National policies, activities and resources related to mental health and addiction workforce development across IIMHL countries

Introduction

> *"Our workforce is the heart and soul of the mental health system. To support people who experience mental illness we need a mental health workforce of the right size and with the right characteristics to meet the demand for services, both in the community and in hospitals. We also need our mental health workforce to understand and support the philosophy of recovery and to have the skills and tools to provide services that are recovery focused"*
> *http://nswmentalhealthcommission.com.au/sites/default/files/Strategic%20Plan%20-%20Section%208a.pdf*

The workforce is ***the*** main resource in mental health and addiction services for each country and thus the Global Health Workforce Alliance states:

> *"Investment in health workforce is one of the best buys in public health"*
> *http://www.who.int/workforcealliance/knowledge/resources/strategy_brochure9-20-14.pdf?ua=1*

Most IIMHL countries have established (or are establishing) national strategies or policies (and subsequent activities) for the development of the mental health and addiction workforce.

This document highlights:

- Government policy and activities on mental health and addiction workforce development among seven IIMHL countries (with Sweden's information to be added soon)
- National activities and resources related to workforce development.

The information was obtained via two main strategies: through IIMHL contacts but mainly through a website search. This search assumes that all websites are up-to-date.

Please note it is not a definitive literature search, but rather a brief snapshot of some national or state resources and activities.

This is a somewhat complex area as each country uses different language and it was sometimes difficult to find national workforce agencies. There was little information in English for Sweden.

If there is a major policy document missing we are happy to include it.

We hope you find it helpful.

Janet Peters and Fran Silvestri

What do we mean by 'Workforce'?

Different countries may use slightly different terminology but the concepts are similar.

Health workers are "all people engaged in actions whose primary intent is to enhance health" (WHO - World Health Report 2006). In mental health this workforce may include peer workers, recovery coaches, doctors (GPs and psychiatrists), clinical psychologists, nurses, social workers, occupational therapists, indigenous workers (and other cultural workers), family workers, public health professionals, community health workers, pharmacists, and all other support workers whose main function relates to delivering preventive, promotive or curative health services.

Health workers typically operate in collaboration with the wider social service workforce, who is responsible to ensure the welfare and protection of socially or economically disadvantaged individuals and families; a closer integration of the health and social service workforce can also improve long-term care for ageing populations.[1]
http://www.who.int/workforcealliance/knowledge/resources/strategy_brochure9-20-14.pdf?ua=1

In the US, SAMHSA states that the mental health and substance abuse workforce includes, but is not limited to:
"Psychiatrists and other physicians, psychologists, social workers, advanced practice psychiatric nurses, marriage and family therapists, certified prevention specialists, addiction counsellors, mental health counsellors, psychiatric rehabilitation specialists, psychiatric aides and technicians, paraprofessionals in psychiatric rehabilitation and addiction recovery fields (such as case managers, homeless outreach specialists, parent aides, etc.), and peer support specialists and recovery coaches".
http://www.samhsa.gov/workforce

One 2015 report notes:

“However no consensus exists on which provider types make up the mental health workforce. While some define the workforce as a broad range of provider types, others take a more narrow approach. For example, the Institute of Medicine (IOM)—a private, non-profit organization that aims to provide evidence-based health policy advice to decision makers, often through congressionally mandated studies—has conceptualized the mental health workforce broadly, including primary care physicians, nurses, physician assistants, peer support specialists, and family caregivers, among others.
https://www.fas.org/sgp/crs/misc/R43255.pdf

In Australia the workforce is described as:

“The mental health workforce comprises workers whose primary roles include early intervention, referral, treatment, care or support to people with a mental illness, in a mental health service or other health service environment, including community-managed mental health services. These workers include : Aboriginal mental health workers, GPs, mental health nurses, occupational therapists, peer workers, psychologists, psychiatrists and social workers”.
http://nswmentalhealthcommission.com.au/sites/default/files/Strategic%20Plan%20-%20Section%208a.pdf

Canada extends this definition:

“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 counsellors, College and University student counsellors, casino hospitality workers and corrections workers.”
http://www.health.gov.on.ca/en/public/programs/mentalhealth/advisorygroup/docs/theme_workforce.pdf

Key workforce issues

Several issues are common across countries:

Changing paradigms with mental health and addiction systems

In Canada 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. There is emerging consensus that mental health treatment supports and services should be based on a recovery philosophy, which requires a shift in values, attitudes and behaviours.

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; with harm reduction providing an integrating philosophy.

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 to take place,

In Canada for example, it was noted that 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 postsecondary and continuing education have often not evolved to reflect these current approaches".*

http://www.health.gov.on.ca/en/public/programs/mentalhealth/advisorygroup/docs/theme_workforce.pdf

Platform Trust and Te Pou of New Zealand have just published a report looking at transforming the current mental health and addiction system (both hospital based and NGO). Called ***On Track: Knowing where we are going – co-creating a mental health and addiction system that New Zealanders want and need.***

This report describes different ways that providers can accelerate system reform by working both within and alongside the current system, with the ultimate goal of replacing it by 2030 or earlier.
http://www.tepou.co.nz/initiatives/ngo-workforce-development-on-track/106

The growth of peer workers

US:

A peer provider (e.g., certified peer specialist, peer support specialist, recovery coach) is a person who uses his or her lived experience of recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resiliency.
http://www.integration.samhsa.gov/workforce/peer-providers

According to CMHS Director Paolo del Vecchio, "One area that provides a lot of promise is the use of peers as providers." SAMHSA supports clarifying competencies for peers and family members to accomplish this work and the development of a peer professional career ladder that will include training and supervision of peers by peers.

Peer providers bring unique strengths and qualities to the integrated care team. These strengths include:

- Personal experience with whole health recovery that includes addressing wellness of both mind and body
- Insight into the experience of internalized stigma and how to combat it
- Compassion and commitment to helping others, rooted in a sense of gratitude
- Can take away the “you do not know what it’s like” excuse
- Experience of moving from hopelessness to hope
- In a unique position to develop a relationship of trust, which is especially helpful in working with people in trauma recovery
- A developed skill in monitoring their illness and self-managing their lives holistically

http://www.samhsa.gov/samhsaNewsLetter/Volume_22_Number_4/building_the_behavioral_health_workforce/

New Zealand:

The service user, consumer and peer workforce is a diverse and rapidly growing workforce in today’s mental health and addiction services in New Zealand. It includes all roles that require lived experience, for example, consumer advisors and peer support workers. In many parts of New Zealand people’s understanding and definitions of peer work vary considerably.

