Ontario Mental Health and Addictions Strategy

Strengthening the Workforce Theme Group Paper

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Preface

The Challenge

Every year, one in every five Ontarians will develop a mental illness or addiction, and one in 10 will have a serious problem with gambling.

Most will have relatively mild symptoms that pass with time, a change in their situation or treatment. However, two to three of every 100 Ontarians will cope with a serious or complex mental illness or addiction throughout their lives[1].

Although many dedicated people work hard to provide mental health and addiction service, the current system is fragmented. People with a mental illness and/or addiction often struggle to find the services they need when they need them.

> Mental illnesses and addictions are serious health problems that cause great hardship for too many Ontarians and their families and friends.

Ontario's Response

There is no health without mental health. In 2008, the Government of Ontario made a commitment to strengthen mental health and addiction services – and to develop a comprehensive 10-year mental health and addiction strategy that would lead to better services for Ontarians. To fulfill that commitment, the Government established an Advisory Group of people with lived experience with mental illness and addictions, family members, service providers and researchers.

The Advisory Group identified five priorities or themes that would help make a real difference in the lives of people with mental illnesses and addictions:

1. Early identification and intervention
2. Consumer partnerships
3. System design
4. Strengthening the workforce
5. Healthy communities

The Advisory Group organized working groups to review the literature and discuss each theme. The working groups developed draft theme papers that explored the key issues and challenges as well as strategic priorities and opportunities. Theme group members looked for best practices, and for ideas to transform mental health and addiction services to meet needs. The draft theme papers were used to develop a consultation paper -- *Every Door is the Right Door* – which set out a proposed vision, mission, goals, and principles to guide for Ontario's mental health and addiction strategy (see next page).

The consultation paper was released at the provincial Summit on Mental Health and Addictions in July 2009, and individuals and organizations were invited to respond. Between September and December 2009, a series of roundtables were held with key groups across the province. The theme working groups used the feedback from the consultation paper and the roundtables to refine their reports. This paper is one in a series of five theme group papers. It focuses on Strengthening the Workforce.

[1] Kessler (1999); Ruggeri *et al* (2000)

Overarching Vision, Goals and Principles for Ontario's 10-Year Mental Health and Addiction Strategy

Vision

Every Ontarian enjoys good health and well-being, and Ontarians with mild to complex mental illness and/or addiction live and participate in welcoming, supportive communities

Goals

- Improve health and well-being for all Ontarians.
- Reduce incidence of mental illnesses and addictions.
- Identify mental illnesses and addictions early and intervene appropriately.
- Provide high quality, effective, integrated, culturally competent, person-directed services and supports for Ontarians with mild to complex symptoms of mental illnesses and/or addictions and their families.

Mission

Every door can be the right door for Ontarians with mental illnesses and addictions.

All doors in the mental health and addiction system and the broader health, children and youth, education, social services, housing, seniors services, settlement services and justice systems lead to integrated, accessible, person-directed services and supports.

Services focus on the hopes and needs of people with mental illness and/or addictions, and engage them in their own health

Principles

Respect. People with lived experience of a mental illness and/or addiction are valued and respected members of their communities. They are treated with dignity and have access to the information they need to make informed decisions about their own treatment and services. They are active members of their treatment and support team. Health and social services are provided in the environment the individual considers to be the least restrictive, intrusive and stigmatizing. Communities and services are proactively engaged in activities designed to eliminate stigma and discrimination.

Diversity. Individuals are offered culturally competent services that meet the needs of a diverse population at all ages and stages of life.

Partnership and Collaboration. People with lived experience are essential partners in system design, policy development, and program and service provision. People with lived experience, families, family organizations, service providers, governments, and the community collaborate to raise awareness about mental health and addiction services and improve knowledge about mental illnesses and addictions. All levels of government and services collaborate to provide seamless, integrated, equitably funded care – and make every door the right door.

Healthy Development, Hope and Recovery. Individuals using mental health and addiction services feel hope and optimism about the future. They have real choice in the services they use, and a variety of options close to where they live. They receive the least intrusive services possible in the least intrusive setting, as well as flexible, individualized supports that involve their families, significant others, and communities when desired. They have opportunities for healthy development and recovery.

Harm Reduction. Individuals are supported regardless of where they are in their journey to reduce the health, economic, and social harms associated with mental illnesses, problematic substance use and harmful gambling.

Excellence and Innovation. The mental health and addiction systems strive for excellence and encourages best practices and innovation. It provides an effective, efficient continuum of high quality care that is evidence- based and results-oriented.

Determinants of Health and Well-being. Mental and physical health and wellbeing is more than just the state of one's health. In addition to caring for mind and body, the system works to reduce or eliminate the underlying individual and social factors that contribute to mental illness and addiction.

Acknowledgements

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Executive Summary

The mental health and addiction workforce is a key component to moving forward in achieving quality, client directed mental health and addiction systems. In order for positive transformation to occur in the mental health and addiction systems, there must be the workforce capacity and capability to respond to system needs. The members of the Strengthening the Workforce theme group recognize that properly placed and trained human resources are critical to the success of the entire strategy and to that end members did volunteer to continue working on moving the strategy to action.

There are several key strategic initiatives underway that provide opportunities for improving the mental health and addiction workforce. For instance, HealthForceOntario, the government's long-term health human resources strategy, has funded a number of innovative projects including the Health Professions Database which is working to collect evidence about Ontario's regulated health professionals to support sound health human resources planning *(see Appendix 3: HealthForceOntario Initiatives).* In addition, the Mental Health Commission of Canada also provides another opportunity through its national anti-stigma and discrimination reduction campaign. Health care workers are one of two specific groups targeted for the first year of the campaign. As well, the Canadian Centre on Substance Abuse (CCSA) has identified behavioural competencies that people working in the addictions field should demonstrate in the workplace from novice to expert skill levels.

This paper identifies three goals for strengthening the mental health and addiction workforce. The first goal is to ensure a competent workforce to enable the delivery of quality mental health and addiction treatment, support and services. A key approach to effective, quality workforce development is that it be 'competency based'. Competency frameworks articulate expectations of capability to perform a particular task and help ensure that individuals holding a specific type of position have the same basic ability. 'Cultural competency' should be a key element of a competent workforce. However, developing a set of competencies is not sufficient. To be effectively implemented, clear objectives, a strong champion, stakeholder involvement and support are all critical to success. They must also be linked to incentives for compliance, e.g. funding or performance evaluation and a process for periodic evaluation and updating.

It is also critical that the existing mental health and addiction workforce be fully supported in maintaining and enhancing current knowledge and skills through ongoing staff development and continuing education. Two areas where continuing education has been identified as priorities are concurrent disorders and peer support.

The second goal is to ensure that at a minimum, the broader health system, the education system, community and social services and the justice system have core mental health and addiction competencies within which to provide their services to persons with lived experience in an equitable and non-stigmatizing manner. This is a necessary condition for the equitable treatment and full participation of persons with lived experience in community life. It should also contribute to improved early identification and intervention for people living with mental illness and addictions which can have a profound impact on health and well being.

The provision of quality and competent care for mental illness and addiction at the primary care level is especially important to the health care of persons with lived experience. Most moderate mental illness or addiction is treated through the primary care system. Persons with lived experience are also more satisfied with their physical and mental health care being integrated in a primary care setting.

However, research suggests that there is a need for improvement in the delivery of mental health and addictions care within the primary care sector. This includes improving access to physical health care as people with serious mental illness are likely to die 25-30 years earlier than people without mental illness.

The third goal is to improve the mental health and addiction sectors as a career choice. With the aging of Ontario's health system workforce, the already serious difficulty in recruiting and retaining mental health and addiction workers will likely become worse. High turnover rates within the sectors and difficulty recruiting affects access to and quality of services as well as burnout amongst existing workers. While there are a number of contributing factors such as the prevalence of stigma and geographical challenges, success in improving workforce recruitment and retention will require a comprehensive response to structural inequities in the current remuneration system. However, any policy action to create a more competitive and equitable remuneration system within the mental health and addictions sectors will need to consider the implications for the broader health system. In order to address this concern, the government's long-term policy objective should be to ensure competitive and equitable remuneration across the health human resources system.

Strategies to improve recruitment and retention within the mental health and addictions sectors should also focus on improving cultural diversity within the workforce. This should help improve the low rates of access to mental health and addiction services by individuals within Aboriginal and other minority groups. In order to achieve this, current obstacles to greater workforce cultural diversity must be addressed such as barriers within the educational system and the stigma associated with working in the sector.

1. Introduction

1.1 A Note on Language

Debate continues with respect to mental illness and addictions surrounding the use of language, as there are currently no universally accepted terminologies. It is recognized that terms are interpreted differently and as such, the usage of the terms within this document serve the purpose of providing meaning to the paper itself and are intended for use only within the context of the paper. They are not intended as recommendations for broader application outside the context of this document. Please refer to the Glossary (Appendix 1) for working definitions of terms as they are used in this document.

1.2 Provincial Health Workforce Strategy

- **HealthForceOntario: the government's long-term health human resources strategy**

HealthForceOntario is the province's long-term strategy to ensure that Ontarians have access to the right number and mix of qualified health care providers, now and in the future. There are four key components of HealthForceOntario:

1. Identifying and addressing Ontario's health human resource needs by examining population needs and health professional supply.
2. Engaging partners in education and healthcare to develop skilled, knowledgeable providers and create the healthcare delivery teams that will make the most of the providers' abilities.
3. Introducing new and expanded roles to increase the number of providers working in healthcare and build on the skills of those already in the system.
4. Making Ontario the employer-of-choice for all health care providers.

The Ministry of Health and Long-Term Care and the Ministry of Training, Colleges and Universities are delivering on the HealthForceOntario strategy in partnership with the province's health care consumers and providers. While the strategy is not specifically targeted to any sector, many of the initiatives such as fostering and building inter-professional teams do provide potential opportunities to help address current workforce issues within the mental health and addictions systems (*for more* details see *Appendix 3: Initiatives under the HealthForceOntario Strategy).*

- **Regulation of the Profession of Psychotherapy under the *Regulated Health Professions Act*, *1991***

As part of the HealthForceOntario strategy, in the future Ontario will be regulating the titles "psychotherapist" and "registered mental health therapists". *The Health System Improvements Act, 2007*, which was given Royal Assent in June, 2007, regulates psychotherapy as a regulated health profession in Ontario through the creation of the *Psychotherapy Act*, *2007*. The legislation will require individuals who deliver psychotherapy services and call themselves "psychotherapists" or "registered mental health therapists" to register with a health regulatory college, the College of Psychotherapists and Registered Mental Health Therapists of Ontario, and to be accountable to this governing body for the services they provide.

It is estimated that more than 4,000 psychotherapists practice in Ontario today. There is a wide spectrum of individuals who provide psychotherapy services. It ranges from professionals who are members of existing regulatory colleges (i.e., psychologists and psychiatrists) to unregulated individuals with little to no formal training. There are no consistent standards for psychotherapy training programs in the province. As a result, Ontarians who receive psychotherapy treatment have no reliable way of knowing whether the individual providing these services have the appropriate competencies and training required for safe practice.

Regulating psychotherapy provides assurances of high standards of care and enhanced public protection for Ontarians who receive psychotherapy services. The College of Psychotherapists and Registered Mental Health Therapists of Ontario will be responsible for setting registration requirements, making practice standards, policies and guidelines for the profession, establishing quality assurance programs to promote the continuing competence of members, and implementing complaints and discipline processes to ensure that members are accountable for providing health care in a safe, competent and ethical manner.

