicians time but also looks professional and provides the message that the service invests into consumer's care.
- Resources are required for sensory equipment, activities, ice breakers etc. The Therapy Lead position has access to a WMH Corporate card and can purchase items required for group therapy directly. This is a very efficient way of ensuring resources are available.
- Dedicated storage for the equipment and consumer booklets.
- Essential is water for consumers, however, it is also nice to have coffee or tea with some biscuits for the lengthy groups.
- Projector or interactive screen and a laptop with speakers to play videos with internet access.
- A white board, pens and stationery.
- A silent clock in the room so the facilitator can keep track of time.
- Assistance with equipment especially technology when required.

c. Budget

Interviewees consistently commented on the importance of a specific budget allocated to the TGP. The absence of a budget when the TGP was established was a barrier to obtaining required resourcing and having a budget for future programs will facilitate sustainability. This relates to both the labour and non-labour budget. A labour budget is required for staffing positions and a non-labour budget for any purchases not related to staffing.

Regarding the non-labour budget, interviewees noted that not having funding for things like consumer handouts influence the quality of the program. There must also be a budget for external training when training cannot be sourced from within the organisation. Clinical personnel should have a corporate credit card for purchases like food items for the cooking program and for sensory items for the sensory group. Other items that need to be budgeted for are licensing of specific programs for example the

CIRCUITS program for Cognitive Remediation Therapy and required technology (tablets, projectors etc.).

A labour budget is required for specific positions that enhance the sustainability of the TGP. Positions with WMHS that were integral around implementation and sustainability are the Therapy Lead position for strategic direction and the Group Coordinator position for operational implementation. Some interviewees commented on the benefits of having a separate therapy team with an option for staff to rotate through these positions, however, this will require more investigation.

> Maybe they can have a staggered plan of three to five years of slowly improving and increasing the funding of group coordinator, group planner, group facilitator so that they don't have to demand money at the very beginning but at the same time staff can see that the health service is being serious to support this and slowly increase the resources that is put in there. So I guess for sustainability, you need personnel, you need time and obviously you need clients, which we have plenty of and you need funding (WMHS Manager).

> Well I, I sometimes wonder about the funding of your, of the group programs. It feels a little bit like everyone's running it in their spare time between their other jobs, and maybe it would work better if it was given more priority. I don't know how that is and that's probably just - and I think it's more just about the people who do work at it, when I do see them, they seem like they're very busy, working very hard to get it done (Clinician).

3.2.2 Motivation

Motivation is separated into reflective motivation which describes an increase in knowledge through reflection of specific plans and strategic directions pertaining to the TGP and automatic motivation achieved through

automated processes including imitation and formed habits (S. Michie et al., 2011)

3.2.2.1 Reflective Motivation

Interviewees reflected on the TGP model of service and stated that the structure is clear and consistent and that this was facilitated through established WMHS policies and procedures around the TGP. This clear structure also pertains to how the strategic directions are set which enhances staff's trust in the program. For example, aggregated data of the top diagnoses groups are considered every year when determining the groups required to meet service demands.

The Clinicians and MHSS Staff noted that the program is comprehensive, covering a diverse range of topics that meet the WMHS population needs. The variety of groups meant that staff from all areas (across MHSS) could express an interest or interests in specific groups. The variety of available group therapies led to the establishment of specific position, named the Group Coordinator position. The Therapy lead and the Governance committee ensure the fidelity of the TGP which enhances trust in the TGP. One Clinician noted:

> It's a broad range of intervention types of groups I'd say, so it can cover a range of difficulties that clients are experiencing. So if you can match up what we agree they may require to maximise their recovery and function at the best they could possibly be, then it's a nice way of getting that intervention in a very clear manner, time limited as well. It's very clear what those expectations are, easier for them to commit to it (Clinician).

Other themes that were identified under reflective motivation are:

- TGP works best if it is a structured team-based approach effectively allowing all members of the team to work towards their full scope of practise.
- Sustainability is enhanced through more staff being involved in the TGP.
- TGP shift the focus to clinicians working towards full scope of practice within discipline scopes and away from generic roles within a medicalised model. Case Managers noted:

> It moves the service away from case management which is more administrative and risk adverse and refer to providing interventions, therapeutic interventions. It just alters, it shifts a little, that focus that can be on the more medicalised model, that I think sometimes sits in case management, to treatment interventions (Clinician).

> I think that in a big team it does tend to come from people who are maybe kind of old-school way of thinking. Maybe they've worked there for a really long time and there's less of a recovery focus. I guess it's just a different perspective. Like it's maybe older people in the team. Some people even say that they don't believe in psychology, for example, so that can be a bit of a barrier (Clinician).

3.2.2.2 Automatic Motivation

Automatic motivation themes identified by interviewees included enhanced staff work satisfaction that leads to staff retention. Staff is upskilled and the TGP reduce bad habits set by clinicians for example a reduction in referrals to TGP because of time pressure. A Clinician stated:

> Yeah, and then, because that actually helps to encourage others to get involved and to give that support if somebody needs to do the

> Dialectical Behaviour Therapy programs and want to do training or facilitation, how to maximise and making somebody's work interesting, otherwise it gets very boring and mundane for a lot of people. I think that's very important to do, for them to feel that they are doing some therapeutic - they have some therapeutic involvement with the client or with the consumer (Clinician).

3.2.3 Capability

Michie et al., (2011) defined capability as the capacity and necessary skill required. Capability is further distinguished between physical and psychological capability. Psychological capability referring to the necessary cognitive ability for example comprehension, reasoning and judgement and physical capability referring to skills and have a focus on training / education to facilitate group therapy.

3.2.3.1 Psychological Capability

Case managers noted that a focus on case management and not on specific therapies meant that case manager's skills mature within the case management paradigm. Consumers receives excellent generic case management however miss the opportunity to receive psychological intervention. Therefore, reflective practice needs to be encouraged but also facilitated to enhance clinical judgement, formulation, and forward planning. One Case Manager stated:

> So you find out that with clinicians who've been in the same role for so many years, it's like they need a crane to change the way they do things. So we're in mental health for counselling however sometimes negative thoughts - just negative talk can go around a thing when it's being introduced, it's enough to sort of spread a little like cancer (Clinician).

3.2.3.2 Physical Capability

Training and education were mentioned in every interview with several themes emerging around this topic. In summary, themes that were identified around training and education are:

- Ongoing training of clinicians is important.
- Training needs to be implemented across a service, from the consultants, peer workers, clinicians, and management.
- Training program needs to be based on the results of clinician's capability which will differ from service to service.
- Capability needs to be determined every year.
- Training needs to be paired with ongoing supervision.
- Training attendance needs to lead to group facilitation.
- Training program essential to assist in TGP sustainability.
- Facilitating training should be part of role descriptions especially of senior staff: HP4/ CNC etc.
- Internal training is efficient and effective however it is important to source external training from specialists as well.
- Training of NGO staff in the region improve their service which benefits WMHS consumers.
- Groups that can be facilitated by NGOs should not be facilitated by clinicians.
- Case managers must be superficially upskilled in various the various groups on offer to consumers (an introduction into the groups) without necessarily requiring upskilling to facilitate a group.
- Consultants needs to be trained in the various group therapies as well.
- Consultants plays a pivotal role in identifying a need for a specific group, providing education to the consumer and sometimes the CM as well as encouraging the consumer to attend and monitoring their attendance.

- Recording training programs assist clinicians who work shifts or are time poor.
- Keeping track of clinicians who have completed training assist in advocating for more training due to training numbers and assist in sustainability of the TGP. Case Managers stated:

> But I always wanted to get involved in this, but once I did the training though, it really opens your eyes even further (Clinician).

> But once you do the training, it's a different world really. That kind of almost like, everything clears up and you know exactly what is happening and you know how you feel more confident and more comfortable in how things are happening, yeah, things need to be done (Clinician).

> Internal training is great, but you risk watering down that. There's a reason that accessing external training is really, really helpful and is highly regarded (Clinician).

3.3 Results: COMB – Consumers

3.3.1 Opportunity

Consumers were able to identify opportunities that could act as enablers or barriers for engagement into the TGP: transport, scheduling, location, virtual care and linguistics.

3.3.1.1 Transport

All the consumers interviewed stated that transport to and from the venue where the group therapy is facilitated is important as they rely on public transport. Two of the consumers who reside in rural areas noted that a pre-referral conversation around logistics including transport would facilitate their attendance. Scheduling individual appointments around group appointments would be helpful so consumers only have to travel once

which would reduce cost and save their time. One consumer noted that they cannot rely on their NDIS funding for transport even thought it was specifically included into their NDIS plan.

3.3.1.2 Scheduling

Consumers requested more input into the timing of group therapy. They noted that the timing influences their ability to attend for example parents need to look after their children in the afternoons and some consumers work etc. The consumers explained that generally groups that run over lunch and during school terms are difficult to attend. When the group is run (weekday) was also noted as a contributing factor for example if a group is always facilitated on a Thursday and the consumer is unable to attend on Thursdays they will miss out on that group. Also mentioned was that group programs facilitated only once a year causes consumers to wait for long periods of time (until the group is next scheduled) if they were unable to attend. For example, if the consumer is just not ready to participate in group therapy, they will have to wait another year. One consumer stated: "Sometimes the time. Like if it's 12:00 pm to 2:00 pm for the Dialectical Behaviour Therapy, it's difficult to schedule lunch and stuff like that."

3.3.1.3 Location

During the interviews consumers explained that the location of the group therapy plays a role in consumer attendance. For example, sometimes a group is facilitated in Goodna and a consumer resides in Ipswich and they then need to travel. Consumer feedback is to facilitate the group therapies across the service at all the sites to enable participation.

3.3.1.4 Virtual Care

Consumers felt that virtual care is an option but faces many barriers to implementation. If the barriers are addressed, it may however lead to enhanced sustainability. They noted that virtual care may reduce transport costs, save them time and facilitate improved participation. However, consumers also noted that they would require suitable devices, sufficient internet connection and support to problem solve if an issue arose.

3.3.1.5 Language

Consumers noted that group therapy participation would be enhanced if other languages or the use of interpreters could be considered for linguistically diverse consumers. However, it was also noted that this would be hard to implement and may influence other group members. An idea raised by a clinician to address this was to analyse data around the specific language group requirements when planning TGP for the next year. For example, there may be a cohort of Swahili consumers that require budgeting, so offer one group in Dinka.

3.3.2 Motivation

Consumers noted that there is a stigma around group therapy and that pre-commitment sessions assisted to prepare them, so they know what to expect. This understanding makes it easier for consumers to attend as it decreases their anxiety that is increased by the stigma. The focus is mainly around skills acquisition and recovery and not on the negative aspects of their journeys. Consumers explained that group therapy normalised things for them and that they did not feel so alone in their recovery journey. They also felt that they could positively contribute towards others' recovery journey through lessons that they have already learned. Consumers stated:

> It's focussed on the mental health issues that I have. It's focussed on those. But it doesn't necessarily focus on the stigma of

those. It's more about the recovery and not actually focussing on the mental health illness itself. But on strategies and that, that can help that. That mental illness (Consumer).

All the groups have helped. With dialectical behaviour therapy, it's had a lot of success with giving me strategies to use when I'm distraught or when I'm struggling. You can just use them at any time and anybody can use them as well. You don't have to have mental illness to use them. It's been a bit of a lifesaver, that one. Because all the behaviours that I had before that were concerning have decreased (Consumer).

The other groups are good because they focus on what was going on at the time. Like the sleeping group, I wasn't sleeping that well. So it was good because it focussed on that and gave me some good strategies as well to be able to deal with that better (Consumer).

A set structure around the group therapy also assisted consumers to address their anxiety. Consumers knew what to expect and came into the group prepared. Part of the set structure is group rules that are set at the commencement of a group and group participants are reminded throughout. One consumer stated: "I think it's good because it's structured. It's every week at the same time and it gives me something to do." Another stated:

I think having other people that are similar or seeking the same kind of help. It's soothing in a way. Because you know you're not alone in what you are experiencing. That's my opinion. I just find it easier to think that I've got the same issues as other people and that we're all to be helped at the same time (Consumer).

During the interviews some consumers compared individual therapy with group therapy. They noted that group therapy facilitated cohesiveness and a feeling of belonging which cannot be facilitated in an individual setting. Group participants explained that they shared their new knowledge after the group with their case manager and felt proud that they could upskill the case manager and that by teaching the case manager they were able to receive ongoing support even after the group concluded. Consumers stated:

> It's just that real collective feeling. I'm sure it could be delivered in an individual setting, especially with - I've got good case managers and stuff. I'm sure they'd be able to deliver it. But I just find the collective approach much better (Consumer).

> Interviewer: The next question asks do you think you would have received the same benefits of group therapy in individual therapy?
> Consumer Interviewee: No, definitely not.

The facilitator's level of confidence, ability to impart knowledge / information and their enthusiasm was noted by consumers as contributing towards the outcome of a group. One consumer stated*:* "They knew their stuff. They come with lots of information and they're very supportive and they just know what they're doing. There is a lot of confidence in the facilitators." Another consumer stated,

> I think a chance at a better life. Like there's enthusiasm by the staff. So that creates enthusiasm in me as well. Because if they believe that it can help me in some way, then I'll start to believe that as well (Consumer).

3.3.3 Capability

Consumers and clinicians agreed that how far along consumers are on their recovery journey should be considered prior to making a referral. In some therapy programs diagnoses also need to be considered for example for Social Cognition Interaction Training (SCIT) the consumer needs to understand paranoia and it was designed for consumers with a diagnosis of Schizophrenia.

Consumers and clinicians also agreed that all referrals into the TGP should be done in collaboration with the consumer, their families, carers and MDT. They noted sometimes it is a very subtle decision. "Because it's not always the case that a client is ready at a particular point in time for a particular intervention. They may require it, but at that part of their journey it may not be right."

CHAPTER 4: Publication - Improving Public Mental Health Service: Is Group Therapy the Answer?

Based on the findings in Chapter 3, an article titled: Improving public mental health service. Is Group Therapy the Answer? was submitted to the Cognitive and Behavioral Practice Journal on 19 August 2022. The University of Southern Queensland policy for Thesis by Publication includes the provision that "papers will have been published, accepted, submitted or prepared for publication during the period of candidature". The paper included in this thesis meets this requirement and is publishable. All authors reviewed and approved the final version of the article.

Abstract

Several psychotherapeutic varieties exist and can be delivered either individually or in a group format. Group Therapy is an effective treatment modality however, there is limited evidence related to the implementation and sustainability of a Therapeutic Group Program (TGP) in an Australian public mental health service setting. The aim of this work-based study was to identify and understand critical elements contributing to the sustainability of a TGP and to enable scaling of implementation in other services. A retrospective analysis of a TGP provided the opportunity to conduct a retrospective analysis of implementation. The TGP consisted of a variety of group therapies for example Dialectical Behaviour Therapy, Cognitive Remediation, Cognitive Behaviour Therapies. Case managers, consumers (patients) and management's perceptions of the barriers and facilitators of TGP implementation were collected via 14 semi-structured interviews. Michie's Behaviour Change Wheel characterising

behaviour change interventions through Capability, Motivation, Opportunity, and Behaviour (COM-B) was utilised for the thematic analyses of the qualitative data. The findings identified the following: Capability: a shift in focus from case management towards therapeutic intervention and specific training programs leading towards participation in the TGP leads to improved staff capability; Motivation: a clear well defined structured evidence-based approach is required as well as opportunities for staff to participate in the TGP as this facilitate enhanced work satisfaction due to staff working to their full scope of practice; and Opportunity: management support, allocated staff, allotted time for staff, adequate resourcing including a specific budget and clear governance structures are required to sustain the TGP. Strategies identified to facilitate the implementation of evidence-based practice included behaviour change interventions and clarity in statements of policy requirements and governance processes related to TGP in policy documents. These strategies would enable to implementation of a TGP within a public mental health setting and provide consumers access to group therapy through a public service.

Keywords: group therapy, psychotherapy, mental health, implementation

INTRODUCTION

The Productivity Commission Inquiry Report of 2020 into Mental Health found that Australians with a mental illness struggle to find services that are right for them and recommended that gaps within community health care be addressed (Commission, 2020). The National Study of Mental Health and Wellbeing conducted in 2021 found that 2 in 5 Australians have experienced a mental disorder in their lifetime (Statistics, 2020-21). Embedded within Recommendation 12 of the Productivity Commission Inquiry report is the provision of more group

therapies. Due to the increase in demand and the shift to community-based interventions, West Moreton Health Service (WMHS), Mental Health and Specialised Services (MHSS) identified a need for a service-based framework to initiate the delivery of cost effective and efficient mental health intervention. Group therapy was considered.

Group Therapy was introduced as a treatment framework in 2017 and has been sustained through the regular facilitation of various groups for example Dialectical Behaviour Therapy and Cognitive Remediation with an average of 6 consumers per group. This provided the opportunity to identify themes, through interviews conducted with WMH management, clinicians and consumers who participated in a group psychotherapy program. To understand the barriers and facilitators to real world implementation and sustaining of group psychotherapy in an Australian public mental health service and too develop ongoing behaviour change interventions that will enable scaling and facilitate sustainability of group psychotherapy within mental health services.

Group psychotherapy, also referred to as therapeutic groups, is one of the best practices in the treatment of a variety of mental disorders (APS, 2018; Lorentzen & Ruud, 2014). According to the Australian Psychological Society various therapeutic groups are on a level one evidence base as described in *Evidence-based Psychological Interventions in the Treatment of Mental Disorders: A Literature Review* (APS, 2018). This hierarchical guide developed by the National Health and Medical Research Council (NHMRC) evaluates and grades the evidence with level one as the highest, most effective level of evidence (NHMRC, 2009) A level one grading is given to systematic reviews of high quality randomised controlled trials. For example, in the treatment of Borderline Personality Disorder the hierarchy of evidence proposed Dialectical Behaviour Therapy (DBT), which has a group component, and for unipolar depressive disorders group Cognitive Behaviour Therapy (CBT) as level one interventions (APS, 2018).

The benefits of group therapy, compared to individual therapy, are well described in literature. For example, a study completed by Norton et al. (2015) included participants attending twelve group sessions of Mindfulness and Acceptance Commitment Therapy and this group intervention significantly reduced participant's social anxiety, depression and rumination and increased the use of mindfulness and acceptance. Yalom (2021) also describes *"curative factors"* that can be facilitated through group intervention as: installation of hope, universality, altruism, imparting information, cohesiveness, interpersonal learning and the development of social techniques (Yalom, 2021).

Curative factors can be facilitated within a group that cannot be facilitated within individual therapy, for example cohesion, universality and altruism (Price et al., 1999, p. 91). Although a wide range of psychosocial interventions are implemented in public mental health service, most are individually based and are not harnessing the curative factors of group psychotherapy (McCarthy & Hart, 2011; Yalom, 2021). Drum stated that group interventions is one of the "least tapped reservoirs" to treat consumers with challenging health conditions (Drum, 2011, p.247). Group therapists come from many professions bringing their professional experience and knowledge which makes group therapy a multidisciplinary intervention modality (Lorentzen, 2014).

Group therapy has been demonstrated as best practice within psychological intervention, however it has been difficult to translate this into practice (Ogrodniczuk, 2010 and Cairns, 2013). In a budget-constrained, time-constrained and resource-constrained service environment, the opportunity to deliver evidence-based therapeutic group treatments can be limited (Drum, 2011). Another factor influencing implementation of group therapy is limited evidence related to best practice guidelines for the commencement / establishment of group therapy.

Enablers of Group Therapies

One strategy that enables successful implementation, includes identifying barriers that may hinder implementation or sustainability, and facilitators that may enable effective implementation and enhance sustainability (Powell et al., 2015). Identifying barriers and addressing these factors early in the implementation process will enhance implementation. It is important to leverage off factors, that may positively impact implementation, at all levels of the organisation from on the ground clinicians to management (Dark, 2015).

According to McCarthy and Hart (2011, p 353) “Nonetheless, economic evidence is based mainly in cost-effectiveness studies regarding medications, with little attention given to psychosocial interventions. Still, there is data supporting the use of combined treatment (i.e., pharmacologic and psychosocial interventions) as a cost-effective intervention.” Utilising resources optimally and proving affordability will encourage health service managers buy into and invest in establishing group therapy programs. One example, that demonstrated cost effectiveness of group therapy, is an economic evaluation of a mindfulness group delivered for consumers with depression, anxiety, stress and adjustment disorders compared to treatment as usual (Saha, 2020). This study concluded that mindfulness group therapy is a cost saving alternative to treatment as usual.

Barriers of Group Therapies

Public Mental Health Services perceive barriers to implementing group therapy to include high cost; the lack of the required levels of expertise (Fuhriman 2001; Saha, 2020) and insufficient training for mental health clinicians to facilitate group therapy (Khawaja et al., 2011; Lorentzen & Ruud, 2014; McCarthy & Hart, 2011). This might be due to individual therapy being valued more than group therapy; variability and a decrease in group therapy training in undergraduate training across multidisciplinary professions; developments in pharmacological treatments;

limited research on group therapy in mental health public services in Australia; and a lack of research (knowledge) in the utilisation of group therapy at a local level (Khawaja et al., 2011; Ogrodniczuk et al., 2010; Whittingham et al., 2021).

Barriers to implementation can arise at any or all levels of a public service including individual / consumer, team, organisation or system. Michie (2011) explains that within these levels, a further barrier to implementation to any evidence-based practice in public health is slow and inconsistent behaviour change and is also the case with the implementation of group therapy (S. Michie et al., 2011). It is therefore important to examine the difficulties undermining change, select strategies to bridge the difficulties and frequently evaluate the change strategies. Identifying specific components with the aim of replicating practical applications or behaviours is complex as there are many overlapping and interacting components that influence behaviour change. Michie explained that there are three essential components at the centre of behaviour change: capability; opportunity; and motivation, that are included in her COM-B System.

In summary, identifying barriers towards the implementation and sustainability of a group program will act as an enabler. The above barriers noted in literature are integral to implementation: reduced competency levels of clinicians to facilitate groups due to inadequate training and the overvaluing of individual therapy over group therapy. However, it is important to ensure that this knowledge is tested within a local context and adapted if required. This study aimed to understand the barriers and facilitators to real world implementation of group psychotherapy in an Australian public mental health service, in order to inform development of strategies that will enable the implementation of evidence-based practice within a target population requiring behaviour change interventions.

METHOD

Design and Setting

This study was informed by the Standards for Reporting Qualitative Research (O'Brien et al., 2014). Qualitative research was used to examine the clinician, management, and consumer's experiences during the process of development and implementation of therapeutic groups. Constructs around sustainability were also investigated.

The West Moreton Hospital and Health Services is a publicly funded open access provider of health services to the community. Services include both acute and case management teams. It is located within Queensland, Australia and encompasses a rural and metropolitan population. This service was selected since a Therapeutic Group Program (TGP) had been facilitated as part of the model of service since 2017. A TGP includes various group therapies on offer based on the population needs and best treatment guidelines. For example, Dialectical Behaviour Therapy for the treatment of consumers with a personality disorder, Cognitive Behaviour Therapy for mood disorders, Social Cognition Interaction Training for consumers diagnosed with psychotic disorders (APS, 2018). This provided an opportunity to conduct a retrospective analysis of implementation and factors influencing sustainability.

One of the authors (ZW) is the Therapy Lead of WMHS and was responsible for the implementation and subsequent sustainability of the TGP. As a clinician and insider researcher, the author has a unique perspective that aided in the understanding of the constructs created by the interviewer and interviewees. To ensure that there was no possibility of unconscious bias that may impact the construct, interviews were conducted by a Clinical Psychologist who was not involved in the establishment or implementation of the TPG, analysis was conducted in collaboration and no identifiable data was provided to the researcher. Participants

Past and current clinicians were identified by using purposive and snowball sampling. Clinicians that had previously or currently facilitated groups or referred to the TGP were included. Inclusion criteria for consumers were that they had accessed the TGP within the previous six months and was capable to provide informed consent. Group Facilitators identified consumers that adhered to these inclusion criteria. . Five consumers were identified and three expressed their interest to be interviewed (n = 3) The COVID-19 pandemic resulted in limited access to consumers, and therefore a reduced number of consumers were interviewed.