This guide has been written for planners and funders of mental health and addiction services. It defines the major types of peer work, policy context, its values, evidence-base and development needs. It finishes with a list of resources planners and funders can refer to for more information. It is designed to be used in conjunction with the Competencies for the mental health and addiction consumer, service user and peer workforce available from www.tepou.co.nz
http://www.tepou.co.nz/uploads/files/resource-assets/service-user-consumer-and-peer-workforce-guide-for-planners-and-funders.pdf

Supply and Demand

> “*A defining feature of health systems in the 21st century will be the capacity to respond to populations’ needs, while at the same time anticipating future scenarios and effectively planning for evolving requirements. Nowhere is this more apparent than in the health workforce domain: a fundamental mismatch exists between supply and demand in both the global and national health labour markets, and this is likely to increase due to prevalent demographic, epidemiologic and macroeconomic trends”.*

http://whoeducationguidelines.org/sites/default/files/uploads/eLearning-healthprof-report.pdf

It is generally accepted that countries will continue to experience increasing demand for health care workers and at a rate that will challenge agencies training and service delivery systems’. The underlying health service demand drivers include:

- population growth

- ageing of the population
- changing nature of the burden of disease and greater focus on health prevention

which taken together with consumer and workforce expectations, combine to result in increasing demand for health care services and for healthcare workforce.

The current and projected shortages in mental health and addiction workforce are driven by a complex interaction of demographic, socio-cultural, clinical and professional factors that exert influences on both the demand for health workers' services, and the supply of health workers. These shortages are not uniformly distributed, but vary by health profession, specialty, jurisdiction and geographical location (metropolitan, rural, remote).
http://www.ahwo.gov.au/publications.asp

Workforce planning and development

There is a difference between having a plan and being able to deliver on it. One author who looked at workforce planning across three countries noted:

- Strong, informed leadership is needed for success, nationally, regionally and locally
- The quality of any workforce plan depends upon the quality of the data (on existing services and workforce supply) that went into it
- It is not enough to lay out a framework and expect local teams to be willing to embrace it effectively – there needs to be ongoing intensive training and management support for staff to get on board; and, a top-down bottom-up approach.
- One successful approach to competencies started with these two guiding principles (rather than the perspective of any one profession as a starting point):
    - **The need to learn about and value the lived experience of consumers and carers; and,**
    - **To recognise and value the healing potential in the relationships between consumers and service providers.**
- For a competency framework to beyond training and planning it must be linked to compensation
- Planning is an opportunity to develop new roles for mental health consumers

http://www.cerforum.org/conferences/200505/papers/mulvale_cerf05.pdf

and, from Canada:

> *"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.*
>
> *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"".
http://www.health.gov.on.ca/en/public/programs/mentalhealth/advisorygroup/docs/theme_workforce.pdf

A culturally appropriate workforce

This is an issue for all countries.

For example the US:

Two main issues related to health disparities and the mental/behavioral health workforce that should be considered in the context of public policy includes: increasing the number of racial and ethnic minority mental/behavioral health professionals and creating a culturally competent workforce to meet the needs of the expanding minority population of the United States.

One of the most significant challenges our nation's mental health care workforce faces is the increasing gap in health care access and health outcomes for racial and ethnic minorities. According to the Annapolis Coalition report, a large majority (approximately 90%) of mental/behavioral health professionals are non-Hispanic White; while, according to the 2004 U.S. Census Bureau, racial and ethnic minorities make up 30% of the U.S. population. It is projected that by 2060, ethnic minorities will have become the majority, constituting 50.4% of the resident population of the United States (Hispanic 26.6%, African American 13.3%, Asian American/Pacific Islander 9.8%, American Indian .08%).
http://www.apa.org/about/gr/issues/workforce/disparity.aspx

Education

There is a need to strengthen mechanisms at the country level between health workforces institutions of higher learning and ministries of health and education, in order to support quality education across an increasing number of health professionals.

eLearning has an under-exploited potential to support health workforce capacity building in different contexts, and can empower health workers to take charge directly of their own competency development, to enable them to play a full role as change agents in addressing the challenges we will face in the 21st century.
http://whoeducationguidelines.org/sites/default/files/uploads/eLearning-healthprof-report.pdf

Lack of data on the workforce

There exists a lack of reliable data on the current mental health and addiction workforce in many countries.

In Canada it was noted that 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, pediatricians, psychologists, pharmacists, family physicians and nurses.
http://www.health.gov.on.ca/en/public/programs/mentalhealth/advisorygroup/docs/theme_workforce.pdf

Staff as "knowledge brokers"

If consumers take a more active role in decisions about their care, professionals may need to take on a 'knowledge broker' role, which is a big change in mindset.

Professionals would make sure patients have all the information they need about the options available, and support them to make an informed decision about what is best for them.

Change of focus to prevention

Shifting the focus towards prevention and well-being could help to address a number of the demographic and financial big picture challenges. By focusing on preventive services, and avoiding the development or deterioration of long-term conditions, expensive treatment and care options may be avoided in the future. This will decrease demand and free up resources for those who really need them.

Shifting towards prevention will be a key challenge for a system that has always focused on treating those who are ill, rather than helping the population to stay healthy. This can significantly alter the requirements of the health and social care workforce as it will impact on the level of health need.
http://www.tepou.co.nz/uploads/files/resource-assets/on-track-knowing-where-we-are-going.pdf

IIMHL and the international peer leadership Academy

"The International Initiative for Mental Health Leadership and Mind Australia are supporting the development of a proposal for an international peer leadership Academy to be based at Yale University and collaborating centres in other countries. The purpose of the Academy will be to train and support emerging and established peer leaders in mental health, from low income and high-income countries, to advocate or manage system transformation from a lived experience perspective.

The survey organisers are seeking the views of people who are involved in mental health systems in any role on the proposed Academy. Your answers will help to inform the proposal they take to funders and customers in time for the Academy to start in 2016. Please pass this survey on to anyone anywhere who has an interest in mental health peer leadership".
http://www.peersupportvic.org/

The deadline for participating in this survey is Saturday 20 June 2015. To take part in the survey go to https://www.surveymonkey.com/r/PeerLeadershipAcademy1

International agencies

World Health Organisation (WHO)

WHO's comprehensive mental health action plan 2013-2020
This has now been adopted by the 66th World Health Assembly. The action plan is the outcome of extensive global and regional consultations over the last year with a broad array of stakeholders including: 135 Member States; 60 WHO CCs and other academic centres; 76 NGOs and 17 other stakeholders and experts.