2.0 Key Issues and Challenges:

- **Changing Paradigm within Mental Health and Addictions System**

Over the last fifteen years there has been a growing change in perspective with regard to mental illness and addictions with far reaching implications for workforce education, training and delivery. In the mental health sector, there have been calls for a "fundamental transformation of how mental health care is delivered."[2] There is emerging consensus that mental health treatment, supports and services should be based on a recovery philosophy. In the addictions sector there has been a systematic reorganization of treatment services to create a broader continuum of community-based treatment options, along with an evolving awareness that people seeking addiction treatment have high rates of co-occurring health and social problems, including mental illness. Both sectors recognize that it is in the domains of primary and community health and social services that identification and early intervention regarding addiction and mental health problems needs take place,

[2] New Freedom Commission on Mental Health (2003)

along with the provision of continuing care and support. This carries with it the need to engage, support and collaborate with community and primary care service providers.[3]

At a system level, a mental health system guided by a recovery philosophy must have policies and procedures in place to increase the possibility of recovery occurring—for both the system itself and for persons with lived experience. At a workforce level, this requires a shift in values, attitudes and workplace functions, including:

- believing in the ability of all people to achieve recovery and wellbeing;
- learning to work in partnership, supporting people to implement their own plans;
- recognizing the role of family, friends and the community in recovery; and
- developing and implementing best practices related to all dimensions of recovery.[4]

A similar substantive transformation has occurred in the field of addiction treatment. Harm reduction provides an integrating philosophy that offers abstinence, moderation and substitution therapies for people who seek assistance, and outreach and risk management services for people who have not benefited from or are not willing to attend treatments for which they are eligible. There is strong evidence that a comprehensive harm reduction approach greatly reduces morbidity and mortality due to risky health behaviours, such as those associated with overdose and infectious disease, while providing interventions for people who elect to participate in treatment, either though self-direction or mandated, as in drug treatment courts or employee assistance programming.[5]

Many workers in the sectors support the shift to both recovery and harm reduction but are not trained in these approaches. There also exists no standard definition of both terms or clarification of how both philosophies may be compatible and integrated into system design and workforce development. For instance, there remain many mental health and addiction programs where having a concurrent disorder limits access to services. Furthermore, functional roles and responsibilities as well as post-secondary and continuing education have often not evolved to reflect these current approaches.[6] Other jurisdictions such as Australia and New Zealand are well ahead of Ontario in this respect.

- **A Workforce Development Approach is needed**

The demands placed on mental health and addiction workers are increasingly challenging. These include:

- an increase in complexity of clients' needs;
- a rapidly expanding knowledge base of increasing technical sophistication combined with often insufficient funding and resources for continuing education and training;
- insufficient workforce/treatment capacity to meet demand especially in rural and remote communities, often contributing to high workloads and levels of stress / burnout;
- stigma, discrimination and misunderstanding of the nature of mental illness and addictions and their resolution, both within the health system and the general public;
- often a lack of recognition or respect of competency through life experience; and
- systemic barriers to working at full scope of practice.

As suggested by the scope of challenges listed above, a worker's ability to respond effectively to mental health and addiction issues extends beyond their own skills, capacities and motivation. To effectively address these challenges, a 'whole systems approach' is required, often referred to as 'workforce development'.

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3 Ontario Substance Abuse Bureau (1999); Kirby, Michael (2006)
4 Silvestri & Hallwright (2001)
5 Amundsen EJ. (2006)
6 MTCU Roundtable (2009)

The traditional approach to workforce planning has been to assess workforce supply against future workforce demand and then address any gap between the two through education and training. By contrast, workforce development is a multi-faceted approach which addresses the range of factors impacting on the ability of the mental health and addiction workforce to function with maximum effectiveness.[7] The optimal impact of workforce development requires the simultaneous implementation of strategies across multiple levels and settings. For instance, for the addiction system, workforce development initiatives would ideally encompass workers in both specialized treatment agencies and agencies that provide counselling to people with problematic substance abuse among more general caseloads.[8]

Application of strategies in isolation is likely to be of limited impact.[9] Workforce development requires a shift away from approaching in isolation the inter-related challenges facing the mental health and addictions workforce. In its broadest sense, it focuses on how each part of the system that influences entry to and exit from the mental health and addiction sector interacts with the other, including: education, training, skills, attitudes, rewards and the associated infrastructure to support practice as well as linkages with other health sectors including primary care.[10]

Other jurisdictions including Australia, New Zealand and England have adapted a workforce development approach to their mental health and addiction sector. In the United States, the Substance Abuse and Mental Health Services Administration (SAMHSA) identified workforce development as a program priority on its "SAMHSA Priorities: Programs and Principles Matrix".[11]

- **Lack of Comprehensive Data on Mental Health and Addiction Workforce**

It is critical that there be accurate data on service needs and preferences of persons with lived experience and on the workforce composition, including demographics, education and employment, to build a workforce framework that addresses short-term to long-term requirements for the sector. One of the challenges on building the evidence-base for the mental health and addiction sector is that the majority of the workforce is unregulated and community-based, which leads to difficulty in obtaining data that is consistent and comparable for workforce planning. Partnership and collaboration between ministries, LHINs and health service providers is required to address these challenges.

There exists a lack of reliable data on the current mental health and addiction workforce. Some of the key data gaps include:

- What are the supply, mix and geographic distribution of the sector workforce?
- What is their demographic, education and employment profile?
- What type of service does the workforce provide and how much?
- What is the rate of turnover within the sector?

The sectors are very diverse. They include unregulated workers in functions such as counselling, peer support and housing support as well as regulated health professionals such as psychiatrists, occupational therapists, social workers, paediatricians, psychologists, pharmacists, family physicians and nurses. The workforce also extends beyond the specialized mental health and addictions system to include persons who require at minimum a basic understanding of mental illness and addictions in order to perform their responsibilities effectively, including police officers, security guards, teachers, guidance counsellors, personal support workers, refugee settlement workers, employment

[7] Skinner *et al* (2005).

[8] Ogborne, A.C., & Graves, G. (2005)

[9] IBID.

[10] NZ Health Funding Authority (2000)

[11] Whitter (2006)

counsellors, College and University student counsellors, casino hospitality workers and corrections workers.

The difficulty in collecting reliable workforce data is compounded by the absence of a standardized list of service provider occupations and a generalized list of duties for each occupation. If one examines the unregulated community mental health and addiction sectors in Ontario there are many job titles used for the same occupation (i.e. different titles, same duties) as well as the same title being used to describe two different occupations (i.e. same title, different duties). There also exist multiple official titles such as "mental health worker/addictions counsellor". With such blurring of duties and titles, it then becomes difficult to measure what occupations are in the sector, what are their specific functions, and how many individuals fill each occupation. There is also a large volunteer contingency in the sector which is an important element of the workforce but about which data is sparse.

Since the early 1990's Ontario has employed people with lived experience in both mental health and addiction services. This includes independent consumer survivor initiatives, as well as the hiring of peer support workers on assertive community treatment teams. A review (Consumer Survivor Initiatives In Ontario: Building For An Equitable Future 2009)[12] has recently been completed for the Ministry which proposes the development of equitable funding and human resource strategies for peer run organizations and the Mental Health Commission is funding a study (Making the Case for Peer Support) looking at how to embed peer support in mental health systems across the country.

As well as the fact that there exists no central source for data collection for unregulated care providers and volunteers, the workforce provides service in a variety of different locations beyond hospitals and community mental health and addiction agencies, including private clinics, long-term care homes, primary care settings and community health centres. For example, methadone maintenance treatment in Canada is overwhelmingly delivered through physicians' offices and pharmacies. Diversity in locations provides challenges for a consistent and standardized data collection process. There is also very little data collected on the salary and benefits within the workforce and variations within the sector and comparable to other sectors such as acute care services.

There are a number of initiatives underway that will help improve the availability of accurate and reliable data on the mental health and addiction workforces. For instance:

- The Human Resources Information Systems (HRIS) Community Mental Health and Addictions Project, funded by MOHLTC will be implementing a human resources and payroll software solution for participating community mental health and addiction health service providers across Ontario. This software will allow for efficient and consistent community mental health and addiction human resources data collection and reporting to both the MOHLTC and to LHINs.

- The Ontario Ministry of Health and Long-Term Care is also pursuing a Health Professions Database that will collect comprehensive workforce information on 20 regulated health professions including psychologists, occupational therapists and speech-language pathologists. The database will provide information on their work (among others) in the mental health and addictions sector.

- The Ontario Ministry of Economic Development and Trade are also conducting a Wage and Benefit Survey to fill some of the gaps that presently exist in sub-provincial occupational data.

- The Ontario Hospital Association, HealthCare Provider Labour Market Survey (2007) released in fall, 2009 also provides a useful inventory of mental health and addictions workers working in hospital settings as well as data on their vacancy and turnover rates.

[12] O'Hagan *et al* (2009)

However, while these initiatives will help in developing an informed analysis of the mental health and addictions workforces, additional information is required for comprehensive workforce development. For instance, reliable data on discrepancies in wages and benefits within the sectors, e.g. between hospital based and community based programs.

3.0 Goals:

Three goals were identified for strengthening the mental health and addictions workforce:

1. Ensure a competent workforce to enable the delivery of quality mental health and addiction treatment, supports and services.
2. Expand workforce development beyond the specialized mental health and addiction systems.
3. Ensure the mental health and addictions systems have the human resources capacity to meet increasing demands.

Below is a discussion for each goal of the strategic priorities, key strategic opportunities, and examples of promising practice.

Goal 1: Ensure a Competent Workforce to Enable the Delivery of Quality Mental Health and Addictions Treatment, Supports and Services

Strategic Priorities

1. Develop a competency-based mental health and addictions workforce

- Background - What are competencies?

Competencies are specific combinations of measurable knowledge, skills and attitudes needed to effectively perform a particular function or role.[13] A competency serves as a human resource tool that puts the focus on worker behaviors. Successful completion of most work tasks requires simultaneous or sequenced demonstration of multiple competencies. For the mental health and addiction systems, possessing certain underlying attitudes reflective of person centred care, strong inter-personal skills, technical skills and knowledge are all necessary competencies.

- Purpose of Competencies to Workforce Planning and Development

Competency-based approaches to training, assessment, and staff development are increasingly viewed as a central strategy for improving the effectiveness of those who provide health care.[14] Competencies have the potential to improve the quality of service and service outcomes by shaping education, training and evaluation of workers and ensuring a standard level of competency across all service providers.[15]

Some of the common applications of competency frameworks include:

- provide a guide for development or enhancement of education and training curricula;
- enhance quality within the field by supporting the adoption of evidence informed practice;

[13] Knowledge may include awareness, information, or understanding about facts, rules, principles, guidelines, concepts, theories or processes needed to successfully perform a task. The knowledge may be concrete, specific and easily measurable or more complex, abstract and difficult to assess. Knowledge is acquired through learning and experience (Marrelli, 2001; Mirabile, 2005). A skill is a capacity to perform mental or physical tasks with a specified outcome. As with knowledge, skills can range from highly concrete and easily identifiable tasks, such as completing a checklist during an assessment interview, to those that are less tangible and more abstract, such as managing a program evaluation process (Lucia & Lepsinger, 1999).

[14] Marrelli *et al* (2005)

[15] Pautler, K., & Mahood, E. (2004)

- provide guidance to employers for human resources planning and recruitment, including development of performance appraisals, personal development plans and design of career pathways; and
- support performance evaluation, and strategic workforce planning.

Competency frameworks articulate expectations of capability to perform a particular task and help ensure that individuals holding a specific type of position have the same basic ability. Evolving job roles due to new models of delivering care, new professions and new modes of health care delivery mean that a given person's pre-employment training profile may over time not fully match the current competency profile required by their new role. Furthermore, job-titles are not standardized nor are the duties consistent among jobs with similar titles. Therefore, using competencies as the basis for planning is more accurate and helpful than using, for example, occupational classifications.

However, it is important to note that core competency requirements for specific functions or roles should be designed to provide enough flexibility that the workforce is not discouraged from adopting innovative new practices. Core competencies must also be flexible enough to reflect the specific cultural or regional environment in which the program or service is being provided. They should also value competencies specific to different service provider groups, recognizing the value added by specialized knowledge and expertise and the collaborative integration of diverse perspectives on mental health and well-being in the workforce. Finally, it needs to be recognized that competencies must align with the regulated scope of practice required by both regulated and unregulated health care professionals as well as system level principles, goals, and functional requirements.

A competency based workforce environment should help enable mental health and addiction workers to function at their full scope of practice and ability. This in turn should help improve recruitment and retention within the sector. A competency framework can also support the development of clear career paths and provide guidance for health service providers in workforce recruitment, training and performance evaluation.

The development and implementation of comprehensive competency models requires considerable investment of expertise and time. In their absence however, planning will continue to be done on the basis of apparent trends and is vulnerable to multiple interpretations and diverse understanding of the future workforce requirements, ultimately impacting upon system performance and client outcomes.

