Mental Health Council of Australia

# WEEKLY BULLETIN

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# BULLETIN NO. 7, 2012

Hi everyone,

There was an exceptional amount of new research and information on new models and programs out there this week. From research on specific mental disorders to issues affecting particular at-risk groups, it was difficult to decide what to include in this Bulletin. The recipients of this publication are so diverse, that I'm sure that there will be at least a few things of interest to everyone. I am hoping that presenting information about advances in mental health and new programs might stimulate conversations with health professionals, service providers and respective government departments about new ways of doing things, whether at the local level or considering changes at the national level.

Kind regards,

Rachelle

**1 Social connectedness: A potential aetiological factor in the development of child post-traumatic stress disorder**

**McDermott, Berry & Cobham**
**Australia & New Zealand Journal of Psychiatry**
Volume 46 Number 2
February 2012

**Abstract**

**Objective:** The aim of this study was to investigate a new social connectedness factor and Posttraumatic Stress Disorder (PTSD) in children who experienced a cyclone disaster.

**Method:** Three months post-disaster school-based screening for PTSD was conducted. 804 children (mean age=10.22 years, SD=1.24) participated. 12.0% of children reported severe or very severe PTSD symptoms.

**Results:** Low connected children, adjusted for age, gender and independent of cyclone exposure and threat perception, were 3.96 times more likely to experience severe to very severe PTSD. A structural model of child PTSD indicated that connectedness was the most important factor explaining variance in children's symptomatology. The final model accounted for 60% of the variance of child PTSD scores.

**Conclusions:** We conclude that child connectedness is a new, significant, independent factor in a model of post-disaster child PTSD. Connectedness may represent a vulnerability factor that can be targeted preventatively in children in disaster-prone regions. Conversely, a pre-disaster intervention that helps children develop high connectedness may have the potential to confer resilience.

http://anp.sagepub.com/content/46/2/109.abstract

**2 Promoting the wellbeing of others at work**

**Australian Psychological Society**
Information sheet

The wellbeing of staff can have a significant impact on the success and smooth operation of any organisation. Below are some simple strategies that supervisors and managers can adopt within their organisation to support the wellbeing of their employees.

**Build an ongoing feedback loop**

Take time to have regular, informal conversations with each member of your team on how they're performing. Regular feedback (rather than an 'annual review') is more likely to engage your employees to do their best and will recognise their contributions. This practice will make them feel valued and help highlight any areas for development as they arise.

**Enhance the meaningfulness of the work**

It is important for your employees to feel connected with the larger purpose of the organisation. Having regular conversations about how individual roles contribute towards driving the overall direction of the organisation can often help your employees feel more connected and valued in what they do.

**Provide role clarity**

A key source of workplace stress is often a lack of clarity around the roles of various employees. It is important to ensure that employees have regular opportunities to discuss their tasks and what is expected of them. Having regular discussions about goals can also help to identify the best ways to support employees to reach these goals (i.e. identify need for additional training or development, coaching, mentoring, etc).

**Encourage trusting and respectful communications**

When having a sensitive conversation with any employee, ensure that this is held in a separate space that provides privacy and respect. This way you can communicate appropriate concerns, support wellbeing and demonstrate your capacity to listen and offer considered responses.

**Set the standard**

If you witness or hear behaviour or conversation that is inappropriate, make the time to intervene promptly. It can sometimes be helpful to address the standards of acceptable behaviour (or language) by sharing examples of how it could negatively impact on the wellbeing of others. Employees will recognise you as someone who cares for their wellbeing at work when you do this.

**Acknowledge good work and practices**

Be just as ready to acknowledge and recognise instances of good performance, outstanding team efforts and innovative ideas as you are to respond to negative elements of employees' behaviour or performance.

**Offer support through organisational resources**

Do not hesitate to draw on organisational resources available to help employees manage their stress and wellbeing at work, such as flexibility, work-life balance policy, OH&S policies and procedures or Peer Support, Mentoring or Employee Assistance Programs.