Initially 15 interviews were planned with clinicians, however only 11 interviews were completed as data saturation was achieved (n = 11). Clinicians represent a multidisciplinary team consisting of mental health nurses, psychologist and consultant psychiatrists. Three interviews were conducted with West Moreton Health Services managers with backgrounds in psychology and occupational therapy. Interviews were conducted both via virtual platforms and in person with an average duration of 45 minutes.

Ethical Considerations

The research was approved by the West Moreton Health Research Ethics Committee and The University of Southern Queensland's Human Research Ethics Committee. On receipt of a signed consent form, each participant was assigned an identifying code to ensure confidentiality during transcription and data analysis. Direct quotations used in this paper have been de-identified to maintain participant anonymity.

Data Collection

Data were collected through semi-structured interviews in 2020 and 2021. The purpose of the interviews was to generate rich qualitative information which was achieved by including

questions regarding overall success of implementation, in addition to perceived barriers and enablers to TGP and were framed with the COM-B in mind. Interviews were concluded with clinicians when no new perspectives or social constructs were added. An example of questions included in the interview guide are included in table 1.

Table 1: Example questions from interview guide

Consumer	Case Management	WMH Management
What did you like or dislike about the group therapy you attended? And did group therapy help you on your recovery journey and if so, how did it help?	What has been key considerations in getting the TGP established and operational within the Health Service? And why did you refer consumers to the TGP?	What worked well in the development of the TGP? What challenges identified in the development of the TGP? And what resources are required?

Data Analysis

Analysing data with the aim of developing strategies that will enable the implementation of evidence-based practice within a target population requires behaviour change interventions. Michie's behaviour change system was chosen to identifyspecific behaviour. In this behaviour system, Capability, Opportunity, and Motivation (COM-B) are components of an overarching model (Michie, 2011). Linking the COM-B system to specific techniques will assist to enable implementation and sustainability of the TGP. Michie's BCT (Behaviour Change Techniques) taxonomy was used to analyse data since facilitating these techniques is associated with successful implementation of evidence-based treatments (Michie, 2013) (Table 2). This manner of coding analysis has been used to determine BCTs that will lead to more effective implementation strategies / behaviour change (Michie, 2018). Michie explained that it is important to define these BCTs to achieve a common understanding.

Table 2: Definition of Behaviour Change Techniques

Intervention	Definition
Education	Increasing knowledge or understanding
Persuasion	Using communication to induce positive or negative feelings or stimulate action
Incentivisation	Creating expectation of reward
Coercion	Creating expectation of punishment or cost
Training	Imparting skills
Restriction	Using rules to reduce the opportunity to engage in the target behaviour (or to increase the target behaviour by reducing the opportunity to engage in competing behaviours)
Environmental restructuring	Changing the physical or social context
Modelling	Providing an example for people to aspire to or imitate
Enablement	Increasing means / reducing barriers to increase capability or opportunity

Interviews were concluded with clinicians when no new perspectives or social constructs were added. Interviews were audio recorded and transcribed verbatim by a professional independent transcribing service. Transcriptions were then checked for errors against recorded versions to ensure an accurate and authentic reproduction. NVivo 10 was used for data analysis and facilitated the development of a structured coding system to facilitate a thematic analysis. Reflection of codes occurred continually to ensure accuracy and validity both by the researcher and a governance committee.

RESULTS

Results of the study are reported using Michie's COM-B System to analyse behaviour that either enabled or act as a barrier towards the successful implementation and sustainability of a TGP (Michie, 2011). Each of the COM-B components are briefly described and the results pertaining to that component discussed. Specific participants in the study are noted throughout as management, referring to operational managers within the public health service, clinicians and consumers.

Capability

Capability includes knowledge, understanding, decision-making and skills as fundamental drivers of behaviour (S. Michie et al., 2011). A consistent narrative amongst MHSS staff was that education, training, incentivisation, persuasion and modelling in the implementation and facilitation of a TGP will lead to sustainability of the TGP.

Education was unanimously perceived as necessary for proficient TGP participation by both clinicians and management. They noted that clinician's capability should be assessed annually with an education program aimed at various levels of capability.

Clinician: But once you do the training, it's a different world really. That kind of almost like, everything clears up and you know exactly what is happening and you know how you feel more confident and more comfortable in how things are happening, yeah, things need to be done.

It was noted that the internal educational program (facilitated by senior staff within West Moreton) was useful, however, external training by experts, for example, accredited Acceptance and Commitment therapist, are required as well. Some participants provided feedback around enhancing trainers' methods of teaching, for example, their use of real life examples. However, they praised their ability to share knowledge.

Clinician: Internal training is great, but you risk watering it down. There's a reason that accessing external training is really, really helpful and is highly regarded.

MHSS Staff commented that education should be provided in various formats. This assisted staff from different settings, across the health service, to attend. For example, acute services find it harder to release staff to attend training than in the community setting. Various formats of training may be accomplished by the recording of education programs for trainees to view when they are next on shift or when capacity allows and face to face education sessions. Participants found that advanced publication of the education program allowed them time to plan and organise their attendance.

Clinicians felt that operational management should set clear expectations around attendance of comprehensive training to enhance TGP facilitation. They further explained that management should keep track of clinicians who have completed the training to ensure sustainability of the TGP. This information will support advocating for more education, if training numbers are high, and facilitate a review of training methods, when training numbers are low. Analysing this data will provide information around team attendance and provide an opportunity to discuss the benefits of ongoing upskilling of specific Team Leaders.

Clinicians explained that they felt valued when they are asked to impart knowledge. However, they reported that they sometimes lack the confidence to train others. One participant mentioned the need for an ongoing education budget to accommodate the sourcing of external trainers.

The importance of clinicians in senior roles, including Consultant Psychiatrist and Senior Peer Workers, within the organisation taking responsibility to facilitate training and provide

supervision was emphasised by participants. Staff capability can also be enhanced through ongoing supervision and facilitation of reflective practice facilitated by Senior Clinicians.

Clinician: Then the senior roles as well there might be some expectations for them to contribute to group development and supervision. That might help to normalise the work that we do and potentially help with the long-term sustainability because now everyone is expected to do some.

Social opportunity

Opportunity includes both physical opportunity and social opportunity (S. Michie et al., 2011). Common themes that were identified by participants around behaviour change interventions to enhance opportunity were persuasion, incentivisation, education, coercion, restriction, modelling, enablement, and environmental restructuring.

MHSS staff and consumers commented on the value of lived experience / peer facilitated groups in the community and requested an increase in these groups both in the community and in the inpatient settings. Participants observed that more groups are required to keep up with the population demand.

WMHS Manager: Given that the service area is expanding, you're having such a huge population that's coming up, expanding these groups would be more sustainable, actually, to the service.

MHSS staff acknowledged that the staff from the high-pressure acute care teams require breaks to reduce burnout. Including other roles outside of the acute care teams for example providing them the opportunity to facilitate group therapy can assist in reducing burnout. An added benefit of training in group facilitation and facilitating groups will be the enhancement

of staff skill levels, whilst simultaneously improving the linkages between the acute units and the community.

Several themes where identified within social opportunity. Most participants indicated that service pressure reduces clinician's time to participate in the TGP. Another theme was that strong leadership support from management, especially Team Leaders, enabled participation in the TGP. Participants shared some ideas on how to address barriers ensuring ongoing sustainability of the TGP. For example, the need for review of the mental health and specialised service wide model to include TGP as an integral part of the service, and to specify TGP as a separate service offered to consumers. Participants also proposed that job descriptions be reviewed to specifically include the facilitation of TGP. Further thought should also be given to safeguarding the TGP against service pressure by increasing the number of case managers, to allow for reduction in case load when a case manager volunteers their time to facilitate a group.

A major barrier identified in the sustainability of the TGP was staffing. Clinicians noted that the volunteering model within WMHS enables staff who are passionate to contribute to the TGP and they felt that this aspect of the model works. However, staff that volunteer are at increased risk of burnout because their Key Performance Indicators (KPIs) are not amended and are prioritised above the TGP. State-wide KPIs are set for case managers and case managers are generally expected to meet the KPIs whilst also participating in the TGP.

Clinician: So generally, if you're doing co-clinical work and you do only that, then there's no growth. The sense of competence dies away and you do not feel like you're contributing to the system, which leads to burn out. So, having something to do, a new challenge and overcoming that, it's very important for growth, both for employees and it adds a service to the patient as well.

Another theme identified by staff was that a structured consistent approach to the TGP enhances social opportunity for clinicians to participate in the TGP. A transparent consistent approach enables understanding at different levels of the organisation about what participating in a TGP would entail. Team leaders for example know if case managers volunteered to facilitate a group, how much time would be spend on the group taking them away from their team.

MHSS staff provided substantial feedback around the role of the Team Leaders in the implementation and sustainability of the TGP. Clinicians are operationally managed by a Team Leader. Each area within the WMH service has a Team Leader. Clinician's reported that Team leaders do not understand the time commitment required to facilitate a group as a barrier. Not assisting clinicians with clear and structured workload management to enable participation in the TGP, and not considering the TGP during the recruitment process, were noted by clinicians as barriers. Some themes emerged about how Team Leaders can best support clinicians to participate in the TGP and this is summarised in Table 3. Frequently reported throughout the interviews was that facilitating a TGP provides an opportunity for clinicians to upskill, and it was suggested that TGP be included as a discussion point during supervision and staff support with protected time endorsed to facilitate group therapy.**Table 3:** Summary of how Team Leaders can provide support to clinicians to participate in the Therapeutic Group Program (TGP)

Facilitators	Barriers
Opportunity for staff upskill	Not understanding time requirements
Participation in TGP discussed during supervision	No workload management
Endorses protected time	Not acknowledging the work satisfaction and passion of clinicians.

Encourages referrals	Not placing an expectation on senior roles to contribute
TGP participation / referrals established as a KPI	Not setting an equitable participation expectation
Considers TGP whilst recruiting	Not demonstrating appreciation towards clinicians participating in TGP
	TGP not described in role descriptions

Protected time to deliver and plan groups was identified as a consistent theme amongst clinicians. Clinicians reported that they require time to: upskill / familiarise themselves with group content, manage referrals into the groups, book rooms, print consumer handouts, facilitate the group, engage in reflection after the groups, write notes, report back to the referring clinicians, and engage in ongoing supervision to ensure validity. A few noted that experience was related to time requirements as those clinicians with less experience require more time to prepare than more experienced group facilitators.

Clinician: So if there is protected time but at the same time no decrease in their actual workload it is not really protected time. It's just shuffling things down the line.

Physical opportunity

The main themes identified during the interviews regarding physical opportunity of the COM-B were staff requirements, physical environment, resources, and budget. Each theme is described below.

Clinicians and management within WMHS identified that dedicated group leadership roles enabled the development of the TGP. They noted that the people within these leadership roles demonstrated passion for TGP and were willing to challenge management who do not value TGP. Within WMHS, a Therapy Lead and a Group Coordinator permanent position were

created to develop the TGP. Participants noted that these positions were important in the development and ongoing sustainability of the TGP.

Participants explained during the interviews that two facilitators are required for all groups, and this is sometimes difficult to source. Frequent staff turnover with the loss of experience and training, lack of psychiatrist involvement in the TGP, and staff not always feeling valued for their contribution towards the TGP program were also identified as concerns. Clinicians stated that administrative and technology support would be invaluable to them to ensure that they can utilise the limited dedicated time they have efficiently and effectively.

The physical environment was recognised as a considerable obstacle for the TGP. This domain generated extensive comments from both clinicians and consumers. Both staff and consumers confirmed that a specifically designed therapeutic group space is required. Consumers explained that consistency is important, for example if a group is eight weeks the same room, it must be available for eight weeks. A consumer noted that room size is important, especially during COVID-19, and that the group's room needs to be noise free and a confidential environment.

Consumer: The noise of the air conditioner in one room, that wasn't very helpful. The size of another room wasn't very helpful; it was a bit too tiny.

Resources and budget were additional themes that were identified. Participants noted that professional printing for consumer handouts, facilitator guidelines, and posters to market the groups should be included in the budget as this saves time and looks more professional. If these resources are not professionally printed the clinician has to allocate time to do this. They also noted that specific items are required in each group room, for example, a silent clock, a white board, tables and chairs. There should be a budget for each group to acquire items for activities; for example, sensory items, stationery, white boards and technology such as

laptops, speakers, and projectors. Consumers and staff agreed that coffee, tea, and water should always be available and some requested snacks like biscuits for the longer groups.

Motivation

Motivation includes behaviours corresponding to reflective motivation and those that are more automatic or habitual, including issues of emotion, professional identity, beliefs about capability and consequences. Behaviour change intervention functions identified by interviewees were persuasion, incentivisation and coercion.

Reflective motivation

Case managers reflected that the TGP is comprehensive and that there are a diverse range of groups covering a broad range of topics that meet their consumer's needs. Clinicians noted that because the TGP is comprehensive it provides opportunity for them to get involved in groups that align with their interest and experience.

Clinician: I think it sustains the therapist as well because it is a challenging form of therapy.

They further noted that group dynamics, which aid consumers recovery, cannot be facilitated in an individual setting. Included in this is the opportunity for consumers to obtain peer support, which is highly valued, sometimes above clinician input. TGP were noted to provide an opportunity for enhanced rapport building between clinicians and the consumers participating which leads to enhanced outcomes.

Clinician: It's a broad range of intervention types of groups I'd say, so it can cover a range of difficulties that clients are experiencing. So if you can match up what we agree they may require to maximise their recovery and function at the best they could possibly be, then it's a

nice way of getting that intervention in a very clear manner, time limited as well. It's very clear what those expectations are, easier for them to commit to it.

Most participants felt that the TGP was effective and noted that this effectiveness is evident in the positive outcomes verified via pre and post measures. A variety of outcomes included, reduced symptoms, increased use and uptake of effective strategies and improved quality of life. A few clinicians attributed the effectiveness of the TGP to the high-fidelity rate of the groups driven by the Therapy Lead and Group Coordinator.

Clinicians stated that TGP saves them time and improves their efficiency by providing an opportunity to cover topics only once within a group and not multiple times individually. Management noted that the TGP is cost effective in that it targets a group of consumers at one time and provides the opportunity for consumers to learn skills which may lead to early discharge reducing the pressure on services. TGP also provides the opportunity to effectively utilise clinicians that have limited capacity. For example, when there is only one psychologist or occupational therapist in the multidisciplinary team, the TGP provides the opportunity for a group of consumers to have access to this discipline.

Clinician: Of course, when my consumer is attending the group, that actually eases some of my workload as well because they are receiving the relevant important service from our team - from a different source, which is great.

Clinicians noted that there are positive and negative attitudes around group therapy in the various teams. These attitudes are reflected in both the numbers of staff participating and of referrals to the TGP. Also mentioned was that incorporating TGP as a treatment option provides the service with the opportunity to veer away from the medical model and shift the

focus from a heavily administrative case management approach toward therapeutic interventions.

Reported was that an increased incentive for referrals into the TGP is if the TGP can assist clinicians to meet state-wide KPIs. For example, Queensland Health has a KPI requiring case managers to meet face to face with consumers every 91 days. If a consumer attends the TGP session, this KPI is met, assisting the clinician with their workload.

Clinician: But it becomes very easy to refer to groups when you start realising how much work the group does for you that I don't have to do anymore.

Automotive motivation

Case managers noted that they experienced pressure to meet state-wide KPIs. High stress periods cause a reduction in their ability to formulate a consumer's intervention plan, resulting in less referrals into the TGP. Ongoing marketing to case managers addresses this habit. Case managers noted that it is important for the TGP to stay front of mind, even during stressful periods. They explained that incorporating TGP into care planning is not automatic but relies heavily on cues and reminders. There are limited or lack of rewards or consequences for not sending through referrals, compared to the state-wide KPIs, which influences referral numbers.

Clinician: I think that in marketing the groups some people don't see the connection between a client going to group and their job becoming easier.

A summary of the various facilitators to establish and sustain a TGP has been included in Table 4. The summary has been organised according to the COM-B framework.

1

2

Table 4 Summary of perceived facilitators to TGP

Capability +	Opportunity +	Motivation =	Behaviour
Education and Training • Education program • Capability assessment • Training budget • Various formats • Published in advance • Clear expectations • Supervision • Reflective practice • Team leader upskilling Incentivisation • Training others • Value trainers Persuasion and Modelling • Training by experienced staff • Supervision • Reflective practice	Social Opportunity Persuasion • Service growth Incentivisation & education • Reduce burnout • Enhance skill level • Improve linkages Coercion • Team Leader support • Include in model of service • Include in role descriptions • Reduction in case load Restriction • Volunteering model • Prioritisation of KPIs Modelling • Team Leader prioritisation • Workload management • Recruitment Enablement • Protected time Physical Opportunity/ Staff requirements • Dedicated positions • Staff turnover • Psychiatrist involvement • Administrative support • Technological support	Physical environment • Specifically designed • Consistently available Resources • Silent clock • White board • Tables and chairs • Technology Budget • Professional printing Refreshments	Reflective Persuasion • Meet consumer's needs • Increase in peer led groups • Believe in Effectiveness • High fidelity rate	

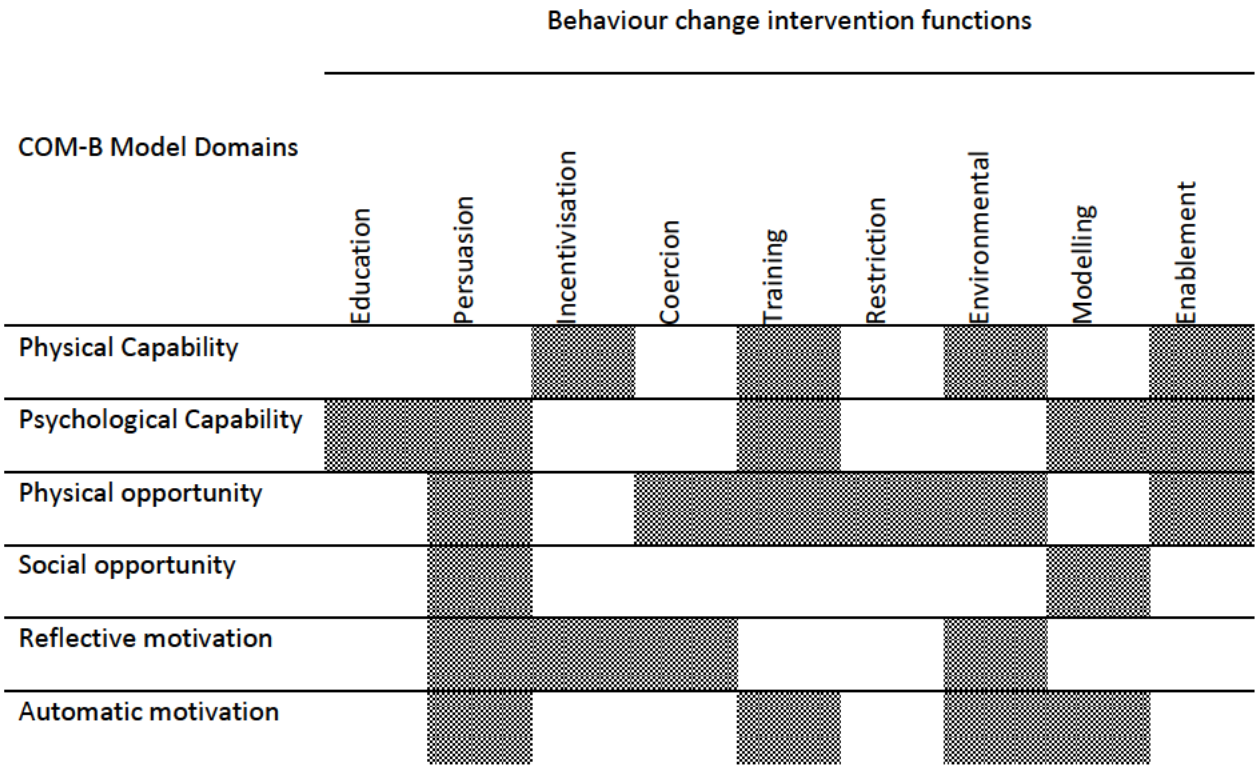
DISCUSSION

This study has identified during interviews with WMH management, clinicians and consumers the themes relate to both implementation of a TGP and sustaining an existing TGP.

Behaviour

By completing a systematic analysis of the above components of the COM-B system: Capability, Opportunity and Motivation and applying Behaviour in context, a starting point to an intervention design / behaviour change technique is achieved (Michie, 2013). The below intervention functions (table 5) provide a starting point (not all encompassing) to change behaviour, and to sustain current behaviours of clinicians as identified through the above domains (S. Michie et al., 2011).

Table 5 Behaviour change intervention functions



It is important to note that potential levers for change should look at a combination of behavioural targets within context. Based on the results in Table 5, the following intervention functions in Table 6 are recommended to potentially enable behaviour change towards a more sustainable TGP.

Table 6 Intervention Function in order of frequency

Persuasion:	• Facilitate positive communication by requesting experienced staff to be part of the education program. • Ongoing discussions with Team Leaders around the added benefits of capable staff to enhance the consumer journey. • Communication around the benefits for the team and consumers. • Recency of evidence needs to be clearly communicated to management and staff. • Completion of fidelity measures should be communicated to enhance believe around effectiveness of the TGP. • Communication needs to be clear, concise whilst relating enthusiasm of staff. Communication should be aimed towards both staff and consumers.
Training:	• Seniors in the various teams to model referrals to TGP. • Supervision to occur either in a group format or an individual format to ensure ongoing capability. • Through participation in the TGP peer supervision occurs. • Enhance management, psychiatrist and senior staff's knowledge around the incorporation of group therapy in treatment planning

Environmental Restructuring:	• Adequate rooms available to facilitate curative factors and now to follow COVID guidelines. • Up to date equipment to communicate to consumers that there is an investment into their care and provides the opportunity to incorporate different educational methodologies. • Administrative and Information Technology (IT) support will ensure clinician's time is used effectively. • Creation of a Therapy Lead and Group Coordinator position demonstrate an investment from management into the TGP.
Incentivisation:	• Management communicates education programs attendance leads to group facilitation • Time away from case management awarded to staff who facilitates group therapy • A reduction in case load will incentivise staff to participate in the TGP • Clear messaging around the reduction in clinicians workload when they participate in the TGP • Communication around the added benefit of the TGP assisting case managers to achieve state-wide KPIs • Messaging that participation in the TGP provides opportunity for discipline specific work, enhanced work satisfaction / variety, and an increase in training opportunities, all of which lead to a reduction in potential burnout • Consumers that participate in the TGP are provided with expert effective treatment

Modelling:	• Seniors in teams participating in the TGP • Psychiatrist participating in the TGP • Advanced peer workers participating in the TGP • Seniors, Psychiatrist and Advanced peer workers model referrals into the TGP
Enablement:	• Yearly capability assessment of staff • Education via various modalities to ensure all teams can attend • Team Leader to support staff participating in the TGP in a structured way • Governance structure is clear • Structured approach around TGP across the service
Education:	• Education program including both internal and external educators, various levels of capability, for example, introductory sessions to advance practitioners incorporating ongoing reflective practise into the education program. • Enhance Team Leader knowledge around the time and capability requirements of staff to facilitate TGP
Coercion:	• Management sets an expectation around Team Leader participating in the TGP Governance structure • Management sets a clear expectation around Team Leaders and Seniors supporting staff • Clinical Director sets an expectation around the involvement of Psychiatrist and Registrars in the TGP

	• Team Leaders sets a clear expectation around Seniors knowledge base, participation and support of TGP
Restriction	• Participating in one of the following initiatives should be an expectation clearly documented in role descriptions: participate in research / quality improvement / TGP / Education program / discipline specific clinics.