- **Existing Competency Models**

Many jurisdictions, including Canada have developed competency frameworks for the mental health and addictions sector, for example:

- *Core Competencies for Canada's Substance Abuse Field* (Canadian Centre of Substance Abuse, 2007)
    - provides a set of core competencies for the field of substance abuse in Canada
- Psychiatric Rehabilitation Practitioner Certification (PSR Canada)
- *Let's Get Real: Real skills for people working in mental health and addictions* (New Zealand Ministry of Health, 2008)
- *Recovery Competencies for New Zealand Mental Health Workers* (New Zealand Mental Health Commission, 2001)
    - describe the competencies mental health workers need to acquire when using a recovery approach in their work
- *The Ten Essential Shared Capabilities: A Framework for the Whole of the Mental Health Workforce* (United Kingdom National Institute for Mental Health England and the Sainsbury Centre for Mental Health, 2004)

    - state the core curricula requirements for professional and non-professionally affiliated mental health workers and what should be embedded in continuing professional development training
- *The Competency Assessment Instrument (*U.S. Center for Health Care Strategies, 2003) measures 15 competencies needed to provide high quality care for those with severe and persistent mental illness

There also exist sets of competencies developed for a particular type of mental health or addictions worker. For example:

- *Registered Psychiatric Nurses: Competency Profile for the Profession in Canada* (Registered Psychiatric Nurses of Canada; 2002)
- *Core Competencies Project for Wellness & Primary Health Care Providers* (National Indian & Inuit Community Health Representatives Organization, 2007)
    - identify core competencies for the proposed new classification of Aboriginal health worker called Wellness & Primary Health Care Provider
- *A Route to Enhanced Competence for Primary Care Mental Health Workers in Relation to People with Mild to Moderate Mental Health Needs* (NHS Education for Scotland, 2004)
- *Competency Standards For Occupational Therapists In Mental Health* (Australia, 1999)
- *Ohio's Core Competencies for Early Childhood Mental Health Professionals* (Ohio Department of Mental Health, 2009)
- *Developing Core Competencies for Working with Women & Girls in Behavioral Health* (SAMHSA Advisory Council on Women's Services, 2009)
- *Psychiatric-Mental Health Nurse Practitioner Competencies* (U.S. National Organization of Nurse Practitioner Faculties, 2003)
- Peer Specialist Certification training (U.S.)
    - provided by 13 states in the United States in 2006. Learning is competency based. Those who pass are Certified Peer Support Specialists

In addition to being applied for particular worker classifications, competency frameworks have also been established for particular treatment, supports or services, often included within broader workforce strategies or standards. For example:

- *Addiction Counseling Competencies* (SAMHSA, U.S.; 2006)
- *Competencies for Substance Abuse Treatment Clinical Supervisors* (SAMHSA, U.S. 2007)
- *Enhancing Concurrent Disorders Knowledge in Ontario* (CAMH, 2004)
- *Ontario Withdrawal Management Standards* (Addictions Ontario, 2008)
- *Levels of Practice for Supporting Individuals with Dual Diagnosis* (Dual Diagnosis Implementation Committee of Toronto, 2003)

- **Process for Developing a Competency Framework**

Marelli et al (2005) recommended a seven-step process for developing competency frameworks:

Table 1: Recommended Process for Developing Competency Frameworks[16]
Step 1: Define the objectives (e.g. establish the unit of analysis and how the competency model will be applied)
Step 2: Obtain the support of a sponsor, who must have influence and jurisdiction over the relevant professions
Step 3: Develop and implement a communication and education plan for each stakeholder group.
Step 4: Plan the methodology. This includes selecting individuals who will contribute data for the project and selecting data collection methods (at least two different

[16] Marelli *et al* 2005

methods should be used).
Step 5: Identify the competencies and create the competency model. This involves reviewing job definitions, identifying competencies by conducting a content analysis, and assembling the model by clustering similar knowledge, skills, abilities, and personal characteristics together. The model should then be reviewed by experts, and behavioral examples should be developed for each competency at three or more levels of proficiency.
Step 6: Apply the competency model in strategic workforce planning, selection of employees, training and development, performance management, succession planning, rewards and recognition, and compensation.
Step 7: Evaluate and update the competency model. It is important to establishing the link between a competency and the desired outcome in order to validate the competencies and to ensure they constitute more than the opinions of experts or common practices.

The process used for developing a competency framework for the mental health and addiction systems is both critical and challenging. Competency development tends to start with the establishment of a steering committee or expert advisory group or work group. To identify competencies, common techniques in use include: literature reviews, environmental scans of existing frameworks, focus groups, and key informant interviews. A key part of most existing competency framework methodologies is consultation with many different types of stakeholders, including people with lived experience, carers, managers, academics, professional organizations and regulatory bodies, and practitioners from multiple professions. The process should be grounded in day-to-day practice, transparency and teamwork models. Special attention should be paid to the descriptions used and the terminologies developed to ensure clarity and consistency across health professions. Effective partnering is critical among mental health and addiction health service providers, government stakeholders, and educational institutions. The competency framework should also be linked to evidence based practice to improve client outcomes and enable innovative new approaches to be adapted.

Developing a set of competencies is not sufficient. To be effectively implemented, clear objectives, a strong champion, stakeholder involvement and support are all critical to success. There must also be set in place the necessary infrastructure to support the competency approach. Incentives for compliance will be needed e.g. through funding or performance evaluation of health service providers. Similarly, providers will need to tool/retool their workforce approaches to support competency development linking these directly to employee compensation and reward processes.[17] The current workforce will also require ongoing training in this new approach. There must also be a process for periodic evaluation and updating of competencies.

In terms of implementation plans, some competency frameworks set out short-term (6-12 months), medium-term (12-19 months), and/or long-term (2-4 years) implementation goals.[18] Other frameworks do not mention specific implementation goals or plans but suggest ways in which the standards could or should be used to enhance education, training, assessment and accreditation.[19] Two national competency frameworks explicitly call for the existing framework being used to be revised in the future.[20]

- **Canadian Centre on Substance Abuse – Workforce Competencies**

[17] Higgins (2004)
[18] NMHWDC (1999), NZ Ministry of Health (2008), NMHETAG (2002)
[19] SCMH (2001), Ford *et al* (1999), O'Hagan (2001), NHS Education for Scotland (2004)
[20] CCSA (2007), NMHWDC (1999)

The Canadian Centre on Substance Abuse (CCSA) workforce competencies are a promising practice that may be regarded as both a model and a baseline standard for further development of mental health and addictions workforce competencies in Ontario. Building on a 2004 Canadian addiction workforce survey that highlighted the need for national standards and competencies for the specialized workforce, the CCSA initiated a collaborative project to identity key technical and behavioural competencies. Seven job clusters were identified: health promotion, support and outreach, counselling, withdrawal management, supervision, administration support, and senior management.

The technical competencies were outlined in 2007 as:

1. Case management
2. Community development
3. Conflict management
4. Counselling
5. Crisis intervention
6. Diversity and cultural responsiveness
7. Ethics and professionalism
8. Family and social support
9. Group facilitation
10. Mental health
11. Outreach
12. Pharmacology
13. Prevention and health promotion
14. Program development, implementation and evaluation
15. Screening and assessment
16. Teamwork
17. Treatment planning
18. Understanding substance use, abuse and dependency

In 2009, the following behavioural competencies were identified:

1. Adaptability/flexibility
2. Analytical thinking and decision making
3. Client-centred change
4. Client service orientation
5. Collaboration and network building
6. Continuous learning
7. Creativity and innovation
8. Developing others
9. Diversity and cultural responsiveness
10. Effective communication
11. Ethical conduct and professionalism
12. Interpersonal rapport/savvy
13. Leadership
14. Planning and organizing
15. Self care
16. Self management
17. Self motivation and drive
18. Teamwork and cooperation

Interview tools and performance management tools were also created as part of the behavioural competencies project to assist organizations to align its work, its job descriptions and the needed competencies with effective means to interview candidates and manage staff performance. The interview and performance management tools align with the 7 job clusters. There are also interview and performance management guides.

Each competency, both technical and behavioural, is defined and four levels of proficiency established for each competency:

- Foundational
- Basic
- Intermediate
- Advanced

This scaled model is based on the understanding that some roles may require a higher level of demonstration of competency, depending on the type of work being performed. Therefore, it may be acceptable for certain roles to require demonstration of a competency at Foundational level, while

other roles may require the demonstration of the same competency at an Intermediate or Advanced level.

As well, the Canadian Centre for Substance Abuse designed this scaled approach to enable the competencies to have application to persons working outside the specialized substance abuse field but who have some work-related connection to individuals or communities affected by substance abuse issues and so would likely be required to demonstrate only some of these competencies. For instance, it could apply to school guidance counsellors, public health nurses, emergency physicians, police officers, etc.

- **Lessons Learned from Other Jurisdictions:**

The success thus far of other jurisdictions such as New Zealand, Australia and the United Kingdom in the adaptation of mental health and addiction competency frameworks has been mixed.

Process
Understanding of the purpose for which competencies will be used is needed from the outset. Other jurisdictions have been criticized for having a lack of consumer and family involvement in the process of identifying and assessing competencies.[21] In addition, obtaining profession and stakeholder buy-in can be difficult. Meaningful involvement by key stakeholders including professional bodies and people with lived experience must be included and time must be spent up front in developing consensus around the process and the objectives in competency development. It is critical for participants to put a face to the process, to be listened to and to develop a sense of ownership. However, involving key stakeholders in the process is a necessary but not sufficient condition to ensure successful adoption of competencies by health service providers or educators. For instance, stakeholders were involved and key groups did endorse the Addiction Counseling Competencies developed by SAMHSA in the United States but this did not lead to changes in practice[22].

Content
The lived experiences of consumers and family members, along with the values, principles and strategic priorities for the sector, need to be brought together with diverse biological, psychological and social models of mental health, mental illness and addiction so that rather than from knowledge about brain and biological and/or psychodynamic theories of causation, etc., critical areas of divisiveness across professions can be avoided. Descriptions of competencies need to take into account the social environments and cultural contexts in which mental health and addiction treatment and services are delivered, rather than focus strictly on the behaviours or activities carried out. The test of behavioural competencies is their positive impact on the particular individuals who are intended to benefit from services and supports.

Competencies need to be designed for continuing relevance, and need to also to pass the test of emerging evidence and evolving knowledge about treatment practices and approaches. Mechanisms for review and for quality improvement need to be inherent to a competency based workforce

Implementation
As mentioned above, a competency based workforce system is widely regarded as a critical element to develop an effective workforce strategy. However, incomplete or absent implementation of competency frameworks is common. Significant challenges have been encountered with integration of competencies and standards into mental health and substance abuse training and education in New Zealand, Australia, and Canada.[23] For instance, a study in 2008 of the curriculum of Canada's 33

[21] Hoge *et al (* 2005a), Hoge *at al* (2005b)
[22] Hoge *et al* (2005b)
[23] Mulvale (2004), Graves *et al* (2008)

Faculties and Schools of Social Work noted that only 1/3rd of courses match the 18 core competencies outlined in the Canadian Centre on Substance Abuse report '*Core Competencies for Canada's Substance Abuse Field.*[24]

A review of US competency frameworks noted that many have not been adopted or incorporated by training programs, licensing agencies, and certification boards and therefore, have had limited impact on the field.[25] Furthermore, even when in use for education and training, competency frameworks in the UK, Australia, and New Zealand have historically not moved beyond this for use in workforce planning and recruitment.[26] For a competency framework to go beyond training, it must be linked to compensation and performance evaluation mechanisms.[27] For instance, a weakness of the U.K. Capable Practitioner Framework (2001) is that while it provided direction for training and education programs, it was not linked to workforce planning, the pay system or occupational standards.[28]

New Zealand established the *Health Practitioners Competence Assurance Act 2003* specifically to ensure adherence to standard competencies among health care professionals. The Act includes mandatory ongoing competency requirements, competency-based practising certificates, and stronger accountability of regulated mental health and addiction workers.[29] They have also set up Te Pau to work with their providers on service development and workforce training.