Communicate about how they might utilise these policies and programs to help manage their wellbeing.

**Get support for yourself**
Managing others can be a highly stressful affair and it is important for you to get the right support and training. An APS organisational psychologist can help you develop your skills as a leader and assist you in managing wellbeing at your workplace.

This tipsheet is an initiative of the APS College of Organisational Psychologists.

Organisational psychology is the science of people at work. Members of the APS College of Organisational Psychologists typically have six years of university education, as well as experience in helping individuals and organisations to increase their performance, resolve problems and increase their wellbeing at work.

http://www.psychology.org.au/wellbeingatwork/

**3 Continued assistance for homeless older people**

**Mark Butler**
Media release
29 February 2012

Nearly 4,000 disadvantaged older Australians a year will continue to receive valuable assistance to help them secure or maintain stable housing and care in the community of their choice.
The Gillard Government will provide more than $14.4 million to guarantee the future of Assistance with Care and Housing for the Aged program (ACHA) over the next 3 years.
The funding guarantee will see 45 ACHA services continue to provide valuable services to older Australians at risk of homelessness or living in insecure housing.

“Last financial year, the ACHA program assisted nearly 4,000 older people, linking them to community care, welfare services and accommodation,” Mr Butler said.

“The guarantee of funding ensures that thousands more older Australians will be able to get help finding suitable accommodation, advice on housing applications and financial services and assistance with removals and the purchase of household items.

“Older Australians who are homeless or living in insecure housing are some of the most vulnerable members of our community. Our commitment to the ACHA program will ensure

that those Australians not only have a roof over their heads but also the confidence and security to participate, and feel included in the community of their choice."

Older Australians who are experiencing homelessness have more complex health needs and requirements and they also do not have the family and social support networks that other older Australians have.

This continued investment in this program demonstrates the Government's commitment to assisting older Australians experiencing homelessness.

http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr12-mb-mb019.htm

## 4 WA's pioneer Indigenous mental health workers

**Western Australian Country Health Service (WACHS)**
Healthinfonet - News

Twenty Western Australian Indigenous people have enrolled in tertiary mental health courses following the success of two trail-blazing Indigenous mental health workers in the Pilbara.
Katie Papertalk and Yvette Kelly recently made history when they became the first Western Australian health service Indigenous graduates from Charles Sturt University in New South Wales (NSW) with a Bachelor of Health Science (Mental Health).

Mental Health Minister Helen Morton said Indigenous mental health was an emerging specialty which needed strong Indigenous input to be relevant to the people it helped.

'Both Ms Papertalk and Ms Kelly now hold high-level professional roles within the mental health service, which is having a significant impact on the creation and delivery of mental health services in the Pilbara,' Mrs Morton said.

The two women won scholarships through the WA Country Health Service (WACHS) Pilbara's *Indigenous employment program* (IEP), which is funded through a partnership between the State Government *Royalties for regions* program and the WA Chamber of Minerals and Energy's Pilbara Industry's Community Council.

Regional Development Minister Brendon Grylls said the women's achievements were a perfect example of empowerment through education.

'On a broader level, these women have inspired peers to follow their lead, creating an interest among Aboriginal people pursuing higher education opportunities to advance their knowledge and skill in Aboriginal mental health,' Mr Grylls said.

http://www.healthinfonet.ecu.edu.au/about/news/637

**5 Dual diagnosis: a challenge for the reformed NHS and for Public Health England**
**The extent and significance of dual diagnosis**

A large proportion of people in England with mental health problems have co-occurring problems with drug or alcohol misuse. Likewise poor mental health is commonplace in people who are dependent on or have problems with drugs and alcohol. And, for many people, mental ill health and substance misuse combine with a range of other needs including poor physical health, insecure housing and offending.