One of our main findings is that policy categories required to sustain the TGP in a public mental health service should aligned with the policy categories identified by Michie (Michie, 2011). Michie identified the policies as: communication / marketing, guidelines, fiscal, regulation, legislation, environmental / social planning, and service provision (Michie, 2011).

Marketing was the first policy that aligns with feedback from interviewees in this study. Michie's definition of marketing was "Using print, electronic, telephonic or broadcast media"(Michie, 2011, p.7). Interviewees noted that marketing should be targeted directly to consumers, providing clarity around what each group therapy can offer to assist them on their recovery journey. Printing of materials, for example flyers, should be done professionally and not printed internally. The printed material should be easily available to consumers and could be placed in areas with high access, for example, waiting rooms and consult rooms. Another marketing strategy identified by interviewees was that each team needs to have a TGP advocate who is trained in the utility of the various groups, to in turn upskill their teams and remind the team of the consumer benefits of TGP during team reviews.

Guidelines is defined by Michie (2011, p.7) as "Creating documents that recommend or mandate practice. This includes all changes to service provision." Clinicians valued the

structured approach to identify new groups, clear governance processes and well-defined referral processes as noted in a local instruction guideline. They noted that these structured processes enhanced the fidelity of programs and the consequent belief in the TGP's effectiveness. Interviewees requested a more structured support to clinician participation in TGP which should also include a reduction in workload. These points can be encapsulated within the above-mentioned guideline.

Fiscal support was noted by interviewees as important for both the clinicians as well as the consumers. Consumers explained that having access to refreshments during group therapy assists them to maintain their focus and motivation. Case managers noted that a more structured support for them to participate in the TGP should include a reduction in workload which would require more case managers. TGP facilitators also requested administrative and information technology support. Other positions that were valued included the Group Coordinator and Therapy Lead positions. Any extra position or support will have a fiscal repercussions.

Regulation is defined as "Establishing rules or principles of behaviour or practice" by Michie (2011, p. 7). Interviewees identified some aspects of the TGP that require the implementation of rules to enhance delivery (S. Michie et al., 2011, p. 7). They noted that sustainability of the TGP will be enhanced if participation of the TGP is embedded in role descriptions for both senior staff and case managers. They also identified the need for a clearly identified KPI for Team Leaders around TGP participation for their staff.

Service provision is defined as "Delivering a service" by Michie, and participants recommended incorporating TGP within treatment guidelines specific to diagnostic populations and groups of consumers experiencing the same symptomology (S. Michie et al., 2011, p. 7). The benefit of upskilling staff to participate in the TGP and the flow-on effect into enhanced individual care was also noted.

Environmental / social planning received the most references from interviewees. This is defined by Michie as “Design and / or controlling the physical or social environment’ (S. Michie et al., 2011, p. 7). Both staff and consumers identified the need for adequate group therapy rooms and equipment as part of the physical environment planning. Identified as part of the social planning were: more equitable participation of senior staff across the service in the TGP, each site within the health service identifying and providing a service to their own consumer cohort, and Group Therapy discussions forming part of the multidisciplinary team discussions. They also mentioned that it would assist in sustainability, if Team Leaders recruited staff with experience in Group Therapy facilitation. Interestingly, interviewees identified that linkages with specialist organisations and research organisations would enhance training opportunities, information sharing and contributions to the broader community.

Similar themes were identified by Cairns (2013, p. 477) in that building capacity through staff training and ongoing professional development enables the implementation of therapies. Cairns also explained that program evaluation, operational support related to clinician’s time spent on therapies and physical resources are critical elements that contribute towards the sustainability of therapies. Dark (2015, p4) found that a lack of knowledge or perceived skills in therapies will negatively affect the implementation of therapies which further supports capacity enhancement. Robust and transparent, well communicated, implementation planning was described by Dark (2018, p6) and a focus on service user (consumer) co-design was recommended. This study enhances the recommendations from the literature with similar themes.

STRENGTHS AND LIMITATIONS

The findings of this research were post implementation and provides a unique perspective however also confirms previous research conducted around implementation of group therapy within the Australian Public Service (Lau, 2017. Dark, 2018. Dark, 2015. Cairns, 2013. Vroom,

2022). This study was conducted in Queensland, Australia and limitations of this explorative qualitative study may be that enablers or barriers identified are hospital and health specific. Another limitation is the small consumer study size of this study, largely due to the Covid-19 pandemic and associated lock downs, which made logistics complex. The small study size especially influenced the consumer sample as information saturation was not achieved. Obtaining the consumer perspective is important as noted by Dark (2018, p6) and a future research study is recommended with a focus on the consumer perspective of the TGP.

CONCLUSIONS

Although Group Therapy is not indicated for all public mental health consumers it is an evidence-based treatment option that should be available for consumers who could potentially benefit. However, due to the perceived complications around implementation and sustainability it is not offered as a standard method of treatment across all public mental health services. The identified real-world barriers and enablers and behaviour change interventions hope to cross the chasm between research and clinical service delivery.

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CHAPTER 5: CONCLUSION

Queensland Health and other non-government agencies are faced with an increase in demand due to population growth and more people experiencing mental health concerns. This increase in demand and complexity must be managed with limited resourcing. Pressure on clinicians is amplified by the knowledge consumers have about optimal care and care options through easy internet searches and comparing treatment regimens of Public Health services. This has led to strategists within these organisations investigating effective utilisation of finite resources including optimum treatment and high productivity rates. The focus is shifting to providing the right treatment, at the right time by the right person (Pain et al., 2018).

Group Therapy is one such treatment. However, the establishment / implementation of such a program faces a number of barriers. The aim of this study was to identify the essential elements and challenges in implementing and maintaining a TGP in a community public mental health service. Group Therapy is an important aspect of intervention for people with a severe and persistent mental health diagnoses, but often not incorporated into treatment due to the perceived barriers. This chapter of the thesis commences by outlining the research findings based on the study Research Question: What critical elements and challenges contributed to the implementation and sustainability of a community TGP in a community public mental health service? And how can the TGP framework be scaled into other public health settings. Reflection whilst conducting research ensures the focus is maintained on the initially established research questions and other possible contributions. The researcher's reflection used the "Triple Dividend" noted by Ferguson and van der Laan (2021) in Chapter 2.

5.1 Response to Research Question (RQ)

5.1.1 Research Questions for Staff

The study aimed to gain the perspective of MHSS Staff who contributed towards the establishment and ongoing facilitation of the TGP. Themes emerged through the exploration of the perspectives of staff participating in the WMHSS TGP. Their reflections around the establishment of the TGP provided rich qualitative information that enabled the researcher to answer the research questions.

5.1.1.1 What are Health Professionals' perceptions of the critical elements that contributed to the development of a community TGP in WMHS?

This first question relates to TGP participants perceptions and their understanding of what contributed to the development of the TGP. This question assisted the researcher in understanding contributing factors from different perspectives. Different perspectives from different teams, different disciplines and experience levels, different levels of involvement and different positions within the organisational structure.

Various elements that contributed positively to the establishment of a TGP were identified. Interviewees noted that having a robust strategic plan tailored on consumer needs keep the program relevant to referrers and to consumers. Placing the consumers first eliminates the possibility that the TGP is based on clinician interest and skill. It ensures the health service offers new opportunities for clinicians to grow within their clinical practice and stay up to date with new evidence. The strategic plan is developed by a well organised governance structure enabling transparency and this creates trust in the program.

Utilising the COM-B to analyse the various elements provided an opportunity to identify strategies that can lead to behaviour change. Behaviour change strategies are required to aid TGP sustainability and scalability. Change within the public sector is slow and implementing various strategies enhances opportunities to bridge the gap between evidence-based research and implementation.

5.1.1.2 RQ 2: What would a framework for implementing TGP look like in the context of WMHS? And how can the TGP framework incorporate scalability into other public health areas?

Table 5 summarises the findings from this study under the headings of Michie's COM-B methodology. Incorporating Michie's COM-B method into a TGP framework will enhance behaviour change (S. Michie et al., 2011) and because of the clear parameters provided will enable other public health areas to implement a TGP.

The research findings form a framework around how a TGP can be developed in any health service. These critical elements enable management to adopt the TGP to suit the unique needs of their consumers and once implemented enhances their ability to affect change and facilitate behaviour change. Table 4, page 21 in the publishable article: Improving public mental health service. Is Group Therapy the Answer? provides a summary of the perceived facilitators to the TGP that acts as building blocks to achieve the full TGP framework.

Michie et al developed replicable interventions as a way to achieve targeted behaviour (Michie, 2013). These interventions can be used in silo or in combination and have been used in a variety of contexts, for example for increased physical activity, smoking cessation etc. Open-sort grouping of behaviour change functions were completed in (Table 6). This was based on results from the COM-B data analysis.

However, also important to consider specific context and therefore gaining management support within the various services will act as one of the most important behaviour change interventions. Other behaviour change interventions are noted in Table 6. Behaviour change interventions are then mapped against intervention functions that will lead to enhanced sustainability explained in Table 7.

Table 6: Behaviour Change Intervention Functions

Behaviour change intervention functions	COM-B Model Domains					
	Physical capability	**Psychological capability**	**Physical opportunity**	**Social opportunity**	**Reflective motivation**	**Automatic motivation**
Education		✓				
Persuasion		✓	✓	✓	✓	✓
Incentivisation	✓				✓	
Coercion			✓		✓	
Training	✓	✓	✓			✓
Restriction			✓			
Environmental	✓		✓		✓	✓
Modelling		✓		✓		✓
Enablement	✓	✓	✓			

Table 7: Intervention Function in Order of Frequency expressed by interviewees

Intervention functions	Description
Persuasion	• Facilitate positive communication by requesting experienced staff to be part of the education program. • Ongoing discussions with Team Leaders around the added benefits of capable staff to enhance the consumer journey. • Communication around the benefits for the team and consumers. • Recency of evidence needs to be clearly communicated to management and staff. • Completion of fidelity measures should be communicated to enhance believe around effectiveness of the TGP. • Communication needs to be clear, concise whilst relating enthusiasm of staff. Communication should be aimed towards both staff and consumers.
Training	• Seniors in the various teams to model referrals to TGP. • Supervision to occur either in a group format or an individual format to ensure ongoing capability. • Through participation in the TGP peer supervision occurs. • Enhance management, psychiatrist and senior staff's knowledge around the incorporation of group therapy in treatment planning

Intervention functions	Description
Environmental restructuring	• Adequate rooms available to facilitate curative factors and now to follow COVID guidelines. • Up to date equipment to communicate to consumers that there is an investment into their care and provides the opportunity to incorporate different educational methodologies. • Administrative and Information Technology (IT) support will ensure clinician's time is used effectively. • Creation of a Therapy Lead and Group Coordinator position demonstrate an investment from management into the TGP.
Incentivisation	• Management communicates education programs attendance leads to group facilitation • Time away from case management awarded to staff who facilitates group therapy • A reduction in case load will incentivise staff to participate in the TGP • Clear messaging around the reduction in case managers workload when they participate in the TGP • Communication around the added benefit of the TGP assisting case managers to achieve state-wide KPIs • Messaging that participation in the TGP provides opportunity for discipline specific work, enhanced work satisfaction / variety, and an increase in training opportunities. • Consumers that participate in the TGP are provided with expert effective treatment

Intervention functions	Description
Modelling	• Seniors in teams participating in the TGP • Psychiatrist participating in the TGP • Advanced peer workers participating in the TGP • Seniors, Psychiatrist and Advanced peer workers model referrals into the TGP
Enablement	• Yearly capability assessment of staff • Education via various modalities to ensure all teams can attend • Team Leader to support staff participating in the TGP in a structured way • Governance structure is clear • Structured approach around TGP across the service
Education	• Education program including both internal and external educators, various levels of capability, for example, introductory sessions to advance practitioners incorporating ongoing reflective practise into the education program. • Enhance Team Leader knowledge around the time and capability requirements of staff to facilitate TGP

Intervention functions	Description
Coercion	• Management sets an expectation around Team Leader participating in the TGP Governance structure • Management sets a clear expectation around Team Leaders and Seniors supporting staff • Clinical Director sets an expectation around the involvement of Psychiatrist and Registrars in the TGP • Team Leaders sets a clear expectation around Seniors' knowledge base, participation and support of TGP
Restriction	• Participating in one of the following initiatives should be an expectation clearly documented in role descriptions: participate in research / quality improvement / TGP / Education program / discipline specific clinics.

5.1.2 Research Questions for Consumers

The aim was met by answering the following research questions of consumers:

5.1.2.1 What resources are required to develop a community TGP in West Moreton Hospital and Health Service?

Physical resourcing elicited robust discussion as clinicians explained that it is not only important to have the resources as described in Table 5 but to make sure these resources demonstrate the investment into the care of consumers. For example, rooms should be tastefully decorated and resemble a home like environment rather that a sterile hospital environment. Resourcing should also be professional for example consumer documentation should be professionally printed and bound.

5.1.2.2 Identify possible strategies to address any issues identified.

All interviewees identified possible strategies throughout the interviews based on the discussion topic at hand. These strategies have been incorporated into the feedback in chapter 3. The passion and commitment of everyone involved in the TGP was evident and interviewees were very willing to share their insights and ideas.

Consumers noted that they were initially apprehensive around group therapy mostly due to the surrounding stigma. However, with the assistance of their case manager robust discussions could occur to address their apprehension and resolve any logistics around attendance. Consumers were of the opinion that they gained knowledge and skills from the group and noted that they would not have obtained the same result from individual therapy which led to the assumption that they experienced May & Yalom's (1989) curative factors described in Chapter 1.

Consumers and clinicians had very similar views around physical resources, especially the rooms. They noted that the size is important and should be big enough to accommodate the group with some space to break out and have discussions with staff when required. One consumer noted that they do not want to return to buildings that remind them of public services. They also noted is the room aesthetics was as important as the size of the room. Other helpful physical resources were the consumer handouts / booklets that they could take home and go through again to remind themselves of content covered.

5.2 Contributions (Reflections)

A range of benefits was anticipated through the practiced-based project from the Master of Professional Studies (Research) program. Benefits included the contribution to the population being studied, to the profession and theory, and to the individual researcher, known as a triple dividend (Fergusson & van der Laan, 2021). Knowledge gained in this study benefited the researcher, WMHS (the organisation), the mental health profession working within public health settings (the Profession) and most importantly the consumers. Below are some reflections around the benefits for each.

5.2.1 Researcher Benefits

The researcher gained knowledge, experience, and a passion for research during the process of completing the Master of Professional Studies (Research) program. The researcher is an insider researcher and the research falls in line with professional aims and work functions. Through the completion of this research study the capability of the researcher to meet WMHS has been enhanced. A secondary benefit is an increased knowledge, and that the researcher is now more effectively able to advocate for research and service improvement when staff voice a need.

In Table 8, the researcher linked learning objectives with Learning areas and Practitioner Capabilities by using the taxonomy of professional capabilities outlined by the Quebec Ministry of Leisure and Sport (van der Laan, 2017). This was done through completing a gap analysis (CV Tool).

Reflecting on these learning objectives identified early in the research process has been rewarding. Although some objectives will be long term aims progress could be seen and the reflection process secures the descriptive title of "lifelong learner."

Table 8: Learning Objectives Related to Practitioner Capabilities

Practitioner capabilities	Learning area	Learning objectives
Personal and Social Capabilities	Collaboration / Teamwork	Demonstrate ability to incorporate the consumer perspective into the development of new initiatives within the Mental Health Sector.
Methodological Capabilities	Work methods / Process logic	Enhance capability to utilise change management methodologies when new innovations within the Mental Health Sector is launched.
Communication-Related Capabilities	Communication Skills	Demonstrate a high level of written and

	Information Management and Dissemination	verbal communication skills.
Intellectual Capabilities	Industry Knowledge Professional Knowledge	Demonstrate a high level of industry knowledge within Mental Health, especially pertaining to trends and future directions, through collaborative dialogues with other Mental Health Clinicians / peers.
Methodological Capabilities	Analytical Skills Work methods / Process Logic	Demonstrate ability to conduct mixed methods research methodology to develop a contemporary Therapeutic Group Framework that can be embedded within the Mental Health Sector.

5.2.2 Organisation

Whilst there are obvious benefits for WMHS consumers and individual benefits for the researcher there is clear corporate benefits for WMHS and potentially for other Hospital and Health districts within Queensland Health. Benefits for WMHS are utilising the results of this research study

and establish a framework around the implementation of therapeutic groups. Having a framework in place will assist with the sustainability of therapeutic groups within WMHS.

Various outcomes could be identified that would benefit WMHS around the sustainability of the TGP. Improved care for consumers and therefore better outcomes through staff that received training in various therapeutic modalities. Clinicians noted that this knowledge and skill is transferrable into individual case management and will lead to improved outcomes. With improved outcomes consumers can be discharged from services which eliminates a bottle neck within services and reduces pressure on staff which leads to the reduction of staff burnout. Clinicians also explained that working towards their full scope of practise and not just as generalist case managers will lead to employee retention.

Since the establishment of the WMHS TGP other Hospital and Health districts have been in contact with the author and sought implementation details. The author relied on narrative to explain the process without being able to share details around the implementation process. The narrative is the author's social construct and might be biased. This work-based study provides a framework that can be replicated within other public health sectors.

For other districts within Queensland Health benefits include utilising the framework to establish therapeutic groups which will lead to enhanced care for consumers with improved outcomes. Improved outcomes facilitate expediate discharge of consumers from the service and reduction of mental health consumers re-presenting to Emergency Departments. Other potential benefits in the longer term, are employee retention due to more

opportunities for skill advancement and reduced burnout of clinicians due to the accompanying peer supervision associated with therapeutic groups.

5.2.3 Relevance to the Profession

Limited literature around the implementation of group therapy in a public sector is available (Burlingame et al., 2003; Cairns et al., 2013; Dark et al., 2018; Dark et al., 2015; Drum et al., 2011; Yalom, 2021). Similar themes were identified by Cairns (2013, p. 477) in that building capacity through staff training and ongoing professional development enables the implementation of therapies. Cairns also explained that programme evaluation, operational support related to clinician's time spent on therapies and physical resources are critical elements that contribute towards the sustainability of therapies. Dark (2015, p4) found that a lack of knowledge or perceived skills in therapies will negatively affect the implementation of therapies which further supports capacity enhancement. Robust and transparent, well communicated, implementation planning was described by Dark (2018, p6) and a focus on service user (consumer) co-design was recommended. This study enhances the recommendations from the literature with similar themes.

Linking implementation science and change management with group therapy as undertaken in this study is unique. This approach has created new knowledge which benefits the mental health profession to offer services based on a solid evidence base.

5.2.4 Relevance to the Consumer

The research shows that therapeutic groups are an effective treatment modality and should be incorporated within the suite of resources available to mental health consumers (Drum et al., 2011). Despite this evidence, group therapy was not available to consumers within the WMHS

adult community pre-2016. This study contributes to the research in a practical way and established building blocks that enabled the establishment of a TGP. With the establishment of the TPG the challenge of providing evidence based mental health treatment within a stringent resourced overburdened service becomes a reality. It provides the opportunity for consumers to attend group therapy and receive psychosocial intervention.

5.2.5 Future Research

The findings of this research were post implementation and provides a unique perspective however also confirms previous research conducted around implementation of group therapywithin the Australian Public Service (Lau, 2017. Dark, 2018. Dark, 2015. Cairns, 2013. Vroom, 2022). This framework could be utilised to mature a TGP framework and assess scalability into other HHS. Once replicated in other HHS replication of this study will enhance the study findings and confirm findings described within this study. Larger consumer studies are required to obtain further findings. Difference recruitment Strategies should be considered for example monetary incentive or a longer period of recruitment. I am hopeful that future researchers would not have to address the barriers created by the COVID pandemic. Further opportunity for research is a randomised control trial with comparison of consumer's recovery journey who access the TGP for consumers who does not. A case study analysis of consumers who access TGP may also shed light on facilitators and barriers of TGP participation and outcome.

5.3 Conclusions

For implementation of therapeutic groups to be considered, the practicality of how to implement groups needs to be explored and analysed. This exploratory work-based study evaluated the implementation process

of therapeutic groups within WMHS by obtaining the social constructs / opinions of stakeholders that were involved in the initial establishment and sustaining of this program. Through the identification of enablers and barriers and using the Logic Model to define the relationship between resources, a visual description of the sequencing of activities has been presented. The activities were also linked to the results of the program to provide stakeholders with a Project Logic model that will assist in scaling a TGP. The Project Logic model can contribute to a Therapeutic Group Framework.

For other districts within Queensland Health, benefits include utilising the Project Logic model to establish therapeutic groups which will lead to enhanced care for consumers with improved outcomes. Improved outcomes facilitate expediated discharge of consumers from the service and reduction of mental health consumers re-presenting to Emergency Departments. Other benefits are employee retention due to more opportunities for skill advancement and reduced burnout of clinicians due to the accompanying peer supervision associated with therapeutic groups for example Dialectical Behaviour Therapy (DBT)

Through the identification of enablers and barriers to the implementation of a group program, WMHH, as an organisation may receive the following benefits:

- Improved care for consumers and therefore enhanced outcomes. With improved outcomes consumers can be discharge from services.
- Employee retention / work satisfaction due to more opportunity for skill enhancement in the workplace.
- Sustainability of the therapeutic groups within the Hospital and Health service that is not mainly reliant on one individual.

Scaling-up is a complex task and it may take many years for a new evidence-based intervention to be broadly implemented. Barker et al., (2016, p1) explained that a framework requires four steps / sequence of activities for a successful scale-up. The four steps are: "1) *Set-up,* which prepares the ground for introduction and testing of the intervention that will be taken to full scale; 2) *Develop the Scalable Unit,* which is an early testing phase; 3) *Test of Scale-up,* which then tests the intervention in a variety of settings that are likely to represent different contexts that will be encountered at full scale; and 4) *Go to Full Scale,* which unfolds rapidly to enable a larger number of sites or divisions to adopt and / or replicate the intervention." Applying this to TPG, the Set-up phase has occurred with the development of the TPG program. This exploratory study will be the second component of developing the unit. A future study will be recommended to Test the Scale-Up unit with the hope of fully up-scaling the TPG into other HHS.

To be able to provide the right treatment, at the right time by the right person (Pain et al., 2018) requires a variety of treatment options. Therapeutic Groups offer an alternative that can enhance individual therapy for consumers with a severe and persistent mental health diagnoses. However, even though the efficacy has been proven through systematically reviewed research the implementation of Therapeutic Groups was not researched well. The purpose of this research was to examine the critical elements that can sustain and provide opportunities around scalability of the TGP. The analysis of these elements provided insight into the themes that emerged of TGP participants: clinicians, consumers and WMHS management. The interviewees were able to provide feedback based on lived experiences and their understanding around the barriers and enablers towards TGP sustainability.

Although this study had limitations, as noted in section 2.4, it does contribute towards knowledge and informs future research. Other potential research could include replication in other locations and with different service providers, a randomised control trial with consumers that participated in the TGP compared to consumers who did not participate in a TGP as part of their recovery journey. Once the recommendations of this study have been incorporated into practise a post qualitative analysis would determine if the constructs provided by management, clinicians and consumers improved the TGP. Future research should also include longitudinal studies to review outcomes for consumers, clinicians, and management after the TGP has been operating over a longer timeframe. This research has provided contributions to the scholarly field of Mental health Therapeutic Group implementation in a public health service.