1.1. Foster a culturally competent mental health and addiction workforce

"Cultural competency" as defined in this report pertains to the following human rights protected groups: age, ability, citizenship, status, faith, family status, gender identity, language, race, sexual orientation and socio-economic status. Organizations need to be able to support and incorporate cultural diversity into their service delivery to clients. Research suggests improved health outcomes when professionals are able to understand and interpret behaviours according to their patients' cultural frame of reference.[30]

Ontario is one of the most ethnically diverse places in the world. Approximately 28 percent of the population was born in other countries and thousands of new immigrants arrive each year. Furthermore, many who identify themselves as belonging to minority groups are Canadians who are 1st or 2nd generation immigrants.[31] Research suggests that ethno-cultural groups need mental health and addiction services as much or more than those of the mainstream population but they access existing programs less frequently.[32] Furthermore within ethno-cultural groups there are some who are further marginalised for instance through homelessness, having a physical disability or by being lesbian, bisexual, gay, transsexual or transgendered.[33]

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[24] Graves, *et al* (2008)
[25] Hoge et al (2005b)
[26] Mulvale, G. (2004)
[27] IBID
[28] IBID
[29] New Zealand Ministry of Health (2005)
[30] Minore, B *et al* (2007)
[31] Mental Health Commission of Canada Task Group on Diversity (2009)
[32] Canadian Women's Health Network (2006)
[33] Toronto-Peel Mental Health Implementation Task Force (2002)

There has been extensive research and development of cultural competencies for the mental health and addictions sectors. For example:

- *Embracing Cultural Competence in the Mental Health and Addiction System* (Ontario Federation of Community Mental Health and Addiction Programs, 2009)
- Environmental scan of cultural competency strategies: mental health and addiction services (Ontario Central LHIN Diversity Project)
- Understanding the issues, best practice and options for service development to meet the needs of ethno-cultural groups, immigrants, refugees, and racialized groups (*Mental Health Commission of Canada Task Group on Diversity, 2009)*
- *Pacific Mental Health and Addiction Cultural & Clinical Competencies Framework. (*The National Centre of Mental Health Research and Workforce Development. New Zealand, 2007).
- Best Practices in Developing Anti-Oppressive, Culturally Competent Supportive Housing (Canada Mortgage and Housing Corporation, 2007)

Research in the United States found significant stigma and discrimination among health care professionals providing mental health and addiction services towards their client group. Similar research results have been found in Canada.[34] Staff should be knowledgeable about cultural differences and their impact on behaviours and attitudes and should respond to them in a sensitive, understanding, respectful, and non-judgmental manner.[35] For example, mental health and addictions workers providing supports and services to Aboriginal communities should be knowledgeable about language and traditional customs and how to take these into account in delivering care. The incorporation of holistic approaches in their plans of care is especially important to First Nations people, because these reflect and respect their beliefs.[36]

It is important to note that whereas stigma is related to a pervasive set of beliefs that people hold, individuals and institutions have a legal obligation under the *Ontario Human Right's Code* not to engage in discrimination, and can be held accountable for discriminatory acts. In addition, people with mental health issues have recourse, for example, through applications at the Ontario Human Rights Tribunal to enforce their rights.[37]

Research suggests that strategic program partnerships and collaborations are important in developing cultural competency for the mental health and addictions workforce. It is also important to embed cultural competency within organizational policies, practices, systems and structures to support the development of a culturally competent organization.[38] A recent literature review of evidence informed practices in mental health service system policy and programs suggests three potential interventions to effectively support the development of culturally competent practices: the development of appropriate linguistic services, the provision of intercultural staff training and education, and racial and ethnic concordance. [39]

- **Mental Health Commission of Canada Anti-Stigma Campaign**

The Mental Health Commission of Canada is launching a national 10-year anti-stigma and discrimination reduction campaign. In the first year, the Commission has chosen to target two specific groups: youth and health care workers. The Commission notes that health care workers have been chosen as a priority because anecdotal information says people who seek help with mental health

[34] Ping Tsao, Carol *et al* (2008)
[35] Ontario Federation of Community Mental Health and Addiction Programs (2009)
[36] Minore et al (2007)
[37] Ontario Human Rights Commission (2009)
[38] Lui *et al* (2008)
[39] Macfarlane *et al* (2009)

problems often feel disrespected and discriminated against by health care workers.[40] The Commission further comments that:

- training in mental health remains neglected in medical schools across the country;
- people with mental health issues who go to emergency rooms at general hospitals for help get pushed to the back of the queue. Physical ailments take precedence because they are perceived as being more urgent;
- mental health care providers anecdotally say they also experience their own form of stigma. This is a 'courtesy stigma' due to the diminished status mental health care providers are assigned by peers. This can negatively impact morale, recruitment and retention of mental health personnel.[41]

Anecdotal evidence suggests that these issues are just as applicable to the addiction sector.

The Commission is developing an integrated social marketing approach to address stigma among health care workers. It will also conduct benchmark surveys at the outset that will help target behaviours, attitudes and readiness for change. This benchmark will allow the program's impact to be measured over time

1.2 Need to Support On-Going Continuing Education within the Workforce

Given the scarcity of human resources within the sector, it is imperative that the existing mental health and addictions workforce be fully supported in maintaining current knowledge and skills to provide consistent quality delivery of treatment, supports and services. Ongoing staff development and training are pivotal and necessary processes to the delivery of current, evidence-based programs and services and ultimately to ensure the application of critical competencies in practice. Present barriers limiting the application of continuing training and education need to be addressed, including lack of resources within the sector for continuing training and education. The following two areas have been identified as areas particularly requiring attention for broad continuing education initiatives in the field:

- Need for Continuing Education on Concurrent Disorders

Research suggests approximately 53% of those with problematic substance abuse will have a mental health disorder at some point in their lives while approximately 30% of those with a mental disorder also have problematic substance abuse.[42] Furthermore, about half of individuals in Ontario with gambling problems also have substance abuse and/or psychiatric functioning issues.[43] Due to the prevalence of people with concurrent disorders there is a high need for workers with the competencies to provide treatment, supports and services to this complex and challenging client group.

The Health Canada Report *Concurrent Disorders Best Practices* (2001) notes that professional training, experiential knowledge and perspectives differ between mental health and substance use systems.[44] This is to some extent a result of differences in roles and responsibilities between the two systems. However, some barriers between the two systems are a result of the separate training and education in the two fields. Continuing education can play a key role in bringing the systems together (i.e., in coordinating and communicating across the systems).[45] To be successful, it should be customized to the unique needs of the workers in these programs. In addition, mechanisms are

[40] Mental Health Commission of Canada (2008)
[41] IBID.
[42] Skinner W, *et al* (2008)
[43] MOHLTC (2009b)
[44] Health Canada (2002)
[45] Skinner W., *et al*. (2008)

needed to share information and lessons learned, provide access to training and ensure that the information learned is sustainable. Other important elements include strong leadership, team-specific training, program-specific needs assessment, requirement for mandatory training, and a multi-modal training design.[46]

The concurrent disorders knowledge exchange plan in 2004 was developed by the Centre for Addiction and Mental Health (CAMH) to improve the application of research-based knowledge on concurrent disorders in assessment, screening, stigma, treatment, family support, system planning and program modelling.[47] Under this plan, a Training Strategy Project was struck in 2003 to identify concurrent disorders training issues and make recommendations for an Ontario-wide training system. Suggested training solutions included the following:[48]

- cross training between experts from different agencies;
- shared training between agencies;
- ongoing consultation from a multi-disciplinary team of experts;
- running workshops;
- using Internet technology;
- training the trainer; and
- producing practice guidebooks for consistency in care

- Need for Peer Support Training

Persons with lived experience and peer workers often need specific training and mentorship to be effective and competent in their roles and in some cases, with (re)integration to the workforce. [49] Research suggests that credible training which is consistent with the role is an important common element to successful peer support initiatives.[50] Peer support training is also needed outside of the specialized mental health and addictions sectors, for instance in the corrections system. An evaluation of peer support programs in Canadian women's prisons based on in-depth interviews of staff, peers and prisoners found that peer support was especially useful to prisoners with mental health problems.[51]

In 2008, the Ontario Peer Development Initiative received a Trillium foundation grant to develop a toolkit for peer support training with the aim of training 200 consumers/survivors and ten trainers in the province.[52] On-going funding needs to be found for this training.

Provincial training for peer support has been integrated into some mental health and addictions programs. For instance, the Ontario Assertive Community Treatment Team Association provides training for Peer Support Specialists working in Assertive Community Treatment (ACT) teams. Training manuals have also been developed for harm reduction training for peer support workers, e.g. *Harm Reduction Training Protocols for Staff, Volunteers, and Community Agencies* prepared by the Superior Points Harm Reduction Program, Thunder Bay District Health Unit. Similarly, the Toronto Harm Reduction Task Force developed a Peer Support training manual. The South Riverdale Community Health Centre and the Canadian Harm Reduction Network also offer training for peer support workers.

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[46] IBID
[47] Centre for Addiction and Mental Health (2004)
[48] IBID
[49] Mason (2006)
[50] Macfarlane *et al* (2009)
[51] Syed and Blanchette (2000)
[52] O'Hagan, Mary, et al (2009)

In general, peer support training needs to be reflective of the local setting. For instance, rural and remote areas will have different training requirements than large urban settings. The training should also be designed to help enable a variety of career pathways throughout the mental health and addictions systems. If offered at University or Community college level, the program should be designed for 'ladder training' e.g. so the 'credit' could be applied to other programs such as the "Mental Health Worker" program offered by Community Colleges. Programs offered at the University and College level also need to identify and address any funding, technological or other accommodation barriers that may prevent persons with lived experience from successfully completing or even enrolling in a program.

Key Strategic Opportunities

1. Define and establish within the next two years a set of core standard workforce competencies (as defined in this report)[53] for the Ontario mental health and addiction sectors in partnership with key stakeholders including: persons with lived experience, the mental health and addiction workforce, regulatory colleges/professions, college and university sector, other ministries and LHINs.

   The competency framework will use a scaled model to indicate different levels of proficiency for a particular competency, similar to the Canadian Centre of Substance Abuse report *Core Competencies for Canada's Substance Abuse Field*. The competencies would apply to both regulated and unregulated workers, including that provided by peer support workers and volunteers. The scope would also include development of culturally competent practices and leadership competencies.

   Objectives of the framework will include:
   - enhancing provision of quality care that is client directed and based on recovery and harm reduction philosophies;
   - support development of reliable, consistent workforce data for future planning of strategies to address current and future system capacity pressures;
   - fostering a diverse and culturally competent workforce;
   - fostering leadership development and implementation of evidence based workforce practices;
   - development of qualification pathways (i.e. career paths/laddering) especially for non-professionally affiliated workers such as peer support workers;
   - informing development of learning outcomes and curriculum within the College and University sector; and
   - assisting in the development of a fair and equitable remuneration system across the mental health and addiction systems.

   The competency framework will be developed through MOHLTC leading an external implementation work group that includes persons with lived experience and family members, service providers, academic experts, professional regulatory bodies, and LHIN representation.

   The external work group's mandate will be to coordinate and implement the transition to a competency-based workforce system. Key components will include:
   - development of a scaled model of core competencies within the mental health and addictions systems;
   - development of a change management strategy and accountability/assurance process for transition to a competency based workforce approach; including working with key partners to educate and apply the competency framework within all aspects of workforce training, development and evaluation;

[53] Competencies are defined as "specific combinations of measurable knowledge, skills and attitudes needed to effectively perform a particular function or role".

- a comprehensive evaluation strategy to review incorporation of competencies within the workforce as well as the education system and accountability and remuneration systems to inform strategic planning and policy development

2. Identify within the next two years current competency frameworks and related education programs including continuing education to determine both gaps and initiatives that can be built upon to expand core competencies within the mental health and addiction workforce.

3. Develop strategies to support ongoing continuing education and competency development in relation to harm reduction and recovery-oriented service provision, including:
   a. develop and fund resources and continuing education to continue improving cultural competency within the sector
   b. support through funding and training innovative training methods including teleconferences, communities of practice, webcasts, and multi-media recordings.

Examples of Promising Practices:

As mentioned earlier, the report Core Competencies for Canada's Substance Abuse Field (Canadian Centre on Substance Abuse, 2007) is regarded as a promising practice. Below is a brief sample of other promising practices within the strategic priorities for this goal.

Strategic Priority #1: Develop a competency-based mental health and addictions workforce

- **Certified Psychiatric Rehabilitation Practitioner credential (CPRP)**

The Certified Psychiatric Rehabilitation Practitioner credential (CPRP) is a test-based certification that fosters the growth of a qualified, ethical, and culturally diverse psychiatric rehabilitation workforce through enforcement of a practitioner code of ethics. Currently there are CPRPs with a variety of backgrounds from psychiatry to occupational therapists to peer specialists, social workers to case workers- they all share a commitment to the fundamental principle that recovery from serious mental illness is possible. There are hundreds of CPRPs throughout Canada who maintain their certification through ongoing professional development.

Strategic priority 1.1: Foster a diverse and culturally competent mental health and addiction workforce

- **Alliance for Non-Profit Management Cultural Competency Award (USA)**

The Alliance for Non-profit Management (USA) is a national organization of service providers, consultants, and non-profit organizations interested in strategy and operations issues in the not-for-profit sector. At its annual conference the Alliance honours an individual, non-profit organization, foundation or grantmaker who have distinguished themselves through their outstanding commitment to diversity and ensuring "best practices" in cultural competency to the non-profit sector and/or the population it serves. This award is based on nominations submitted to the Alliance Cultural Competency Advisor Group.