The four major objectives of the action plan are to:

- strengthen effective leadership and governance for mental health.
- provide comprehensive, integrated and responsive mental health and social care services in community-based settings.
- implement strategies for promotion and prevention in mental health.
- strengthen information systems, evidence and research for mental health.

The plan sets important new directions for mental health including a central role for provision of community based care and a greater emphasis on human rights. It introduces the notion of recovery, moving away from a pure medical model, and addresses income generation and education opportunities, housing and social services and other social determinants of mental health in order to ensure a comprehensive response to mental health.
http://www.who.int/mental_health/action_plan_2013/en/

Integrating the response to mental health disorders and other chronic diseases in health care systems

WHO and the Calouste Gulbenkian Foundation Report, 2014
Strong links exist between mental disorders and other chronic diseases, not only with respect to their causes and consequences, but also in terms of their prevention and management. Inevitably, redesigning health systems and services towards integrated care poses serious challenges to existing infrastructure, budgets, and health workers.

But providing seamless, integrated care that caters to the overall health needs of the person is not just a laudable goal; it is also the most appropriate, feasible, and efficient way of preventing and managing mental disorders and other chronic diseases.
http://apps.who.int/iris/bitstream/10665/112830/1/9789241506793_eng.pdf

Mental Health Policy and Service Guidance Package World Health Organization Human Resources and Training in Mental Health, 2005

What is the purpose of the guidance package?

The purpose of the guidance package is to assist policy-makers and planners to:

- develop a policy and comprehensive strategy for improving the mental health of populations
- use existing resources to achieve the greatest possible benefits
- provide effective services to persons in need
- assist the reintegration of people with mental disorders into all aspects of community life, thus improving their overall quality of life.

What is in the package?
The guidance package consists of a series of interrelated, user-friendly modules that are designed to address the wide variety of needs and priorities in policy development and service planning. The topic of each module represents a core aspect of mental health. The guidance package comprises the following modules:

- The Mental Health Context
- Mental Health Policy, Plans and Programmes
- Mental Health Financing
- Mental Health Legislation and Human Rights
- Advocacy for Mental Health
- Organization of Services for Mental Health
- Planning and Budgeting to Deliver Services for Mental Health
- Quality Improvement for Mental Health
- Improving Access and Use of Psychotropic Medicines
- Child and Adolescent Mental Health Policies and Plans
- Human Resources and Training for Mental Health
- Mental Health Information Systems

http://www.who.int/mental_health/policy/Training_in_Mental_Health.pdf

Organization for Economic Co-operation and Development (OECD)

Workforce
Health workers are crucial for ensuring access to high quality and cost-effective care. The work of the OECD examines trends and priorities in health workforce policy in OECD countries. Current projects analyse different aspects of health workforce policy, including how countries can improve their health workforce planning, what policymakers can do to ensure that doctors practice where they are most needed, and whether health workers put their skills to effective use in their jobs. In addition, a data collection effort is underway to document and analyse recent trends in health worker migration.

OECD has several publications relating to the workforce.
http://www.oecd.org/els/health-systems/workforce.htm

Making Mental Health Count, July 2014: The Social and Economic Costs of Neglecting Mental Health Care
Despite the enormous burden that mental ill-health imposes on individuals, their families, society, health systems and the economy, mental health care remains a neglected area of health policy in too many countries. Mental disorders represent a considerable disease burden, and have a significant impact on the lives of the OECD population, and account for considerable direct and indirect costs. This report argues that even in those OECD countries with a long history of deinstitutionalisation, there is still a long way to go to make community-based mental health care that achieves good outcomes for people with severe mental illness a reality. The disproportionate focus on severe mental illness has meant that mild-to-moderate mental illnesses, which makes up the largest burden of disease, have remained overwhelmingly neglected.

This book addresses the high cost of mental illness, weaknesses and innovative developments in the organisation of care, changes and future directions for the mental health workforce, the need to develop better indicators for mental health care and quality, and tools for better governance of the mental health system. The high burden of mental ill health and the accompanying costs in terms of reduced quality of life, loss of productivity, and premature mortality, mean that making mental health count for all OECD countries is a priority.
http://www.oecd.org/els/health-systems/Focus-on-Health-Making-Mental-Health-Count.pdf

Global Health Workforce Alliance

HEALTH WORKFORCE 2030: A Global strategy on human resources for health
A global strategy on human resources for health that addresses, in an integrated way, all aspects ranging from planning, education, management, retention, incentives, linkages with the social service workforce, can inform more incisive, multi-sectoral action, based on new evidence and best practices. This brochure sheds light on why a global strategy on HRH is necessary and outlines the process of developing WHOs strategy.
http://www.who.int/workforcealliance/knowledge/resources/strategy_brochure9-20-14.pdf?ua=1

World Federation for Mental Health

Founded in 1948, the mission of our international organization includes:

- The prevention of mental and emotional disorders;
- The proper treatment and care of those with such disorders;
- And the promotion of mental health.

The Federation, through its members and contacts in many countries, has responded to international mental health crises through its role as the only worldwide grassroots advocacy and public education organization in the mental health field. Its organizational and individual membership includes mental health workers of all disciplines, consumers of mental health services, family members, and concerned citizens.

The WFMH has a "People's Charter for Mental Health" to show the actions needed by governments and specific NGOs to improve mental health care. The Charter, a joint initiative of WFMH with the Movement for Global Mental Health, was published in 2013 and is available on this website.
http://wfmh.com/initiatives/great-push-for-mental-health-initiative/

AUSTRALIA

National policy

The Australian Government and all state and territory governments share responsibility for mental health policy and the provision of support services for Australians living with a mental disorder. State and territory governments are responsible for the funding and provision of state and territory public specialised mental health services and associated psychosocial support services. The Australian Government has primarily taken the lead in national mental health reform initiatives but also funds a range of services for people living with mental health difficulties.

These provisions are coordinated and monitored on a national basis through a range of national initiatives—including nationally agreed strategies and plans.

Over the last three decades governments have worked together, via the National Mental Health Strategy, to develop mental health programs and services to better address the mental health needs of Australians. The National Mental Health Strategy has included four five-

year *National Mental Health Plans* which covered the period 1993 to 2014, with the Council of Australian Governments (COAG) National Action Plan on Mental Health overlapping between 2006 and 2011.

