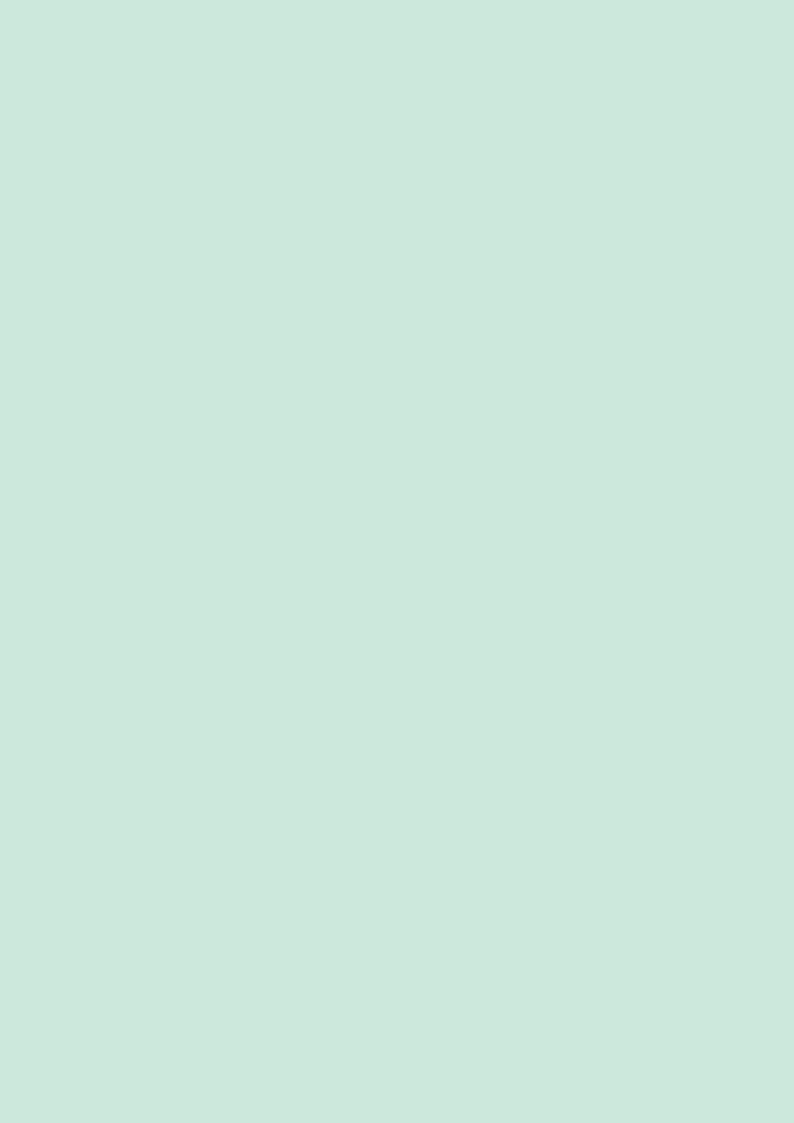




International Initiative for Mental Health Leadership



Lead the change you want to see: connecting leaders globally



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PURPOSE OF THIS REPORT

The International Initiative for Mental Health Leadership (IIMHL) (www.iimhl.com) is a unique international collaborative that focuses on improving mental health and addictions services. IIMHL is a collaboration of eight countries: Australia, England, Canada, New Zealand, Republic of Ireland, Scotland, Sweden and USA.

IIMHL organises systems for international networking, innovation sharing and problem solving across countries and agencies. Effective leadership will promote better outcomes for people who use mental health and addiction services and their families.

The Leadership Exchange is a week-long learning event which is held every 16 months.

Knowledge transfer through IIMHL includes not only the Leadership Exchange, but also promotion of workshops/training/education, support of learning collaboratives and information dissemination between Exchanges.

This report is designed to give an overview of IIMHL activities for the twelve months January to December 2013. This includes the activities of Disability leaders who have been organising the International Initiative for Disability Leadership (IIDL) within IIMHL.

CHAIRPERSON'S REPORT

It has been my great pleasure to take up the IIMHL Chairmanship from Kathy Langlois. Kathy was a highly effective chair who sustained the momentum and energy of IIMHL and has continued to be a great advocate for mental health particularly amongst indigenous peoples. Over 300 delegates were welcomed to New Zealand for an exciting and diverse series of Exchange meetings and a wonderful Combined Meeting in Auckland. The organizing team went to extraordinary efforts to extend a genuine welcome and to embrace the full spectrum of mental health issues.



Martin Rogan Chair SCLG, IIMHL

IIMHL continues to attract new members wishing to connect with their peers and fellow leaders in mental health. The impact of the economic difficulties has created a new demand for services from citizens hurt by austerity and unemployment. Working within constrained resources, mental health services have had to adopt new creative and imaginative approaches. Many services have had to fundamentally re-visit how services are offered and re-imagine service models in a new and exciting way. Service users, family members and service providers are working together to find new ways to advance the recovery agenda and to rebuild lives within the community. IIMHL is a key partner in supporting this adaptation and creates a dynamic forum for leaders to address current challenges.

Members continue to foster active links and networks through email, telecalls, Skype, webinars and seminar meetings. These are powerful and fruitful change agents and can greatly accelerate the uptake of new and emerging thinking; track trends and identify promising practice. IIMHL continues

to be an efficient vehicle to learn and to share; the generosity of members is a key attribute and has proven to be the most effective platform for connecting with mental health leaders worldwide.

2013 also saw Sweden join the IIMHL family, opening up new horizons for service quality and innovation; we expect to welcome new members in 2014. IIMHL maintains its focus on showcasing new possibilities in mental health while addressing the real challenges of preserving service quality and access. It manages to retain a collective presence while accommodating special focus and niche topic groups.

I would particularly like to acknowledge Fran, Janet Peters, David Robinson, Erin Geaney, Lorna Sullivan and Frank Collins for their unstinting work, passion and unquenchable good humor. This dynamic team has worked hard to ensure great connectivity, timely responses to members' queries and do so with great cheer and enthusiasm – they have yet to disappoint.

The Sponsoring Countries Leadership Group met in Washington in December to set a pathway for the future and we are now looking forward to the 2014 Leadership Exchange meetings which will be held in England, Scotland, Sweden and Ireland; I really hope you can join us.

Together we can do it better!

PRESIDENT & CEO'S REPORT

I am delighted to have the opportunity to introduce our 2013 annual report. You will have a chance to read about all of our activities in 2013. This report also provides a brief overview of developments in three of our countries: United States, Sweden and Canada.



Fran Silvestri
President & CEO,
IIMHI

This past year we have welcomed new members to both IIMHL and IIDL. We are excited that Sweden has joined and become an active member of IIMHL. We know our Swedish colleagues have much to share with our seven other sponsoring countries. Their joining IIMHL in 2013 has allowed us to include them in hosting matches in the 2014 Leadership Exchange.

We also have welcomed Scotland and the Australia Capitol Territory as new sponsors of IIDL joining New Zealand and Ireland. Their addition to IIDL will be valuable as the sister component of IIMHL. Leaders who participate in both sectors have much to share.

In 2013 we held our 9th IIMHL Leadership Exchange in Australia and New Zealand. The theme for the successful Leadership Exchange was "Service innovation across the lifespan – what does it take to make an impact?" Leaders from across the countries participated in wonderful matches in both countries hosted by leaders who understand the benefit in rapidly sharing innovative ideas across

the countries. I want to thank Te Pou in New Zealand for leading the organisation of the Leadership Exchange for both IIMHL and IIDL. There are many leaders to thank such as Rod Bartling from the Mental Health and Addiction section of the New Zealand Ministry of Health; Barbara Crawford and Toni Atkinson from the Disability section of the Ministry. In particular from Te Pou, Robyn Shearer, Rob Gill and Lana Griffith who worked endlessly with Erin Geaney and David Robinson. Also Lorna Sullivan who assisted with the IIDL Exchange. Finally, the work of Janet Peters was instrumental in the success of the 2013 IIMHL Leadership Exchange.