The 2002 Co-morbidity of Substance Misuse and Mental Illness Collaborative study or COSMIC1 concluded that:

- 75 per cent of users of drug services and 85 per cent of users of alcohol services were experiencing mental health problems;
- 30 per cent of the drug treatment population and over 50 per cent of those in treatment for alcohol problems had 'multiple morbidity';
- 38 per cent of drug users with a psychiatric disorder were receiving no treatment for their mental health problem;
- 44 per cent of mental health service users either reported drug use or were assessed to have used alcohol at hazardous or harmful levels in the past year.

A 2002 study in Bromley by Geraldine Strathdee2 and colleagues, found that:

- Dual diagnosis was present in 20 per cent of community mental health clients; 43 per cent of psychiatric in-patients; 56 per cent of people in secure services;
- The group identified as dually diagnosed had worse physical health, higher levels of personality disorder, greater levels of disability, greater risk profiles and lower quality of life than those who were not identified as having a dual diagnosis.

In addition, the Prison Reform Trust's 2010 Bromley Briefing reports that 75 per cent of all prisoners have a dual diagnosis.

**Where are we now?**
In 2002 the Department of Health published a Dual Diagnosis Good Practice Guide.4 It stipulated that mental health services were responsible for ensuring anyone with a severe mental health problem and a substance misuse problem were their responsibility and that

integrated care was the norm for this group. A number of guidance documents have since been published including a guide for the Management of Dual Diagnosis in Prisons (2009).

There has undoubtedly been real progress on this issue. However, support for people with a dual diagnosis, including those with a range of multiple needs, is still frequently inadequate. While the need for integrated support for people with concurrent mental health and drug or alcohol problems is widely understood, the reality is often very different:

- 'Drug Misuse and Dependence – UK Guidelines on Clinical Management' (2007) concluded that 'there is still a need for more collaborative planning, delivery and accountability of services for people with co-morbidity, including those with mild-to-moderate mental ill-health, early traumatic experiences and personality traits and disorders'. It expressed concern about lack of specified core competencies, inadequate assessment and co-ordination of services, and only limited progress on the development of integrated care.

- A CSIP 'Themed Review' on Dual Diagnosis (2008) found that four in 10 Local Implementation Teams had no agreed dual diagnosis strategy, less than two thirds had conducted a needs assessment and fewer than half had assessed training needs, with evidence of signficant regional variations (it also commented that local definitions tended to focus on people with severe mental health problems and stressed the need for those with 'less severe mental illness to be considered').

- Lord Bradley's review of people with mental health problems or learning difficulties in the criminal justice system concluded that 'despite the recognised high prevalence of dual diagnosis among offenders with mental health problems, services are not well organised to meet this need. In fact, services are currently organised in such a way as to positively disadvantage those needing to access services for both mental health and substance misuse/alcohol problems'.

An effective response to dual diagnosis is essential for the effective delivery of key policy objectives, including drug recovery, welfare reform and the 'rehabilitation revolution'. For example, the 2010 Drug Strategy recognises that one of the the key outcomes to the delivery of a successful recovery-orientated system is 'improvement in mental and physical health and wellbeing'.

While there is guidance and there are recognised pathways for accessing appropriate provision for those with severe mental health problems alongside substance misuse issues (what might be called 'classic' dual diagnosis) it is still a challenge to make these a reality on the ground.

For the larger number of individuals with less severe mental health conditions alongside substance misuse problems, however, provision is less developed and they may be particularly at risk from any fragmentation of service provision arising from the different commissioning arrangements for mental health and substance misuse services under the current reforms. It is important that the differing needs of both these groups are considered as the reform process develops.

There is now an increased focus on people with co-morbidity whose mental health problems are not at the most severe end of the spectrum which needs to be sustained whatever new commissioning arrangements emerge. For example, the Improving Access to Psychological Therapies programme (IAPT) has produced a 'Positive practice guide for working with people who use drugs and alcohol' (2012), in partnership with DrugScope and the National Treatment Agency.

At the same time, the current set of health reforms poses both threats and opportunities for people with dual diagnosis or multiple needs. This discussion paper examines these threats and opportunities and how they might be managed.