Strategic priority 1.2: Need to Support On-Going Continuing Education within the Workforce

- **New York State Health Workforce Retraining Initiative**

Under the *Health Care Reform Act* the Health Workforce Retraining Initiative provides funding to train health care workers to meet the needs of a changing health care environment. In 2002, seven of nine sponsors that applied for support for training addiction workers received a total of $3 million. Such funding paid for testing and assessment, tuition and instruction, staff replacement costs, and other educational costs for a contract period of two or more years.

- **Seniors Health Research Transfer Network (SHRTN)**

SHRTN is a Province-wide Knowledge Exchange Network of people involved in seniors' health care. SHRTN provides innovative training and education related to mental health and addictions including the use of webinars, enabling distance learning opportunities for rural and remote communities.

Goal 2: Expand Workforce Development Beyond the Specialized Mental Health and Addiction systems

Strategic Priorities

1. Ensure core mental health and addiction competencies within the broader health system and the education, community social services and justice systems

To enable the full participation of individuals with mental illness and addictions in their communities, equitable, respectful and competent service delivery from a wide variety of workers within the broader health system, the education system, community social services and the justice system is required. Examples of the need for core mental health and addiction competencies across our service systems include:

- **Justice System:**

The police are often the first responders in situations where there is a mental health crisis. A survey in 2007 of 27 of the 37 municipal forces (73%), and the OPP reported over 40,000 encounters with persons experiencing mental health problems,[54] almost 12,000 suicide-related calls and over 16,000 *Mental Health Act* apprehensions. [55]

In the Justice system, there has been considerable work done to educate service providers including first responders on mental health and addictions issues. However there remains a need for more training in this area. For instance, 84% of police forces surveyed in 2008 provide basic training for front-line officers on diversion but within forces providing this training only 59% of front-line officers have received it.[56]

Mental illness and addictions are highly prevalent within the corrections system. Estimates of the prevalence of mental illness among provincial inmates average 27.6% (current) to 34.6% (lifetime). Inmates who have a mental disorder are more likely to have lived in a foster home and to have experienced physical or sexual abuse as children and/or as an adult.[57] Estimates of the prevalence of substance abuse range from 29% to 90% of inmates.[58] A 1995 study reported that 85.9% of admissions to the Vancouver Pre-trial Services Centre in British Columbia received a substance use disorder diagnosis.[59] The prevalence of serious mental disorders among inmates is on average 2.5 times greater than in the general public; substance abuse is on average 8 times higher.

Historically, there has been a general lack of systematic staff education and professional training available on mental illness and addictions. A British Columbia study notes that correctional officers view mentally disordered offenders as being more difficult to work with than other inmates and feel the need for additional training in identifying and managing them.[60] Research suggests that many roles

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[54] Police records use the term "emotionally disturbed person"

[55] Durbin, Janet *et al* (2009)

[54.] IBID

[57] Brown, Gregory (2009)

[58] IBID.

[59] Roesch (1995)

[60] Somers, Julian et al (2008)

and duties that have traditionally been reserved for clinicians can and should be performed by correctional staff as well as mental health professionals.[61] For instance, it has been suggested that correctional officers who are in frequent contact with inmates should be capable of detecting early signs of mental health problems, to assist the offender with his or her immediate concerns, and to refer these problems to mental health professionals as appropriate.[62] As mentioned earlier in this report, an evaluation of peer support programs in Canadian women's prisons found that the program was especially useful to prisoners with mental health problems.[63]

The Correctional Service of Canada (CSC) has created an overall mental health strategy, which includes a commitment to provide mental health awareness training to all staff. The CSC delivers two-day mental health awareness training to front line staff at selected parole offices and community correctional centres. As of March 31, 2009 , more than 1,000 staff have received training.[64]

- **Social Services**

Settlement service providers are often the first point of contact for newcomers seeking support for a mental health or addiction issue. Language and cultural differences and other challenges newcomers face such as separation from established social support networks can prevent them from seeking and receiving effective help from the health system. However, settlement agencies often lack both the resource capacity and training to recognize symptoms of mental illness and addiction and navigate the system on behalf of their clients.[65]

- **Post-Secondary Education System**

A 2004 survey of Canadian Colleges and Universities found that mental health (anxiety, depression) was the most frequent health issue/challenge identified by both students and Student Services Administrators.[66] Anecdotal information suggests that problematic substance abuse is also a significant challenge. For instance, at one Ontario College 70 of 100 Aboriginal students attending on a scholarship program dropped out. Upon investigation, it was discovered that 65% dropped out because of problematic substance abuse.[67] There is need for more opportunities to train faculty on mental illness and addictions, such as the 'mental health first aid' training offered by some Colleges and Universities to faculty and staff.[68] The Mental Health Commission has the Canadian license for mental health first aid.

- **Community Health Services**

As a further example, research suggests that women with substance use problems often make initial contact with services other than the specialized substance abuse treatment services. They may visit their doctor or other primary health-care worker for routine health care, seek counselling services for family or mental health problems, seek specialized medical services such as prenatal or gynaecological care or come to the attention of child-welfare authorities or the criminal justice system. Training staff in these settings to routinely screen for substance use problems, and referring or briefly

[61] Dvoskin and Spiers (2004)
[62] Ogloff. et al (2004)
[63] Syed and Blanchette 2000
[64] Correctional Services of Canada (2010)
[65] Ontario Ministry of Citizenship and Immigration (2009)
[66] Adlaf, Edward et al (2005)
[67] MTCU Roundtable (2009)
[68] IBID

intervening when problems are identified can contribute to improved outcome, particularly if intervention occurs at an earlier stage of problem use.[69]

Inadequate mental health and addictions training and education within the broader health system, the education system, community social services and the justice system contributes to the prevalence of stigma and discrimination within service delivery. It also results in inefficient use of community mental health and addiction workforce resources as the sector tries to address the service gaps for their clients through developing a parallel set of community services such as social-recreational activities. Perhaps the most significant consequence is that individuals who experience mental health issues are at high risk for losing access to important community environments and resources fundamental to full citizenship.

Community mental health and addiction health service providers must often devote considerable resources to advocate for their clients to receive access to services they are fully entitled to. For instance, over 80% of clients with a mental disorder have their first application for Ontario Disability Support (ODSP) rejected. As a result, mental health service providers are often required to devote scarce resources to advocating for ODSP on their client's behalf and assisting them through the application process. In short, mental health and addiction care providers are often overstretching themselves assisting consumers with issues related to other non-health related fields such as justice, income, education and housing.

There is a need for policies that cut across ministry boundaries, allowing for co-ordination between various human service systems, and in the case of Aboriginal clients, between the federal and provincial levels of government. A key requirement to achieve improved service co-ordination is that people working within the health, education, social services and criminal justice systems need to have a core set of competencies to equitably service people with mental illness or addiction. This should be incorporated into their training and evaluation. This could have a substantial impact in improving the quality of life for persons with lived experience by not only improving access to community services but also through reducing stigma/discrimination through improved understanding within their communities of mental disorders and addiction.

The *Accessibility for Ontarians with Disabilities Act, 2005* is meant to address these very concerns. The *Act* states that Ontario is to be accessible and barrier free for people with disabilities by 2025. This explicitly includes people with disabilities emerging in the context of mental illness. The public sector, including hospitals and schools must comply with customer service standards for accessibility by January 1, 2010. The *Act* requires that policies, practices and procedures be consistent with the following three principles:

i. The goods or services must be provided in a manner that respects the dignity and independence of persons with disabilities;

ii. The provision of goods or services to persons with disabilities and others must be integrated unless an alternate measure is necessary, whether temporarily or on a permanent basis, to enable a person with a disability to obtain, use or benefit from the goods or services;

iii. Persons with disabilities must be given an opportunity equal to that given to others to obtain, use and benefit from the goods or services.

These requirements provide further impetus for the development and implementation of a core set of competencies on mental health and addictions for the broader health, education, social services and criminal justice systems.

[69] United Nations Office On Drugs And Crime (2004)

2. Promote and better enable collaborative care between mental health and addiction sectors and the primary care sector

Collaborative practice between mental health and addiction sectors and primary care is important from a variety of perspectives. While primary care can occur through a broad range of community sites and with a wide range of health service providers most people's health care starts with their family doctor, and if recovery is supported, can return to the domain of the family doctor. Ensuring appropriate training and supports are in place for health care practitioners working in primary care to provide mental health and addiction care will not only assist with early intervention and screening but will create a safe and supportive environment for people to seek treatment.

Research suggests that in Ontario almost 90% of persons with moderate mental health problems rely solely on primary care services for all of their health needs.[70] However, only 40% of individuals experiencing depression received mental health treatment or referrals from their family doctors.[71] Problem gambling and substance abuse are also often undetected within primary care settings.

Some groups are especially disadvantaged in accessing mental health or addiction treatment, support and services through primary care. For instance, children and youth with anxiety or mood disorders are often not assessed and referred for specialist treatment unless their disorder is accompanied by behavioural problems.[72] Research suggests that older adults with substance use, mental health and gambling problems are often left untreated,[73] one of the key reasons being primary care providers' inability to identify persons at risk.[74] Newcomers to Canada and Aboriginal peoples also experience difficulty obtaining proper assessment and treatment of mental illness in primary care settings, due to cultural and language barriers.[75]

Less than 5 percent of persons in Ontario using addictions services are referred from a primary care physician; almost half (46%) of people self-referred in 2008/09.[76] Anecdotal research suggests that family physicians may often be discouraged from completing the time-consuming assessment referral process because of the long wait times to access addiction treatment services.[77] However, it has been noted that primary care providers are well positioned to help initiate the needed behavioural changes by taking more visible roles in prevention, early intervention, and referral.[78]

Access to family physicians is also often a challenge for persons with a mental illness or addiction. In addition, research suggests physical health issues in people with serious mental illness are often missed when symptoms are attributed to mental health problems.[79] A possible contributing factor is that health professionals from a wide range of occupations have been found to have prejudices and negative attitudes towards people with mental illness.[80] Similarly, stigma by physicians towards persons with addictions has also been noted in research as a concern.[81]

There are many different forms and levels of collaboration and integration of primary care with mental health and addictions treatment, support and services such as:

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[70] Parikh, Lin, & Lesage (1997)
[71] Wang, Langille, & Patten (2003)
[72] Wren, Scholle, Heo, & Comer (2003)
[73] CAMH (2009)
[74] Mackenzie *et al* (1999)
[75] Sadavoy *et al* (2004); Kirmayer *et al* (2000)
[76] CAMH, DATIS (2009a)
[77] OMA Roundtable (2009)
[78] Tami L. Mark, et al (2009)
[79] CMHA Ontario (2009a)
[80] Ping Tsao,Carol, *et al*, (2008)
[81] Leschner (2000, CAMH (1999)

- addition of primary care workers to community mental health teams,
- outpatient clinics that operate mental health and addictions treatment within health centres,
- attached mental health and addiction workers in primary care settings, and
- the consultation model (where primary care teams are provided with advice and skills from specialist mental health and addiction health service providers)[82]

In rural and northern communities multidisciplinary primary health care teams are being used to provide services for people with mental health needs due to a lack of psychiatric care.[83] In many rural communities, innovative collaborations have emerged in the face of limited health human resources to draw on a broader range of knowledge and skills, which include social service agencies, law enforcement, religious groups and the educational system.[84] However, the lack of health human resources also serves as a barrier to effective collaboration.[85]

Much work related to collaborative mental health and primary care has been accomplished through focused federal initiatives such as the Canadian Collaborative Mental Health Initiative and this work can be built upon to advance practice in Ontario. Key elements that seem to be contributing factors to effective implementation of collaborative primary care models include: integration of multiple disciplines, integration with primary health care, co-location of services, supportive systems, funding arrangements, clinical relationships, client centeredness, patient education, and provider skills and education.[86] Enabling and supportive work structures are also important.