Under these arrangements, state and territory governments have generally funded and provide specialist care for Australians affected by severe mental health disorders. The Australian Government funds a range of services for Australians with mental health disorders (through the Medicare and Pharmaceutical Benefits Schedules) and also provides social support and income support programmes. Funding for the latter programmes is largely provided through the Australian Government's disability and carer support income payment programmes.
https://mhsa.aihw.gov.au/national-policies/

The national programmes being implemented by the Department of Health, with the aim of improving the mental health of Australians, are directed by the:

- E-mental health strategy for Australia
- Fourth national mental health plan
- National Aboriginal and Torres Strait Islander suicide prevention strategy
- National mental health policy 2008
- National mental health strategy
- National suicide prevention strategy
- Roadmap for national mental health reform

http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-policy

National Mental Health Report 2013: tracking progress of mental health reform in Australia 1993 – 2011.

Department of Health and Ageing (2013), Commonwealth of Australia, Canberra.
From this report:

National workforce trends

- The direct care workforce employed in state and territory mental health services increased by 72%, from 14,084 full-time equivalent (FTE) in 1992-93 to 24,292 FTE in 2010-11
- On a per capita basis, this equates to an increase from 80 FTE per 100,000 in the former period to 108 FTE per 100,000 in 2010-11, or an 4 NATIONAL MENTAL HEALTH REPORT 2013 increase of 35%. New South Wales reported the most growth (52%), followed by Tasmania (47%) and Queensland (43%).
- Nationally, the absolute increase in the direct care workforce size of 72% was lower than the increase in recurrent expenditure on state and territory inpatient and community-based services (119%). Factors such as rising labour costs and increases in overhead and infrastructure costs may contribute to this discrepancy.
- At a conservative estimate, 3,119 full-time equivalent mental health professionals provided services through Australian Government funded primary mental health care

initiatives in 2010-11. The majority of these (1,928 or 62%) were psychologists. The next largest professional group was psychiatrists (817 or 26%).
- In total, 1,517 full-time equivalent mental health professionals were employed in private hospitals in 2010-11. The workforce mix mainly comprised nurses (1,165, 77%) and allied health professionals (310, 20%). Medical practitioner services provided to consumers treated in private hospitals are delivered primarily through the Medicare Benefits Schedule rather than direct employment arrangements.

And:

Priority area 4: Quality improvement and innovation

Indicator 21: Proportion of total mental health workforce accounted for by consumer and carer workers

- Nationally, in 2010-11, 4.6 per 1,000 (or 0.5%) of the total full-time equivalent (FTE) mental health workforce was accounted for by consumer and carer workers. This represents an increase of 33% since the 2002-03 level of 3.5 FTE per 1,000 (0.3%). This growth is due to an almost fourfold increase in the number of FTE carer workers per 1,000, compared to a slight decrease in FTE consumer workers per 1,000.
- There is substantial variation across jurisdictions, with the highest proportions in South Australia (6.3 per 1,000 in 2010-11, or 0.6%) and Victoria (6.1 per 1,000, 0.6%), and the lowest rates in the Australian Capital Territory and the Northern Territory (0.0 per 1,000, or 0.0%).

Indicator 22: Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards

- In 2010-11, 84% of specialised mental health services in Australia had undertaken external accreditation and been judged to meet all standards set out in the National Standards for Mental Health Services (Level 1). A further 8% met some but not all standards (Level 2), 4% had made some progress towards external review (Level 3) and 4% did not meet criteria for Levels 1-3 (Level 4).
- In two jurisdictions (the Australian Capital Territory and the Northern Territory) 100% of services met the standards set for Level 1. Three others (Queensland, Victoria and South Australia) came close to this, with at least 96% of their services achieving Level 1. In other states the proportion of services achieving Level 1 was lower. In New South Wales (79% at Level 1) and Tasmania (48% at Level 1), the balance of services had undertaken external review and reached threshold for Level 2, whereas in Western Australia (49% at Level 1), the balance had not completed external review and were graded as Levels 3 or 4.
- Ongoing effort is required to ensure more uniform levels of accreditation across jurisdictions.

https://www.health.gov.au/internet/main/publishing.nsf/Content/B090F03865A7FAB9CA257C1B0079E198/$File/rep13.pdf

In early 2014, the Australian Government requested the National Mental Health Commission to undertake a wide ranging review of existing mental health programmes and services

across the government, non-government and private sectors with a view to identifying ways to deliver services more efficiently and effectively. The final report was provided to the Government in December 2014.
https://mhsa.aihw.gov.au/national-policies/

National Mental Health Commission (NMHC)

Strategic priorities:
Goal 1: To ensure mental health and wellbeing is a national priority
Goal 2: To increase accountability and transparency through credible, useful public reporting and advice, informed by collaboration
Goal 3: To provide leadership and information that helps to empower people with lived experience, their families and support people
Goal 4: To work with others to influence decision-making, set goals and transform systems and supports to improve people's lives
http://www.mentalhealthcommission.gov.au/media/113743/NMHC%20strategic%20priorities%202014%20-%202015.pdf

Our Work

- National Contributing Life Survey Project
- National Seclusion and Restraint Project
- National Future Leaders in Mental Health Project
- Mental Health Peer Work Qualification Development Project
- Mentally Healthy Workplace Alliance
- Communications Charter
- Meetings
- The Sydney Declaration

Foundations of Mental Health Peer Work training materials now available

The *Mental Health Peer Work Qualification Development Project* aims to develop and support a nationally recognised qualification for peer workers (Certificate IV in Mental Health Peer Work) to help facilitate broader engagement of peer workers throughout the mental health sector. The development of the qualification has involved a rigorous process with input from technical and advisory groups including peer workers and people with a lived experience. The project is funded by the National Mental Health Commission and coordinated by the Mental Health Coordinating Council on behalf of Community Mental Health Australia. The first batch of training and assessment materials are now ready for registered training organisations (RTOs) across Australia to use.

These allow RTOs to deliver the Peer Worker qualification for the consumer and carer peer workforce. All resources are freely available.

The development of the resources was informed by broad consultation and national advisory groups including carer and consumer peer workers and services that support peer workforce.

The Commission thanks everyone who has dedicated their time and expertise to this project. In particular, we acknowledge and thank Community Mental Health Australia (CMHA) for their collaborative efforts and skill, dedication and determination in producing these high quality products.

The resources have undergone a rigorous pilot to ensure applicability. Any future updating or changing of resources is the responsibility of those who utilise the resources and not CMHA or the National Mental Health Commission. All resources are freely available for download below.

An RTO user guide has been developed to assist the delivery of the qualification:

- RTO user guide for the Certificate IV in Mental Health Peer Work

This user guide will help RTOs navigate their way through the structure of the Certificate and resources.