We have some changes that will occur in 2014. The first is that in the 2014 Leadership Exchange we have shifted to fewer matches but with each match focusing on a key topic. The overall theme is to build collaboration. Please go to our website to view the 2014 match topics.

In 2014 we will work with our partners Mental Health Commission of Canada (MHCC) and the National Mental Health Commission of Australia to continue to build the International Knowledge Exchange Network for Mental Health (IKEN-MH). This is an opportunity to continue the transfer of information between leaders internationally.

I want to thank Kathy Langlois for her leadership as Chair for the past two years. She has been inspirational and a wonderful guide to all of us. What makes this transition easier is that we have the wonderful Martin Rogan as our Chair for the next two years.

IIMHL remains a very small 'virtual' organization yet our reach continues to grow. Our success relies on the participation of the leaders and organizations that have become part of the fabric of IIMHL. IIMHL offers a conduit to find colleagues and ideas that we all need to continue to improve what we do. It is critical that we learn about innovations by expanding our curiosity and determination to find out how we can work better and more effectively.

Thanks to all of you who have contributed to IIMHL's success in 2013 and we look forward to continuing to build more effective leadership together.

IIMHL VISION, MISSION AND GOALS

We have a new tagline:

'Lead the change you want to see: connecting leaders globally'.

The vision, mission and goals have been refined over time since IIMHL's inception:

Vision. "We seek a future where everyone with a mental illness / mental health issue and those who care for them will have access to effective treatment and support from communities and providers who have the knowledge and competence to offer services that promote recovery."

Mission. To achieve its vision IIMHL provides an international infrastructure to identify and exchange information about effective leadership, management and operational practices in the delivery of mental health services. It encourages the development of organizational and management best practice within mental health services through collaborative and innovative arrangements among mental health leaders.

Goals.

- Provide a single international point of reference for key mental health and addiction leaders
- Strengthen workforce development and mentoring of mental health and addiction leaders
- Identify and disseminate best management and operational practices
- Foster innovation and creativity
- Expand the knowledge of:
 - > Building community capacity
 - > Implementing best practices for consumer recovery
 - > Expanding methodologies for integration with other health and social systems
- Promote international collaboration and research
- Provide assistance to international organizations such as the World Health Organization (WHO), Organisation
 for Economic Cooperation and Development (OECD), the World Federation for Mental Health (WFMH) and
 sponsoring countries to build low and middle income countries to increase their ability to operate community
 based recovery systems.

BRIEF HISTORY

IIMHL was initiated in 2003 by three countries (England, the United States of America and New Zealand). Additional sponsoring countries now include Australia, Canada, the Republic of Ireland, Scotland and Sweden.

At the outset, the sole focus for IIMHL was on mental health, however during the second Leadership Exchange in Washington, the three founding countries agreed that IIMHL should remain open to opportunities to work with other related sectors such as substance abuse and learning disabilities.

In 2006 several disability leaders attended the Leadership Exchange in Scotland, and they decided to set up a work programme to develop IIDL. The intent was to offer disability leaders the same opportunities as IIMHL affords mental health leaders. The disability leaders agreed to initially utilise the same infrastructure as IIMHL, but to seek separate funding for the IIDL work programme. The programme is currently sponsored by New Zealand, ACT state of Australia, Ireland and Scotland. Disability leaders continue to see value in shared learning between mental health leaders and disability leaders and in sharing infrastructure costs and so IIDL continues to operate as a work programme within IIMHL.

Leaders involved in IIMHL include government officials, peer support leaders, CEOs and leaders of mental health, addiction and disability services (both governmental and NGO), key decision-makers, funders, service users, family members, clinical and community workers, educators and researchers, indigenous peoples and people of other cultures.

As at December 2013, more than 1,000 organisations had joined IIMHL and IIDL. There are over 2,500 subscribers registered on the database representing 25 countries and all receiving the IIMHL / IIDL Update.

Since its inception, a major mechanism through which IIMHL achieves its purpose has been its international Leadership Exchanges, currently held every 16 months. Leadership Exchanges are a week-long event. There

is a two-day visit by leaders from sponsoring countries with hosts with shared interests who participate in a jointly developed programme to support knowledge exchange. Then there is a two-day 'Combined Meeting' that both hosts and visitors attend. This meeting comprises presentations on topics of interest and further opportunities to exchange knowledge.

The first Leadership Exchange combined meeting was held in Birmingham, England in June 2003 and there have subsequently been seven further Leadership Exchanges. The three regions (North America, Australasia and the United Kingdom/Republic of Ireland) take turns hosting the Leadership Exchange. The ninth Leadership Exchange was held in Australasia from 4 March to 8 March 2013, with the combined meeting hosted in Auckland, New Zealand.

The Leadership Exchange continues to provide opportunities for shared learning, including peer feedback regarding services, development of collaborative projects and research and provision of information about effective innovations and their implementation.

Over recent years IIMHL has expanded the range of other low-cost mechanisms for transfer of knowledge. By 2013 these mechanisms included IIMHL-sponsored visits by subject experts to member countries and webinars. Work has continued on the International Knowledge Exchange Network for Mental Health (IKEN-MH) to be co-hosted by the Mental Health Commission of Canada, the Mental Health Commission of Australia and IIMHL. These knowledge transfer mechanisms are all described in greater detail later in this annual report.

IIMHL STRUCTURE

As of January 2010, IIMHL has operated as a 501(c) (3) US non-profit corporation. It has a small Board of Directors currently comprising five former SCLG members who collectively have a long history with IIMHL. The Board has fiduciary responsibility for the fiscal and corporate functions and reviews the performance of IIMHL.

Each of the eight member countries identifies representatives to participate in the SCLG and pays a fee into a small fund to cover the administration and operations of IIMHL. The SCLG also includes the President/CEO of IIMHL.

The By-Laws for IIMHL specify the composition of the IIMHL SCLG and authorise the SCLG to choose the subject or theme for the Leadership Exchanges, and to provide suggestions and advice to the Board and President/CEO regarding the activities and expenditures of IIMHL.

A small "virtual" international IIMHL office is led by the President/CEO. A team of three part-time contractors provide administrative and operational support for IIMHL and IIDL, including support for the website and database.

Each sponsoring country nominates key people to liaise with IIMHL, and these people also contribute to the operation of IIMHL in various ways.

BENEFITS TO MEMBER COUNTRIES

According to the Institute of Medicine report, Crossing the Quality Chasm: A New Health System for the 21st Century¹, the lag between discovering effective forms of treatment and incorporating them into routine patient care within the United States is unnecessarily long, lasting about 15 to 20 years. It is reasonable to assume that the delay is even longer for adoption internationally.

The IIMHL collaboration affords a low-cost way to exchange knowledge rapidly between sponsoring countries and to thereby decrease this delay between identifying new and effective services and implementing them on a wider scale.

^{1.} Institute of Medicine Committee on Quality of Health Care in America (2001). Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: National Academies Press.

This has been particularly critical during 2013. In the face of economic constraint across all jurisdictions and countries, IIMHL and IIDL have provided an opportunity for participating countries to learn from each other about how to improve system performance including service quality and safety. Information has also been shared about ways in which countries are re-focusing expenditure on mental health, alcohol and other drug and disability services in order to ensure service effectiveness and value for money while at the same time living within their means.

Sponsoring countries shape the focus of knowledge exchange to ensure its value and relevance to them. The list below describes some areas of focus in 2013:

- International Knowledge Exchange Network for Mental Health (IKEN-MH)
- The use of e-technology
- Clinical Indicators/KPI's and outcome measurement
- Talking therapies
- Wraparound services for youth
- Trauma-informed care
- Elimination of seclusion and restraint
- Workforce development

Elimination and Reduction of Seclusion and Restraint

In 2005, IIMHL worked with the National Association of State Mental Health Program Directors to arrange visits to various cities in Australia and New Zealand in order to provide information about techniques to reduce seclusion and restraint. A national programme was rapidly established in New Zealand and as a result over 400 staff have been trained in sensory modulation to date. In Australia in 2013 the National safety priorities in mental health: a national plan for reducing harm, endorsed by the Australian Health Ministers' Advisory Council (AHMAC) in 2005, is Australia's first national statement about safety improvement activity in mental health. The Plan provides leadership in four national priority areas where stakeholders agreed collectively that adverse events can be prevented, and mental health services made safer.