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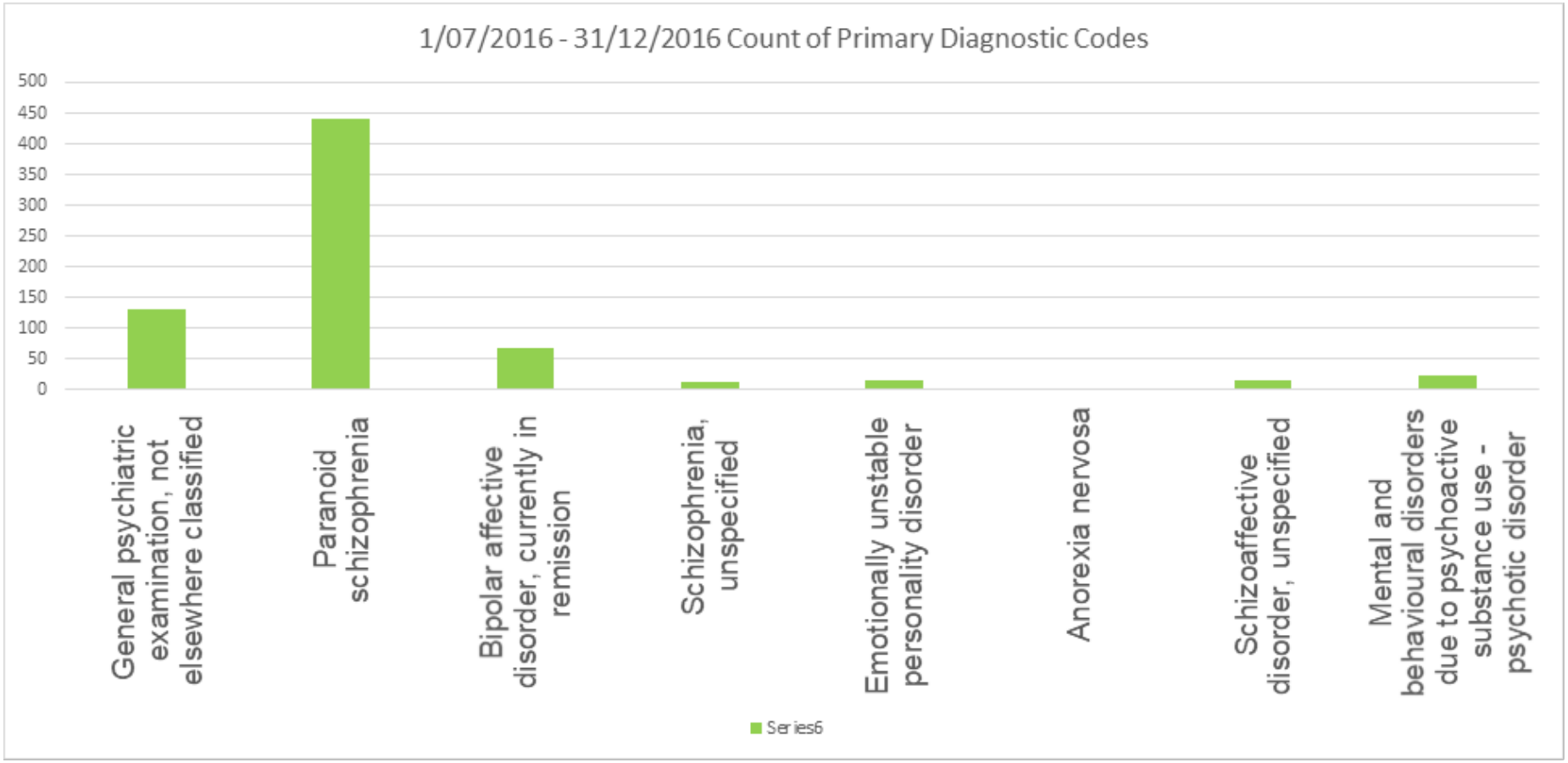
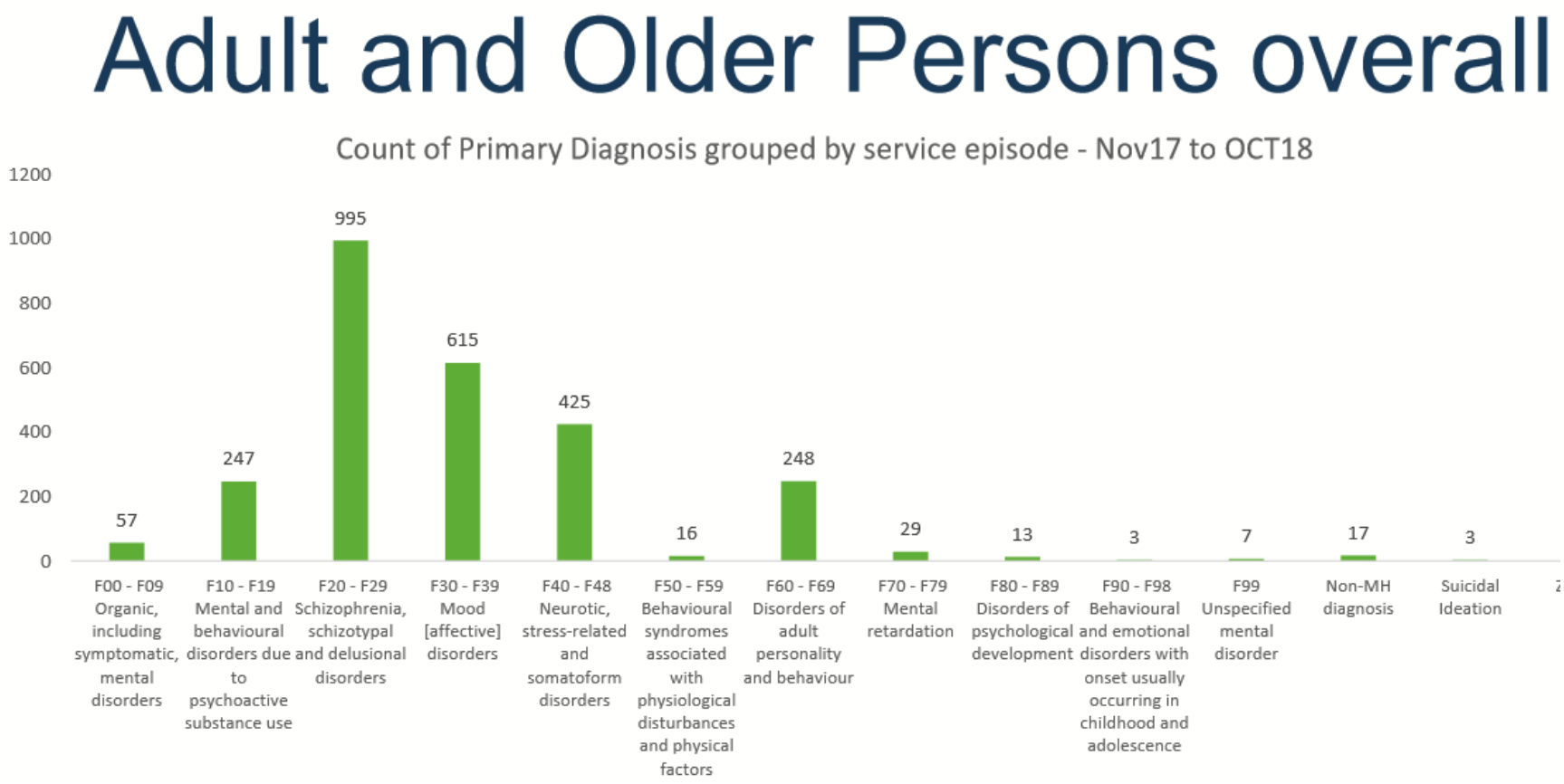
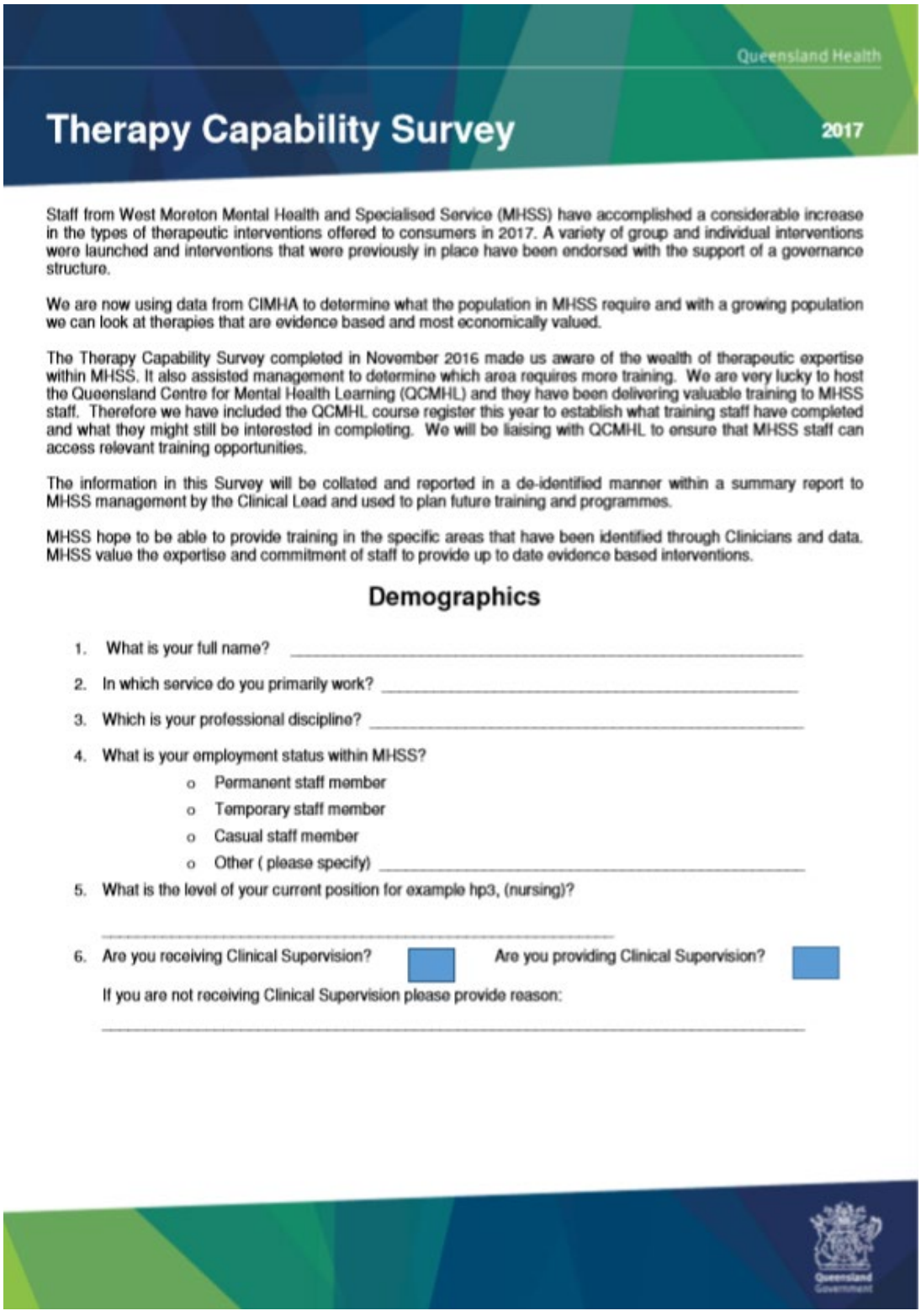
Appendix A: Top Diagnostic Groups within MHSS, WMHS



Appendix B: Grouped Diagnoses November 2017 – October 2018



Appendix C: Therapy Capability Survey



Queensland Health

Therapy Capability Survey 2017

Staff from West Moreton Mental Health and Specialised Service (MHSS) have accomplished a considerable increase in the types of therapeutic interventions offered to consumers in 2017. A variety of group and individual interventions were launched and interventions that were previously in place have been endorsed with the support of a governance structure.

We are now using data from CIMHA to determine what the population in MHSS require and with a growing population we can look at therapies that are evidence based and most economically valued.

The Therapy Capability Survey completed in November 2016 made us aware of the wealth of therapeutic expertise within MHSS. It also assisted management to determine which area requires more training. We are very lucky to host the Queensland Centre for Mental Health Learning (QCMHL) and they have been delivering valuable training to MHSS staff. Therefore we have included the QCMHL course register this year to establish what training staff have completed and what they might still be interested in completing. We will be liaising with QCMHL to ensure that MHSS staff can access relevant training opportunities.

The information in this Survey will be collated and reported in a de-identified manner within a summary report to MHSS management by the Clinical Lead and used to plan future training and programmes.

MHSS hope to be able to provide training in the specific areas that have been identified through Clinicians and data. MHSS value the expertise and commitment of staff to provide up to date evidence based interventions.

Demographics

1. What is your full name? _____
2. In which service do you primarily work? _____
3. Which is your professional discipline? _____
4. What is your employment status within MHSS?
   - o Permanent staff member
   - o Temporary staff member
   - o Casual staff member
   - o Other (please specify) _____
5. What is the level of your current position for example hp3, (nursing)?

   _____
6. Are you receiving Clinical Supervision? ☐ Are you providing Clinical Supervision? ☐

   If you are not receiving Clinical Supervision please provide reason:

   _____

Queensland Government

Skills Matrix

Please indicate your current level of training, experience and interest.

None (N)	*No training or experience.*
Basic / Beginner (B)	*Some training at a seminar or workshop; occasional 'on the job' experience.*
Intermediate (I)	*Training at an undergraduate tertiary level; regular experience through work.*
Advanced (A)	*Training at a postgraduate level; regular experience through work; receive / provide supervision; provide training to others.*

Please note that any fields left blank will be assigned as "none" for training and experience and "no" for interest

	Training (N, B, I, A)	Experience (N,B,I,A)	Are you interested in further training? (Y or N)
Acceptance Commitment Therapy (ACT)			
Brief Family Intervention			
Cognitive Behaviour Therapy (CBT)			
Cognitive Behaviour Therapy for Psychosis (CBTp)			
Cognitive Remediation Therapy (CRT)			
Dialectical Behaviour Therapy (DBT)			
Family Therapy			
Interpersonal psychotherapy (IPT)			
Mindfulness-based cognitive therapy (MBCT)			
Motivational Interviewing			
Narrative Therapy			
Psychodynamic Psychotherapy			
Psycho-Education			
Reason & Rehabilitation (R & R II)			
Recovery-Focussed Care			
Schema Therapy			
Sensory Profiling and Modulation			
Smoking Cessation			
Social Cognition Interaction Training (SCIT)			
Social Cognition Interaction Training (SCIT)			
Social Skills			
Solution-Focused Therapy (SFT)			
Substance Use Interventions			
Trauma-Informed Care / Therapies			
Weight Management			
Other:			

Appendix D: Group Outlines

3. REFERRAL PROCESS (PLEASE UTILISE CARE PLAN AS REFERRAL)
consistent process: call for referrals, ensure consent form consumer, ensure discussion has occurred with treating team, have a waiting list process

4. RESOURCE REQUIREMENTS:	
STAFF: *number, designation, training requirements, licensing, staff names that will be facilitating*	
TIME: *include preparation time, program delivery time, frequency*	
ROOM/VENUE: *eg preferred place to run, specific location (gym, pool) or description (eg quiet room with chairs)*	
EQUIPMENT:	
OTHER:	
ESTIMATED COSTS (IF ANY): include initial costs, ongoing costs if applicable, and any costs to the consumer.	
LOCATION OF RESOURCES AND SUPPORT MATERIALS: **(include electronic resources)**	
Duration of session and number of sessions:	

5. Group process / method:			
☐ OPEN GROUP OR		☐ CLOSED GROUP	
Maximum participants:		Maximum participants:	12
Inclusion criteria / additional factors for this program:			
Eg stable mental state over the preceding 24 hours, accepting of guidance and direction from staff, language, literacy, numeracy skills; gender specific or mixed; cultural needs. Include contra-indications, what commitment is necessary for the group for e.g. Pre-commitment sessions completed.			
IF A PARTICIPANT SELF-IDENTIFIES AS FROM AN INDIGENOUS BACKGROUND, PLEASE LIAISE WITH THE INDIGENOUS PROGRAM DEVELOPMENT OFFICER TO ENSURE PROGRAM CONTENT IS CULTURALLY SENSITIVE AND FOR SUPPORT WITH PROGRAM ENGAGEMENT.			

v

6. Risk and safety considerations: *eg sharps, equipment, consumers sharing potentially traumatising experiences, absconding, safety of personal property, money handling, potential hazards, chemicals.*

Potential risk	Management

7. Relevant procedures, workplace instructions or protocols:

.

8. Documentation: eg cimha pos entry, clinical note, other.

9. Evaluation methods: *eg pre- and post-measures; outcome measures; consumer survey; skill demonstration.*

10. Consultation

The program was developed/sourced in consultation with:

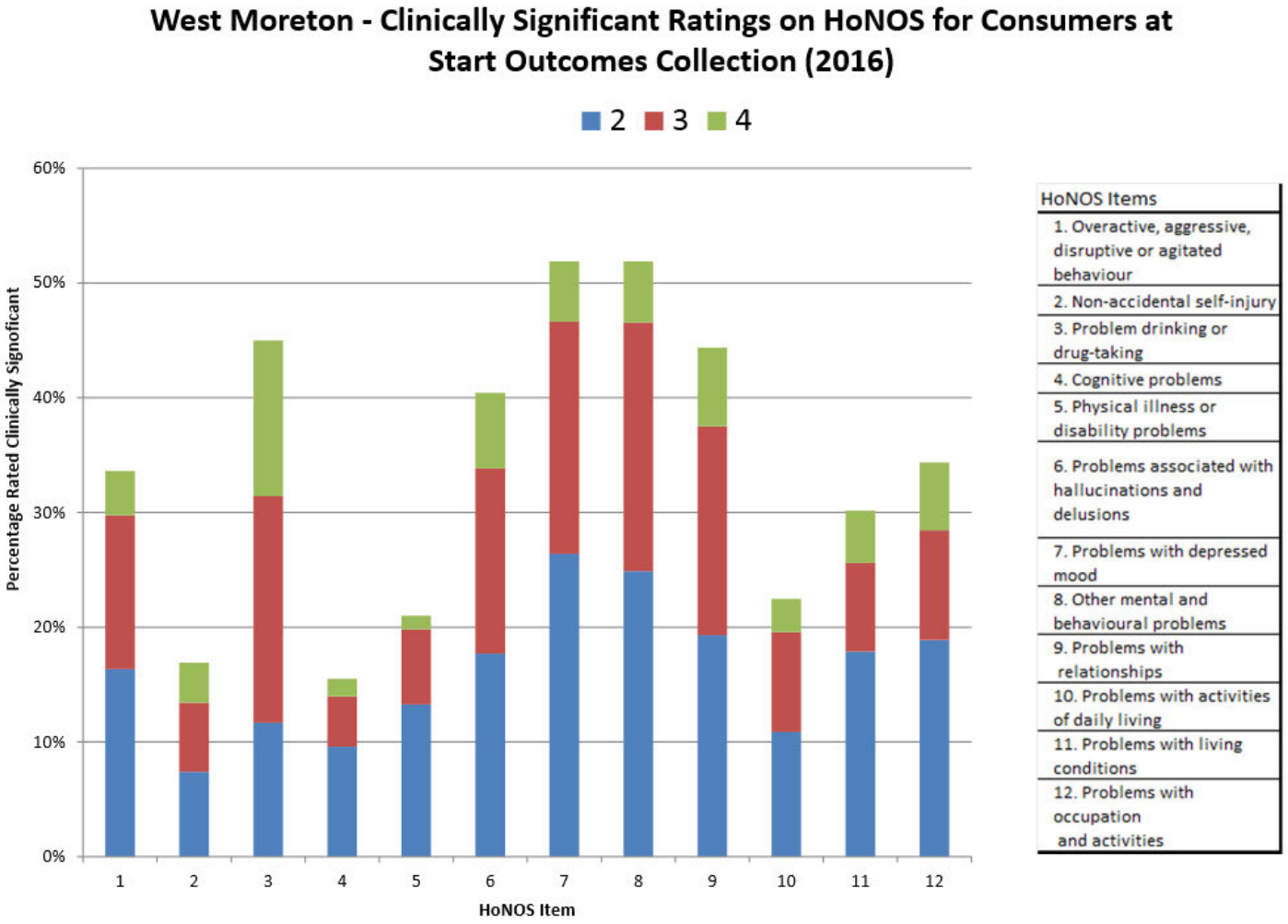
Name	Position	Date

11. Endorsement:	
☐ Site operational team meeting	Date:
☐ Therapeutic program Governance Committee	Date:
☐ CPIC	Date:
☐ Other – specify:	Date:
To be next reviewed:	Date:

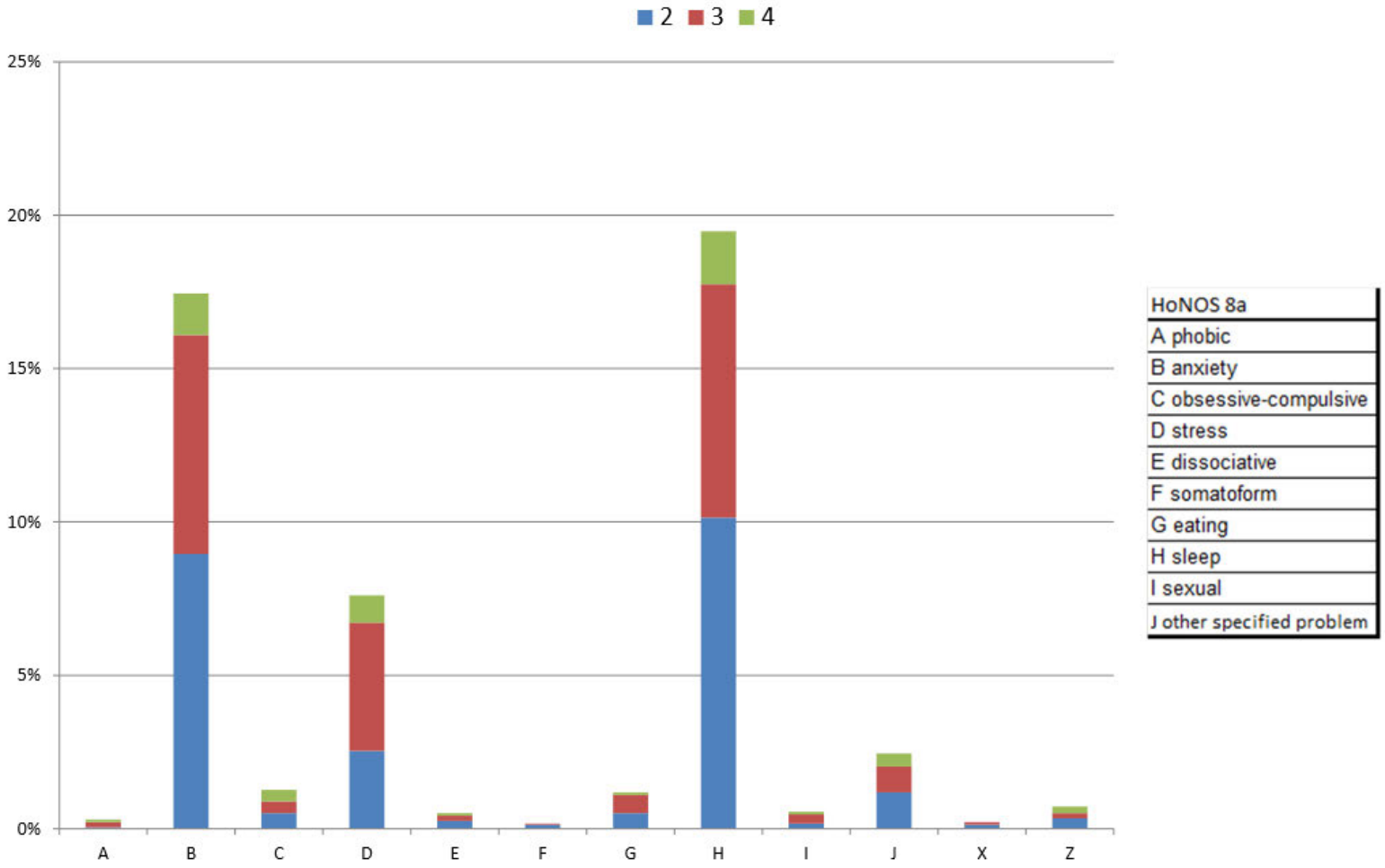
Appendix E: 2017 MHSS CAS Therapeutic Group Program