Resources available as at 12 March 2015 are:

- Foundations of Mental Health Peer Work 1 - Resource book 1
- Foundations of Mental Health Peer Work 1 - Assessment book 1
- Foundations of Mental Health Peer Work 1 - PowerPoint 1
- Foundations of Mental Health Peer Work 1 - Training plan 1
- Foundations of Mental Health Peer Work 2 - Resource book 2
- Foundations of Mental Health Peer Work 2 - Assessment book 2
- Foundations of Mental Health Peer Work 2 - PowerPoint 2
- Foundations of Mental Health Peer Work 2 - Training plan 2
- Foundations of Mental Health Peer Work 3 – Resource book 3
- Foundations of Mental Health Peer Work 3 – Assessment book 3
- Foundations of Mental Health Peer Work 3 – PowerPoint 3
- Foundations of Mental Health Peer Work 3 – Training plan 3

The remaining resources will be loaded to this the website following their pilot: http://www.mentalhealthcommission.gov.au/our-work/mental-health-peer-work-qualification-development-project.aspx

NMHC Reports

The Australian Government has tasked the Commission to undertake a national review of mental health services and programmes. The final report will be provided to the Government by 30 November 2014.

In 2012 and 2013 they produced two annual National Report Cards on Mental Health and Suicide Prevention. The report cards inform Australians of where we are doing well and where we need to do better in mental health. As well as looking at the facts and figures, the report card tells the real and everyday experiences of Australians. We will be reporting back on all our recommendations at the end of the year.

The Commission is working with the Australian Commission on Safety and Quality in Health Care (ACSQHC) on a scoping study on the implementation of national standards in mental health services.

In 2013, Expert Reference Group chaired by Professor Allan Fels AO provided a report to the COAG Working Group on Mental Health Reform regarding National Targets and Indicators for mental health reform.

They also coordinate Spotlight Reports to shine a light on issues and areas of interest identified by the Commission. These reports are commissioned to inform our work and do not necessarily reflect the views of the Commission.
http://www.mentalhealthcommission.gov.au/our-reports.aspx

Australian Institute of Health and Welfare

Mental health services—in brief 2014
This report by the Australian Institute of Health and Welfare provides an overview of data about the national response of the health and welfare system to the mental health care needs of Australians. It is designed to accompany the more comprehensive data on Australia's mental health services available online at https://mhsa.aihw.gov.au

State and territory governments fund and deliver public sector mental health services that provide specialised care for people with severe mental illness. These include admitted patient services delivered in hospital settings and services delivered in community settings.

The Australian Government also funds a range of mainstream programs and services which provide essential support for people with mental illness. These include income support, social and community support, disability services, workforce participation programs, and housing assistance.
http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129549620

Health Workforce Australia

In the 2014 Budget the Australian Government announced the closure of Health Workforce Australia (HWA), with essential functions transferring to the Department of Health. HWA closed on 6 August. Funding agreements and other business functions are being managed by the Department of Health.
https://www.hwa.gov.au/

Before it closed the following was a report undertaken by this agency:

The Mental Health Non-Government Organisation (NGO) Workforce Project aimed to improve the understanding of the mental health NGO sector and the people who work in it. It included a survey of organisations about their characteristics and a survey of individual staff members. This fact sheet noted There is a wide range of NGO services. Community managed mental

health organisations provide valuable community based support options that are support recovery.

Mental health NGOs may promote self-help and provide support and advocacy services for people who have a mental health problem or a mental illness, and carers or families. Psychosocial rehabilitation and support services provided by non-government community agencies include housing support, individual support, day programs, prevocational training, residential services, outreach and respite care. The mental health NGO sector assists consumers and carers to maximise recovery, independent or supported living, and active participation in the community, leading to the delivery of recovery focused mental health care.

More information related to NGOs is contained in the link below.
https://www.hwa.gov.au/sites/default/files/factsheet_snapshot_mental_health_ngo_sector_20120319b.pdf

Mental Health Peer Workforce Study, 2014

Purpose
The purpose of this document is to report on the findings of the mental health peer workforce (MHPW) study, and to provide a set of recommendations that will strengthen and develop the mental health peer workforce as an important component of quality, recovery-focused mental health services.

The focus of this study is the mental health peer workforce in public, non government and private mental health services. For the purposes of this report, peer workers (PWs) are defined as people who are employed in roles that require them to identify as being, or having been a mental health consumer or carer. Peer work requires that lived experience of mental illness is an essential criterion of job descriptions, although job titles and related tasks vary (Mental Health Coordinating Council, 2011). Peer support, which is one element of peer work, is based on the belief that people who have faced, endured and overcome adversity can offer useful support, encouragement, hope, and perhaps mentorship to others facing similar situations (Davidson et al, 2006).

The requirement of lived experience of mental illness or mental health issues for identified peer roles leads to key differences between a peer role and the role of other mental health workers. 'It is possible to be a mental health worker without lived experience however it is not possible to be a consumer worker or carer worker without the lived experience' (Watson 2007, quoted in Beattie, Meagher and Farrugia 2013 p19). There are also people working in mental health who choose not to disclose lived experience. By definition, they are not peer workers, and are outside the scope of this study.
http://www.hwa.gov.au/sites/default/files/HWA_Mental%20health%20Peer%20Workforce%20Study_LR.pdf

National practice standards for the mental health workforce 2013

These standards outline capabilities that all mental health professionals should achieve in their work. They are intended to complement discipline-specific practice standards or competencies of the professions of nursing, occupational therapy, psychiatry, psychology and social work.

This revised set of standards (updated from the 2010 version) is intended to strengthen the workforce and to outline the values, attitudes, knowledge and skills required when individual members of one of the five professions listed above work in a mental health service. Implementing the practice standards will promote a coordinated and consistent approach to professional development and service improvement.

- Standard 1: Rights, responsibilities, safety and privacy
- Standard 2: Working with people, families and carers in recovery-focused ways
- Standard 3: Meeting diverse needs
- Standard 4: Working with Aboriginal and Torres Strait Islander people, families and communities
- Standard 5: Access
- Standard 6: Individual planning
- Standard 7: Treatment and support
- Standard 8 Transitions in care
- Standard 9: Integration and partnership
- Standard 10: Quality improvement
- Standard 11: Communication and information management
- Standard 12: Health promotion and prevention
- Standard 13: Ethical practice and professional development responsibilities

http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-wkstd13

A national framework for recovery-oriented mental health services: Guide for practitioners and providers

Commonwealth of Australia 2013
This document is a guide for mental health practitioners and services to Australia's national framework for recovery-oriented mental health services. It provides definitions for the concepts of recovery and lived experience. It describes the practice domains and key capabilities necessary for the mental health workforce to function in accordance with recovery-oriented principles. And it provides guidance on tailoring recovery-oriented approaches to respond to the diversity of people with mental health issues, to people indifferent life circumstances and at different ages and stages of life.