The four national priority areas identified for first national action are:

- Reducing suicide and deliberate self-harm in mental health services;
- Reducing use of, and where possible eliminating, restraint and seclusion;
- Reducing adverse drug events in mental health services; and
- Safe transport of people experiencing mental disorders. http://www.health.gov.au/internet/mhsc/publishing.nsf/Content/initiatives-1

Wraparound Milwaukee

Wraparound Milwaukee, which pools funding from child welfare, Medicaid, juvenile justice and mental health budgets, has long been one of the nation's largest and most effective wraparound programs, serving 1,400 children and youth each year. With an annual budget of nearly \$50 million, Wraparound Milwaukee has dramatically reduced the county's use of psychiatric hospital and residential treatment centers. A recent study found that just 15 percent of delinquent teens participating in Wraparound Milwaukee — about half of the total program population - re-offended during their period of enrolment. http://www.publicintegrity.org/2013/07/03/12931/only-few-states-enact-evidence-based-care-troubled-youth

Since 2010, IIMHL have facilitated presentations on Milwaukee Wraparound in Australia, England, the Republic of Ireland and New Zealand and this has generated interest in all of these countries. Currently New Zealand is exploring this approach in the Waikato and Australia is also working at implementing the Milwaukee approach.

E-technology

All countries are interested in e-technologies with this being a focus both in past Leadership Exchanges and also in 2014.

Canada particularly is promoting this work (as described later in this report).

MEMBERSHIP OF IIMHL

When leaders join IIMHL, they have access to a global network through:

- The Leadership Exchange
- Participation in research or other collaborative activities
- Learning about innovations
- Linking with international colleagues
- Twice-monthly email bulletins (called IIMHL Update) which includes information on the latest Mental Health issues:
 - > News
 - > Research
 - > Webinars on best practice

It is up to each leader to make the most of their learning experience by continuing connections with like leaders.

IIMHL LEADERSHIP EXCHANGE

The philosophy behind the IIMHL Leadership Exchange is that once key leaders are linked together, they have the opportunity to begin collaborating and building an international partnership. The aim is to build relationships and networks that are mutually helpful for leaders, organizations and countries. The benefits of such a collaborative effort will cascade down to all staff and consumers. These benefits could include:

- Joint programme and service development
- Staff exchanges and sabbaticals
- Sharing of managerial, operational and clinical expertise (e.g. in service evaluation)
- Research
- Peer consultation

The exchange process involves IIMHL with the regional countries (e.g. in 2013 it was New Zealand and Australia) matching leaders. Leaders may be Government officials, provider organizations, planning and/or funding, researchers, leaders from indigenous or specific ethnic groups, family leaders or consumer leaders. The exchange starts with a two-day site visit and is followed with a two-day meeting. Each exchange occurs in a different region: Australia/New Zealand; North America, UK and Republic of Ireland, with one of the countries hosting the two-day combined meeting.

The next two Leadership Exchanges will be held:

- 9th to 13th June 2014: England, Scotland, Sweden and Ireland with the Combined Meeting held in Manchester, England
- 21st to 25th September 2015: The USA and Canada with the Combined Meeting held in Vancouver, Canada.

IIMHL ACTIVITIES TO SUPPORT KNOWLEDGE TRANSFER

Through all its activities, IIMHL aims to find best and promising practice and facilitate the rapid transfer of this knowledge between countries so that it can be applied in practice, through changing both policy and service delivery. IIMHL's activities during 2013 are described below.

Hosting of the 9th Leadership Exchange (2013). The 2013 Leadership Exchange involved Australia and New Zealand hosting 48 site visits, followed by a meeting in Auckland, New Zealand in March 2013. IIDL was an integral part of the 2013 Exchange.

In 2013, the IIMHL operations team worked with a New Zealand project team to prepare for the 2013 Leadership Exchange. This work included:

- Identifying hosts and their chosen topics for the sites and providing information to potential visitors
- Supporting visitors to identify a site with a topic in which they have an interest
- Supporting hosts and visitors involved in each site to develop a programme that ensures that their collective learning needs were met

- Working with the Host Country Project Team to prepare the Agenda for the two-day meeting (with the theme of 'Service Innovation across the lifespan what does it take to make an impact?')
- Organising the meeting venue, speakers, entertainment and cultural groups and arranging potential accommodation for meeting attendees
- Organising for some of the visiting experts to deliver workshops within Australia and New Zealand regarding topics of local interest

2013 saw further development of a trend over recent years away from small site visits involving leaders from similar organisations / roles to larger visits that are focused on a particular theme (e.g. children's services, workforce issues, indigenous peoples' issues, clinical leadership, service user developments, addiction, disability or outcomes). These theme-based exchanges enable the SCLG to target knowledge exchange in relation to key areas of current importance within their countries. Feedback from participants in these larger exchanges has been very positive. The SCLG formally adopted this theme-based approach when it met in March of 2013.

Continued knowledge exchange between Leadership Exchanges. Over the years since its inception, IIMHL has encouraged each leader involved in the Leadership Exchange to make the most of their learning experience by continuing connections with like leaders in the months between the Exchanges. The intent is that the benefits of such a collaborative effort will cascade down to all staff and service users. Potential avenues for collaboration include joint programmes and service development, staff exchanges and sabbaticals, collaborative service evaluation, managerial, operational and clinical knowledge sharing, research and peer consultation.

During 2013, some of the matched leaders from previous theme-based Leadership Exchanges have continued to work together to share knowledge. Specifically, learning activities have continued in relation to: the Clinical Leaders Group (who are doing some joint research through Columbia University), the Workforce Collaborative that has continued to share information between countries, the Child and Adolescent Mental Health Services collaborative, the Wharerātā Group of indigenous leaders, Interrelate – the Service user Coalition from the seven original countries, and the Disability Leadership.

The International Knowledge Exchange Network for Mental Health. This is a venture between the Mental Health Commission of Canada, the National Mental Health Commission of Australia and IIMHL that was launched in July 2012 and aims to provide technological support for collaborative theme-based learning in between Exchanges. This will increase the opportunity for leaders to participate in shared learning irrespective of their attendance at the Leadership Exchanges. Further work on this is described in the section on Canada.

IIMHL Update. The IIMHL Update is a twice-monthly email that includes information on the latest Mental Health and Disability information:

- News
- National best practice documents
- Research
- Policy Documents
- Webinars on best practice and innovations

Examples of key best practice documents shared via IIMHL Update in 2013 are:

USA	 National strategy for suicide prevention 2012 Sibelius: Bring mental illness out of the shadows 	
England	 Social & Emotional Wellbeing: The Early Years Resilience and Results Well-Being in the UK 	
New Zealand	 Child Poverty Report NZ New Zealand Suicide Prevention Action Plan 2013 - 2016 	Continued on page 9.

Geneva	WHO Quality Rights Tool Kit WHO Draft Comprehensive Mental Health Action Plan
Australia	 New Australian Mental Health Roadmap Trauma Informed Care Guidelines in Australia
Ireland	Advancing the Shared Care Approach
Scotland	 Can Mental Health Services as we Know Them Really Support Recovery? Healthcare Technology and Mental Health Technology
Canada	 Canadian Trauma Informed Care Work National Guidelines for a Comprehensive Service System to Support Family Caregivers of Adults with Mental Health Problems and Illnesses

"Make it so" newsletter for key leaders. Occasionally, IIMHL prepares a newsletter for key leaders at high levels within each country to rapidly share the current state of international knowledge about a specific topic of interest.