**Health reforms**

The Health and Social Care Bill sets out major changes to health, social services and public health as well as treatment services for people with drug and alcohol problems. These include:

The creation of a new public health system:

A national body, Public Health England, will be responsible for implementing national public health policy while Directors of Public Health will be moved from the NHS to upper tier local authorities. Both will be established in April 2012 in shadow form and take full responsibility for public health in April 2013.

The abolition of the National Treatment Agency as a separate body:

The remaining functions of the NTA will in future be the responsibility of Public Health England.

The emergence of GP-led commissioning in the NHS:

Primary care trusts (PCTs) will be replaced by clinical commissioning groups (CCGs) formed of groups of general practices along with representatives of other clinical groups covering a geographical area and responsible for commissioning the majority of specialist health services for their patients with representation from other clinical groups.

The creation of an NHS National Commissioning Board:

The board will take responsibility for holding CCGs to account for achieving improved outcomes for patients. It will also commission health services in prisons and some 'tertiary' services including high and possibly medium secure mental health care.

The development of Health and Wellbeing Boards:
Upper tier local authorities will be required to set up these new boards to coordinate local strategies for health and wellbeing and to join up NHS, public health and social care services for people of all ages.

Outcome measures and Payment by Results:
In mental health and substance misuse services alike, existing contractual arrangements between commissioners and providers are being replaced by new systems that base payments on the delivery of packages of care (in the case of mental health services) and on the outcomes services achieve for users (in the case of the drug and alcohol recovery pilots).

**Strategies**
In addition to these reforms, the Government has published strategies for mental health and for drug recovery and is in the process of developing an alcohol strategy. Achieving the objectives of these strategies will be contingent on how much influence they have over the wider reform processes.

The 2011 mental health strategy, No Health Without Mental Health, sets out six headline objectives including: more people will enjoy better mental health, and: more people with mental health problems will recover. The strategy is a cross-government document that aims to draw together a range of activities across departments to achieve the agreed objectives.

Similarly, the 2010 drug strategy, Reducing Demand, Restricting Supply, Building Recovery recognises the clear association between mental illness and drug dependence. It stresses the importance of mental health and substance misuse services working together in relation to prevention and early intervention as well as in treatment and recovery. As such, it illustrates the complexity of the relationship between mental health and substance misuse problems which ranges from the aetiology of disorders to recovery outcomes.

**Implications**
In combination, these reforms will have major implications for mental health and substance use services. Key issues include:

Directors of Public Health:
The creation of a new public health service, led by high profile local Directors of Public Health, has the potential to transform local drug and alcohol services as well as linking

promotion and prevention much more closely with treatment and care for substance use and mental health. There is, conversely, a risk that drug and alcohol services are not prioritised by Directors of Public Health given their broad responsibilities.

Joint commissioning:
If we are finally to offer people with a dual diagnosis integrated services, joint commissioning of mental health and drug or alcohol services needs to become the norm. The existing gap between services may continue or worsen unless arrangements are made to ensure that CCGs and local public health structures work together to commission services and ensure that all contracts with providers stipulate effective joint working and clear pathways to meet the needs of people with co-existing mental health and substance misuse problems.

Joined-up support will be particularly important within the justice system. Prison health care will be commissioned nationally through the Commissioning Board, as will some secure mental health services. It is vital that they develop effective partnerships with drug and alcohol services, especially within prisons and at transition points when people move into and out of custody.

Payment systems:
The Department of Health has developed a set of 'clusters' of NHS mental health service types in order to produce a tariff for introducing payment by results (PBR) for mental health based on best practice treatment provision. Similar developments are taking place in substance use services, with eight pilots testing a PBR approach to drug and alcohol recovery services, which is focused on outcomes rather than activities. Concerns have been expressed that the mental health cluster for dual diagnosis is too restrictive. Similarly, our understanding is that people with 'dual diagnosis' are explicitly excluded from the drug and alcohol recovery PBR pilots. If the two payment systems being developed do not combine fully or leave out significant groups of people, they will create barriers to better services rather than encouraging improved care for all.