Practice domains and capabilities

Domains
Domain 1: Promoting a culture and language of hope and optimism (overarching domain) The culture and language of a recovery-oriented mental health service communicates

positive expectations, promotes hope and optimism and results in a person feeling valued, important, welcome and safe.

Domain 2: Person 1st and holistic
Domain 3: Supporting personal recovery
Domain 4: Organisational commitment and workforce development
Domain 5: Action on social inclusion and the social determinants of health, mental health and wellbeing

Sixteen Capabilities sit under the domains.
http://www.health.gov.au/internet/main/publishing.nsf/Content/67D17065514CF8E8CA257C1D00017A90/$File/recovgde.pdf

A mental health workforce strategy for multicultural Australia

Access to services staffed by mental health practitioners who can adequately assist and support them has a direct and positive impact on the health care outcomes of people of migrant and refugee background. People from diverse cultural and linguistic backgrounds face additional barriers and challenges in accessing the services and support they need when mental health issues arise.

In response, the Mental Health in Multicultural Australia (MHiMA) project is developing a draft national strategy that aims to improve the capacity of the mental health workforce to provide high quality treatment, care and support and address the needs and preferences of all members of Australia's multicultural community.

The strategy will be developed following a thorough review of evidence, practice information and sector consultation, including:

- Current, peer-reviewed literature on mental health, cultural diversity and workforce;
- Best practice guidelines and standards related to mental health, cultural diversity and workforce;
- Relevant existing national and state/ territory policies, frameworks and strategies; and
- Key stakeholders across a range of sectors including mental health professionals, services and organisations, education and training providers and culturally diverse consumers of mental health, their families and carers.

The aim is to identify the most critical issues with a view to developing focused and practical actions that can be undertaken in the short to mid-term, and beyond by 2015.
http://www.mhima.org.au/a-mental-health-workforce-strategy-for-multicultural-australia

Multicultural Mental Health Australia

National Cultural Competency Tool (NCCT) for Mental Health Services, 2010
The NCCT has been designed for use by all mental health services. This includes mainstream, multicultural, clinical, community-based and office-based services in all states

and territories, irrespective of size, location or type of service. Its development has been informed through extensive consultation across mental health sectors nationally.

The NCCT is a resource pack consisting of a set of National Cultural Competency Standards and a range of practical aids and strategies. The National Cultural Competency Standards are aligned with Standard 4 - Diversity Responsiveness of the National Standards for Mental Health Services, 2010 and the tool aims to assist services in working progressively to achieve this standard.

This national tool will assist services in meeting the National Standards for Mental Health Services (NSMHS), which will in turn facilitate effective engagement by the mental health workforce with people from CALD backgrounds. Enhanced competency and confidence in working transculturally will positively influence the recovery process.
file:///Users/janetpeters/Downloads/Final+MMHA+NCCT+as+16+Sept+2010.pdf

Examples of State or Territory activities

Examples of the workforce work of four states are outlined below.

- ### Victoria

The Victoria's Specialist Mental Health Workforce Framework: Strategic Directions 2014--24, supported by implementation plans for clinical mental health services and Mental Health Community Support Services (MHCSS) was published.

The strategy and implementation plans provide clear direction about future workforce development strategies and actions that will help Victoria's mental health workforce to respond to the significant reforms currently taking place in the mental health service system. These documents adopt a new way of thinking about workforce development, taking a holistic approach to workforce planning and focusing on enhancing practice, culture and the work environments of organisations. This will ensure that Victoria's mental health workers feel valued, supported and have the capacity to work strongly in partnership with people with mental illness, their carers and families.

A workforce data collection of the then-Psychiatric Disability Rehabilitation Support Services undertaken in 2012 has also been released. This census was conducted to establish a baseline report about our community mental health sector workforce prior to the re-commissioning of MHCSS services.

- Victoria’s specialist mental health workforce framework Strategic directions 2014-24
- Clinical mental health implementation plan 2014-17
- Mental Health Community Support Services implementation plan 2014–19
- Victorian psychiatric disability and rehabilitation support services (PDRSS) workforce census report 2012

http://www.health.vic.gov.au/workforce/reform/mental-health-strategy.htm

- ## Western Australia

The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025

The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (the Plan), was developed by the Mental Health Commission, the Drug and Alcohol Office and the Department of Health. The Department of Corrective Services was also involved in developing the forensic component of the Plan. Combining research, evidence, expert opinion, world's-best practice and some of the latest planning tools, we are now able to estimate the optimal mix of services required for our growing population over the next ten years.

As actions outlined in the Plan are implemented, over the next ten years there would be emerging new work roles in the mental health, alcohol and other drug workforce. Along with new roles comes the need for a greater focus on core competencies and increased service standards to reflect new, more flexible and responsive ways of providing services.

Build capacity across the specialist workforce.

A specifically qualified workforce is essential to provide services across the mental health, alcohol and other drug system. Increases in workforce numbers and improvements in the capabilities of the workforce are essential. It is important that this is supported by the establishment of substantive work roles and career pathways. A key element of this change would result in a workforce that has greater capacity to manage co-occurring mental health, alcohol and other drug problems.

Figure 20 identifies the levels of involvement various services would need to have in mental health, alcohol and other drug service delivery in the optimal mix of services. It also depicts the specificity of workforce capabilities across the whole health service delivery spectrum.

- Tier 1 Whole of population focus, prevention, social determinants, education, law enforcement, and community services.
- Tier 2 Primary healthcare, community services, information services, peer support, and self-help groups.
- Tier 3 Specialist assessment and referral, corrections, case management, relapse prevention, community pharmacotherapy, and counselling.
- Tier 4 Services for people with complex needs, specialist case management, and residential rehabilitation.

An efficient system requires all services in Tier 1 to have the knowledge and skills to screen for mental health, alcohol and other drug problems and refer to specialist services for assessment and treatment where needed. Tier 2 workforces should receive mandatory training on Mental Health First Aid. Tier 3 workers are competent in the provision of psychiatric treatment, and alcohol and other drug specific interventions. Tier 4 worker have the capacity to provide specialist mental health, alcohol and other drug services including recovery programs.

Also of note is to:

- Increase peer workforce
- Increase Aboriginal workforce
- Increase community coordination
- Increase communication and treatment technology.

http://www.mentalhealth.wa.gov.au/Libraries/pdf_docs/Plan_27_11_2014_for_consultation_3.sflb.ashx

Government of Western Australia
The Mental Health Commission offers scholarships to complete approved university and polytechnic studies in mental health. The scheme is part of the Commission's commitment to building a sustainable, highly trained and capable mental health workforce.