In 2013, one such newsletter was circulated. Its topic was infant mental health. The next topic is mental health and drug courts. Past and future e-summaries are now available on the IIMHL website.

IIMHL-facilitated visits by subject experts. This is a mechanism through which leaders that have in-depth knowledge of a particular innovation or cost-effective service can present their expertise at low- or no-cost to the sponsoring region. Some examples of presentations that IIMHL supported in 2013:

- Robyn Shearer from New Zealand who presented the work of Te Pou on New Zealand's national workforce development to Sweden, England, Ireland, Scotland, OECD and WHO Region Office Europe
- Bruce Kamradt from Wraparound Milwaukee who presented in Sweden
- Ken Jue presenting in New Zealand on Inshape
- Geoff Huggins and staff talked about developments in Scotland on Change Management, Scottish developments and Talking Therapies in the USA and Canada
- Prof Luis Salvador-Carulla from Australia spoke in New Zealand on the classification and assessment of mental health services
- Ian McPherson at the National Council of Community Behavioral Health Organizations (NCCBH) annual meeting on Increased Access to Psychological Therapies (IAPT)

Planning for the 2014 Leadership Exchange. Work commenced with Ireland, Scotland, Sweden and England to identify a 2014 Leadership Exchange theme, a venue for the combined meeting, potential match sites and logistics. The theme is "Building international collaboratives for leaders".

AN EXAMPLE OF KNOWLEDGE EXCHANGE ACTIVITIES IN 2013

In addition to the IIMHL Leadership Exchanges, IIMHL facilitates the sharing of knowledge and innovations between and within sponsoring countries. The work below shows two examples.

CLINICAL LEADERS GROUP PROJECT

An update on the activities undertaken in 2013:

The project, "Measuring Quality of Mental Health Care: An International Comparison", was initiated by a group of clinical experts under the auspices of the International Initiative for Mental Health Leadership (IIMHL). Led by Columbia University in New York, the project is currently in its third phase and aims to raise awareness

amongst clinicians and policymakers regarding the quality of care of mental health systems and, ultimately, to be able to compare system performance across countries to inform initiatives for transformation of mental health services.

Activities undertaken in 2013 include the following:

Implementation of Phase III of the International Mental Health Indicator project. Based on the work previously achieved in Phase I and II, we drafted and submitted a proposal and work plan for Phase III of the project. Phase III will focus on pilot effort to identify and collect data on a selected number of indicators across and to develop consensus for an overarching shared framework of potential core performance indicators and outcome measures that will be collectable by all participating countries. The following countries are participating in Phase III: Australia, Canada, England, Ireland, New Zealand, Scotland, and the US (participation by Germany and the Netherlands is pending).

We are also seeking to develop a limited set of recovery oriented measures for quality improvement and accountability which could be implemented and collected across participating countries.

Survey. We developed and implemented a survey to review the feasibility of the most highly ranked indicators in the Delphi process of Phase II of the project, review current definitions of those indicators across participating countries, and include additional indicators for which countries are currently collecting data for further consideration. The results are currently reviewed and will be further discussed during the IIMHL Clinical Leaders Group meeting in England (June 2014).

Simultaneously, we have been conducting an international literature review (review of reviews) of existing recovery oriented measures and compilation of identified measures.

Publications. So far, we have had 15 papers published summarizing the work of Phase I and II of the project.

A manuscript that describes and analyses the results of the Delphi process in Phase II of the project is currently in review with the journal Administration and Policy in Mental Health and Mental Health Services Research. In addition, a paper on alternative operationalizations of quality measures based on the results of the Delphi process is in development.

Next steps (2014):

We will continue to compile and review the responses to the measure survey to identify a list of measures that are seen as important, valid and reasonably comparable to be included in a pilot test. To this end we will initiate the collection and submission of actual data for a comparable time frame on a pilot basis.

At the same time, we will compile a set of existing recovery measures to be included in a Delphi process to review and rate identified candidate recovery measures and to assess the feasibility for data collection. A final report on both components of Phase III will be issued in December 2014.

IIMHL Clinical Leadership Meeting – England, June 2014. Dr. Pincus who leads the IIMHL Clinical Indicator Project will be chairing the IIMHL Clinical Leaders Group meeting in June 2014. He will provide an overview of the work achieved including a detailed description of the methodology and preliminary results of the survey of clinical quality indicators in participating counties. The group will review and discuss the work completed in Phase III with particular focus on how it can be further validated, the next phase in gathering data, gaps and other important domains for quality indicators such as recovery.

Harold Alan Pincus, M.D.
Professor and Vice Chair
Department of Psychiatry
College of Physicians and Surgeons
Co-Director
Irving Institute for Clinical and Translational Research Columbia University
Director of Quality and Outcomes Research
New York-Presbyterian Hospital

SPARK TRAINING

The SPARK Training Workshop is an initiative created by the Mental Health Commission of Canada (MHCC) to help participants learn techniques for moving evidence-informed research and knowledge from the fields of mental

health, substance use and addictions more quickly into practice. IIMHL has supported this initiative as part of the knowledge exchange work.

SPARK brings together dozens of participants for two and a half days of training with internationally respected knowledge translation professionals, followed by ongoing mentoring in groups. Ideally, participants come from diverse areas of mental health and different geographic locations within Canada and other countries.

ORGANISATION FOR ECONOMIC COOPERATION AND DEVELOPMENT (OECD)

IIMHL has been assisting the OECD in its preparation of their paper "Making Mental Health Count" by locating a series of reviewers to share their impressions of a draft of the paper. This follows our meeting with OECD on future developments in MH along with a linkage to the Clinical Leaders group project on indicators.

WORLD HEALTH ORGANISATION

WHO has asked and our SCLG agreed to help distribute information regarding an invitation to participate in the Global Clinical Practice Network for ICD-11. An invitation to IIMHL leaders and their list servers will be sent out in early 2014.

COUNTRIES' REPORTS

Each year we choose several of our sponsoring countries to report on their work and trends within their countries. This year we have reports from the USA, Sweden, and Canada

USA. Paolo del Vecchio from the Substance Abuse and Mental Health Services Administration (SAMHSA), reported on key mental health and addiction activities in 2013 for the USA:

White House National Conference on Mental Health. On June 3, President Obama convened the White House National Conference on Mental Health to address the mental health needs of communities across the United States. In his remarks that day, the President stated clearly that "people can recover" from mental illnesses and need the support of their families and friends to help them on their journeys of recovery. At the conference, the President launched a national conversation on mental health to help bring mental illness out of the shadows and help Americans talk about these important issues. The national conversation on mental health is designed to spread the message that it's okay to talk about mental health and that if you or someone you know needs help, it's available and effective. It is also designed to help change negative attitudes about people with mental illnesses, and build acceptance and support in communities, congregations, schools and families.

Community conversations are taking place all across the country. These conversations are being hosted by mayors and community leaders and include young people, parents, peers, and teachers to develop strategies to reduce negative attitudes toward people with mental illness and addiction, to recognize the warning signs, and to enhance access to treatment.

At the White House conference, the President also announced the launch of a new, centralized website on mental health called *MentalHealth.gov* and released several new proposals to increase access to mental health treatment and services.

MentalHealth.gov features easy-to-understand information about the basic signs of mental health problems, how to talk about mental health and mental illness, and how to find help for you or a loved one. As the website continues to develop, it will become an ever-expanding source of useful information to ensure Americans have the information they need about how to recover from mental illnesses and live successfully in their communities.

The President announced several new program proposals to ensure that students and young adults have access to treatment for mental health issues.