**Ways forward**
Local leadership is vital to ensure people requiring support from more than one service get coordinated and consistent responses and appropriate priority from a range of agencies. Directors of Public Health are likely to be pivotal in this regard, especially given the pressure on many agencies' budgets which could affect people whose needs cross boundaries particularly hard.
Health and Wellbeing Boards should offer a forum for joining up local services and could coordinate the commissioning of services for people with multiple service needs (including for example supported housing, health and social care).

Robust outcome measures are vital to support the commissioning and provision of integrated support for the full range of people with a dual diagnosis. We need to develop meaningful and measurable outcome indicators that cross public sector silos and align different organisations to the same ends, achieving outcomes that matter to service users in a timely manner.

Payment by Results systems for alcohol, drug and mental health services need to be aligned carefully to ensure all groups of service users are included and that early intervention is promoted. Incentives will also be needed to encourage providers to work with people who have complex and multiple needs. A focus on recovery, quality of life and self-reported improvements in wellbeing may help to achieve this.

Pooled and community budgets also offer the potential to improve support for a wide range of people with dual diagnosis. Pooled budgeting has been an effective way of joining up health and social care services in some areas. Much of the focus on community budgets to date, meanwhile, has been on families with the most complex and entrenched needs. Both approaches could be developed further to offer improved support to a wider range of people, probably at lower overall cost and before emerging problems develop into a crisis.

Building on the momentum in prisons and the criminal justice system will improve health outcomes among offenders and reduce re-offending. The recommendations of Lord Bradley's review on diversion (2009) and Lord Patel's report on prison drug treatment (2010) provide guidance on the way forward. The role of 'offender health' within the emerging commissioning landscape creates opportunities for 'joined up' approaches, and for the identification of dual diagnosis as a strategic priority for this population. The Government has indicated an interest in looking at innovative community sentences for offenders with co-morbid substance misuse and mental health problems.

A shared vision of recovery could provide a narrative and a driver for integrated systems and approaches to service delivery. The 2010 Drug Strategy set out the Government's vision for a recovery-oriented drug and alcohol treatment system that is able to engage holistically to address the multiple needs of individual service users, including their mental health issues. Recovery is also growing in currency as an underlying principle for mental health services. In this context, recovery is focused on enabling people to take control of their lives, with or without the symptoms of mental illness, supported by professionals on their own terms. Developing a shared understanding of what recovery means for people with a dual diagnosis or complex needs may go some way to bringing services together more effectively in practice. In the USA, SAMSHA has developed just such a definition and a similar process could be valuable in the UK.

Workforce development has an important role to play in ensuring that both workforces are receiving the necessary training and support to work effectively and confidently with clients with co-occurring substance misuse and mental health problems. For example, the recent establishment of the independent Substance Misuse Skills Consortium provides an opportunity to improve awareness and training on mental health issues for workers in drug and alcohol services.

http://www.centreformentalhealth.org.uk/pdfs/dual_diagnosis.pdf

**6 Long-term conditions and mental health**

**Naylor et al**
**Centre for Mental Health – United Kingdom**
February 2012

**Key messages**

- Many people with long-term physical health conditions also have mental health problems. These can lead to significantly poorer health outcomes and reduced quality of life.
- Costs to the health care system are also significant – by interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem.

- This suggests that between 12 per cent and 18 per cent of all NHS expenditure on long-term conditions is linked to poor mental health and wellbeing – between £8 billion and £13 billion in England each year. The more conservative of these figures equates to around £1 in every £8 spent on long-term conditions.

- People with long-term conditions and co-morbid mental health problems disproportionately live in deprived areas and have access to fewer resources of all kinds. The interaction between co-morbidities and deprivation makes a significant contribution to generating and maintaining inequalities.

- Care for large numbers of people with long-term conditions could be improved by better integrating mental health support with primary care and chronic disease management programmes, with closer working between mental health specialists and other professionals.