Group	Commencing on	Commencing on	Sessions
Life skills group	1 February 2017	14 July 2017 (referral end date 30 June 2017)	10 sessions twice weekly
Sensory Connections	24 March 2017		6 sessions once a week
Budgeting	20 March 2017	14 August 2017 (referral end date 28 July 2017)	5-6 sessions once a week
Psychoeducation	10 July 2017	Ongoing	
SCIT	4 May 2017 (referral end date 12 May 2017)		8 sessions once a week
DBT	24 August 2017 (referral end date 11 August 2017)		12 sessions once a week
ACT	9 October 2017 (referral end date 29 September 2017)		4 sessions once a week
Basic Cooking	2 May 2017 (referral end date 21 April 2017)	Ongoing	1 session a fortnight

Appendix F: Outcome Measures



West Moreton - Clinically Significant Ratings on HoNOS 8A for Consumers at Start Outcomes Collection (2016)



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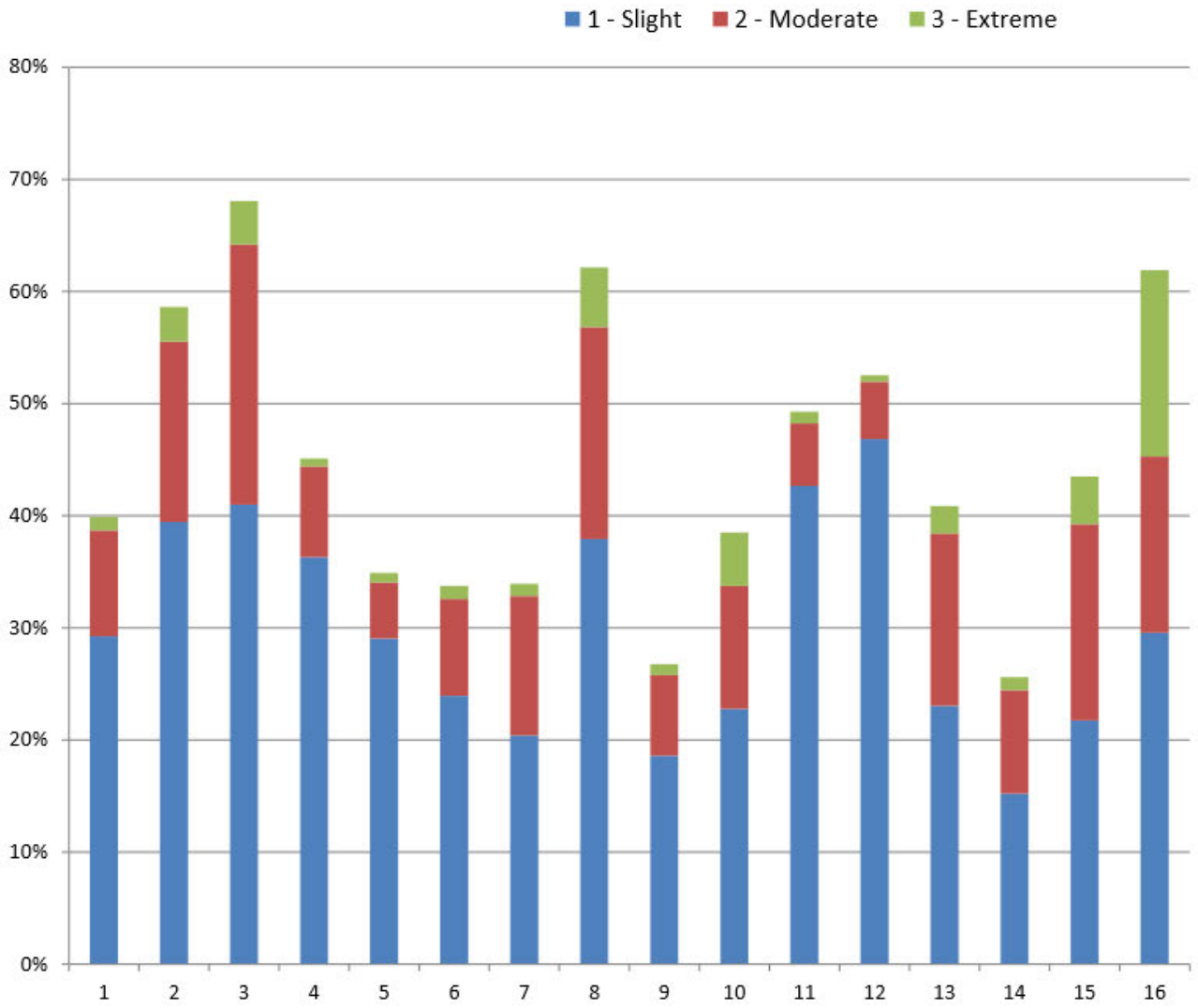
West Moreton - Slight, Moderate and Extreme Problems Ratings on LSP-16 at Case Review Collection (2016)



LSP 16
1 Difficulty with initiating and responding to conversation
2 Withdraw from social contact
3 Show warmth to others
4 Well groomed
5 Wear clean clothes
6 Neglect her or his physical health
7 Violent to others
8 Make and/or keep up friendships
9 Maintain an adequate diet
10 Look after and take her or his own prescribed medication
11 Willing to take psychiatric medication when prescribed by a doctor
12 Co-operate with health services
13 Problems (e.g. friction, avoidance) living with others in the household
14 Behave offensively
15 Behave irresponsibly
16 Capable of Fulltime work

Appendix G: 2019 and 2020 WMHS Therapeutic Group Program

West Moreton Health

West Moreton Mental Health and Specialised Services

2019 Therapeutic Groups Program

Group	Term 1	Term 2	Term 3	Term 4	Sessions
Introduction to CBT			July 2019 Dates to be confirmed (IP)		4 Sessions once a week 2hrs (time to be confirmed)
Skillfull Thinking (Mood)				October 2019 Dates to be confirmed (IP)	1 refresher + four sessions once a week 2hrs (time to be confirmed)
Sensory Connections		23rd April (G)		8th October (G)	10 sessions once a week Tuesdays 1:00pm – 2:00pm
Budgeting	31st January (IP)	2nd May (G)	18th July (IP)	10th October (G)	5 sessions once a week Thursdays 9:00am-11:00am
Psycho-education	4th Feb (G & IP) 18th Feb 4th March 18th March	29th April (G & IP) 13th May 27th May 10th June	29th July (G & IP 12th August 26th August 9th September	14th October (G & IP 28th October 11th November	Topic will be advertised Monday 1:00pm-2:00pm Every fortnight
SCIT	8th February (IP)			11th October (G)	8 sessions once a week Fridays 9:00am – 11:00am
DBT	31st January 2019 (IP)	2nd May 2019 (IP)	18th July 2019 (IP)	10th October (IP)	10 sessions once a week. Thursdays 12:00pm – 2:00pm
Introduction to Navigating Happiness	4th March (Monday) (G)	30th April (Tuesday) (IP)	15th July (Monday) (G)	11th October (Friday) (IP)	4 sessions once a week 10:00am– 12:00pm
CRT	4th February (G)		29th July (G)		20 sessions twice a week Monday & Wednesdays 9:00am – 10:00am
Sleeping Well	6th March (G)	29th May (IP)	28th August (G)	6th November (IP)	4 sessions once a week Wednesdays 3:00pm – 4:00pm
Reason and Rehabilitation		23rd April 2019 (IP)			18 sessions once a week Tuesdays 2:00pm - 4:00pm
Anger Management (AODS WMMHSS)	15th January (IP)				**Please contact AODS on 3817 2400 for referrals** 11 sessions once a week Tuesdays Womens Group 9:30am -11:00am Mens group 2:00pm-3:30pm
SPORT Social Problem Offence Related Thinking			18th September (IP)		14 sessions once a week Wednesday 10:00am - 12:00pm
Carer's Support Group All Family and Friends from WMMHS consumers welcome	Every last Friday of the month	Every last Friday of the month	Every last Friday of the month	Every last Friday of the month	In collaboration with MIND and EACH One session a month 10:00am - 12:00pm Gailes Commyunity Care Unit

Mental Health and Specialised Services
2020 Therapeutic Groups Program

Group	Term 1 28/01/20 - 03/04/20	Term 2 20/04/20 - 26/06/20	Term 3 13/07/20 – 18/09/20	Term 4 06/10/20 – 11/12/20	Sessions	Day and Time
Budgeting	IP 5th February	CCU 23rd April	G 16th July	IP 16th October	5 sessions once a week	IP: Thursdays 9:00am-11:00am G: Thursdays 9:00am-11:00am CCU: Thursdays 9:00am-11:00am
CRT	CCU 22nd January	IP 21st April	CCU 15th July	IP 13th October	20 sessions twice a week	IP: Tuesdays and Fridays 1:00pm – 2:00pm CCU: Wednesdays and Fridays 1:00pm – 2:00pm
DBT Full Program	Distress Tolerance G 30th January	Emotional Regulation G 23rd April	Interpersonal Effectiveness G 16th July	Distress Tolerance IP 15th October	10 sessions once a week	G: Thursdays 12:00pm – 2:00pm
DBT Skills Only	Distress Tolerance IP 30th January	Emotional Regulation IP 23rd April	Interpersonal Effectiveness IP 16th July	Distress Tolerance G 15th October	8 sessions once a week	IP: Thursday 9:30am 12:00
Navigating Happiness	G 27th January	IP 6th May	CCU	G 12th October	4 sessions once a week	IP: Wednesday 12:30 14:30 G: Monday 09:30 -11:30 CCU: 10:00am- 12:00pm
Making Sense	IP 31st January	CCU 24th April		CCU 9th October	8 sessions once a week	IP: Fridays 9:00am – 11:00am CCU: Fridays 9:00am – 11:00am
Sleeping Well	CCU 5th February	G 21st May	IP 11th August	CCU 11th November	4 sessions once a week	IP: Tuesdays 2:00pm – 3:00pm G: Wednesdays 3:00pm – 4:00pm CCU: Wednesdays 3:00pm – 4:00pm
Sensory Group		CCU	IP 14th August		6 sessions once a week	IP: Tuesdays 1:00pm – 2:00pm CCU: Wednesdays 1:00pm – 2:00pm
Skilfull Thinking Intro	IP 11th February	G 3rd June	IP	CCU	4 Sessions once a week 2hrs	IP: Tuesday 2-4pm G: Wednesday 1-3pm
Skilfull Thinking (Psychosis)			IP	G 11th November	Four sessions once a week 2hrs	IP: Wednesday G: Wednesday 9 – 11:00
Anger Management	IP	IP	IP	IP	Eleven sessions once a week	IP: 09:30 – 11:00am G:
Taking Control	IP & G	IP & G	IP & G	IP & G	Six sessions once a week	IP: 1:00pm G:
SPORT			IP 15th July →	IP	14 sessions once a week	IP: Wednesday 10:00am - 12:00pm
R & R 2 MHP		IP 16th June →	IP		18 sessions once a week	IP: Tuesdays 2:00pm - 4:00pm
Wise Choices Intro			IP , 22nd July	G	10 Sessions once a week, for 2 hours	IP: Tuesdays – 09:00 – 11:00 G:
Wise Choices Advanced				IP	10 Sessions once a week, for 2 hours	IP:

CCU – Gailes Community Care Unit IP – Ipswich Health Plaza
G – Goodna Community Services

General information about Mental Health and Specialised Services

The therapeutic group program in West Moreton is offered to people who have a mental health condition and care is managed by the local mental health team.

Referrals occur through the Care Plan. Please contact the Group Coordinator for further information.

BUDGETING - This group focuses on the importance of developing a budget plan to manage finances, ensure there's sufficient money for basic/daily needs, prevent debts and have some savings. It has been developed from the Money Minded training program offered by ANZ bank and the Smith Foundation.

COGNITIVE REMEDIATION THERAPY (CRT). CRT is a psychological intervention to improve thinking skills (e.g. memory, attention, executive functioning). CRT is a computerised web-based programme 'Computerised Interactive Remediation of Cognition – Training for Schizophrenia' (CIRCuiTS). This program was developed in the United Kingdom and is based on clear theoretical principles and evidence-based teaching techniques.

DIALECTICAL BEHAVIOUR THERAPY (DBT). DBT is offered to consumers with a diagnoses of Borderline Personality Disorder and teaches skills in mindfulness, interpersonal effectiveness, distress tolerance and emotion regulation. The full group consists of a weekly skills group, weekly meetings with a DBT therapist and out of session phone coaching. DBT Skills only group consist of a weekly skills group.

NAVIGATING HAPPINESS is a four week group introducing people to concepts of Acceptance and Commitment Therapy (ACT). The group focuses on developing skills around mindfulness and psychological flexibility. There are three key themes: Open Up, Be Present and Do What Matters.

SLEEPING WELL. Sleeping Well is designed to address issues around sleep. This program will look at sleep hygiene, the importance of sleep and our mental health, how the body and mind need sleep in order to function properly. During this program, participants will be able to learn strategies to combat sleep issues such as insomnia, nightmares and restlessness.

SPORT. The SPORT program was specifically created for use with Intellectual Disability and is a simple Cognitive Behaviour Therapy (CBT) program. It promotes identification of thinking errors, and problem situations and pro social thinking to replace offending behaviours. It replaces cognitive distortions with more positive values.

MAKING SENSE (SOCIAL COGNITION INTERACTION TRAINING). Making sense is based on SCIT and it is designed to assist people who have difficulties with their communication skills. Specifically, for people who frequently misunderstand or misinterpret what other people are saying, or alternatively, are frequently misunderstood themselves.

This program aims for people to understand the link between their emotions, thoughts and actions. It is the interaction between emotions, thoughts and actions that frame how people communicate with other people and in turn 'filter' what they hear and understand. Making Sense primarily focuses on seven emotions and dealing with these emotions along with ensuring messages between people are clear and understood are the two primary goals of the Making Sense program.

SENSORY GROUP - The Sensory Group is an Occupational Therapy based group to help people: identify their own sensory preferences and tendencies, increase their understanding and use of sensory approaches, and to also help increase a persons capacity to self-regulate through the use of individually tailored and meaningful sensory strategies. It is a person-centered, strength oriented, skill building group. The skills developed are individualised, meaningful and relevant to the person and their unique needs and sensory preferences. This 6 session program is based on the Sensory Connection Group Program by Karen Moore, The Alert Program by Shellenberger and Williams, as well as evolving neurological research coupled with the use of hands on sensory approaches and activities.

SKILLFULL THINKING - INTRODUCTION. A four week program introducing the basic concepts of Cognitive Behavioural Therapy with the aim of developing good understanding on how thoughts, feelings behaviours all influence each other. The program will provide some psychoeducation, individual goal setting and problem solving. This program forms the basis for people then moving onto other CBT specific programs such as mood.

SKILLFUL THINKING - MOOD. Cognitive Behavioural Therapy program specifically designed for those who experience issues with there mood. The program expands upon the concepts learnt in the Introduction to CBT course. The program offers a refresher session and then four weeks. Suitability to the program is assessed by Psychologists.

Reason and Rehabilitation II - The Reasoning and rehabilitation Program for Youth and Adults with Mental Health Problems (R&R2 MHP) is a group program that aims to help participants make changes to their behaviour and lessen the chance of re-offending. It is designed for people with a mental illness who have also offended or with a forensic history. May assist with evidence for MHRT review of forensic orders. The R&R2 MHP program helps participants develop the ability to: think about other people's perspectives, understand the consequences of behaviour, make lifestyle changes, become more independent, solve problems, and focus on living successfully in the community.

WISE CHOICES – INTRODUCTION. The Wise Choices introduction program, is a run over ten sessions introduceing basic Acceptance and Commitment Therapy for people suffering with BPD. Covering topics of thoughts and feelings, mindfulness skills, defusings/unlocking from unhelpful thoughts.

TAKING BACK CONTROL - Back in Control Relapse Prevention is a 6 module education program designed for people who have had problems with substance use. Getting off substances is the relatively easy part of overcoming a problem with substance use. Staying off and regaining control over the substance (and over your life) can be much more difficult.

ANGER MANAGEMENT - Anger management is a 11 session program delivered in a group setting with approximately 8 participants in each group. The program is designed for males and females over the age of 18 who experience issues managing aggressive behavior and anger **and** have a substance use and/or mental health issue

Group Co-ordinator
Mobile: 0428463620
Email: WM_MHSS_CAS_Groups@health.qld.gov.au

For DBT referrals:

Appendix H: Evidence based psychological intervention

CATEGORISATION OF LEVEL OF EVIDENCE SUMMARY TABLE: **ADULTS**

ADULTS	Level I	Level II	Level III	Level IV
Adjustment disorder	-	Psychodynamic	CBT (Level III-2)	-
Anxiety disorders				
Generalised anxiety disorder	CBT	Online CBT(G+UG), ACT, Online ACT(G), MBCT, MBSR, MCT, Psychodynamic therapy, Online Psychodynamic therapy(G), Psychoeducation (group)	-	-
Obsessive compulsive disorder	CBT (ERP), Online CBT(G), Computer-based ERP (G)	ACT, FI, MBCT, MCT	-	-
Panic disorder	CBT	Online CBT(G+UG), ACT, Psychodynamic therapy	-	MBCT
Posttraumatic stress disorder	CBT (trauma-focused), EMDR	DBT, EFT, MCT, MBSR	-	-
Social anxiety disorder	CBT, Online CBT	ACT, IPT, MBSR, Psychodynamic therapy	-	-
Specific phobia	CBT (exposure)	Computer-based exposure (G+UG), Virtual reality-based exposure (G+UG)	-	-
Attention deficit hyperactivity disorder	CBT	Online CBT(G+UG), DBT, MCT, MBCT, Psychoeducation	-	-
Borderline personality disorder	DBT, Psychodynamic therapy, Schema therapy	ACT, CBT, IPT, Psychoeducation	-	MBCT
Dissociative disorders	-	-	-	Psychodynamic therapy
Eating disorders				
Anorexia nervosa	-	CBT (eating-disorder focused), Online CBT, FI, Psychodynamic therapy	-	DBT
Binge eating disorder	CBT	Online CBT(G), Bibliotherapy (G), DBT, IPT, MBSR, Psychoeducation	EFT (Level III-3)	ACT
Bulimia nervosa	CBT	Online CBT(G), Bibliotherapy, DBT	IPT (Level III-3)	Psychoeducation
Mood disorders				
Bipolar disorder	CBT	FI, MBCT, Psychoeducation	-	IPSRT
Depression	CBT, Online CBT(G+UG), IPT, MBCT, PST, Psychodynamic therapy, Psychoeducation	ACT, Online ACT(G), DBT, EFT, EMDR, FI, Online PST(G), Schema therapy, SFT	-	MCT
Psychotic disorders	CBT, FI, Psychoeducation	ACT, MCT	Psychodynamic therapy (Level III-2)	-
Sexual disorders	CBT (including systematic desensitisation)	IPT, Psychoeducation	MBCT (Level III-2)	-
Sleep disorders	CBT, Online CBT (G+UG), MBSR	-	-	-
Somatoform disorders				
Body dysmorphic disorder	CBT	Online CBT(G), MCT	-	ACT
Hypochondriasis	CBT, Psychoeducation	Online CBT (G+UG), ACT, Bibliotherapy, MBCT	-	MCT
Pain disorder	-	ACT, Online ACT(G), CBT	-	-
Somatisation disorder	-	CBT	-	-
Substance use disorders	CBT (including motivational interviewing)	ACT, DBT, FI, Mindfulness-based relapse prevention, Psychodynamic therapy	-	IPT, Psychoeducation

ACT: Acceptance and commitment therapy
CBT: Cognitive behaviour therapy
CAT: Cognitive analytic therapy
CRT: Cognitive remediation therapy
DBT: Dialectical behaviour therapy
EFT: Emotion-focused therapy
EMDR: Eye movement desensitisation and reprocessing
ERP: Exposure and response prevention
FI: Family intervention
IPSRT: Interpersonal and social rhythm therapy
IPT: Interpersonal psychotherapy
MBCT: Mindfulness-based cognitive therapy
MBSR: Mindfulness-based stress reduction
MCT: Metacognitive therapy
PST: Problem-solving therapy
SFT: Solution-focused therapy

Appendix I: Population Groups and Evidence-Based Care

Diagnoses	Evidence-Based Treatment	Level of Evidence
Schizophrenia	CBT (Cognitive Behaviour Therapy)	Level I
	Family Therapy	Level I
	CRT (Cognitive Remediation Therapy)	Level II equivalent
	SCIT (Social Cognition Interaction Training)	Level II equivalent
	Sensory Approaches	Level II equivalent
Bipolar and Mood	Mindfulness-based cognitive therapy (MBCT)	Level II
	CBT	Level II
	Interpersonal psychotherapy (IPT)	Level II
	Family Therapy	Level II
	Psycho-Education	Level II equivalent
	Sensory Approaches	
Substance use disorder	CBT	Level I
	Solution-focused brief therapy	Level II
	DBT (Dialectical Behaviour Therapy)	Level II
	Self-help	Level II
	Sensory Approaches	Level II equivalent
Personality Disorder	DBT	Level I
	SCHEMA-Focused	Level II
	Psycho-dynamic	Level II
	Sensory Approaches	Level II equivalent

Appendix J: Organisational Description

There are four operational streams within MHSS:

1. Community and Acute Services.
2. Forensic and Secure Services.
3. Prison Health Services.
4. Service Development and Performance.

This study will be conducted in West Moreton Hospital and Health Service (WMHS), Mental Health and Specialised Services (MHSS), Community and Acute Services (CAS). MHSS is one of 10 divisions within WMHS.

Mental Health and Specialised Services (MHSS)

MHSS is one of ten divisions within West Moreton Health. MHSS provides mental health treatment and support services to people of all ages at varying stages of mental illness. Clinical services support the recovery of people with severe mental illness by providing evidence based, consumer focused and recovery orientated care in partnership with consumers, carers and other service providers. MHSS also currently provides primary health care services to prisoners in five of south east Queensland's correctional centres.

Within MHSS there are four operational streams plus two State-wide Services, these are:

- Community and Acute Services;
- Forensic and Secure Services;
- Mental Health Clinical Support;
- Prison Mental Health Services;
- Queensland Centre for Mental Health Research (state-wide); and
- Queensland Centre for Mental Health Learning (statewide).

MHSS has a strong partnership with the Mental Health Alcohol and Other Drugs Branch, Queensland Department of Health and a wide range of non-government service providers. It also works closely with neighbouring

public mental health services and Primary Health Networks in south east Queensland.

Community and Acute Services (CAS)

CAS provide recovery orientated care through the provision of inpatient, residential and community mental health services as well as alcohol and other drug services. This includes mental health assessment, early intervention, treatment and continuing care. Specialist mental health services are available for children, adolescents, adults and older persons who have or are at risk of having a serious mental illness.

The service works in partnership with community managed organisations, primary care and other government departments to support people with severe mental illness and complex care needs to live meaningful lives in our community.

Acute Care Team

The Acute Care Team (ACT) functions as the first point of contact to community and acute mental health services 24 hours, 7 days a week. Following assessment, the team facilitates the most appropriate type of care (e.g. inpatient, community, crisis interventions) for the individual. Anyone can access this service by calling 1300 MH CALL (1300 64 22 55) directly and talking to a health care professional.