There is wide evidence in support of the integration of mental health and addiction care in primary care settings:[87]

- primary health care settings are the predominant locus of treatment for problems that are clearly psychological or psychiatric in nature, such as depression and anxiety;
- people are more satisfied with their physical and mental health care being integrated in a primary care setting;
- primary health care is a better fit with the typical way a majority of people present their undifferentiated mental health problems; with this better fit, there is increased adherence to treatment regimes and better health outcomes;
- many studies report positive patient outcomes associated with the use of collaborative mental health care. Improvements were seen in overall symptoms, depression and anxiety free days, and adherence to medication and treatment plans. Some studies found quicker time to diagnosis and increases in patient satisfaction;
- family physicians with access to collaborative care also reported greater knowledge, better skills, and more comfort in managing psychiatric disorders and greater satisfaction with mental health services;
- training primary-care providers and networking and linking with health and social service providers can help in the identification and referral process of women with substance use problems. It also helps to ensure that these clients can access the services they require;[88]
- the range of mental health and addiction needs that present in primary care settings exceed the capacity and skills of even well-trained primary care physicians and referral out is a poor alternative because many people do not present at the next level of care;

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[82] MOHLTC (2009)
[83] Minore, B., *et al*, (2005)
[84] IBID
[85] IBID
[86] MOHLTC (2009)
[87] IBID
[88] United Nations Office On Drugs And Crime (2004)

- over the long-term integrated care appears to be a break-even or cost-saving approach: costs associated with increased client loads in the primary care system are offset by reductions in the number of referrals to specialists.

Since April 2005, 150 family health teams have been created in Ontario. Fifty more are being planned. The Ministry of Health and Long-Term Care has recognized that mental health and addiction treatment, supports and services are important aspects of primary care and the Family Health Networks (FHNs) and Family Health Groups (FHGs) receive funding specifically to address the extra time required for these patients.

However, ministry initiatives to promote collaborative care, such as inclusion of mental health and addictions workers with family health teams, have had poor results to date. Currently, only 28 of the 150 family health teams employ a mental health or addiction worker. Key barriers preventing greater collaboration of primary care with mental health and addictions include: lack of comprehensive legislation and policy, insufficient remuneration, undefined scopes of practice, uncertain liability, the absence of inter-professional education and challenges facing peer support models.[89]

Other common challenges with collaborative care identified from international research are that the new roles often lack the opportunity for career progression and development and there is a lack of clarity of specific duties and responsibilities.[90]

The structure of some community mental health teams may also constrain the ability of practitioners to develop and deliver services that address the range of community living issues faced by the individuals they serve.[91] It is also important to ensure that collaborative models such as family health teams result in an improved integration of community service delivery and avoid simply creating another 'service silo'. A further challenge is that up to five years may be required before a multi-disciplinary team is fully staffed and functional.

Many disciplines are also not being used to their full potential in primary care settings. For instance, it has been suggested that primary care could benefit from using psychologists in primary care beyond providing counselling.[92] For example, their role could be expanded to include:

- consultation for complex cases;
- early identification and intervention;
- making a diagnosis which enables them to explain to patients what treatment options are available and work collaboratively with clients;
- suggesting treatment options for counsellors and social workers; and
- making linkages with appropriate providers.

Other jurisdictions including the United Kingdom, New Zealand and Australia are directly addressing primary mental health and addictions care in the larger context of mental health and addictions care reform. For instance, Australia and the United Kingdom have introduced specific funding initiatives for psychologists providing treatment for individuals seen in primary care.[93] The United Kingdom has also introduced the new role of *mental health worker* to help manage the interface with specialists, and to provide brief counselling to clients. The position of *community development worker* was also created with the role of assisting primary care settings in facilitating access to mental health care, especially

[89] Bosco (2005)
[90] MOHLTC (2009)
[91] Horgan (2007); Krupa *et al* (2004)
[92] Vines, Robert et al (2004)
[93] Thames Valley Family Practice Research Unit (2009)

for minority group members, and to help ensure that services respond to cultural and linguistic needs.[94]

In the United States, the National Institute on Drug Abuse launched a primary-care initiative to address training issues. It includes a physician outreach initiative to involve primary health-care providers in the early recognition, assessment, and intervention with substance-abusing adolescents and their families.[95]

Key Strategic Opportunities:

1. As part of the development within the next two years of a scaled model of core standard workforce competencies *(see Key Strategic Opportunities, Goal 1)* include a set of 'base' competencies with respect to mental health and addictions applicable to persons working outside the specialized mental health and addictions fields but who have some work-related connection to individuals or communities affected by mental health or substance abuse issues.
2. Based on a set of core standard workforce competencies (*see recommendation 1*), develop and implement continuing education initiatives to help workers within the broader community health system and the education, community social services and justice systems in their interactions with people experiencing mental health and addiction issues.
   - e.g. continuing education initiatives could be developed for settlement workers, College and University faculty, the justice system, Unions and Professional Associations
   - the objective would be to help ensure these sectors have at minimum a core set of mental health and addiction competencies and also to improve collaboration with the mental health and addiction sectors
   - initiatives would include expanding continuing education on how to identify signs and symptoms of mental illness and addictions; understanding the mental health and addictions system so that referrals can be made; cultural competency; and on how to address stigma;
   - a knowledge exchange portal would be developed within the next two years to provide continuing education support and exchange of information regarding 'lessons learned' and successful continuing education initiatives
3. Promote and expand upon evidence based programs for the training of primary care physicians about identification, assessment and treatment of mental health and addictions issues
   - e.g. such as the Collaborative Mental Health Care Network provided by the Ontario College of Family Physicians
4. Promote innovative mentoring programs for workers within the mental health and addictions sectors:
   - e.g. such as the Medical Monitoring for Addiction and Pain (MMAP) Network Program developed in collaboration between the College of Physicians and Surgeons of Ontario, the Ontario College of Family Physicians and the MOHLTC.
5. Review current policies and incentives in place to encourage mental health and addictions workers within family health teams in Ontario and establish specific targets to increase representation of mental health and addictions workers within family health teams.
   a. Expand opportunities within the next two years to embed primary care workers in mental health and addictions service delivery settings and vice versa (mental health and addictions workers in primary care settings)

[94] Department of Health (2005)

[95] United Nations Office On Drugs And *Crime (* 2004)

Examples of Promising Practices

There exist many promising practices in place to expand workforce development beyond the specialized mental health and addictions systems. Some of these have already been referenced in the paper, such as 'mental health first aid' training offered by many Colleges and Universities to faculty and staff. Below is a brief sample of other promising practices within each of the two strategic priorities for this goal.

Strategic priority #1: Ensure core mental health and addiction competencies within the broader health system and the education, community social services and justice systems

- Post-Secondary Education System

National Institute on Drug Abuse (NIDA) Centers of Excellence (CoE) for Physician Information (U.S.A)
The NIDA CoEs were established through a partnership with the American Medical Association's medical education research collaborative, Innovative Strategies for Transforming the Education of Physicians (ISTEP). Seven Centres of Excellence for Physician information were sponsored across the United States. The Centers are charged with the task of developing innovative drug abuse and addiction curriculum resources with the goal of helping to fill the gaps in current medical students/resident physician curricula. The ultimate goals are to raise primary care physicians' awareness of drug addiction as a health problem and to facilitate dissemination of knowledge to best prevent and diagnose abuse of prescription and illicit drugs and treat patients who are struggling with it.

- Social Services

Ontario Council of Agencies Serving Immigrants (OCASI) and Hong Fook Mental Health Association - Journey to Promote Mental Health project
Hong Fook and OCASI initiated a partnership to develop a culturally sensitive training program for settlement service workers working with diverse newcomers. The partnership's objective is to enhance the capacity of settlement service workers in addressing the mental health issues presented by the individuals they serve and making timely referrals to appropriate services in the mental health and community health systems.

- Justice system

Lanark County L.E.A.D. Team protocol (Lanark County Police and Lanark County Mental Health, Emergency Department, Ambulance Services, Diversion)
The program brings police officers, paramedics, mental health professionals and emergency room staff together for training. Through training provided in partnership with local mental health service providers, Officers develop skills in de-escalating volatile situations involving 'emotionally disturbed' persons, gathering relevant history, assessing medical information and evaluating the individual's social support system. An American review of this training approach found it resulted in a decrease in arrest rates for the mentally ill, an impressive rate of diversion into the health care system, and a resulting low rate of mental illness in jails.[96]

[96] Hughes, Graham (2008)

Strategic priority #2: Promote and better enable collaborative care between mental health and addiction sectors and the primary care sector

The Canadian Collaborative Mental Health Initiative (CCMHI)
The CCMH has produced a toolkit entitled *Strengthening Collaboration through Inter-professional Education: a Resource for Collaborative Mental Health Care Educators*. The toolkit highlights the importance of inter-professional education in promoting collaborative care. It is tailored to education program developers in regulatory agencies, professional associations, regional health authorities, family health teams, governmental departments, and educators within both academic (universities and colleges) and care delivery settings. Materials provided include case studies and activities accompanied by sample lesson plans and other tools to aid educators in the implementation of educational events.

Medical Monitoring for Addiction and Pain Network Program (College of Physicians and Surgeons of Ontario, Ontario College of Family Physicians)
The Ontario College of Family Physicians (OCFP) and the College of Physicians and Surgeons of Ontario (CPSO) partnered to develop a new shared-care model in the fields of addictions, pain management, and methadone prescribing. The MMAP initiative supports physicians with expertise in pain management and addictions including methadone prescribers to mentor family physicians interested in chronic pain and or addictions. The evaluation of the program has demonstrated that the project has had a positive impact on the ability of family doctors to manage the complex patient and family problems that present to their practices as a result of chronic pain syndromes and/or addictions.[97]

Goal 3: Ensure the mental health and addictions systems have the human resources capacity to meet increasing demands

Strategic Priorities

1. Improve the Mental Health and Addictions Sectors as a Career Choice

Recruitment and retention of the mental health and addiction workforce is a key concern across most jurisdictions including Ontario. Staff turnover in the community mental health sectors can be as high as 40 percent per year in some regions.[98] Similarly, a 2005 national survey of addiction treatment workers found that 30% under the age of 40 intended to leave the field within the next five years and 39% of survey respondents indicated they plan to leave before reaching age 55.[99] There is little to suggest this has changed.

Recruitment and retention issues should be seen in the context of skilled labour shortages generally within the health system. With the aging of the health service workforce and growing demand for services, current problems with recruitment and retention concerns will continue to grow. For instance, data from the regulatory bodies representing the 2008 membership indicates that 25% of the nursing workforce, 44% of psychologists and 50% of psychiatrists in Ontario are in the 55^{+} age cohort.[100] This indicates that Ontario is facing an aging health care workforce that will be within retirement range in the next 5-10 years. The sectors also faces the challenges of national and international employment competition for skilled health care workers and the need to adapt to changing patterns and expectations of work, work-life balance and career paths.

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[97] Cord, Michael (2009)
[98] CMHA (2009)
[99] Ogborne, A.C., & Graves, G. (2005)
[100] College of Nurses of Ontario, Data Query Tool (2008), MOHLTC, *Health Professionals Database, 2008* (2010)

High turnover contributes to role overload and burnout of existing workers, diversion of senior staff time into recruiting and training newly hired staff and higher operating costs for service providers. High turnover also contributes towards lack of consistency in service delivery to clients, potentially impacting upon the quality and effectiveness of service delivery. It may also create service delays and severely limit the ability to achieve improved access to mental health and addictions treatment, supports and services. For instance, the single largest barrier to incorporating mental health and addictions care in smaller or more isolated communities is the difficulty recruiting and retaining workers with mental health and addictions expertise.[101]

Emerging information and communications technologies (ICTs) may provide an opportunity to help address gaps in service delivery in rural and remote communities. For instance, telemental health initiatives have shown their ability to bring psychiatric services into seriously underserved rural and remote communities, markedly improving accessibility and reducing waiting time for specialist services. The expanding Ontario Telemedicine Network *(www. otn.ca)* has the potential to provide increased mental health services in a growing number of clinical settings. However, the potential for growth is challenged by the workforce shortages the investment in technology is intended to address. For instance, NORTH Network in Ontario has expressed concerns in the past over its ability to sustain the growth of its telepsychiatry program because of the overall shortage of psychiatrists in the province.[102]

Historically, significant wage disparities have existed between the community and institutional mental health sectors especially with respect to unregulated direct service workers, raising the concern of the Auditor General of Ontario that uncompetitive wages are "making recruitment and retention of qualified staff difficult and eroding the capacity of the community mental health system."[103]This situation is similar if not more dire in the addictions system which has not seen the same expansion as mental health.[104] The wage disparities have a direct impact on the competence levels of the staff and create a powerful obstacle for both new hiring and movement into the community mental health and addiction sector from the institutional sector. Therefore, although the policy priority has been to shift to community based care, inequitable remuneration for staff in community versus institutional positions has had the reverse impact, i.e. poaching of community workers by the institutional sector.