- Collaborative care arrangements between primary care and mental health specialists can improve outcomes with no or limited additional net costs.

- Innovative forms of liaison psychiatry demonstrate that providing better support for co-morbid mental health needs can reduce physical health care costs in acute hospitals.

- Clinical commissioning groups should prioritise integrating mental and physical health care more closely as a key part of their strategies to improve quality and productivity in health care.

- Improved support for the emotional, behavioural and mental health aspects of physical illness could play an important role in helping the NHS to meet the Quality, Innovation, Productivity and Prevention (QIPP) challenge. This will require removal of policy barriers to integration, for example, through redesign of payment mechanisms.

The full publication can be found at the below link:

http://www.centreformentalhealth.org.uk/pdfs/cost_of_comorbidities.pdf

**7 Mental health problems trigger strongest prejudice, WHO report finds**
**World Health Organization**

**World Health Organization**
23 June 2011

Although one in four people will experience some sort of mental health problems during the course of their lives, users or ex-users of mental health services were found to be the most discriminated and stigmatized of all disabled people, often with deadly consequences. The World Health Organization (WHO) World Report on Disability, the first major publication of its kind, gave an important account of the plight of people with mental health problems all over the world. The WHO found (ex-) users of mental health services to have a lower life expectancy and more chronic health conditions than the general population. People with long term mental health problems were more likely to be obese and have heart disease, high blood pressure, respiratory disease, diabetes, strokes, or breast cancer. They were also more prone to developing chronic health conditions at a younger age, and to dying sooner after diagnosis.

http://whqlibdoc.who.int/publications/2011/9789240685215_eng.pdf

## 8 Training gurus from all over the world meet in Italy

**Mental Health Gap Action Program**
mhGAP newsletter
December 2011

The publication of WHO's mhGAP Intervention Guide in 2010 led to numerous requests for a training package to accompany the guide. WHO is currently doing just that. We realize that practical training material is essential if governments and NGOs are to scale up the care of people with mental, neurological and substance use (MNS) disorders in non-specialized health care.

Altogether, the Intervention Guide covers 11 MNS conditions such as epilepsy and depression. The first drafts of training materials that can be used by trainers for four of these conditions -- psychosis, depression, self-harm/suicide and epilepsy – were written in Ethiopia, Jordan and Zambia close to field conditions. In addition, training materials covering the entire Intervention Guide were reviewed by more than 100 experts in early 2011, and the material was pilot-tested in Ethiopia, Jordan, Panama, and Nigeria.

In close collaboration with WHO, the Italian NGO, Cittadinanza, organized a mhGAP meeting in Rimini, Italy, on capacity building in non-specialized mental health care in October 2011. Approximately 70 participants from all over the world representing governments, NGOs, academia and foundations attended. They discussed different aspects of capacity building, including training preparations, supervision, refresher training, training of trainers, and evaluating training. WHO has used some important comments made in Rimini to strengthen the training package and hopes to make it available for further field testing early next year. This will be a key step towards improving care and services for people with MNS disorders.

http://www.who.int/mental_health/mhgap/mhGAP_nl_december_2011.pdf

## 9 UndocuHealth – serving the needs of undocumented immigrants with mental health issues

**National Immigrant Youth Alliance – United States**
February 2012

UndocuHealth is a project of the National Immigrant Youth Alliance– an undocumented youth-LED network of grassroots organizations, campus-based student groups and individuals committed to achieving equality for all immigrant youth, regardless of their legal

status. As NIYA, we have been able to provide direct, one-on-one support to undocumented youth facing deportation. We have focused our efforts in empowering undocumented youth to be unafraid and unashamed, and accept themselves for who they really are. But despite our efforts, we know that there's more that needs to be done when are faced with an oppressive system that drives some of us to question whether or not our life is worth living the way it is. We stand together, in solidarity with those facing depression and other mental health issues that are a result of years of living in a society that tells us that our lives are not worth living, years of feeling like our dreams and life are slipping away.