Adult Acute Mental Health Unit

The Adult Acute Mental Health Unit (AMHU) is situated within the Ipswich Hospital. It provides multidisciplinary inpatient care 24 hours a day, 7 days a week through specialist assessment, clinical interventions and treatment services. There is a focus on recovery and rehabilitation within a safe, therapeutic and consumer friendly environment. This service can be accessed by adults between 18 and 64 years who are experiencing acute episodes of mental illness and cannot be adequately supported in the community environment. The AMHU is dedicated to providing all consumers with continuity of care during their recovery and assists with building relationships the community to assist with continuing recovery.

Alcohol and Other Drugs Service

Alcohol and Other Drugs Service (AODS) provides a free, professional and confidential service for adults and young people who have concerns about their own or another's alcohol or other drug use. The service supports individuals and/or families to make informed decisions and aims to reduce the risk of harm associated with alcohol and other drug use.

Child and Youth Mental Health Service

Child and Youth Mental Health Service (CYMHS) is a specialised team of health professionals that provides assessment, treatment and management of children and young people aged 0 to 17 years who have/or at risk of developing severe and complex mental health issues.

All programs provide targeted treatment/ interventions taking into consideration the child's/young person's age and physical, psychological and social needs. Interventions may include individual therapy, family therapy and group work.

Assertive Mobile Youth Outreach Service

Assertive Mobile Youth Outreach Service (AMYOS) is part of the West Moreton Child and Youth Mental Health Service. It provides free, confidential assessment, therapy and support to young people aged 13 to 18 years and their families/carers who are experiencing complex or severe mental health problems and who maybe having difficulties engaging with main stream child and youth mental health services. It is a mobile service and offers frequent out-of-office support to young people and their families in variety of locations including in home or at school. AMYOS is available during Monday to Friday from 9 am to 5 pm.

The team at AMYOS includes a variety of mental health professionals including psychologists, social workers, mental health nurses, occupational therapists and speech pathologists. AMYOS also works closely with CYMHS and other service providers to ensure that young people and their families/carers receive the most appropriate intervention and treatment.

Evolve Therapeutic Service

The Evolve Therapeutic Service is part of Evolve Interagency Services (Evolve), which is a state-wide service, cross government initiative. It provides mental health support, behavioural support and participation in education for children and young people in the care of Child Safety Services. The service is provided through coordinated sustainable partnerships between the Child Safety Services, Queensland Health, Disability Services and the Department of Education and Training.

Evolve is a multi-disciplinary, multi-specialist team providing specialist level clinical advice, consultancy and leadership to internal and external clients of Queensland Health including but not limited to Department of Communities, Child Safety, Department of Education and Disability Services management and staff.

The service aims to establish effective partnerships and joint planning at all levels of the mental health, child protection, education and disability sectors. The service contributes to the evidence base in the specialist mental health and child protection field, through research, conference presentations and publications.

Continuing Care Teams

The Goodna and Ipswich/Rural Continuing Care Teams (CCT) provide community based mental health assessment, treatment and support for adults (18-65 years) and their families/carers living with mental illness.

The teams foster a recovery-oriented approach, one that is person-centred, strengths based, collaborative and empowering. There is an emphasis on consumer choice, building resilience and enhancing opportunities for social inclusion. The staff within the CCTs approach their work with a core belief that consumers can and do recover from mental illness.

The CCTs are multidisciplinary teams providing specialised mental health assessments and interventions in a culturally diverse population to

enhance community integration and networking with available support agencies.

Gailes Community Care Unit

The Gailes Community Care Unit (CCU) is a residential accommodation facility for adult mental health consumers who are in recovery but require additional support and life skills rehabilitation to successfully transition to independent community living.

The Gailes CCU is located in the community to simulate an independent living environment. It provides 24 hour, 7 days a week care and supervised residential rehabilitation, to help residents transition back to independent living within their community. The service aims to promote an individual's recovery from mental illness by providing opportunities that maximise their strengths and potential.

Living Well Team

The newly established Living Well Team's (LWT) focus is to provide care coordination and psychological intervention to consumers with a Personality Disorder. Intervention includes Dialectical Behaviour Therapy and Brief Intervention following the Project Air guidelines (Gold Card Clinic). This team will also have a focus on providing consumers with the option of Virtual Care making use of state of the art technology and systems.

This is a multidisciplinary team comprised of occupational therapist, psychologists, social workers and mental health nurses, a lived experience peer worker, administration staff and some consultant time.

Older Person's Mental Health Service

The Older Person's Mental Health Service (OPMHS) provides comprehensive multidisciplinary assessment and treatment for older adults over the age of 65 years who have a mental illness, dementia with behavioural or psychological symptoms or a longstanding mental illness complicated by age related illness. It comprises three aspects of the care:

The Older Person's Mental Health Unit (OPMHU) provides inpatient care for both acute and extended treatment. Services are provided by a multi-disciplinary team including psychogeriatric consultant psychiatrists, psychiatric registrar, medical officer, psychologist, occupational therapist, social worker and nursing staff.

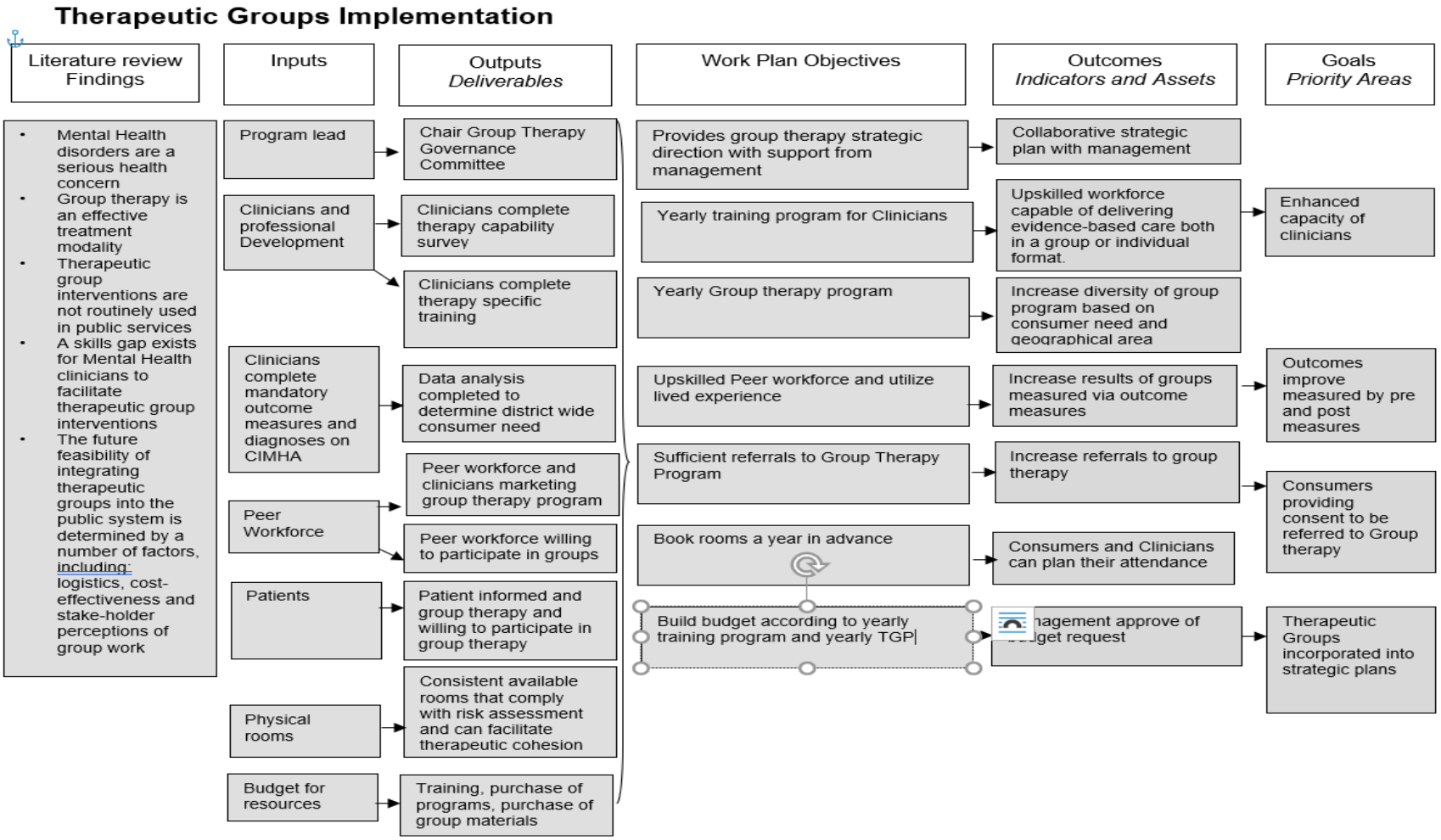
This service also provides care to older adults in the community experiencing severe mental health problems including psychogeriatric outpatient clinics, reviews for people in Residential Aged Care Facilities and home visits.

A Psychogeriatric Neurocognitive Assessment Clinic is also available specialising in the assessment of patients with cognitive problems and neuropsychiatric symptoms.

Recovery, Resource and Partnership Team

The Recovery, Resource and Partnership Team (RRPT) engages in a wide array of activities aimed at improving consumer's mental health care and engaging their access to other health and community services; educating the community; undertaking service improvement projects and providing specialist clinical consultation. The team comprises senior staff from a range of disciplines and areas of expertise. Activities includes: developing partnerships, strengthening established community linkages, providing community education and professional advice, establishing new programs, improving the use of existing resources, providing specialist, knowledge and support to clinical and non-clinical staff and direct clinical work with individuals and groups.

Appendix K: Preliminary Logic Model



Appendix L: Behaviour Change Intervention Function

The most frequently used Behaviour Change Intervention Function with the establishment of the TGP and subsequent sustainability and as identified through the semi-structured interviews were (in order of frequency):

	Education	Persuasion	Incentivisation	Training	Environmental restructuring	Modelling	Enablement
Communication/Marketing	✓	✓	✓			✓	
Guidelines	✓	✓	✓	✓	✓		✓
Fiscal			✓	✓	✓		✓
Regulation	✓	✓	✓	✓	✓		✓
Legislation	✓	✓	✓	✓	✓		✓
Environmental/Social planning					✓		✓
Service provision	✓	✓	✓	✓		✓	✓

Appendix M: Behaviour Change Policy and Requirements

Policy	Definition	Identified by interviewees
Communication/Marketing	Using print, electronic, telephonic or broadcast media.	Marketing directly to consumers with clarity about what a group can offer them for example through flyers. Printing should be done professionally. Flyers available in waiting rooms, consult rooms etc. Advocates for the TGP reminding staff in meetings Included in supervision discussions
Guidelines	Creating documents that recommend or mandate practice. This includes all changes to service provision.	Structured approach to determining groups Consistent referral pathways Clear governance structure to ensure support from management and fidelity of programs Structured support of case managers participating in TGP which should include a reduction in workload.
Fiscal	Financial cost	Clear budget for TGP

		Reduction in workload may require more case manager positions. Administrative and Information technology support. Group Coordinator and Therapy lead positions included in budget Financial support for coffee, tea and biscuits.
Regulation	Establishing rules or principles of behaviour or practice	Include TGP participation in role descriptions of senior staff and clinicians. Include participation of their staff as a KPI for Team Leaders. Guideline with time requirement for each group. Care plan act as a referral, not other referral forms required
Legislation	Making or changing laws	
Environmental / social planning	Design and / or controlling the physical or social environment	Adequate group therapy room, and equipment Equitable participation of seniors across the service. Each site within the service should provide identified groups to their consumer cohort.

		Group therapy referrals as part of multidisciplinary team discussions. Team leaders recruit staff with experience of group facilitation a key criteria. Linkages with specialist organisations Linkages with research organisations.
Service provision	Delivering a service	Incorporate TGP in treatment guidelines

Appendix N: Participation Information Form

Queensland Government

Consumer

UNIVERSITY OF SOUTHERN QUEENSLAND AUSTRALIA

Participant Information Sheet – Consumer

Title	Retrospective process analysis of the establishment and implementation of a Therapeutic Group Program in a public mental health service.
Protocol Number	HREC/2020/QWMS/62557
Coordinating Principal Investigator/ Principal Investigator	Ms Zonia Weideman
Associate Investigator(s)	Dr Karen Trimmer Professor University of Southern Queensland Email: Karen.Trimmer@usq.edu.au Tel: (07) 4631 2371 Dr Tracy Kolbe-Alexander A/Professor Associate Head of School – Research

	University of Southern Queensland l Ipswich, Queensland l 4305 l AUSTRALIA Tel: (07) 3812 6178
Location	West Moreton Health

Introduction

You are being asked to take part in this project which is looking at Group Therapy as a treatment option within a public mental health service.

What is the purpose of the research?

This study will look at how a Group Therapy program should be established in a mental health service and the possible benefits of Group Therapy as part of your recovery journey. Knowing about these reasons may help us to provide better services in the future.

Are there any requirements to participate?

Yes. To take part in the study you must:

- be aged between 18 to 65 years
- have a Queensland Health case manager
- participated in Group Therapy over the previous 6 months
- be willing to participate and provide consent

If I choose to participate what will I be asked to do?

You will be asked to take part in an interview / discussion about your thoughts on Group Therapy as part of your treatment. The interview will be

done in person or via Telehealth with a Research Assistant (RA) and will take about 30 minutes, or possibly a little longer. You can have a support person with you during the interview. You can choose this person yourself or arrangements can be made on your behalf for a peer worker to be there with you. This decision is entirely up to you.

Prior to starting the interview, the RA will check with you and any support person present that you have been provided with information regarding the study, you have understood what is involved and that you provide consent.
The interview will be audio (tape) recorded. Recording the interview in this way will help us understand your opinions and we do not have to write a lot of notes during the interview. The tape will be destroyed once we have completed the study.

The type of questions to be asked include:

- What groups did you participate in?
- What did you like or dislike about the group therapy you attended?
- Why did you attend the group therapy?
- Was group therapy what you think it was going to be / was it what you expected and why?
- Did group therapy help you on your recovery journey and if so, how did it help?

You will also be asked to provide consent for the study team to review your medical records regarding your Group Therapy attendance and the results of your attendance in the past 6 months.

Do I have to participate?

No, you do not have to participate, and you do not have to provide any reasons why. If you choose not to participate, this will not affect your current or any future care you may require from West Moreton Health.

Can I withdraw?

You can withdraw from this study at any time by contacting Zonia Weideman, the research contact person for this study. Her contact details are provided at the end of the document. You do not have to provide any reasons why and no data or information about you will be used in the study. Your decision to withdraw from the study will not affect your current or any future care you may require from West Moreton Health.

What are the possible benefits of taking part?

While participating in the study may not benefit you individually now, it is anticipated your participation may result in changes within mental health service responses and practices around group therapy which may benefit consumers attending in the future.

What are the possible risks and disadvantages of taking part?

You will be asked to attend an interview / discussion with a research assistant in person or via Telehealth. We would like to learn more about your experiences in attending Group Therapy as part of your treatment by Mental Health services in West Moreton Health Service. We would like to know if you found it helpful and how things could be done better. A copy of the interview questions will be provided to you prior to the interview and your support person can be with you before, during and after the interview.

Should any of these questions cause you discomfort or make you feel uncomfortable, you may choose not to answer a specific question or stop the interview immediately. Support can be provided by either the interviewer or support person in the first instance. Your case manager will be available and able to be contacted, if you would like additional support.

You will also be asked to allow the study team access to information about your previous attendance to Group Therapy from your medical records over the past 6 months. All information you provide directly (through an interview) or allow the study team to access (from your medical records) will remain confidential (private) and not be passed onto or used by anyone else without your approval, including your case manager and Group Therapist. All the information you provide for the study will be put with information from other people to form a general impression so that you cannot be identified.

What happens when the research project ends?

A report of the study outcomes will be provided to the West Moreton HHS Executive. We can provide you with a summary of the study if you wish. However, you will need to provide your e-mail contact on the Consent Form. Direct quotes from your interview may be reproduced in the report but your name will not. The findings of the study may be also be presented at mental health conferences and / or written up in a medical journal.

What will happen to information about me?

By completing the Consent Form, you agree to participate in the study. You will be given a confidential study Code to ensure the information provided by any participant cannot be identified by anyone other than the research team members.

Interviews will be tape recorded (with your consent) and then typed up by the research assistant. The recording of your interview will then be deleted. All the written versions of your interview will be given a code so that no one (other than the research team) can identify what you told us. All information from your medical record will also be given a similar code.

All data collected will be stored in a secure room in the research centre. All data collected will be held for a period of 7 years at which point it will be

destroyed. Only members of the study team will have access to the secured offices and cabinets where information will be stored.

Your information will only be used for the purpose of this study and it will only be provided to other people with your permission, except as required by law. In accordance with relevant Australian and/or Queensland privacy and other relevant laws, you have the right to request access to the information about you that is collected and stored by the research team. You also have the right to request that any information with which you disagree be corrected. Please inform the study team member named at the end of this document if you would like to access your information.

Complaints

If you wish to make a complaint about the conduct of this research project, you should contact the Research Ethics and Governance Officer for West Moreton Health. Contact details are provided below.

Who has reviewed the research project?

Ethical approval to conduct the study has been provided by the Human Research Ethics Committee of West Moreton Health and the University of Southern Queensland.

This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)*. This statement has been developed to protect the interests of people who agree to participate in human research studies.

Further information and who to contact

The person you may need to contact will depend on the nature of your query. If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact the following people:

Research contact person

Name	Ms Zonia Weideman
Position	Principal Investigator
Telephone	07 3813 6181
Email	Zonia.weideman@health.qld.gov.au

For matters relating to research at the site at which you are participating, the details of the local site complaints person are:

Complaints contact person

Name	Sharleen Young
Position	Research Ethics and Governance Officer(s)
Telephone	07 3413 7475 (Ipswich) or 07 3271 8656 (The Park)
Email	Wmhsd_ethics@health.qld.gov.au

Appendix O: Participation Information Form Case Managers and Management

Participant Information Sheet – Case Managers and Management

Title	Retrospective process analysis of the establishment and implementation of a Therapeutic Group Program in a public mental health service.
Protocol Number	
Coordinating Principal Investigator/ Principal Investigator	Ms Zonia Weideman
Associate Investigator(s)	Dr Karen Trimmer Professor University of Southern Queensland Email: Karen.Trimmer@usq.edu.au Tel: (07) 4631 2371 Dr Tracy Kolbe-Alexander A/Professor

	Associate Head of School – Research University of Southern Queensland l Ipswich, Queensland l 4305 Tel: (07) 3812 6178
Location	West Moreton Health

Introduction

You are invited to take part in this project which aims to explore case manager and patient perceptions of the establishment of a Therapeutic Group Program (TGP) within West Moreton Health (WMH), Mental Health and Specialised Services (MHSS), Community and Acute Services (CAS).

What is the purpose of the research?

The over-arching aim of this study is to identify critical elements in the establishment of a TGP. For example what worked well during the implementation process, what challenges emerged, why clinicians became involved and referred to the TGP, when clinicians included TGP into care planning, how can TGP sustainability be ensured and what resources are required for establishment and sustainability. The findings from this study will be used to develop a framework for implementation and sustainability of therapeutic groups with the goal of scaling the framework up into other Hospital and Health Services.

Are there any requirements to participate?

Yes. To take part in the study you must:

- Case Managers who have been part of the establishment of the TGP
- Case Managers who have referred to the TGP
- Case Manager should be willing to be involved in this research study and provide informed consent

CAS Management inclusion criteria:

- Managers who were part of the establishment of the TGP
- Managers must be willing to be involved in this research study and provide informed consent

If I choose to participate what will I be asked to do?

You will be invited to participate in an individual semi structured interview. This interview will be conducted face to face, by telephone or via Microsoft Teams as per your availability and preference. It is anticipated that the interview will take approximately 30 minutes or longer. The interview will be audio recorded. The audio recording will be deleted once it has been transcribed.

Do I have to participate?

Participation in this study is voluntary and the decision to participate is at your own discretion. You have been provided with this Participant Information Sheet to assist you to decide whether you would like to participate.

Can I withdraw?

You can withdraw from this study at any time by contacting Zonia Weideman, the research contact person for this study. Her contact details are provided at the end of the document. None of your personal data or information will be used in the study. Your decision to participate or not participate in the study will not affect your work with West Moreton Health or your current or future contact / employment with West Moreton Health.

What are the possible benefits of taking part?

While participating in the study may not benefit you individually, it is anticipated your participation may result in changes within mental health service responses and practices that better support intervention and management of patients through Group Therapy.

What are the possible risks and disadvantages of taking part?

You will be asked to attend an individual interview with a research assistant (RA). In this interview you will be asked about your views, opinions and experiences related to the establishment of a TGP, the referral of consumers to the TGP and your general perceptions around the TGP. You will be provided with the questions beforehand. Should any of these questions cause you to become distressed, you may choose not to answer a question or cease the interview immediately. Appropriate reassurance and support will be provided by the RA. A follow up phone call will be made to you the next day by the RA to see if any additional support may be required. Staff continuing to show signs of distress will be referred to either the Peer Support Program (PSP) or the Employee Assistance Service (EAS) for ongoing support.

Please note that the intention of this study is to explore your views and experiences of managing this specific client group, and is in no way intended to be a review of your own performance or individual clinical practice.

What happens when the research project ends?

A report of the study outcomes and suggested strategies will be provided to the study funders. Copies of the report will also be provided to the West Moreton HHS Executive. We can provide you with a summary of the study findings – you will need to provide your e-mail contact on the Consent Form. The findings of the study will also be presented at selected conferences and written up for peer reviewed journals.

What will happen to information about me?

By completing and returning the Consent Form you agree to participate in the study. On receipt of a signed Consent Form, you will be given a study

ID code to ensure anonymity and confidentiality of data. All personal information provided will be coded against this anonymous ID number.

Interviews will be recorded (with your consent). Once transcribed, the recording will be deleted. All transcripts will be de-identified using the anonymous ID code.

All data collected will be stored in a secure room at the Service Evaluation and Research Unit. Electronic files will be stored on a secure, password protected server. All data collected will be held for a period of 7 years at which point they will be destroyed via secure office service protocols. Only members of the study team will have access to the secured offices and cabinets where information will be stored. De-identified, aggregated data will be used in the report and other publications to ensure respondent anonymity and confidentiality.

Your information will only be used for the purpose of this study and it will only be disclosed with your permission, except as required by law. In accordance with relevant Australian and/or Queensland privacy and other relevant laws, you have the right to request access to the information about you that is collected and stored by the research team. You also have the right to request that any information with which you disagree be corrected. Please inform the study team member named at the end of this document if you would like to access your information.

Complaints

If you wish to make a complaint about the conduct of this research project, you should contact the Research Ethics and Governance Officer for West Moreton Health. Contact details are provided below.

Who has reviewed the research project?

Ethical approval to conduct the study has been provided by the Human Research Ethics Committee of West Moreton Health.

This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)*. This statement has been developed to protect the interests of people who agree to participate in human research studies.