- The first proposal is **Project AWARE**, which stands for Advancing Wellness and Resilience in Education. This program would train teachers and other adults who regularly interact with students to recognize young people who need help and ensure they are referred to mental health treatment and services. This program would reach 750,000 young people every year and would have two components:
 - > The first part would provide \$15 million for "Mental Health First Aid" training for teachers and other adults who interact with youth to detect and respond to mental illness in children and young adults, including

- how to encourage adolescents and families experiencing these problems to seek treatment.
- > The second part would provide \$40 million to help school districts work with law enforcement, mental health agencies, and other local organizations to assure students with mental health issues or other behavioral issues are referred to and receive the services they need.
- The second proposal is a new competitive grant program called "Healthy Transitions." This program would provide \$25 million for innovative State-based strategies supporting young people ages 16 to 25 with mental health or substance abuse issues.
- The third proposal would provide \$50 million to train more than 5,000 additional mental health professionals, like social workers, counsellors, psychologists, to work with students and young adults in schools and communities. Of that \$50 million: \$35 million would go to HRSA's workforce programs; \$10 million would go to SAMHSA's peer and para-professional program, and \$5 million would go to SAMHSA's Minority Fellowship Program.

In December 2013, Vice President Biden announced \$100 million to increase access to mental health services, to include:

- **\$50** million for Mental Health Services at Community Health Centers: The Department of Health and Human Services (HHS) will soon issue a \$50 million funding opportunity to help Community Health Centers establish or expand behavioral health services for people living with mental illness or addiction. Community Health Centers can use these new funds, made available through the Affordable Care Act, for efforts such as hiring new mental health professionals and adding mental and substance abuse disorder services.
- \$50 million to Improve Mental Health Facilities: Because proximity to mental health services can be a unique challenge in rural America, the Department of Agriculture has a new goal: to finance \$50 million for the construction, expansion, or improvement of mental health facilities in rural areas over the next three years. These funds, made available through the Department's Community Facilities direct loan program, can be used to improve or construct mental health service facilities or put in place innovative tools such as telemedicine to expand access to mental health services at rural schools, community centers, hospitals, and other community-based settings.

Affordable Care Act and Parity Regulations – Coverage for Behavioral Health. The Affordable Care Act was passed by Congress and then signed into law by the President on March 23, 2010. It extends health coverage to 62 million Americans who previously had no health insurance, provides more affordable options for quality health insurance and prevents discrimination against individuals with pre-existing conditions by insurance companies. The Act significantly extends the reach of the Mental Health Parity and Addiction Equity Act (MHPAEA), ensuring that millions of Americans will now have access to behavioral health services. MHPAEA requires many insurance plans that cover mental health or substance use disorders to offer coverage for those services that is no more restrictive than the coverage for medical/surgical conditions. On Friday, November 8 2013, the U.S. Departments of Health and Human Services, Labor and the Treasury issued the final rule to implement the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act. Starting in 2014, the Affordable Care Act will require all small group and individual market plans created before March 23, 2010 to comply with federal parity requirements. Qualified Health Plans offered through the Health Insurance Marketplaces in every state must include coverage for mental health and substance use disorders as one of the ten categories of Essential Health Benefits, and that coverage must comply with the federal parity requirements set forth in MHPAEA.

Primary Care Integration. Integrating care is vital to addressing all the healthcare needs of individuals with mental health and substance use problems—regardless of whether primary care services are integrated into behavioral health systems, or vice versa. A wealth of evidence, examples, and models exist supporting and illustrating primary and behavioral healthcare integration as a means for delivering quality care and improving overall health outcomes. SAMHSA collaborated with Health Resources Services Administration (HRSA) to develop the **SAMHSA-HRSA Center for Integrated Health Solutions (CIHS)** which promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings. For example, primary care settings have become a gateway for many individuals with behavioral health and primary care needs. To address these needs, many primary care providers are integrating behavioral health care services into their setting. Models have emerged that include the use of care managers and behavioral health consultants. Another model approach is the health home, which offers coordinated care to individuals with multiple chronic health conditions, including mental health and substance use disorders. The health home is a team-based clinical approach that includes the consumer, his or her providers, and family members, when appropriate.

Underage Drinking. Talk. They Hear You. – SAMHSA's National Underage Drinking Prevention Media Campaign.

In May 2013, SAMHSA launched its latest national media campaign to prevent underage drinking, called "Talk. They Hear You." The media campaign provides parents and other caregivers with advice on how to talk to their kids about the dangers of underage drinking. As of October 2013, the media campaign was seen by more than three quarters of a billion people. This includes 206 million from news stories including the Today Show, National Public Radio, and Fox Boston; 544 million from running the TV PSA; and 59 million from placements of the PSAs in Times Square, shopping malls, airports, buses, and subways. For more information about the campaign, visit www.samhsa.gov/underagedrinking

Technology-Based Products to Prevent High-Risk Drinking among College Students Challenge. In September 2013, the Substance Abuse and Mental Health Services Administration (SAMHSA) announced the three prize-winners for its Technology-based Products to Prevent High-risk Drinking among College Students Challenge. SAMHSA launched this Challenge in May 2013 to help decrease high-risk drinking, including underage drinking, among college students. High-risk drinking is widely prevalent among many college campuses. For example, according to the latest findings from SAMHSA's National Survey on Drug Use and Health, 40.1 percent of full-time college students were binge drinkers. SAMHSA opened the challenge to seek solutions to prevent high-risk drinking among college students through cost-effective, portable, technology-based products. These products also needed to effectively reach college students and their parents, as well as administrators, faculty, and staff. In addition, they had to be adaptable in order to meet the local needs of academic institutions throughout the United States. For more information about the Challenge and its prize-winners, visit www.samhsa.gov/newsroom/advisories/1309183038.aspx.

Prescription Drug Abuse. Drug Monitoring Programs (PDMPs).

Research suggests PDMPs reduce the prescribing of Schedule II opioid analgesics, lower substance abuse treatment admission rates, and result in lower annual increases in opioid misuse or abuse in states with PDMPs compared to those without them. In a study examining the impact of PDMPs on changes in clinical practice, clinician review of PDMP data changed clinical management in 41% of cases. Of these cases, 61% percent received fewer or no opioids than the clinician originally planned to prescribe prior to reviewing the PDMP data, and 39% received more opioid medication than previously planned because the clinician was able to confirm the patient didn't have a recent history of opioid use. Other tools such as clinical decision support tools and use of electronic health records that incorporate PDMP and other pertinent clinical data show promise for improving prescribing behaviors and reducing adverse events.

To support the use of PDMPs, SAMHSA has funded three programs that facilitate the implementation of technologies that provide timely access to PDMP data for primary care and emergency department providers, and pharmacists by integrating existing technologies like electronic health records (EHRs), health information exchanges (HIEs) and pharmacy systems to securely connected state PDMPs. In FY2011, SAMHSA funded the Enhancing Access to Prescription Drug Monitoring Programs using Health Information Technology (HIT) project, managed by the Office of the National Coordinator for Health Information Technology (ONC), in collaboration with SAMHSA, CDC, and ONDCP and continued to fund this program in FY2012 and FY2013. Expanding on the innovations of the Enhancing Access project, SAMHSA also funded the PDMP Electronic Health Record (EHR) Integration and Interoperability Expansion and the PDMP and EHR Data Integration Cooperative Agreements, providing funding to states to further improve real-time access to PDMP data by integrating PDMPs into existing technologies like EHRs and/or strengthening state PDMP interoperability. Nine states were provided funding for the former program in 2012; seven states were provided funding for the program in 2013.

Prescription Drug Abuse Prevention. According to SAMHSA's 2012 national survey data, the nonmedical use of prescription drugs remain second behind marijuana when looking at the past month illicit drug use among persons aged 12 or older. A number of SAMHSA's programs aim to address the prescription drug abuse and misuse issue.

SAMHSA's Strategic Prevention Framework - Partnerships for Success II (SPF-PFS II) grant program is designed to address two of the nation's top substance abuse prevention priorities:

- 1) underage drinking among persons aged 12 to 20; and
- 2) prescription drug misuse and abuse among persons aged 12 to 25. It is also intended to bring SAMHSA's Strategic Prevention Framework (SPF) to a national scale.