• Tasmania

A Workforce for the Future: Tasmanian Community Services Sector Workforce Development Plan 2012 – 2015.

Priorities are:

One: Increasing and retaining our current and future workforce
We will work together across the sector to create attractive accessible career options for our current and future workforce. We will structure pathways within our sector and promote community services as a rewarding career choice. We will improve Human Resources (HR) knowledge and practice, and build productive, supportive workplace cultures.

Two: Building workforce development and planning capacity across the sector
We will improve information and data about our workforce, including training needs analyses, as the basis for improving our capacity for strategic future-focused workforce development and planning.

Three: Raising and updating our skills right across the sector
We will invest in skills development and training in evidence-based practice. We will work in partnership with the VET and higher education institutions to create practical articulation pathways that reflect the needs of our current and future workforce.

The Plan covers the period 2012-2015 and includes the following specialist sectors:

- Alcohol and other drugs
- Children and family support services
- Community mental health
- Community and neighbourhood houses
- Housing and homelessness services
- Migrant and refugee support services
- Youth specific services.

http://www.mhct.org/documents/workforcedevelopmentplan_proof3Draft4.pdf

- ## New South Wales

Mental health and wellbeing is everyone's responsibility. And that doesn't just mean everyone in the health sector. That's why one of the most important aspects of the Commission's *Living Well: A Strategic Plan for Mental Health in NSW 2014–2024*, released in December 2014, is that it is a whole-of-government plan with a whole-of-community focus.
http://www.mhpn.org.au/NewsArticle/417/NSW-MHC-strategic-plan-released#.VRGn4pOUc-I

An excerpt from this report notes:

"We need to build a vibrant professional community mental health workforce that eases the pressure on acute crisis services and enables consumers to find care and support closer to home. We need a new way of arranging our workforce to make the most of people's skills. This will require:

- *rapid growth of the peer workforce*
- *strategies to ensure the most efficient use of the scarce specialist clinical workforce, including relieving people of non-clinical work*
- *workforce planning that acknowledges the different demands of community-based care and recovery-oriented practice*
- *better integration of GPs within our mental health system".*

The indicators of reform at a glance
We will increase

- positive mental health and wellbeing
- participation by people with a mental illness
- the peer workforce
- positive experience of service delivery
- the proportion of NSW mental health funding spent on community-based services.

We will decrease

- psychological distress in the community
- discrimination and stigma
- suicide and suicidal behaviour
- the use of involuntary treatment orders
- the proportion of people in the prison population who have mental illness.

http://nswmentalhealthcommission.com.au/node/2066

Agencies & activities

The Centre of Excellence in Peer Support (CEPS)

Funded by Mind Australia this provides a centralised specialist clearinghouse and online resource centre for mental health peer support. It was set up in response to the growing interest in and recognition of peer support work, for both consumers and families/carers. A collaborative project, CEPS aims to support a sustainable peer support sector by providing linkage, service mapping and information sharing. It is intended for use by consumers, families/carers, peer support workers, community mental health organisations, NGOs and individuals who provide or want to provide peer support. It was launched in June 2011.

This website aims to support best practice in peer support by providing central point for information sharing and exchange. It provides access to resources, research, a Directory of services and a community of practice, through the Forum. You can advertise or find out about upcoming training and employment opportunities (positions currently advertised) here. The website is designed as a collaborative resource, made up of the contributions of the diverse range of people and organisations who provide peer support. Please contribute your knowledge, experience, suggestions, ideas, research and resources you have to share by emailing peersupport@mindaustralia.org.au.
http://www.peersupportvic.org/index.php/2014-12-15-22-41-32/2014-12-15-22-45-36

The National Mental Health Consumer and Carer Forum (NMHCCF)

The National Mental Health Consumer & Carer Forum (The Forum) is a united, independent and national voice of consumers and carers committed to reforming mental health in Australia.

Our membership comprises a mental health consumer and carer representative from each state and territory, plus representatives from key national health and mental health consumer and carer organisations, as well as major population groups.

The NMHCCF:

- provides a strong, united voice for mental health consumers and carers focused on influencing national, state and territory policy and service development discussion
- utilises our members lived experience and expertise in mental health to identify what does and does not work in mental health, as well as key human service policies and practice
- promotes approaches that support individual recovery and contributes to an improved mental health and human services system at all levels.

http://nmhccf.org.au/publication/nmhccf-brochure

VICSERV

VICSERV is a membership-based organisation and the peak body representing community managed mental health services in Victoria.

They pursue the development and reform of mental health services and they support members by:

- Promoting recovery oriented practice
- Building and disseminating knowledge
- Providing leadership
- Building partnerships and networks
- Undertaking workforce development, training and capacity building
- Promoting quality in service delivery
- Undertaking advocacy and community education

http://www.vicserv.org.au/about-us/who-we-are.html

Report: Community Managed Mental Health: An agenda for the future.
This paper is a major statement about the required elements for reform within community managed mental health services and in government policy and funding. It has been prepared by VICSERV with three aims.

- First, to provide a roadmap for the development of community managed mental health services in Victoria over the next five years.
- Secondly, as a resource for VICSERV members in their deliberations about required changes in their organisations and,
- Thirdly, to inform and influence the Victorian and Commonwealth Governments' policy and funding of these services.

http://www.vicserv.org.au/uploads/documents/policy%20documents/AgendaForTheFutureMay2012.pdf

Mental Health Coordinating Council

This agency is the peak body for NGOs for NSW.

Our overall strategy in workforce development aims to ensure that:

- service delivery is characterised by quality, innovation, and evidence based practice;
- service delivery involves a continuous process of enhancing the workforce to ensure it is capable of delivering organisational objectives into the future; and
- necessary steps are taken to improve the skills and capacity of the mental health workforce

- This includes addressing career development, workforce expansion, organisational governance and management.

http://www.mhcc.org.au/sector-development/workforce-development/developing-our-workforce.aspx

What We Do

- Advocate for policy development and legislative reform;
- Represent the views of our sector to government and the broader human services sector through consultation with consumers, carers, and other stakeholders;
- Build sector capacity through partnerships, collaboration, and workforce development;
- Inform the sector on strategic directions in community mental health;
- Research, publish and report on current directions in community mental health and related areas;
- Provide high quality, accredited training in recovery oriented and trauma informed practice;
- Support and nurture its member organisations to deliver recovery oriented services in collaboration with consumers, carers, other organisations and the community.