Further information and who to contact

The person you may need to contact will depend on the nature of your query. If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact the following people:

Research contact person

Name	Ms Zonia Weideman
Position	Principal Investigator
Telephone	07 3813 6181
Email	Zonia.weideman@health.qld.gov.au

For matters relating to research at the site at which you are participating, the details of the local site complaints person are:

Complaints contact person

Name	Sharleen Young
Position	Research Ethics and Governance Officer(s)
Telephone	07 3413 7475 (Ipswich) or 07 3271 8656 (The Park)
Email	Wmhsd_ethics@health.qld.gov.au

Appendix P: Consent Form – Consumers

Consent Form – Consumers

Title	Retrospective process analysis of the establishment and implementation of a Therapeutic Group Program in a public mental health service
Protocol Number	HREC / 2020 / QWMS / 62557
Coordinating Principal Investigator/ Principal Investigator	Ms Zonia Weideman
Associate Investigator(s)	Dr Karen Trimmer Professor University of Southern Queensland Email: Karen.Trimmer@usq.edu.au Tel: (07) 4631 2371 Dr Tracy Kolbe-Alexander A/Professor Associate Head of School – Research University of Southern Queensland l Ipswich, Queensland l 4305 l AUSTRALIA Tel: (07) 3812 6178
Location	West Moreton Health

Declaration by Participant

I have read or had the Participant Information Sheet explained to me and I have had an opportunity to ask questions. I am satisfied with the answers I have received.

I understand that my participation in the study is voluntary and that I can withdraw from the study at any time without giving a reason. None of my information will then be used in the study.

I consent to: (please tick the box if you agree)

- □ take part in an interview in person (approximately 30 minutes or longer) and:
- □ the interview being recorded, which is to be deleted once transcribed
- □ information about my group attendance in my medical record for the previous 6 months to be used for the purposes of the study

I understand that I can nominate a support person to be with me during the interview, if I wish.

I understand that I can request that a support person (e.g. peer worker) be arranged to be with me during the interview, if I wish.

I understand that I will be given a signed copy of this document to keep for my own records, along with the Information Sheet.

□ I would like to receive feedback on the study findings.

Email:

_____

Participant Details

Name of Participant (please print) _____

Signature _____ Date _____

Witness Details

Name of Witness (please print) _____

Signature _____ Date _____

Supporting Person Details (if applicable)

Name (please print) _____

Signature _____ Date _____

Researcher Declaration†

I have given a verbal explanation of the study; its procedures and risks. I believe that the participant has understood that explanation.

Name of Researcher please print)	_____
Signature	Date _____

† An appropriately qualified member of the study team must provide the explanation of, and information concerning, the study.

Note: All parties signing the consent section must date their own signature.

Appendix Q: Consent Form – Clinician and Management

Consent Form – Mental Health Clinicians and Management

Title	Retrospective process analysis of the establishment and implementation of a Therapeutic Group Program in a public mental health service.
Qld Health Protocol Number	HREC / 2020 / QWMS / 62557
USQ Human Research Ethics Approval Number:	H20REA201
Principal Investigator	Ms Zonia Weideman Therapy Lead / Team Leader West Moreton Health Service Tel: (07) 3813 6181
Associate Investigator(s) / Supervisors	Dr Karen Trimmer Professor University of Southern Queensland Email: Karen.Trimmer@usq.edu.au Tel: (07) 4631 2371 Dr Tracy Kolbe-Alexander A/Professor Associate Head of School – Research University of Southern Queensland l Ipswich, Queensland l 4305 Tel: (07) 3812 6178

Location	West Moreton Health – Community and Acute Services

Declaration by Participant

I have read or had the Participant Information Sheet explained to me and I have had an opportunity to ask questions. I am satisfied with the answers I have received.

I understand that my participation in the study is voluntary and that I can withdraw from the study at any time without giving a reason. If I withdraw, none of my information will be used in the study.

I consent to: (please tick the box if you agree)

- □ take part in an interview of approximately 30 minutes and:
- □ the interview being audio-recorded (the recording will be deleted once transcribed)

I understand that I will be given a signed copy of this document to keep for my own records, along with the Information Sheet.

□ I would like to receive feedback on the study findings.

Email:

_____

Participant Details

Name of Participant (please print) _____

Signature _____ Date _____

Witness Details

Name of Witness (please print) _____

Signature _____ Date _____

Researcher Declaration†

I have given a verbal explanation of the study; its procedures and risks. I believe that the participant has understood that explanation.

Name of Researcher (please print) _____

Signature _____ Date _____

† An appropriately qualified member of the study team must provide the explanation of, and information concerning, the study.

Note: All parties signing the consent section must date their own signature

Appendix R: Interview Guide

Therapeutic Group Program (TGP): Consumers - Interview Guide

1. What groups did you participate in?
2. What did you like or dislike about the group therapy you attended?
3. Why did you attend the group therapy?
4. Was group therapy what you think it was going to be, so was it what you expected?
5. Did group therapy help you on your recovery journey and if so, how did it help?
6. Do you think you would have received the same benefits in individual therapy than you did in group therapy?
    a) What is the benefit of group therapy?
1. How have your perceptions changed around group therapy now that you attended?
2. Physical resources
    a) Did the room in which the group was held make it easy for you to listen and participate?
    b) Could you find the room easily?

Identify possible strategies to address any issues identified throughout the interview.

Therapeutic Group Program (TGP): MH Clinicians - Interview Guide

1. What are your perceptions of the TGP within West Moreton?
2. What have been the key considerations in getting the TGP established and operational within the HHS?

Cues:

- What worked well in the development of a TGP?
- What challenges emerged in the development of a TGP?
- What resources are required?
    - Sub 1: What physical resources are required?
    - Sub 2: What staff resources are required?

3. How does the TGP fit within your normal/everyday service delivery?

Cues:

- Why did you get involved in the delivering of TGP?
- Have you chosen not to get involved? If yes, why?
- Why did you refer consumers to the TGP?
- Have you chosen not to refer a consumer to the TGP? If yes, why?
- When in the consumer journey did you refer to the TGP?
- What other enables or barriers can affect the TGP?

4. Is the current TGP sustainable?

- If yes – why
- If no why – what would need to be done

5. How do you think the TGP framework can be incorporated into another public HHS?
6. Final Comments

Therapeutic Group Program (TGP): Management Interview Guide

1. What are your perceptions of the TGP within West Moreton?
2. What has been the key considerations in getting the TGP established and operational within the HHS?

Cues:

- What worked well in the development of the TGP?
- What challenges emerged in the development of the TGP?
- What resources are required?
  - Sub 1: What physical resources are required?
  - Sub 2: What staff resources are required?

3. How does the TGP fit within everyday service delivery?

Cues:

- Would you support a staff member to deliver a TGP?
- Why and when would you support / not support a staff member to deliver a TGP?

- Why would you encourage / discourage a staff member to refer a consumer to the TGP?
- When in the consumer journey would you encourage a referral to the TGP?

4. Is the current TGP sustainable?

- If yes, why?
- If no, why – what would need to be done?

5. How do you think the TGP framework can be incorporated into another public HHS?
6. Final Comments

Introduction to Interview:

- Make sure consent is understood and signed
- Participation in this study is completely voluntarily and consent can be withdrawn at any time.
- Go through the Participant Information Sheet
- The Researcher will acknowledge her dual role as Therapy Lead (leader) and Interviewer and possible repercussions of this dual role will be discussed
- Explain complaints or escalation process
- Address any further privacy and / or confidentiality concerns

Ensure:

- The interviews will be conducted in private to ensure confidentiality.
- The Researcher will take a non-judgemental stance and listen and encourage participation in a save way.

Appendix S: Data management plan

University of Southern Queensland

USQ Library

Further information:

https://www.usq.edu.au/library/research-support/data-management

ResearchLibrarian@usq.edu.au

Data Management Plan

The responsibilities for the effective management of research data and material are stated in the *Australian Code for the Responsible Conduct of Research (2018)* as follows:

> *Responsibilities of Institutions* - R8 "Provide access to facilities for the safe and secure storage and management of research data, records and primary materials and, where possible and appropriate, allow access and reference."
>
> *Responsibilities of Researchers* – R22 "Retain clear, accurate, secure and complete records of all research including research data and primary materials. Where possible and appropriate, allow access and reference to these by interested parties"

The *USQ Data Management Plan* guides researchers to document and establish key elements of research data management including:

- Ownership of research data
- Research data processing
- Storage and backup of research data
- Retention and disposal of research data
- Access to research data for sharing and reuse

Project name:	Retrospective process analysis of the	Project contact:	Zonia Weideman

	establishment and implementation of a Therapeutic Group Program in a public mental health service		
Project ID:	ZWEID	Contact email:	Zonia.weideman@health.qld.gov.au
Funding body/s:		Contact number:	07 38136181
Duration of project:	*2 year*	Date submitted:	29 May 2020

1. Research Data Summary

Provide a summary of data being created or collected. Include:

This project will result in 3 data sets. The data sets will include interview responses from participants who partook in Therapeutic Group Programs (TGP), West Moreton Health (WMH) Mental Health Clinicians who facilitated the TGP and WMH management who endorsed the TGP.
The raw data will be collated from the interviews, transcribed and then imported into Nvivo 10 for thematic analysis of data.. All data will be considered sensitive and confidential.

The total volume of data estimated would not be expected to exceed the 150GB provided to USQ researchers and, as such, will not cost USQ any extra. The use of the data generated for this project will not be available for re-use without ethical approval, not until the research is published.

2. Research Data Ownership and Intellectual Property

Identify if data will be owned by:

The principal investigator – Mrs Zonia Weideman and as per the Research Collaboration agreement between WMH and USQ
Other Investigators will be Dr Tracy Kolbe-Alexander and Prof Karen Trimmer from USQ as indicated in the Research Collaboration agreement between West Moreton Hospital and Health service and USQ.
The research documents (consent forms, etc) will be stored in a locked filing cabinet in a locked room at Ipswich Health Plaza for a period of 15 years from the completion of the research and then shredded using a secure disposal system. All audio-recorded interviews will be password protected and deleted following transcription of interviews.

3. Research Data Processing

The resources required to process the data to get the research results will include the following:

On receipt of a signed consent form, each participant will be assigned an ID code to ensure anonymity and confidentiality of data. Identifying codes will be recorded on a master sheet which will be stored in a separate secured location to that of the study data. Only the researcher will have access to the Master ID sheet and will update the sheet as required.

Direct quotations from the transcripts may be used within the final report and other publications. In these instances, quotes will be de-identified suing the ID codes generated in order to ensure participant anonymity. Qualitative data will be obtained through interviews. Interviews will be transcribed by an independent transcriber. De-identified handwritten notes and transcribed interviews will be imported into Nvivo 10. Nvivo will be used to develop a structured coding system for thematic analysis of data. Analysis of the provisional codes will occur to generate primary codes. Continual reflection of the codes will need to occur to ensure accuracy and validity.

Themes will be identified and reviewed according to Michie's COMB system, Bronfenbrenner's bioecological model and the Logic Model. This will guide the analysis and ensure themes are not missed. Only the themes emerging and aggregate data will be made available in the research report and any peer-review publication that might emerge.

The data and broad findings will be shared via peer-review publication (journal article), the data may be requested by the journal publisher. This data is anonymous as there are no personal identifiers, will only be provided upon request. Individuals will not be able to be identified, as interviews will be coded with participant identifiers.

4. Data Format

Describe the data formats, software and equipment that you plan to use during your research:

The researcher will use Microsoft Office 365 on WMH secure computers. Metadata used in this project will incorporate medical standard terms and will provide adequate detail which would be easily identifiable by other researchers in the field and, of course, the research team.

Data Storage

Describe the data storage arrangements that will be used for your research data:

All data will be stored in 3 separate locations: 1. on a WMH password protected network 2. In a WMH locked cabinet and 3. On USQ one drive.
Digital data:

1. Data will be backed up using WMH's password protected and network protected one drive. This data will only be able to be accessed by the research team and will be password protected (as described in section 1). The standard WMH network policies will be adequate to ensure that the data is stored safely (i.e. we are using WMH secured facilities).
2. Data will be backed up using USQ 's password protected and network protected one drive. This data will only be able to be accessed by the research team and will be password protected (as described in section 1). The standard USQ network policies will be adequate to ensure that the data is stored safely.

Non-digital data:

3. Non-digital data will be stored under lock and key in Zonia Weideman's office in a locked filing cabinet.

6. Data sharing and reuse

Describe the data sharing and reuse strategy planned for your research:

There is no data sharing required at present.
Data for use in other projects can only be used if ethics approval is provided and following the terms stipulated in section 1. However, since, the de-identified data and broad findings will be shared by publication (journal article), the data may be requested by the journal article

publisher. Again, this data is de-identified and will only be provided upon request. The data will be transparent and reusable by placing the naming conventions above and ensuring that the data are filed in a logical manner. Data sets within a document/file will be labelled/titled appropriately to ensure its transparency and reuse. Individuals will not be able to be identified, as the data will be labelled using de-identifiable titles and naming conventions. During the active phase of the research, the research team will be able to access the data, edit it if need be and view and access it freely. Again, once the project is complete the data will only be able to be reused in a de-identifiable format.
Finally, data will be made available once the research is published (journal article, electronic and hardcopy). The data is sensitive and confidential. Hence, it is suggested that access to the data other than this project must seek approval from the USQ Human Ethics Committee and West Moreton Hospital and Health Service Human Ethics Committee , prior to the data being used.

7. Data retention, archiving and disposal

Describe the data retention, archiving and disposal strategy planned for your research:

The data will be stored on a WMH secure drive and backed up on WMH Onedrive all data will be stored by these means for the required time unless otherwise stated.
Ethics approval will be kept for Retain for 15 years after project concluded or abandoned, as stated in section 601.2/C115 of Queensland Government's University Sector Retention and Disposal Schedule (QSA09/384), Section 8. Further, all records relating to the monitoring of ethical practices, such as annual review of activities and summary reports, will be kept for 7 years under 601.2/C116 of the same policy.

Consent forms will be retained for 15 years after the project has concluded or is abandoned by WMH as stated in 601.2/C111 (Consent) of the above policy. The data generated for this project will be considered as *Research Data – Significant*, according to the definitions of the above policy and, as such, will be retained indefinitely as stated in 601.2/C123 of the above policy. Records relating to the management of clinical and related waste in accordance with regulatory requirements set out under the Environmental Protection (Waste Management) Regulation 2000 will be retained by WMH for 5 years after last action (601.2/C130). The Master set of manuals, handbooks, directives, etc., detailing procedures supporting the research function is to be obtained until superseded (601.2/C138). All records relating to risk assessment and risk management plans are to be retained by USQ and WMH for 7 years after last action (601.2/C145), which is managed through the USQ Risk management plan system.

Intellectual property (IP) records will be retained as follows:

- General administrative correspondence - Retain for 5 years after last action (601.2/C117)
- Records relating to the arrangements for the use of IP - Retain for 7 years after last action (601.3/C136)
- Records relating to infringements and disputes concerning IP - Retain for 10 years after last action (601.2/C119)

Records relating to the activities associated with collating and reporting research output and quality in order to establish eligibility for Commonwealth funding will be retained as follows:

- Master set of research publications of WMH - Retain permanently (601.3/C154)
- Final institution submission to the Commonwealth department responsible for higher education – Retain permanently (601.2/C127)

8. Data used but not created by this research project

Describe the data management arrangements for data used but not created by your research:

The data obtained for this project from its participants will only be used once the informed consent is obtained and signed. All data used for this project will be 'new' and will not be purchased commercially, will only be obtained through informed consent and by the research team.

Further information available from USQ Policy and Procedures Library:
USQ Research Code of Conduct
Policy: https://policy.usq.edu.au/documents/142208PL
USQ Research Data Management Policy:
https://policy.usq.edu.au/documents/151987PL
USQ Research Data Management Procedure:
https://policy.usq.edu.au/documents/151985PL

Appendix T: Ethics Approval WM

Queensland Government

West Moreton **Health**

Office of the Human Research Ethics Committee
The Park – Centre for Mental Health
Level 2 Dawson House
Locked Bag 500
Archerfield, QLD 4108

Enquiries to: Research Ethics and Governance Officer
Telephone: 07 3271 8656
Our Ref: [13-20]

20/07/2020

Ms Zonia Weideman
West Moreton Health
Ipswich Health Plaza
21 Bell Street
Ipswich QLD 4305

Dear Ms Weideman,

HREC reference number: **HREC/2020/QWMS/62557 (Jul ver 2)**
Project title: **Retrospective process analysis of the establishment and implementation of a Therapeutic Group Program in a public mental health service**

Thank you for submitting the above project for ethical and scientific review. This project was first considered by the West Moreton Hospital and Health Service (WMHHS) Human Research Ethics Committee (HREC) meeting held on 9 June 2020.

This HREC is constituted and operates in accordance with the National Health and Medical Research Council's (NHMRC) *National Statement on Ethical Conduct in Human Research 2007 (updated 2018), NHMRC and Universities Australia Australian Code for the Responsible Conduct of Research (2018)* and the *CPMP/ICH Note for Guidance on Good Clinical Practice.*

I am pleased to advise that the Human Research Ethics Committee has granted approval of this research project. The documents reviewed and approved include:

Appendix U: Standard Research Collaboration Agreement

This document is to be used when the HHS engages in research activities and HHS personnel make an intellectual, creative or inventive contribution to the project.
This document <u>should not</u> be used when research entities are only accessing HHS facilities or HHS data or materials. In those circumstances, please use the Standard Data Access and Materials Agreement or Standard Facilities Access Agreement.
Please refer any queries regarding the appropriate agreement to the HHS Legal Office.

RESEARCH COLLABORATION AGREEMENT

BETWEEN: WEST MORETON HOSPITAL AND HEALTH SERVICE acting through the Mental Health and Specialised Services, Community and Acute Service ABN 64 468 984 022 a body corporate established by the *Hospital and Health Boards Act 2011* (Qld) and having its principal place of business at The Plaza, Bell street, Ipswich, Queensland 4305 ("WMHS")

AND: The University of Southern Queensland (USQ) as the Collaborator listed in Schedule 1 (the "Collaborator")

BACKGROUND

A. WMHS is a public Hospital and Health Service established under the *Hospital and Health Boards Act 2011* (Qld) on the principle, among other things, to ensure "opportunities for research and development

relevant to the delivery of public sector health services should be promoted".

B. The Collaborator carries out research into various fields including human health sciences.

C. The Parties wish to collaborate in carrying out a research project in the field of human health sciences on the terms set out in this Agreement.

OPERATIVE PROVISIONS

1. Definitions and Interpretation

1.1. Definitions

Activities, in relation to a Party, means the activities required of a Party in order to carry out the Project as set out in the Schedule, Protocol and Ethics Approval.

Agreement means this document and all annexures, attachments and schedules incorporated by reference.

Background IP means any Intellectual Property created prior to the commencement of the Project or independently of the Project, and which a Party contributes for the purpose of carrying out the Project but does not include Clinical Subject Data or Clinical Subject Materials.

Clinical Subject means any human subject involved in the Project or whose data will be handled in the course of the Project, including in the course of carrying out this Agreement.

Clinical Subject Data means data or other information collected from a Clinical Subject or created in the course of clinical treatment or observation about a Clinical Subject in the course of the Project and includes all medical records in relation to the Clinical Subject used in the course of the Project but does not include Clinical Subject Materials.

Clinical Subject Materials means physical samples of biological material such as tissue, blood or urine samples as set out in the Schedule.

Code means the Australian Code for the Responsible Conduct of Research issued by the National Health and Medical Research Council.

Commencement Date means the date set out in the Schedule.

Commercialisation means the provision of rights in Intellectual Property or services including the exploitation of Intellectual Property in exchange for any benefit, whether monetary or otherwise, but which does not include carrying out future research making use of such Intellectual Property under a competitive grants or public good scheme or for teaching award courses.

Commercialisation Lead mean:

(a) the entity named to carry out commercialisation in **Schedule 1;** or,

(b) if no entity is set out in **Schedule 1** as the Commercialisation Lead, then the Party appointed as the Project IP Owner; or,

(c) if there is no Commercialisation Lead in **Schedule 1** and no entity is set out as Project IP Owner, then clause 8 shall be of no effect.

Completion Date means the date specified in the Schedule.

Confidential Information means any information passed by one Party to the other Party that is, or ought to reasonably be known to be, secret but does not include information that is:

a. in the public domain;

b. the Parties agree is not confidential;

c. independently discovered or received by the other party without reference to the information disclosed under this Agreement; or,

d. provided to the Collaborator in accordance with consent of a Clinical Subject.

e.

Contributions means the in-kind and cash contributions that a Party is contributing to the Project in accordance with clause 4 as described in the Schedule.

Ethics Committee means the human research ethics committee or other appropriate ethics committee specified in the Schedule.

Ethics Approval means the documents, including any NEAF, which is submitted, anticipated and approved by the Ethics Committee.

Expert Determination means a process of arbitration by an independent expert referred to the Parties by the President of the Licensing Executive Society for Australia and New Zealand and

carried out in accordance with the expert determination rules of the Institute of Arbitrators and Mediators Australia.

Intellectual Property means all intellectual property rights, including but not limited to:

(a) trade and service marks (including goodwill in those marks), patents, inventions, discoveries, copyright, rights in circuit layouts, designs, domain names, registrable plant varieties or processes;

(b) any application or right to apply for registration of any rights referred to in paragraph (a); and

(c) all rights of a similar nature to any of the rights in paragraph (a) and (b) which may subsist anywhere in the world (including Australia), whether or not such rights are registered or capable of being registered.

Internal Purposes means the research, health, teaching and academic purposes of that Party without disclosure or dissemination to any third party other than students and does not include Commercialisation.

Moral Rights has the same meaning as set out in the *Copyright Act 1968* (Cth).

NEAF means the relevant and applicable National Ethics Application Form.

Party means WMHS or the Collaborator or both as the context dictates and Parties shall have a corresponding meaning.

Personal Information is information or an opinion, including information or an opinion forming part of a database, whether true

or not, about an individual whose identity is apparent, or can reasonably be ascertained, from the information or opinion.

Project means the study as described in the Schedule.

Project IP means all Intellectual Property created in the course of the Project but does not include:
(a) Background IP;
(b) Student IP; or,
(c) Clinical Subject Data.

Project IP Owner means the Party specified in the Schedule provided if no Project IP Owner is specified in the Schedule, then Project IP Owner shall mean all of the Parties to this Agreement as tenants in common in equal shares.

Protocol means the protocol for the Project attached in Schedule 3, as amended from time to time by agreement between the Parties.

Public Health Application means an application under s.281 of the *Public Health Act 2005* (Qld) to the State of Queensland for the applicant to be provided with health information for research purposes.

Publish/Publication means to publish by way of a paper, article, manuscript, report, poster, internet posting, conference presentation, abstract, outline, video, instruction material or other disclosure, in printed, electronic, oral or other form and includes a Student's thesis.

Relevant Privacy Laws means the *Information Privacy Act 2009* (Qld), the *Public Health Act 2005* (Qld), the *Hospital and Health Boards Act 2011* (Qld) and any other legislation (including delegated and subordinate legislation such as regulations), code or guideline which applies in the jurisdiction where the Project is to be conducted and which relates to the protection of Personal Information.

Student means students enrolled with a Party and who participates in the Project.

Student IP means copyright in a Student's thesis, articles or other output created in the course of their enrolment with a Party and resulting from the Student's involvement in the Project.

1.2. Interpretation

The following rules apply in interpreting this Agreement unless the context otherwise requires:

a. headings are for convenience only and do not affect interpretation;
b. words importing a gender include the other genders;
c. words in the singular include the plural and vice versa;
d. "include", "includes" and "including" must be read as if followed by the words "without limitation";
e. all dollar amounts refer to Australian currency;
f. a reference to any legislation includes any subordinate legislation made under it and any legislation amending, consolidating or replacing it;
g. a reference to an entity or person includes an individual, corporation, partnership or other legal entity;

h. a party includes its executors, administrators, liquidators, successors and permitted assigns;

i. "consent" means prior written consent;

j. A reference to a clause, schedule or Schedule means a clause or Schedule to this Agreement;

k. a reference to an attachment or annexure is a reference to an attachment or annexure to this Agreement as the context requires;

l. if a day on which an act is to be done is a Saturday, Sunday or public holiday in the place where the act is to be done, the act may be done on the next Business Day in that place, unless the Parties agree otherwise;

m. if any expression is defined, other grammatical forms of that expression will have corresponding meanings, unless the context otherwise requires; and

n. a reference to a clause is a reference to all of its sub-clauses.