The National Immigrant Youth Alliance declares January 31st as the National Undocumented Mental Health Day in memory of those whom we've lost to this oppressive system, those who have survived and continue to survive every day, especially Yanelli Hernandez Serrano.

http://undocuhealth.org/about/

**10 Improving safety in mental health**

**NHS Institute for Innovation and Improvement**

Like all other care sectors, mental health has its share of harmful events which could, or should, have been avoided.

Everyone involved in providing mental health services can help to reduce harm and improve patient safety. The vulnerable nature of many service users means mental health staff can play a particularly active and important role in safeguarding and improving safety.

The Safer Care team is dedicated to building an NHS where every member of staff has the passion, confidence and skills to eliminate harm to patients. We work with NHS Trusts in all sectors – including mental health – to help them build their capacity and capability for quality and safety improvement.

**The Leading Improvement in Patient Safety (LIPS) programme for mental health**
In partnership with mental health professionals, we have developed a version of the LIPS programme for mental health. It has the same aims and outcomes as the acclaimed acute LIPS programme but has been designed to meet the specific needs of the mental health sector. It includes specific examples drawn for clinical practice in mental health, together with tailored measurement tools.

As there are relatively few mental health NHS Trusts, delivering this programme to groups of trusts on a regional basis would produce shared learning and greater cost effectiveness.

**Who is Mental Health LIPS for?**

The programme is geared to safety improvement at all levels within organisations. It is aimed at senior medical and nursing staff, including directors, chief executives and their board-level colleagues and patient safety leaders. Effective leadership and championing of safety improvement from the most senior levels in the organisation is crucial for effective improvement projects to work. This is why we make securing that level of involvement in the LIPS programme a condition of participation.

**What does the programme involve?**

The programme is delivered in three modules over a total of seven days. A mix of teaching, group discussions, reflection and practical exercises is led by experts from the NHS Institute.

The programme elements are:

**Module one - Getting Started (two days)**

- Understanding the causes of harm to patients
- How to use targeted case note review to measure your harm rate
- Understanding why we reliably fail
- Human factors in patient safety
- Using driver diagrams to plan an improvement project
- The Model for Improvement and small scale tests of change
- Measurement for improvement
- Improving culture, teamwork and communication

**Module two - Executive Quality and Safety Academy (EQSA) - running concurrently with Getting Started: (two days)**

Designed to increase your executive team capacity to lead organisational improvement. Leave with a detailed plan to improve safety in your trust. Webinar to review progress and submit aims

**Module three - Core Module (three days)**

- Understand more about reliability; human factors, driver diagrams and how they apply to improvement within patient safety issues in mental health.
- An opportunity to present learning and outcomes to your Chief Executives

**Targeted Case Note Review**

A tool has been developed to measure rates of patient harm in mental health. A development group, which included senior staff from NHS Mental Health Trusts, worked with us to develop this tool. It produces an accurate measure of harm identified from case

notes and provides opportunities to learn from such events. The tool is specific to mental health settings and does not rely on reporting culture. Once improvement initiatives are put in place, the tool allows organisations to track progress over time.

In order to use find out more and use the targeted case note review tool and its associated portal, you will need to register to use the Trigger Tools portal. Click here to complete registration.

For more information about the LIPS programme for mental health – including pricing and how to apply – please email: safer.care@institute.nhs.uk

http://www.institute.nhs.uk/safer_care/general/improving_safety_in_mental_health.html

# Ongoing - Mental Health Carers Forum

If you are a carer and would like to talk with other mental health carers about issues of concern to you please complete the form at:

http://www.mhca.org.au/carerform/index.php

*The email is sent every week and contains items which may interest mental health consumers, carers and service providers and which otherwise they may not be able to access Thank you for subscribing to this MH email if you wish to unsubscribe please contact rachelle.irving@mhca.org.au* Rachelle Irving, Director, Projects & Research, Mental Health Council of Australia.

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www.mhca.org.au