SAMHSA's Preventing Prescription Abuse in the Workplace (PAW) Technical Assistance Contract provides technical assistance to help local, government, and military workplace and communities understand the prescription drug abuse problem and reduce related problems by stimulating, informing, and supporting employer-and community-based prevention/early intervention efforts. Lastly, the Division of Workplace Programs (DWP) is a division in SAMHSA that specifically oversees the Federal Drug-Free Workplace Program, which is aimed at eliminating illicit drug use in the federal workforce, and the National Laboratory Certification Program (NLCP), which certifies laboratories to conduct forensic drug testing for the federal agencies and for some federally-regulated industries.

Opioid Overdose Tool Kit. Opiate overdose continues to be a major public health problem in the United States. It has contributed significantly to accidental deaths among those who use, misuse or abuse illicit and prescription opioid analgesics. In fact, overdose deaths involving prescription opioid analgesics have increased to almost 17,000 deaths a year. As a result, drug poisoning deaths in the U.S. almost doubled between 2001 and 2010. This increase coincided with a nearly fourfold increase in the use of prescribed opioids for the treatment of pain. To address this problem, in the fall of 2013, SAMHSA introduced the Opioid Overdose Prevention Toolkit. The toolkit equips communities and local governments with material to develop policies and practices to help prevent opioid-related overdoses and deaths.

Suicide Prevention. With the WHO's World Suicide Report slated for release on World Suicide Prevention Day in September 2014, suicide prevention is truly a global concern. SAMHSA is contributing to that report based on its expertise and significant suicide prevention resources that include: the National Strategy for Suicide Prevention; the National Suicide Prevention Lifeline, a free, 24-hour hotline available to anyone in suicidal crisis or emotional distress; the Suicide Prevention Resource Center, which provides prevention support, training, and resources to assist organizations and individuals to develop suicide prevention programs, interventions and policies; and support for the National Action Alliance for Suicide Prevention, a public/private partnership that helped plan, implement and now oversees the US National Strategy for Suicide Prevention. SAMHSA has also developed toolkits to promote mental health and prevent the risk of suicide among high school students and among residents in senior living facilities and maintains reports and statistics on suicides.

Recovery Support. In 2011, SAMHSA funded the Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) to promote the widespread adoption of recovery concepts and practices throughout the United States. BRSS TACS serves as a coordinated effort to facilitate the adoption and implementation of recovery concepts, policies, practices, and services, leveraging previous and current accomplishments by SAMHSA and other leaders in the behavioral health recovery movement.

September is **Recovery Month** in the US. Recovery Month promotes the societal benefits of prevention, treatment, and recovery for mental and substance use disorders, celebrates people in recovery, lauds the contributions of treatment and service providers, and promotes the message that recovery in all its forms is possible. **Recovery Month** spreads the positive message that behavioral health is essential to overall health, that prevention works, treatment is effective and people can and do recover.

Peer support services are a critical component of recovery services and an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders. SAMHSA is currently working with the US Centers for Medicaid and Medicare Services to encourage State Medicaid Directors to use these services with the proviso that "Peer support providers should be self-identified consumers who are in recovery from mental illness and/or substance use disorders. Supervision and care coordination are core components of peer support services. Additionally, peer support providers must be sufficiently trained to deliver services."

Addressing and Tracking Health Disparities. In 2011, the Department of Health and Human Services (HHS) released the Secretary's Action Plan to Reduce Racial and Ethnic Health Disparities. The number one Secretarial priority in the Action Plan is to: "Assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that: Program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications." To that end, SAMHSA's Office of Behavioral Health Equity (OBHE) developed a SAMHSA-wide approach to addressing behavioral health disparities that: (1) requires submission of a behavioral health disparity impact statement from all SAMHSA-funded grantees that indicates how the grantee will promote access, service use, and positive outcomes for disparity-vulnerable populations; (2) builds SAMHSA staff capacity to understand behavioral health disparities and to work with their grantees to use performance data to measure, track and reduce disparities

for ethnic/racial and LGBT populations in their grant catchment area; and (3) for grantees, provide tools and online training resources to enable them to increase awareness of disparities, use performance data to identify and track progress to reduce disparities, and implement the national Culturally and Linguistically Appropriate Services (CLAS) standards.

In a second disparities initiative using its National Network to Eliminate Disparities in Behavioral Health (the NNED), OBHE convened its third annual NNEDLearn Conference and trained over 120 practitioners that serve diverse racial and ethnic populations around the country in evidence-based and culturally-adapted evidence-based interventions including Motivational Interviewing, Project ASIST (suicide prevention for Tribes), Latino Culturally-Adapted CBT, Strengthening Families for Diverse Families, Achieving Whole Health for AAPI Peers, and Prime-Time Sister Circles: Promoting Positive Behaviors in African American Women.

Improving Services for Children who have Experienced Trauma. Two years ago, HHS established a child trauma goal that aims to improve systems and services to help children who have experienced trauma get better outcomes in social and emotional well-being, long-term health, and success in life. Work to address the goal is led by HHS's Administration on Children, Youth, and Families (ACYF) in partnership with the Center for Medicare and Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA). The strategies and milestones of the goal aim to improve trauma screening, assessment, and, ultimately, access to appropriate trauma-informed evidence-based services over time. By widely integrating early and ongoing screening and assessment, systems can better identify children affected by trauma, match children's changing needs with the appropriate array of services, and monitor changes in children's outcomes as they participate in services. Through its work on this goal, HHS is committed to expanding access to services that match the assessed needs of children and show the greatest evidence of effectiveness in improving outcomes for children with trauma.

Milestones over the last two years include:

- i) the development of discretionary funding, policy guidance, and technical assistance to states as they work to better address the social-emotional, mental and behavioral health needs of children known to child welfare:
- ii) a Dear State Director letter to provide guidance on financing the implementation and delivery of evidencebased trauma screening, assessments, and intervention; and (iii) a series of informational bulletins released by CMS related to the coverage of mental health services and the management of psychotropic medications.

Criminal Justice. In 2013, SAMHSA awarded funds to support the Law Enforcement and Behavioral health Partnerships for Early Diversion grant program. This program supports diversion for people with behavioral health and co-occurring substance use disorders at the earliest possible encounter with law enforcement. In May, SAMHSA also sponsored a cross-department (Bureau of Indian Affairs at the US Department of Interior and the Bureau of Justice Assistance at the US Department of Justice (DOJ) Tribal Policy Academy for eight tribes to develop a plan for alternatives to incarceration for adults, and produced, in consultation with DOJ, a webinar and accompanying document on Guidelines for the Successful Transition of Persons with Behavioral Health Disorders from Jail and Prison.

CANADA. Nicholas Watters from the Mental Health Commission of Canada (MHCC) noted the following knowledge exchange activities for Canada:

- MHCC took part in the 2013 IIMHL Leadership Exchange "Innovations in E-Therapies" from 04-08 March 2013 in New Zealand. MHCC was able to learn from countries around the world about best practices in e-mentalhealth and how other countries have taken leadership at a national level. Based on these learnings, MHCC launched a national initiative on e-mental health. MHCC has developed a steering committee of national experts and leaders, and has begun development on a briefing paper that outlines the strengths and potential barriers to using technology, as well as opportunities and recommendations for future use, ultimately bringing credibility, attention and investment to the area. MHCC is working with the IIMHL group to get feedback and input on the document and hopes to present a final version at IIMHL 2014.
- The Data project under the MHCC Knowledge Exchange Centre is engaging with the IIMHL through providing support of its efforts for creation of international mental health and mental illness data indicators, spearheaded by Dr. Harold Pincus.
- The MHCC KEC in collaboration with the IIMHL created the International Knowledge Exchange Network for Mental Health (IKEN-MH), which is comprised of eight experts in the field of mental health from across the globe. Nicholas Watters (MHCC) and Fran Silvestri (CEO, IIMHL) Chair this Network. The collective goal of

- the group is to reduce the time from innovation to implementation to improve mental health globally and collaborate to create a community of practice.
- In 2013, the IKEN-MH took part in the Global Implementation Conference in Washington, DC. The GIC gathers implementation stakeholders to promote collaboration and exchange information about advances in implementation science, practice, and policy. Two IKEN-MH members, Nicholas Watters (Mental Health Commission of Canada) and Fredrik Lindencrona (Sveriges Kommuner Och Landsting) were part of a session that highlighted successfully collaborations between countries focusing on policy change, and successful programs aimed at building knowledge exchange capacity.