2. Term and termination

1. This Agreement commences on the Commencement Date and shall continue until the Completion Date unless terminated earlier.
2. A Party may terminate for breach of this Agreement provided that it gives notice of the breach and that the breach is not rectified within thirty (30) days of that notice.
3. If a Party is wholly or partially precluded from complying with its obligations under this Agreement by failure to obtain and maintain Ethics Approvals, the Party may by written notice to the other Party terminate the Agreement, with immediate effect, without further liability for its failure to obtain and maintain such approvals.

4. Termination of this Agreement shall be without prejudice to the rights accruing to the Parties prior to the date of termination.
5. The Collaborator shall, at the election of WMHS, destroy or return to WMHS all Clinical Subject Data and other materials provided by WMHS under this Agreement on the Completion Date or termination of this Agreement, whichever is earlier.
6. WMHS shall, at the election of the Collaborator, destroy or return to the Collaborator all Clinical Subject Data and other materials provided by the Collaborator under this Agreement on the Completion Date or termination of this Agreement, whichever is earlier.
7. Despite clauses 2.5 and 2.6, each Party may retain a single copy of any record, data or information for confidential and secret record keeping purposes as required by the Code or any other applicable law.
8. The Parties may extend the Completion Date by mutual written agreement.

3. The Project

1. The Parties agree that the Project will be performed in compliance with:
2. the Protocol;
3. the terms and conditions of this Agreement;
4. the principles of good scientific and clinical research practices including the Code;
5. all applicable local, state and federal laws, legislation, regulations, rules, by-laws, including without limitation the Relevant Privacy Laws; and
6. the NEAF, Ethics Approval and all relevant directions issued by the Ethics Committee from time to time.

7. The Parties shall exercise due skill, care and attention in carrying out the Project.
8. Each Party shall carry out their specific Activities in order to carry out the Project.
9. The Parties shall direct their respective Investigators to be involved in regular meetings in relation to the Project including to discuss findings and the conduct of the Project, including any amendment or variation to the Protocol that may be required from time to time.
10. The timing and agenda for the meetings described in clause 3.4 will be agreed between the Parties from time to time.
11. The Parties shall provide reports on the progress of the Project at the times and in the manner set out in the Schedule. Each Party shall give the other Party all information reasonably required to make the reports required under this clause.

4. Contributions

1. Each Party shall provide their Contributions as set out in the Schedule.
2. All cash Contributions are subject to provision of a valid tax invoice from the Party receiving that Contribution.
3. All tax invoices shall be payable no earlier than thirty (30) days of receipt.
4. An in-kind Contribution may describe the cost of a Party performing its Activities under this Agreement.
5. Any cash Contribution described in this Agreement shall be exclusive of GST.

5. Interaction with Clinical Subjects

1. This clause shall only apply where the Schedule provides a Party (the "Collecting Party") will interact with and/or collect data from Clinical Subjects in the course of this Agreement.
2. The Collecting Party shall identify and seek participation of Clinical Subjects in the Project in accordance with the requirements of:
3. The Ethics Approval;
4. Principles of Good Clinical Practice; and,
5. Relevant Privacy Laws.
6. If a Clinical Subject wishes to enter into the Project, the Collecting Party shall seek and obtain consent from the Clinical Subject in the form approved in the Ethics Approval and shall collect the relevant Clinical Subject Data in accordance with the Ethics Approval and any associated Protocol.
7. On request and subject to compliance with the terms of this Agreement by the Parties, the Collecting Party shall provide the other Party with the Clinical Subject Data:
8. (a) in de-identified form; and,
9. (b) at the times specified in the Schedule.
10. The Parties acknowledge that the safety and well-being of Clinical Subjects is paramount and nothing in this Agreement shall inhibit the care, safety or well-being of those Clinical Subjects. The Collecting Party shall have absolute discretion to discontinue collection of data from a Clinical Subject or interaction with a Clinical Subject where required for the care of the Clinical Subject.

6. Public Health Applications

1. This clause shall only apply where the collection, use or disclosure of Clinical Subject Data is the subject of a Public Health Application under the Public Health Act 2005 (Qld).
2. The Parties shall comply with all requirements of the approval of a Public Health Application in respect of the Clinical Subject Data.
3. If a Public Health Application is required in relation to the Clinical Subject Data, this Agreement shall be conditional on provision of approval for that Public Health Application.
4. Nothing in this Agreement shall oblige WMHS to make any particular effort or take any specific steps in relation to obtaining approval for a Public Health Application.

A. Intellectual Property

1. The Parties agree and acknowledge that WMHS manages employees of the State of Queensland acting through the Department of Health and represents the State of Queensland acting through the Department of Health in dealing with Intellectual Property.
2. All references to WMHS as a party to this clause shall bind the State of Queensland acting through the Department of Health.

A. Clinical Subject Data

3. Nothing in this Agreement shall affect ownership of Clinical Subject Data
4. Subject to the terms of this Agreement, each Party that contributes Clinical Subject Data to the Project grants the other Party a non-exclusive, royalty-free licence to:

- use the Clinical Subject Data for the purposes of the Project;
- grant a sub-licence to any Student to use the Clinical Subject Data for the purpose of their enrolled course with the Collaborator on terms no less onerous than set out in this Agreement;
- to use the Clinical Subject Data for the same purposes as set out in clauses 7.9 and 7.11 but only to the extent that consent is given by the relevant Clinical Subject for such use or such Clinical Subject Data is de-identified.

5. Nothing in Agreement shall permit either Party to use the Clinical Subject Data for Commercialisation.

B. Background IP

6. Nothing in this Agreement shall affect ownership of Background IP.
7. Each Party grants to the other Party a non-exclusive, royalty-free licence to:
   - use the Background IP for the purposes of the Project;
   - grant a sub-licence to any Student to use the Clinical Subject Data for the purpose of their enrolled course with the Collaborator on terms no less onerous than set out in this Agreement.

For the avoidance of doubt, the licence in this clause does not include the right to Commercialise the Background IP.

C. Project IP

8. Project IP shall vest in the Project IP Owner.

9. The Project IP Owner grants to the other Parties to this Agreement a perpetual, irrevocable, royalty-free, worldwide, non-exclusive licence exercise all rights in the Project IP for:

1. performing the Project;
2. Internal Purposes.

10. The Project IP Owner grants the other Party a right to sub-licence the Project IP to a Student for the purpose of the Student creating the Student IP provided the Student is bound to obligations of confidentiality and publication no less onerous than as set out in this Agreement.

11. The Project IP Owner grants the other Party a non-exclusive, royalty-free, perpetual and world-wide licence to use, modify and adapt (including a right to sub-licence) the Project IP for:

1. future research collaborations, including with third parties, provided that all future collaborators are bound to comply with the terms of clauses 8 and 9 of this Agreement;
2. WMHS to sub-licence the State of Queensland and all other hospital and health services established under the *Hospital and Health Boards Act 2011* (Qld) to provide public health services.

12. Except for clause 7.11.2, the licences granted in clauses 7.9 to 7.11 do not include a right for a Party to Commercialise the Project IP.

13. Each Party shall enter into all documents and obtain agreements with all personnel, officers, Investigators and Students

as necessary to ensure the terms of this clause 7 are given full effect.

D. Student IP

14. The Parties agree and acknowledge that Student IP will vest in the Student.

15. The Party that contributes a Student shall ensure the Student enters into an agreement on terms no less onerous than set out in this Agreement in relation to Confidential Information, Background IP, Project IP and Student IP.

8. IP Protection and Commercialisation

A. IP Registration

1. Where one or more Party are Project IP Owners, a Project IP Owner may give notice to the other Party that they intend to register rights in respect of the Project IP at any time.

2. Within two (2) months of giving notice under clause 8.1, the Project IP Owners shall agree to terms of IP protection, including division of costs of obtaining such IP protection and the scope of proposed registration of Project IP.

3. A Project IP Owner shall not unreasonably withhold giving permission under clause 8.2 to the other Project IP Owner to register rights in respect of the Project IP.

4. All Project IP rights shall be registered in the names of the Project IP Owners, unless otherwise agreed in writing by the Parties.

5. If Project IP Owners cannot agree to terms of IP protection as required in clause 8.2then the matter may be referred by either Project IP Owner for Expert Determination.

B. IP Protection

6. In the event that a Project IP Owner wishes to commence any proceeding in respect of infringement or registration of the Project IP, then that Project IP Owner shall give notice to the other Project IP Owners, if any, and shall not take a step in the matter unless it receives the consent of those other Parties, such consent not to be unreasonably withheld.

7. Subject to clause 8.8, a Party (the "surrendering party") may surrender its rights in the Project IP to the other co-owners of the Project IP in order to avoid being joined to potential proceedings and the other Parties (**Other Parties**) shall indemnify the surrendering Party in respect of those proceedings.

8. If WMHS is an Other Party under clause 8.7 the parties agree that it will not provide an indemnity to the surrendering party under that clause.

C. Commercialisation Agreements

9. The Project IP Owners grant the Commercialisation Lead a licence to Commercialise the Project IP provided:

    1. such Commercialisation shall not extinguish the existing licences granted under this Agreement, except as expressly agreed by such licensed Parties.

    2. the Commercialisation Lead must account for any net revenue generated by the Commercialisation to the other Parties.

10. Any agreement between the Project IP Owners and the Commercialisation Lead shall include a provision that the agreement may be terminated if the Commercialisation Lead does not make adequate progress on Commercialisation within twelve (12) months of the grant of the licence.

11. A Party to this Agreement may request that it be made the new Commercialisation Lead in the event the agreement under clause 8.9 is terminated by reason of clause 8.10.

D. Commercialisation Revenue

12. In each year that the Commercialisation of the Project IP generate any net revenue then the Commercialisation Lead must distribute such net revenue to the Parties to this Agreement based on the following factors:

a. the value of Confidential Information, Background IP and Clinical Subject Data provided by each Party in the Project;

b. the value of Contributions by each Party to the Project, including the value of access to facilities of a Party;

c. the extent of each Party's intellectual contribution to the Project IP;

d. the costs incurred by each Party in relation to IP Protection or Commercialisation of the Project IP; and,

e. Any additional activities or work carried out by the Commercialisation Lead outside of the Project to cause the Project IP to be in a form which is adequate for Commercialisation.

13. If a Party disputes a distribution by the Commercialisation Lead in relation to the distribution under clause 8.9, then that Party shall refer the matter to Expert Determination and each Party agree to be bound by the distribution determined by the Expert in the course of the Expert Determination.

9. Moral Rights

1. Unless otherwise agreed, the Parties shall respect the Moral Rights of authors of Background IP and Project IP.

10. Confidentiality

1. Except as is expressly contemplated in this clause and clauses 9 and 11, each Party:

   a. must not make public or disclose to any person (other than to the Student and to its personnel who need to have access to such information for the purposes of, this Agreement) any Confidential Information of the other Party; and

   b. must not use the Confidential Information of the other Party other than for the purposes permitted under this Agreement, without the express prior written approval of the other Party.

2. The HHS may disclose:

   a. the terms of this Agreement; and

   b. any other document or information in connection with this Agreement,

   to the extent required to comply with any request, direction or order of any Queensland Government Minister, the State, or any government agency and its officers provided that in disclosing such information it makes the recipient aware of its confidential nature.

3. Each Party (the Recipient) must:

   a. where requested to do so by the other Party (the Discloser), upon breach of the Recipient's obligations of confidentiality or privacy to that other Party; or

   b. when this Agreement is otherwise terminated, or

   c. when the Project is completed and the examination process for the Student's Thesis has been completed,

promptly return, destroy or erase any documents or records that contain the Discloser's Confidential Information (whether in electronic or hard copy and in any storage device), as requested by the Discloser, except the Recipient may retain and store copies as required to comply with any applicable statutory record keeping legislation.

4. Either Party may disclose the Confidential Information of the other Party to its solicitors, auditors, insurers or accountants, in order to obtain advice in relation to this Agreement, provided that the Party disclosing that Confidential Information must ensure that every person to whom such disclosure is so made is bound by, and complies with, obligations of confidentiality to use the same solely for the purpose for which it was disclosed and treats the Confidential Information as confidential.

5.

5. Each Party will require its Students to only use and disclose WMHS Confidential Information as permitted by this clause as if the Student were a Party.

11. Publication

1. The Parties shall comply with the Code in relation to all publications and authorship matters.

2. The Collaborator shall acknowledge the support of WMHS in relation to the collection of the Clinical Subject Data or Clinical Subject Materials in all Publications which incorporate the Clinical Subject Data or the Results.

3. Subject to enforcing compliance with the terms of this Agreement, the Parties acknowledge that the Collaborator may engage a Student in the course of the Project and nothing in this Agreement shall be used to inhibit the examination of that Student.

4. Where a Party, including a Student who has contributed to the Project for that Party, ("the Publishing Party") proposes a Publication which includes or refers to the Clinical Subject Data, Project IP or other Confidential Information of the other Party provided or created under this Agreement, the Publishing Party shall submit that manuscript to the other Party ("the Consenting Party") for review at least thirty (30) days prior to submission for publication or presentation. The Consenting Party shall respond within twenty-one days of receiving the request either:

a. providing its written consent to the publication or presentation;

b. providing its consent to the publication or presentation subject to Clinical Subject Data being anonymised or its Confidential Information being severed from the draft or such other amendment which in the reasonable opinion of the Consenting Party is necessary, which may include removal of Confidential Information for the purpose of registration of Intellectual Property or Commercialisation; or

c. requesting a delay in disclosure of the publication or presentation of no more than 90 days so as to not prejudice Project IP protection or Commercialisation of its Confidential Information or other Project IP contained in the Publication.

5. In the event that the Publishing Party shall not have received a response from the Consenting Party within twenty-one (21) days after submission consent will be deemed to have been granted to publish the Publication in the form of the draft submitted for review.

12. Liability

1. Each party is liable for its acts and omissions in relation to the conduct of the Project.

2. Each party must maintain such insurances as are reasonably prudent relation to any liability which it may incur in conducting the Project or performing its obligations under this Agreement.

3. WMHS satisfies the requirements of clause 12.2 if it holds insurance through the Queensland Government Insurance Fund.

4. Neither Party provides any warranty or representation in relation to the use, accuracy, viability or quality of the Clinical Subject Data, Confidential Information and Background Intellectual Property. The other Party acknowledges and agrees that all use of the Clinical Subject Data, Confidential Information and Background Intellectual Property shall be at their own risk.

5. To the extent permitted by law and subject to any express contemplation by the Parties including in clause 12.4, neither Party shall be liable for the consequential or indirect loss or damage incurred by the other Party in the course of the Project.

13. Dispute Resolution

1. A Party must not commence legal proceedings relating to this agreement unless the Party wishing to commence proceedings has complied with this clause. However, this clause will not apply where a Party seeks urgent interlocutory relief from a court.

2. The Parties will co-operate with each other and use their best endeavours to resolve by mutual agreement any differences between them and all other difficulties which may arise from time to time relating to this Agreement.

3. Where a Party wishes to raise a dispute under this Agreement, it must give notice to the other Party and the Parties must within thirty (30) days convene a meeting of their representatives who have authority to resolve such a dispute to discuss and seek to resolve the dispute in good faith.

4. The Parties agree to be bound by the dispute resolution rules of the Institute of Arbitrators and Mediators Australia in respect of any dispute resolution under this clause.

14. General

1. Each party must do all things necessary or desirable to give effect to the provisions of this Agreement including by signing all documents and performing all acts.
2. This Agreement:
    1. contains the entire agreement of the Parties; and
    2. supersedes all prior representations, conduct and agreements,

    with respect to its subject matter.
3. Each party is responsible for its own costs of entering into and performing this Agreement.
4. The laws of Queensland, Australia apply to this Agreement and each party irrevocably submits to the exclusive jurisdiction of the courts of Queensland, Australia and courts competent to hear appeals from those courts.
5. To the extent that any portion of this Agreement is void or otherwise unenforceable then that portion will be severed and this Agreement will be construed as if the severable portion had never existed.
6. This Agreement will be validly executed if signed and communicated by any means including by facsimile or electronic transmission and in any number of counterparts and the counterparts taken together will constitute one agreement.

Execution as an Agreement

Executed for and on behalf of

WEST MORETON HOSPITAL AND HEALTH SERVICE

acting through the Mental Health and Specialised Services, Community and Acute Service

by an authorised person in the presence of

[redacted]

Signature of authorised person
Name of Authorised Person:
Assoc. Professor Deepak Doshi
Chief Medical Officer
Date: 8/10/2020

[redacted]

Signature of witness
Name of witness:
Wendy Utz
Executive Support Officer
Date: 8/10/2020

Executed for and on behalf of **The Collaborator** by an authorised person in the presence of

Signature of authorised person Signature of witness

Name of authorised person Name of witness

Date:

Page Break

Schedule

Project Title	Retrospective process analysis of the establishment and implementation of a 'Therapeutic Group Program' in a public mental health service.
Collaborator	University of Southern Queensland (USQ), ABN: 40 234 732 081, 11 Salisbury Road, Ipswich, Queensland, 4305

Commencement Date	Commencement upon the last party signing this Agreement.
Completion Date	20 July 2023
Investigators	**West Moreton Health** Zonia Weideman, West Moreton Hospital and Health Service, Mental Health and Specialised Service, Community and Acute Services **University of Southern Queensland** Professor Karen Trimmer, University of Southern Queensland Associate Professor Tracy Kolbe-Alexander, University of Southern Queensland
Students	NIL
Project Description	The aim of this study is to identify the essential elements and challenges associated with implementing a Therapeutic Groups Program (TGP) in a community public mental health service. The study will employ a qualitative approach, using semi structured interviews with management, case managers and patients. Expected outcomes include gaining a deeper insight into the barriers between the evidence base and Therapeutic Groups being delivered in the public mental health service and developing a Therapeutic Group Framework with practical steps to implement a TGP within a health service.
Activities	Participant recruitment – **All parties** All parties will develop and agree to the recruitment strategy.

	Data analysis and interpretation – **All parties** Contribution to the interpretation of findings will be made by **all parties** *Reporting of findings* – **WMH & USQ** The finalisation of research findings for dissemination including publication will be the responsibility of **WMH and USQ**. All investigators will contribute and provide input into any publications according to accepted National Health and Medical Research Council guidelines for authorship.
Contributions	WMHS are providing an in-kind contribution of $19 916.18 as per the CAS RRPT In Kind costings HP4 HP5 Jul2020 (attached). HP 4 Recruitment 5 hours HP 4 Interviews 35 hours HP 5 Prepare Ethics 60 hours HP5 Prepare Interviewer 3 hours HP 5 Analyse Data 40 hours HP 5 Write publication 50 hours USQ is providing $1 250.00 of funds as part of the Higher Degree Research Resources (Higher Degree Research Resource Requirement Plan attached) USQ is providing an in-kind contribution of $4 213.00 being for 20 hours costed time each for Professor Karen Trimmer and Associate Professor Tracy Kolbe-Alexander (based on 2020 rates).
Clinical Subjects	WMHS Managers minimum of 3 with an aim of 10

	WMHS Case managers, minimum of 10 with an aim 15 WMHS Consumers, minimum of 10 with an aim 15
Ethics Committee	WMHS HREC: HREC/2020/QWMS/62557 approval granted 20 July 2020 (attached) USQ Human Ethics Review –submitted
Interaction with Clinical Subjects	Will WMHS be required to interact with Clinical Subjects: Yes X No ¨ If so, list documents in the package of materials to be provided to Clinical Subjects: [Insert details of materials provided to Clinical Subjects] For Consumers: Consumer Consent Form (attached) Participant Information Sheet (attached) For Management and Case managers Clinician and Management Consent Form (attached) Participant Information Sheet – Case Managers and Management (attached)
Public Health Application (if any)	Is a Public Health Application required for the data collection: Yes ¨ No X If yes, what are the requirements of the approval:
Clinical Subject Materials (if any)	NA

Date for data provision	As collected and de-identified. Data provision will be for the full duration of the ethics approval including any relevant extensions.
Background IP	Queensland Health
Project IP Owner	Joint IP shared between both parties
Commercialisation Lead	NA
Reports	Progress reports submitted to WMH and USQ Human Research Ethics Committee by Primary Investigator. The researchers are planning to submit a manuscript for publication in a peer-review journal, with the consent of the participants. Presentation of findings at professional conferences will also be explored.

Annexure/s

1. Ethics approval documents
2. Protocol for the Project
3. CAS RRPT In Kind costings HP4 HP5 Jul2020
4. Higher Degree Research Resource Requirement Plan
5. Consumer Consent Form
6. Participant Information Sheet
7. Clinician and Management Consent Form
8. Participant Information Sheet – Case Managers and Management

Appendix V: Confirmation Email of journal

This email originated from outside Queensland Health. DO NOT click on any links or open attachments unless you recognise the sender and know the content is safe.
Journal: Cognitive and Behavioral Practice
Title: Improving public mental health services. Is Group Therapy an answer?

Dear Mrs zonia weideman,

We have received the above referenced manuscript you submitted to Cognitive and Behavioral Practice. However, further action is required to complete the submission.

Manuscripts are sent out initially for masked review. Kindly peruse your manuscript carefully and remove all embedded identifiers at this time (e.g., specific locations of where participant recruitment took place, etc.). In addition, your manuscript must be formatted in accordance with the American Psychological Association Publication Manual. Please visit the tutorial link below which may be useful in formatting running heads, page numbering, headings and subheadings, as well as general spacing and table formatting. At a glance, I can identify a few formatting issues. The first line of each page should contain a brief running head with a page number at the right margin on the same line, not at bottoms of pages. The manuscript should be double spaced throughout with no additional spacing between the running head and first line of text, between paragraphs, before/after headings/subheadings or between references in the References section. The References section should begin on a new page with the first line of each new reference beginning at the left margin and each subsequent line of that reference indented by five spaces. Please avoid the use of use 'et al.' in the References section. All tables and figures should appear after the References section, leaving place holders within the body of the text (e.g., 'Insert Table 1 about here').

http://www.apastyle.org/learn/tutorials/basics-tutorial.aspx

Regarding references, here are three important things to keep in mind:

1. Article titles are lowercase (e.g., Increasing parental involvement in youth with ADHD).

2. Names of journals are upper- and lowercase (e.g., Behaviour Research and Therapy).

3. Names of journals are never abbreviated.

One or two authors (APA, 2010, pp. 175-176, 184) Citing:Include the author(s) lastname(s) in every citation.
References: All authors' Lastname, FirstInitial, MiddleInitials; example, Smith, A. B., & Jones, F.

Three to five authors,
Citing: All authors in the very first citation but only the first author's lastname and et al. in subsequent citations; example, (Smith, Jones, & Brown, 2009) then (Smith et al., 2009) afterward.
References: Include all authors; example (Smith, A. B., Jones, F., & Brown, F. X.

Six to seven authors
Citing: Include lastname of the first author then et al., example, (Jones, et al., 2010).
Referencing: include all authors.

Eight or more authors

Citing: Include lastname of the first author then et al., example, (Jones, et al., 2010).
Referencing: include the first six authors, then three ellipses, then the last author's name; example, Jones, A. B., Smith, C. C., Chen, X.-M., Brown, F. G. M., Cooper, S. S., Farelli, F. I., . . . Rasputin, V.

In cases where there are more than one reference by the same authors, include enough information in citations for the reader to distinguish between the references.

When you are ready to proceed with your submission, please log in as an author at https://www.editorialmanager.com/candbp/, and navigate to the "Submissions Sent Back to Author" folder. There you can edit your submission by clicking "Edit submission" under the "Action Link" menu.

Thank you for considering this journal, and we look forward to receiving your submission.

Kind regards,

Bonnie Brown, BS, RN
Editorial Assistant
Cognitive and Behavioral Practice

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