The broader health and social services sector also competes very successfully for community mental health and addictions staff, contributing to a 'brain drain' from the sector. For instance, a study of retention rates in Ontario for each sub-sector of nursing employment over the 1993-2001 period found that the community mental health field ranked 13th out of 19 sub-sectors in terms of highest proportion leaving the sector. The study also reported that the 'stickiness' or probability of a nurse remaining in the mental health field in one year's time dropped dramatically during this time frame, from 81.5 in 1997 to only 40.4 in 2001.[105]

Another form of competition exists at the pre-employment educational level. Students have limited information about work in the community mental health and addiction field but those who have study placements very quickly discover that the compensation is very poor. This is communicated amongst their peers in the educational facilities, deterring potential recruits.[106]

However, research from other jurisdictions suggests that salary levels is generally only one of many factors that staff cite for leaving a position within the mental health or addictions sectors. Other factors

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[101] Minore et al (2005)
[102] Health Canada (2004)
[103] Office of the Auditor General of Ontario (2008)
[104] CMHA (2009a)
[105] Alameddine, Mohammad, *et al* (2006)
[106] IBID.

that impact turnover include: the availability of clinical supervision, non-financial rewards and recognition, clarity regarding functional job duties and the nature of the work environment, including a supportive team approach to delivering care that is respectful of each team member's scope of practice.[107]

The stigma attached to working in the field also contributes to difficulty recruiting and retaining mental health and addictions workers and discourages students from even considering the sectors as a career option. Both the United States and New Zealand's recruitment strategies for their respective mental health and addictions workforce recommend the development of a national campaign promoting the sector as a career choice.[108] New Zealand has also established workforce targets, which have driven funding, training and service development.

A further structural obstacle is the lack of reliable data upon which to base workforce recruitment plans. In order to build a workforce strategy that addresses short-term to long-term requirements for the sector, it is critical that there be current, reliable data on service needs and preferences and on the workforce composition, including demographics, competencies and employment. Staff satisfaction and exit interviews are also a potentially valuable source of information regarding retention, especially if targeted to key areas, e.g. communities where the sector has chronic workforce shortages, high attrition rates or distinctive demographics.

One strategy being considered by some jurisdictions to improve recruitment and retention in the mental health and addictions sector is the development of a student loan forgiveness initiative. That is, individuals would receive a graduated incentive by means of loan compensation in exchange for employment commitment.[109]

For example, while not targeted to specific health sectors, the provincial Underserviced Area Program is composed of several strategies to support the recruitment and retention of health care professionals in communities designated as underserviced areas. Strategies include both financial incentives such as subsidized tuition in exchange for a commitment to practice in an underserviced area and professional development opportunities to reduce professional isolation. However, an evaluation of the impact of financial incentives on physician recruitment and retention had mixed results. For instance, the evaluation noted that the vast majority of those who enrolled in the program had already planned anyways to work in an underserviced area.[110]

- **Need to Foster a Diverse Workforce**

The mental health and addictions workforce at all levels of the system (direct service, managerial, governance) should be reflective of the people being served by the system, e.g. with respect to culture, race, sexual orientation and lived experience.[111] However, research suggests that individuals within Aboriginal and other minority groups face a number of obstacles in entering the mental health workforce including: financial issues; training and intervention models that are not culturally sensitive; the stigma associated with the mental health field; poor access to training and professional support; and discrimination.[112] The inability of the system to recognize competency through life experience is another issue.

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[107] Connecticut Alcohol & Drug Policy Council (2008)
[108] SAMHSA, 2007; New Zealand Ministry of Health (2005)
[109] IBID.
[110] Minore, Bruce et al. (2002).
[111] Toronto-Peel Mental Health Implementation Task Force (2002)
[112] Suaalii-Sauni et al (2007), Minore, Bruce *et al* (2007), Wilczynski *et al* (2007)

A lack of diversity within the workforce can contribute to the perpetuation of various barriers to access and the delivery of quality care for various groups of people (e.g., due to people not feeling comfortable accessing various treatment, supports and services, a lack of attention paid to particular groups' unique needs; and the perpetuation of discriminatory practices). Further, leadership and advocacy on behalf of various groups of people can end up falling to a small number of people who get burned out over time.[113]

Achieving a more diverse workforce should not only help improve recruitment into the sector but may also contribute to a wider set of competencies amongst workers and support cultural concordance in service delivery.[114] Furthermore, international evidence suggests that services delivered by providers and workers from similar ethno-cultural communities are likely to be more effective than services delivered by members of other communities.[115]

Some jurisdictions have set specific recruitment targets to achieve a more diverse workplace. For instance, New Zealand has committed to increase the proportion of its indigenous people (Maori) in the dedicated mental health workforce from 15 percent to 20 percent.[116]

Key Strategic Opportunities

MOHLTC in partnership with LHINs, other ministries and key stakeholders:

1. Research, design and implement a comprehensive strategy to improve the availability of accurate and reliable workforce data that is outcome focused. Strategy objectives would include:
   a. establishing a base of reliable workforce data on the supply, mix and distribution of the workforce;
   b. support the collection of data on flow and retention rates within the workforce including key factors affecting the current high rates of turnover within the sector, and opportunities to effectively address this challenge;
   - analysis would consider hospital vs. community settings, 'old' vs. 'new' programs and addictions vs. mental health settings;
   c. support the collection of workforce data to identify specific workforce development needs to address key gaps in workforce capacity within the system and to improve representation of diverse population within the workforce; and
   d. ensuring that funding is allocated to achieve workforce needs

2. Conduct a comprehensive review of current remuneration levels within the mental health and addictions sector and implement a strategy to address inequities in remuneration levels within the next three to five years.
   a. This initiative is linked to the broader recommendation of developing a 'functionally based" mental health and addictions system. As a first step, the review would consider current inequities amongst workers performing functionally similar roles and responsibilities.

3. Develop and implement policies within the next two years to help enable the workforce within the mental health and addictions sectors respond to diversity. Strategy objectives would include:
   a. addressing educational barriers for diverse populations, particularly Aboriginal students, seeking careers in the mental health and addiction sector;
   b. development of recruitment initiatives targeted to specific under-represented populations within the workforce;

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[113] Toronto-Peel Mental Health Implementation Task Force (2002)

[114] Wille, Annemarie (2006).

[115] New Zealand Ministry of Health (2002) However, a recent rapid literature review concluded that matching substance abuse clients to counsellors on the basis of race or gender does not appear to affect treatment outcome (CAMH 2009).

[116] Te Rau Matatini (2006).

   c. improvement of cultural competency through mechanisms such as committed funding for anti-oppression training; and
   d. foster language and cultural interpretation through mechanisms such as committed funding, and training in the use of interpreters.
4. Research and develop policy options to improve recruitment and retention targeted specifically to communities most in need such as rural and remote locations.
   a. Support initiatives to encourage workers in considering working in under-serviced areas.
   b. Develop policies to reduce the stigma associated with working in the mental health and addictions sector. This could include working in partnership with the Mental Health Commission of Canada and the Canadian Centre on Substance Abuse on targeted anti-stigma initiatives.

Examples of Promising Practices

There are no clear, evidence based promising practices with respect to improving the mental health and addiction sectors as a career choice. At a systems level, many jurisdictions have implemented policies and strategies to address this issue but there is no clear evidence to date of any approach being particularly effective.

Appendix 1 – Glossary

Addictions:
The term addiction is most commonly used to refer to the problematic use of alcohol and other drugs. Individuals also engage in other potentially addictive behaviours such as gambling, internet gaming and shopping, etc. For the purposes of this report, addiction is, which is use (or behaviour) that has become habitual and compulsive despite negative health and social impacts.[117]

The behaviours of primary focus are the use of psychoactive substances (alcohol and other drugs), and gambling. It is important to note that these behaviours occur along a continuum and do not always result in addiction. The spectrum of psychoactive substance use, as outlined below, also applies to other behaviours such as gambling:

- Beneficial use, which has positive health or social impacts (e.g., medical psycho- pharmaceuticals, coffee to increase alertness, etc.)
- Casual/non-problematic use, which is recreational or other use that has negligible health or social impacts
- Problematic use, which is use that begins to have negative consequences for individuals, friends/family, or society (e.g., impaired driving; binge consumption; harmful ways in which drugs are taken)
- Chronic dependence, which is use that has become habitual and compulsive despite negative health and social impacts.

Concurrent disorders: applies to people who have been diagnosed with both a mental illness and an addiction.

Consumer, Consumer/Survivor, and Person with Lived Experience:
The term "consumer" or "consumer/survivor" has been used to self-identify by some service users, particularly in the mental health field, in place of terms such as "patient" or "client" which some deem problematic. The term "persons with lived experience" or "people with lived experience" will be used throughout this report to describe those who have previously or currently live with mental illness, problematic substance use or gambling, in addition to the term "consumer", with the acknowledgement that there are a range of terms people use to self-identify, and alternate terms may be preferred to describe one's self or experiences.

Discrimination: treatment or consideration of, or making a distinction in favour of or against, a person or thing based on the group, class, or category to which that person or thing belongs rather than on individual merit. The Ontario Human Rights Commission defines discrimination as "unfair treatment due to a person's identity, such as race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or disability."[118]

Dual diagnosis: applies to people diagnosed with a developmental disability and a serious mental illness.

Family:
The term "family" is used in this document to describe any person who is identified as such by a person with lived experience of mental illness, problematic substance use or gambling. In the case of children, parents or legal guardians are included in the definition of "family"; however, others such as friends may also be included in the definition of family.

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[117] British Columbia Ministry of Health Services (2004)
[118] OHRC (2009)

Harm Reduction:
"Harm reduction" is both a philosophy and a set of practices that are pragmatic, evidence-based, and rooted in the intention to reduce harm. Harm reduction strategies embrace a long-term view of intervention and change, and place an emphasis on immediate, achievable and protective approaches to positive change.

Health Promotion: the process of enabling people to increase control over and to improve their health.[119]

Mental Health: according to the WHO there is no "official" definition of mental health. However, most experts agree that mental health and the absence of mental illness is not the same thing; the absence of a recognized mental disorder is not the only indicator for mental health. Therefore, mental health can be understood as a resource that:

- enables individuals and communities to control their subjective well-being and to cope with adversity and change
- supports meaningful and inclusive participation in social environments.

Mental Health and Addictions Systems:
The term "mental health and addictions systems" is used throughout this report to refer to specialized health treatment, services and supports for people with mental illness, problematic substance use and gambling. However, people with mental health or addiction issues may also interact with many other general health, social and community based services, including primary care, long-term care, home care, income support, police, justice and corrections, housing, and schools.

Peer-Support: a process of providing emotional support, practical support or information exchange between people who share a common experience or identity. In the context of mental health and addictions, "peer support" includes peer counselling, peer outreach and education, or participation in peer support groups. Some peer support roles are voluntary, while others are paid positions in organizations.

Person-Directed:
This approach values and supports active participation in decision making on the part of persons with lived experience, wherever possible, while recognizing the need to consider a person's ability to make specific decisions and desire for involvement at any given time. It is an approach that is mutually respectful and collaborative between providers and people with lived experience.

Psychosocial Rehabilitation (PSR)

Psychosocial rehabilitation (also known as psychiatric rehabilitation) promotes recovery, full community integration and improved quality of life for persons who have been diagnosed with any mental health condition that seriously impairs functioning. Psychosocial rehabilitation services are collaborative, person directed, and individualized, and an essential element of the human services spectrum, and should be evidence-based. They focus on helping individuals re-discover skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning and social environments of their choice.

Recovery:
There is significant divergence around the word recovery and its interpretation differs among many groups. In this paper, we endorse a broad vision of recovery that involves a process of restoring or

[119] WHO (1986)

developing a positive and meaningful sense of identity apart from one's condition, and a meaningful sense of belonging while rebuilding a life despite or within the limitations imposed by that condition.

A recovery oriented system of care identifies and builds upon each individual's assets, strengths, and areas of health and competence to support achieving a sense of mastery over his or her condition while regaining a meaningful and constructive sense of membership in the broader community.

Serious Mental Illness: The three categories used to identify people with serious mental illness are: disability, anticipated duration and/or current duration, and diagnoses. The critical dimension is the extent of disability and serious risk of harm to themselves or others, related to a diagnosable disorder.