SWEDEN. 2013 was the second year of the coordinated strategy for mental health in Sweden. A short summary of the basic features of the strategy:

- runs for five years (2012-2016)
- approaches 90M Euros yearly (which is estimated to give the sector about 2-3% more funding than the regular budget spend per year)
- is done in large part as an agreement between national government through the Ministry of Health and Social Affairs and the SALAR as the member organization for the autonomous sub-national governments (i.e. local and regional authorities)
- is coordinated by a function at the Ministry of Health and Social Affairs directly reporting to the deputy minister and a function at the Swedish Association for Local Authorities and regions
- focuses on early intervention for children and youth and those with the highest level of needs among adults
- uses three main drivers performance-based reimbursement to local and regional authorities, funding for improvement programs and assignments to national agencies.

Performance-based reimbursement – targets and outcomes. The performance-based reimbursements schemes address key goals of the strategy and are negotiated yearly between the national and sub-national levels of government. In order to be reimbursed, a local or regional authority needs to fulfill basic requirements and specific targets.

Basic requirements. The regional and local authorities within each region:

- have developed mutual agreements about the respective responsibilities for children and youth and persons with severe mental illness
- provide web-based information about where children and youth and their families can get support, treatment and other forms of help they might need

Specific goals and targets - Children and Youth

Target 1 & 2 - Improved access.

- At least 90% of children and youth who applied for care have waited less than 30 days to meet with a specialist
- At least 80% of children and youth who applied for care have waited less than 30 days to start treatment or extensive clinical assessment

Target 3 & 4 – Coordinated individual care plan. Regional authorities and local authorities

- have reported all coordinated care plans that were developed for children and youth under 18 years of age
- have estimated the need for such plans for all children and youth under 18 years of age

Specific goals and targets - Adults with complex problems

Target 1 – Quality registers. Regional authorities

- have reported information to the relevant quality registers for at least .5% of the population in the regional authority
- run a program to reduce seclusion and restraint

Target 2 – Registration of Seclusion and Restraint events. Regional authorities

- have participated in the "Better care less coercion" A national development program for quality in in-patient psychiatric wards focusing on preventing seclusion and restraint
- have reported their analysis of the data they have sent into the national registry for reporting events of seclusion and restraint

Target 3 – Survey over the living conditions for persons with severe mental health in the local authorities.

• Local authorities have conducted a survey over the living conditions for those with severe mental illness. Data from the survey has been reported to Swedish Association for Local Authorities and Regions. Local

authorities have analysed the size of this group in their locality and how well their needs are covered, especially in terms of housing and employment

Summary results

Basic requirements and specific targets	# Regional Authorities (21)		# Local Authorities (290)
Fulfill basic requirements and at least one specific target	21		275
Targets for Children and Youth			
Less than 30 days to first visit	17		NA
Less than 30 days to treatment or systematic evaluation	15		NA
# of coordinated care plans reported	21		284
# of needed coordinated care plans estimated	21		284
Targets for Adults with complex needs			
Reporting to quality registers	20		NA
Reporting events of seclusion and restraint	21		NA
Survey of the living conditions for adults with severe mental illness			

Improvement programs run by the Swedish Association of Local Authorities and Regions

Psynk – Mental Health for Children and Youth (Contact: Fredrik Lindencrona - fredrik.lindencrona@skl.se)

Psynk aims to develop models, services and systems that can better help children and youth and their families across the prevention spectrum through to intense and coordinated specialized care. The program addresses the trajectory of children and youth's development from before birth up to early adulthood at twenty-five. The developmental aspect of the project involves synchronising all of society's interventions for children and adolescents who suffer from, or risk developing, mental ill health. Around 50 municipalities, and their associated county councils, participate through local improvement efforts at various levels in five themes that function like integrated sub-programs in the overall program:

- School results and mental health: addressing the educational systems role in mental health throughout a child or youth's life
- "First-line": development of a new service level (primary care level; between school-based services and secondary specialist care) where mild to moderate problems can he handled. In line with recent research mental health, family-related problems and school-related problems tend to cluster and these services need to be able to cater for a combination of these problems

• Children with complex needs: addressing how systems can be developed to cope better with children, young people and families with the most severe and complex problems that often demand a high level of coordination

Previous experiences have shown that this type of "content-focused" development strategies can be difficult to really affect local policy and practice if central issues like financing and governance are not addressed. In order to address these levels directly Psynk includes two sub-programs:

- Early interventions/Social Investment: developing the capacity, models and strategies take investments into important issues with the right programs for real results
- Shared governance helping politicians and senior management from local and regional authorities improve the way they interact to achieve real results

Better care – less coercion – part 2 A national development program for quality in in-patient psychiatric wards (Contact: Catrin Hägerholm – *catrin.hagerholm@skl.se*)

Better care – less coercion is a national program that uses IHIs (Institute of Healthcare Improvement) well-known breakthrough series to improve care in psychiatric in-patient wards. All clinics in the country have participated in at least one learning collaborative to run their own systematic quality improvement initiative for their psychiatric wards. During part 2 (2013-2014) some issues such as leadership and management training, implementation and sustainability of the improvement methods, and some specific areas (self-harm) have been included.

I-nod (Contact: Mikael Sandlund – *mikael.sandlund@psychiat.umu.se*)

I-nod aims at helping people with severe mental illness to get high-quality integrated services where comprehensive and complex needs can be met within a joined-up organizational frame such as a team. The project supports recovery through addressing better quality or services and a higher degree of user involvement and voice. I-nod tries to work based in the latest evidence on effective psychosocial interventions and tries to identify and promote best practice. The program is organized in four sub-themes:

- prinSIP encourage and improve how coordinated care planning is conducted for adults with severe mental illness
- F-ACT –flexible ACT (Assertive Community Treatment)
- Puzzel coordination between probation services, forensic psychiatry and substance abuse services
- Evaluation of project on client level as well as implementation projects.

The National Self-Injury Project (Contact: Eva Klingberg - eva.klingberg@kentor.se)

In an agreement between the Swedish Association of Local Authorities and Regions (SALAR) and the government from October 2011, the parties have agreed upon an initiative aiming at developing and coordinating activities in order to decrease the number of young with self-injurious behaviour. The goal of the agreement is to develop and coordinate activities in order to decrease the number of young with serious self-injurious behaviour, and to create a better early stage care through a structure that provides for proper care for these persons. The overall goal is thus to decrease the number of people that are taken into professional care within inpatient units, and to decrease the number of involuntary and coercive measures. Activities include:

- Create a compilation of current national and international knowledge and available resources in the country within the area
- Form a national network driven by three regional nodes across the country
- Conduct a prevalence study self-injurious behaviour within child and adult psychiatric clinics in Sweden
- Web-based training aimed at increasing the competence among people that encounter self-injurious behaviour in their professional role, but also in private life, may it be in the role of being afflicted yourself or in being a relative or otherwise close friend/relative
- Evaluation of Emotion Regulation Group Therapy (ERGT) aimed at self-injurious behaviour among adults
- Assignments to national agencies

The national coordination function within the Ministry of Health and Social Affairs has assigned national agencies and other national level actors with specific tasks during 2013. One of the most prominent of these is an assignment to five agencies (headed by the National Board on Health and Welfare) to coordinate their respective responsibilities for knowledge production for knowledge management in the mental health sector. The other four agencies are: the Public Health Institute, the Medical Products Agency, the Dental and Pharmaceutical Benefits Agency and the Swedish Council on Health Technology Assessment.