- Disability: Refers to the fact that some individuals lack the ability to perform basic living skills such as eating, bathing, or dressing; maintaining a household, managing money, getting around the community and appropriate use of medication; and functioning in social, family and vocational-educational contexts.
- Anticipated Duration/Current Duration: Evidence may indicate that a person's problem may be ongoing in nature. This does not mean that the problems are continuous; there may be intermittent periods of full recovery or enduring long-term recovery, and some can fully recover.
- Diagnoses: For example, schizophrenia, mood disorders, organic brain syndrome, and paranoid and other psychoses. Other diagnosable disorders such as severe personality disorder, concurrent disorder and dual diagnosis are also included.[120]

Stigma: is attached to people or groups who are viewed as different from society's norms, mainstream behaviours or identities. In effect, stigma is often used as a way of discrediting, isolating and ultimately attempting to control people who fall within a stigmatized group.[121] It is a social process, experienced or anticipated, characterized by exclusion, rejection, blame or devaluation.[122]

Trauma-informed Services: take into account the impact of trauma and integrate this knowledge into the services being provided. A trauma informed perspective views the behaviours as a response or coping mechanism of past or current abusive/traumatic experiences. Trauma informed services do not require that the issue be disclosed; rather, it is the understanding that trauma may have an impact in an individual's life and be prepared to work in ways that will support the individual across the continuum of services. In trauma-informed services, all staff are trauma trained and understand the impact of trauma on the lives of those who are seeking help.[123]

[120] MOHLTC (1999)
[121] Canale (2001)
[122] Weiss and Ramakrishan, 2004
[123] *Bradley, Jean Tweed Centre*

Appendix 2: Example of a Scaled Model for a Competency Framework

Core Competencies for Canada's Substance Abuse Field

(Canadian Centre on Substance Abuse version1.0 FINAL REPORT (November 2007)

Definition of levels

	1. Foundational	2. Basic	3. Intermediate	4. Advanced
Definition	Limited knowledge and understanding of key concepts; ability to apply the competency consistently and effectively in restricted situations	Basic knowledge and understanding of key concepts; ability to apply the competency, consistently and effectively, in routine situations; demonstrates commitment to further develop skills (as applicable)	Considerable knowledge and understanding of key concepts; ability to apply the competency, consistently and effectively, in a variety of situations using discretionary decision-making skills; demonstrates commitment to further develop skills (as applicable)	Advanced knowledge and understanding of key concepts; ability to apply the competency, consistently and effectively, across a broad range of increasingly complex situations; ability to mentor, coach, or supervise others in the development of this competency, and to facilitate change and increase capacity across systems, communities, populations, etc.
How are knowledge and skills developed?	Through in-service training, introductory-level college/university courses	Through the completion of a college diploma, work experience, mentoring program, in-service training, or combination thereof	Through the completion of a university degree in addiction studies; university degree in related discipline studies combined with professional development training and work experience; diploma or certificate in addiction studies or related studies combined with work experience	Through the completion of a graduate or undergraduate-level university degree in addiction studies combined with significant work experience; graduate or undergraduate-level university degree in related discipline combined with professional development training and significant work experience; diploma or certificate in addiction studies combined with significant work experience; exceptional life experience

Case Management is the knowledge and skill required to match clients with the most appropriate available services as determined through the screening, assessment, and treatment planning process, and to effectively manage client movement within and between service(s) through accurate documentation, the appropriate sharing of client information, and collaboration with partner services as required.

	1 = Foundational	2 = Basic	3 = Intermediate	4 = Advanced
EXAMPLES	• Has a limited understanding of screening and assessment and their relationship to treatment planning and case management • Demonstrates a limited understanding of auxiliary/complementary resources available within the community • Demonstrates limited knowledge of the referral process to and from external resources, including required documentation and information-sharing protocols • May assist case management workers/teams in an administrative or support capacity, e.g., tracks telephone messages, updates client files, etc.	• Is able to use information obtained through the assessment process to facilitate an initial match between clients and the most appropriate available services • Is familiar with a range of service options and is able to apply this information in referring clients to the most appropriate available services • Accurately documents required information; shares information appropriately and in accordance with information-sharing protocols • Establishes and maintains helping relationship with clients, family members, co-workers and external colleagues	• Establishes and maintains therapeutic rapport to assist clients in exploring and considering a range of treatment options and in making and following through on decisions related to treatment planning • Is effective in the ongoing evaluation of treatment plans, making adjustments, as appropriate • Has established effective relationships with a range of service providers, both within and beyond the immediate agency, and is able to call upon these relationships to facilitate client referrals • Works collaboratively as part of multi-disciplinary teams in the establishment and maintenance of effective treatment plans, as appropriate	• Has advanced skills in enhancing client motivation in order to make and follow through on decisions related to treatment planning • Is effective in the ongoing evaluation of complex treatment plans, engaging with the client and other resources (e.g., mental health specialists) in adjusting the plan, as appropriate • Supervises and mentors multi-disciplinary case management teams, ensuring adherence to case management protocols and implementing changes to protocols, as appropriate

Appendix 3: Initiatives under the HealthForceOntario Strategy

Below is a brief summary of some of the HealthForceOntario initiatives that are most applicable to the mental health and addictions workforce.

- **MOHLTC Inter-Professional Care / Education Fund (HealthForceOntario)**

The Inter-professional Care / Education Fund (ICEF) and related Inter-professional Care (IPC) funding programs are a Provincial initiative to support innovative health education or health care projects that foster and build inter-professional teams in Ontario. IPC projects are jointly funded by the Ministry of Health and Long-Term Care and the Ministry of Training, Colleges and Universities.

The ICEP program has funded at least ten programs with a focus on mental health or addictions. For example, three of the projects funded from the initiative include:

- Inter-professional Education and Practice in Developmental Disabilities (Centre for Addiction and Mental Health);
- Implementation of the CCSMH Guidelines for Assessment and Treatment of Mental Health Issues in Long Term Care Home (Baycrest Centre for Geriatric Care)
- EnHANCE Ontario, a multi-partner project whose aim is "to lead a sustainable culture change by identifying inter-organizational factors that impact the ability of health care providers to work collaboratively across organizations to deliver interprofessional care to patients seeking access to services across mental health and addiction and primary care settings".

- **Regulation of the Profession of Psychotherapy under the Regulated Health Professions Act, 1991**

The *Health System Improvements Act, 2007*, which was given Royal Assent in June, 2007, regulates psychotherapy as a regulated health profession in Ontario through the creation of the *Psychotherapy Act*, *2007*. The legislation will require individuals who deliver psychotherapy services and call themselves "psychotherapists", "registered psychotherapists" or "registered mental health therapists" to register with a health regulatory college, the College of Registered Psychotherapists and Registered Mental Health Therapists of Ontario, and to be accountable to this governing body for the services they provide.

It is estimated that more than 4,000 psychotherapists practice in Ontario today. There is a wide spectrum of individuals who provide psychotherapy services. It ranges from professionals who are members of existing regulatory colleges (i.e., psychologists and psychiatrists) to unregulated individuals with little to no formal training. There are no consistent standards for psychotherapy training programs in the province. As a result, Ontarians who receive psychotherapy treatment have no reliable way of knowing whether the individual providing these services have the appropriate competencies and training required for safe practice

Regulating psychotherapy provides assurances of high standards of care and enhanced public protection for Ontarians who receive psychotherapy services.

The College of Registered Psychotherapists and Registered Mental Health Therapists of Ontario will be responsible for setting registration requirements, making practice standards, policies and guidelines for the profession, establishing quality assurance programs to promote the continuing competence of members, and implementing complaints and discipline processes to ensure that members are accountable for providing health care in a safe, competent and ethical manner.

- **Nursing Education Initiative**

Established in 1999, the Nursing Education Initiative has been supporting the nursing profession through the development and implementation of nursing education grants, best practice guidelines (BPGs), nursing fellowships and recruitment/retention activities for over 10 years.

A cornerstone of the initiative is the education grants which provide nurses across the province with enhanced access to continuing education and professional development. Nurses are eligible to receive up to $1,500 a year for reimbursement of costs associated with continuing education.

The Nursing Education Initiative also provides funding to the Registered Nurses Association of Ontario and the Registered Practical Nurses Association of Ontario to develop strategies to assist in the recruitment and retention of nurses in Ontario. Examples of these strategies include:

- engagement of nursing students and new nursing graduates in career development and planning.
- promotion and support for employed nurses in career transitioning, building career resilience, and creating career mobility.

The Registered Nurses Association of Ontario (RNAO) also receives annual funding from the Ministry of Health and Long-Term Care (MOHLTC) for the development and administration of the Best Practice Guidelines program.

- **Healthy Work Environments**

The Ministry's Healthy Work Environments initiative has been focused on identifying and developing resources that will provide health care workers with the necessary supports to help them stay healthy, serve patients better, and miss less from work because of injury or illness. Four key areas of focus include: workplace violence prevention; worker safety; respect in the workplace; and, leadership development.

For example the Ministry has provided funding for:

- the Ontario Safety Association for Community and Healthcare to conduct education sessions throughout Ontario to all health care workers on workplace violence prevention;
- a HWE Leadership Development project with a mental health institution for managers / supervisors to keep their workers safe and healthy;
- a workplace safety initiative for Family Health Teams, to allow health care practitioners to roster difficult to serve patients (such as patients with mental health and addictions illnesses), while protecting workers from potential violent situations; and
- a project for EMS/ED staff as well as community agencies (e.g. police) to enhance communication strategies, to deal with difficult to serve patients (such as some patients with mental health and addictions illnesses).

- **The Family Medicine Innovation Fund**

The Family Medicine Innovation Fund was established to support pan-Ontario family medicine focused projects. One proposed under consideration from McMaster University in partnership with the University of Toronto is to develop a focused Mental Health Addictions and Pain third year program.

- **Residents Training in Psychiatry**

There are approximately 227 residents training in Psychiatry funded for an estimated $32.7 million in 2008/09. Expansion is under development and funding will be made available per negotiations with the medical schools.

- **Underserviced Area Program - Psychiatric Outreach Program**

The program provides assistance to communities that have long-standing, unresolved difficulties securing the required number of physicians. As of December 2009, 133 communities were designated as underserviced for general practitioners/family physicians and 13 have been designated as underserviced for specialists with practice opportunities available for 29 specialties including Psychiatry.

The UAP also manages the Ontario Psychiatric Outreach Program (OPOP), formed in 1999, is a collaborative and dynamic network of dedicated academics and practitioners in the mental health field, sharing expertise and resources to deliver clinical services and education to Ontario's rural, remote and under-serviced areas.

- **The Resident Loan Interest Relief Program**

The Resident Loan Interest Relief Program was negotiated as part of the 2008 Physician Services Agreement to provide eligible Ontario Medical Residents (including those in specialties such as psychiatry) with financial assistance during a critical time of professional development. During residency, the program will pay interest and defer principal payment on any outstanding Canadian federal or provincial government student loan.

- **Health Professions Database**

The database will provide standardized consistent and comparable demographic, geographic, educational and employment information on all of the regulated allied health professions in Ontario, including psychologists, occupational therapists, physiotherapists, speech-language pathologists and audiologists. In August, 2009, 19 regulatory Colleges provided their first submission (of 2008 data) to the HPDB. Aggregate data and analytical reports from the database will be available in 2010.

By 2011, the MOHLTC will also be collecting data from the College of Nurses of Ontario. In the future, the HPDB will collect data from the remaining health regulatory Colleges including the upcoming College of Psychotherapists and Registered Mental Health Therapists of Ontario. Data collection from the College of Social Workers may also be considered.

- **Ontario Physician Human Resources Data Centre (OPHRDC)**

The data centre is a source for information on physician usage and postgraduate medical education training in Ontario, including demographic and geographic information on psychiatrists. Health planners, researchers, legislators and journalists, as well as the general public, can obtain full access by registering on the website www.ophrdc.org.

- **Family Medicine Training**

Currently there are over 800 residents in family medicine training funded for an estimated $80.8 million in 2008/09. Approximately 540 more family physicians will be trained in Ontario by 2014 to

increase the number of family physicians practising. Family Physicians/General Practitioners are the first point of contact for patients with mental health or addiction issues.

- **New Chair for Health Human Resources**

$3 million was awarded to endow a permanent Chair in Ontario to foster leading edge research in health human resources.

- **Allied Health Professional Development Fund**

The fund provides financial support to health professionals within nine regulated Allied Health professions to participate in professional development activities. Currently, these professions are: Audiology, Dietetics, Medical Laboratory Technology, Medical Radiation Technology, Occupational Therapy, Pharmacy, Physiotherapy, Respiratory Therapy and Speech-Language Pathology. Eligibility to apply is limited to the professionals in the nine professions listed above who are registered with their respective regulatory college at the time of participation in the professional development activity.

Practicing members of nine allied health professions are able to apply for as much as $1,500 for professional development courses and programs. For 2009/10, the fund will reimburse for professional development opportunities completed between April 1, 2009 and March 31, 2010.

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