Work has been undertaken to start a closer dialogue with regional and local authorities about their need for knowledge, trying to understand it both in substantive – What? (terms and processes) How? (terms). Work will continue during the coming years to build a more efficient "evidence-to-implementation process" through work in collaboration with Swedish Association of Local Authorities and Regions on a few issues such as ADHD, how to succeed in collaboration, coordinated care planning, physical health and mental health integration etc. (Contact: Mattias Fredricson – mattias.fredricson@socialstyrelsen.se)

Summary. The National Coordination Strategy, in large part an agreement between national and sub-national government levels, contributes about 2-3% more funding to the mental health sector than estimated ordinary yearly funding. The strategy runs until 2016 and focuses on children and youth and adults with severe mental illness. The strategy combines reimbursement schemes based on goals and targets, with strategic improvement programs. A third driver for improvement of the sector is specified assignments to a few agencies. Most activities address two main areas – the need for improved coordination across levels of government, between national agencies and between local authorities and regional authorities. The second overarching theme is to get better data and information about service quality and need among patients and to set some processes in motion to make systematic quality improvement a reality for the sector.

At the level of national agencies – one of the more important improvement strategies concern how the five most important agencies within the Mental Health Sector are assigned with trying to collaborate better between themselves and with providers to produce more coordinated material that more easily can be implemented in local authorities and regions.

INTERNATIONAL INITIATIVE FOR DISABILITY LEADERSHIP (IIDL) IN 2013

Lorna Sullivan from New Zealand has written the following update for this area.

Development of the Initiative. The International Initiative for Disability Leadership (IIDL) has continued to grow and diversify its membership to include disabled and family leaders which complements the leadership of innovative support agencies. The maturity of this leadership network now enables IIDL to collectively support transformational agendas that are well positioned to operate within the reform environments emerging world wide from the establishment of direct payments and self-directed supports. This growth of disabled persons and family leadership becomes of critical importance as we collectively begin to recognise that many of the current approaches to service provision are not only unsustainable over the longer term, but that they do little to advance the life opportunities and social value of the people they are designed to support. The ability of IIDL to successfully position our work across the range of leadership approaches provides us with the opportunity to now set a longer term vision for the leadership agenda to be promoted by IIDL. The establishment of this leadership strategy will help ensure our work remains focussed on the substantive challenges to be addressed for sustainable change. The approach now enables IIDL leaders to be connected to a diverse international network with a clear agenda of disabled persons undertaking the collective and individual leadership in self-determining the life of their choice with support to governments and service providers in better understanding what is required to enable this to emerge.

As we now progress our work for the 2014 exchange, *Building International Learning Collaboratives for Leaders*, we have invested in the engagement of leadership for capacity building, community development and service transformation from collective to individualised responses. What better investment than to join other countries and leaders in doing this.

Benefits for Governments. Governments and Government agencies within our member countries continue to seek solutions to common problems and issues, to find sustainable alternatives to the traditional approaches of collective and custodial support approaches for disabled people. For Member Governments now have access to a diverse and knowledgeable network of leaders committed to lend their expertise and experience to the challenges Governments are facing. However, the effectiveness of the network in support of Government agendas remains dependant on the active involvement of these Governments and Officials in engaging the network and in engaging in the collaborative leadership relationships that network makes available. Sponsoring Governments would strategically strengthen leadership skills in their own domestic sectors through the encouragement of leaders, families, disabled people, and senior executives, to join and play an active role in IIDL.

2013. The 2013 exchange in Auckland, New Zealand was a coming of age for the IIDL network. This exchange brought together leaders who have been working in collaborative partnerships now for the past four and five years. The quality and sophistication of the knowledge shared across the exchange sites continues to grow as does the personal and professional networking both at the exchange and in respect of specific projects between exchanges. The exchange sites in the New Zealand exchange were as diverse as consumer directed monitoring and evaluation, individualised funding and consumer directed systems, political and systemic advocacy of people with disabilities, family capacity development and the transformation journey being experienced by leading service agencies. As a result we continue to see a steady increase in membership, and an increase in the financial membership of small country and State Governments.

IIDL is now an integral partner of IIMHL. Unfortunately, despite an increase in financial membership we continue to operate with very limited financial resources. This does have the impact of limiting the amount of work we can undertake, however, we continue to be nurtured by IIMHL and to have access to their resources to ensure the disability initiative is able to continue to grow and contribute.

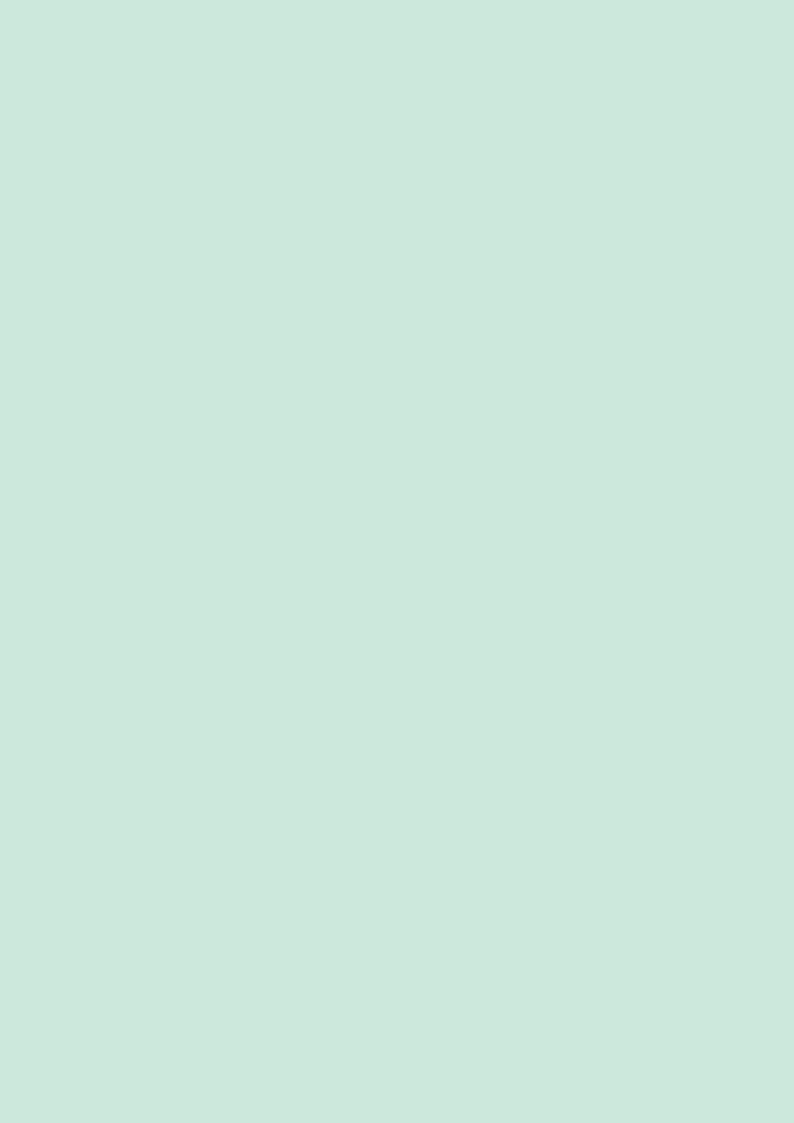
The relevance and impact of international networks such as IIDL and IIMHL are becoming increasingly recognised as Governments, the service sector, disabled people and communities come to acknowledge that it is only within collaborative association that the complexities of reform will be achieved. IIDL has successfully positioned itself to provide this collective leadership, practical application and ongoing learning, around the issues of service transformation and change. This makes the IIDL network a unique and valuable asset for Government policy-makers and provider agencies alike.

IIDL 2013 webinars and articles - examples:

Country	Topic
Ireland	Strategic Plan 2013-2015 - Ireland Value for Money and Policy Review of Disability Services in Ireland
Canada	Review of Disability Policy in Canada
England	Families and Personalisation Project - 'Better Lives' Commissioning for Community Inclusion
USA	Self Determination and Aging

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International Initiative for Mental Health Leadership