MHCC achieves this by:

- Providing leadership and representation
- Working with and developing the sector
- Providing quality training solutions.

http://www.mhcc.org.au/home/about-mhcc/what-we-do.aspx

Many resources are available on this website for example:

- **Workforce development guide**
  This workforce development guide is the Mental Health Coordinating Council's response to an identified need for a coordinated and strategic approach to the growth of the community-based mental health sector. The guide is fundamentally structured towards a whole-of-systems approach, which will assist community organisations to embody the principles of a recovery-oriented organisation and work effectively, and in collaboration with consumers and carers, to achieve these outcomes in practical terms.

http://www.mhcc.org.au/home/publications/workforce-development-guide.aspx

- **Recovery for Young People: Recovery Orientation in Youth Mental Health and Child and Adolescent Mental Health Services (CAMHS**): Mental Health Coordinating Council 2014, Discussion Paper, MHCC, Sydney, NSW.

http://www.mhcc.org.au/media/50501/mhccrecoveryforyoungpeople-discussionpaper.pdf

- **Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia, A National Strategic Direction**

http://www.mhcc.org.au/media/32045/ticp_awg_position_paper__v_44_final___07_11_13.pdf

The Mental Health Coalition of South Australia

This is the peak body for the non-government mental health sector in South Australia.
Our Vision: All South Australians affected by mental illness are receiving the support they need to live well in the community.

Our Mission: To influence the development, range and responsiveness of services to support people affected by mental illness by:

- Working to reduce stigma and increase an understanding of mental illness and its prevention
- Representing and working with the community mental health service sector (non government) to support people affected by mental illness
- Promoting and building the role of the community mental health service sector (non government).

http://mhcsa.org.au/about

Among other things this agency provides training including:

- Certificate IV Mental Health CHC40512, a nationally recognised qualification
- Forensic Mental Health workshop
- Open Your Mind workshop
- Lived experience and peer work professional development
- Other mental health training customised for your organisation.

http://mhcsa.org.au/training

Australasian College of Health Service Management (NSW Branch)

Reading List on Workforce Planning
This is an 11-page list of online references related to workforce planning in mental health across several countries.
www.achsm.org.au/DownloadDocument.ashx?DocumentID=215

CANADA

National policy

Government of Canada

Mental health is a crucial dimension of overall health and an essential resource for living. It influences how we feel, perceive, think, communicate and understand. Without good mental health, people can be unable to fulfil their full potential or play an active part in everyday life. Mental health issues can address many areas, from enhancing our emotional well-being, treating and preventing severe mental illness to the prevention of suicide.

Provincial and territorial governments have primary jurisdiction for the planning and delivery of mental health services in Canada. The federal government, primarily through Health Canada and the Public Health Agency of Canada, collaborates with the provinces and territories in a variety of ways to develop responsive, coordinated and efficient mental health service systems.

Health Canada and the Public Health Agency of Canada support mental health research, develop programs and policies designed to promote and support the needs of people with mental health problems and disorders.
http://www.hc-sc.gc.ca/hl-vs/mental/index-eng.php

Health care in Canada is changing. Provincial governments are investing a higher proportion of their revenues to meet public needs and expectations for health care. These demands are shaped by broader access to information on health care treatments and options, as knowledgeable patients/consumers request advanced treatments informed by current research. Consumers are also expecting smoother care pathways, with transitions across departments, institutions, and settings built around their needs and experience, rather than the convenience of the health care provider.

Canadians – as individuals and through the governments they elect – expect assurance that greater investment achieves more than increased health care activity. We call for a sustainable system that is accountable for clinical outcomes.
http://www.camh.ca/en/hospital/about_camh/mission_and_strategic_plan/Documents/StrategicPlan_Short_10May2012.PDF

Mental Health Strategy for Canada

Changing Directions, Changing Lives, released in May 2012, is the first mental health strategy for Canada. It aims to help improve the mental health and well-being of all people living in Canada, and to create a mental health system that can truly meet the needs of people living with mental health problems and illnesses and their families.

Mental health concerns us all. Mother, father, neighbour, friend – one in five Canadians will experience a mental health problem or illness every year, with a cost of well over $50 billion to our economy. And many people either don't seek or can't get the services and supports they need to recover a meaningful life.

The Strategy draws on the experience, knowledge and wisdom of thousands of people across the country, and provides an opportunity for everyone's efforts – large and small – to help bring about change.

A first phase of work was completed in 2009 with the release of Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada, which put forward a vision and broad goals for transforming the mental health system.

The Strategy translates this vision into 26 priorities and 109 recommendations for action, grouped under the following **6 Strategic Directions**:

1. Promote mental health across the lifespan in homes, schools, and workplaces, and prevent mental illness and suicide wherever possible.
2. Foster recovery and well-being for people of all ages living with mental health problems and illnesses, and uphold their rights.
3. Provide access to the right combination of services, treatments and supports, when and where people need them.
4. Reduce disparities in risk factors and access to mental health services, and strengthen the response to the needs of diverse communities and Northerners.
5. Work with First Nations, Inuit, and Métis to address their mental health needs, acknowledging their distinct circumstances, rights and cultures.
6. Mobilize leadership, improve knowledge, and foster collaboration at all levels.

http://www.mentalhealthcommission.ca/English/initiatives-and-projects/mental-health-strategy-canada

Mental Health Commission of Canada

National Standard for Psychological Health and Safety in the Workplace

The free and voluntary National Standard for Psychological Health and Safety in the Workplace was published in 2012. It is intended to provide systemic voluntary guidelines for Canadian employers that will enable them to develop and continuously improve psychologically healthy and safe work environments for their employees.

The Mental Health Commission of Canada (MHCC) championed the development of the Standard in collaboration with the Canadian Standards Association (CSA) and the Bureau de normalization du Québec (BNQ). Information is also available regarding implementation.
http://www.mentalhealthcommission.ca/English/issues/workplace/national-standard

The Aspiring Workforce Report: Employment and income for people with serious mental illness

This report was produced in collaboration with the Centre for Addiction and Mental Health (CAMH), the University of Toronto, and Queen's University. It provides several recommendations to help policy makers, governments, and employers strengthen workplace support for Canadians with serious mental illness.

The recommendations include ensuring supported employment programs that help people find and keep jobs are well-matched to interests and career goals; the development of a formal network to advance the development, growth, and legitimacy of social businesses for people with mental illnesses; changes to disability support policies to provide flexibility that recognizes individuals with mental health issues often have intermittent work capacity; and, increasing the Aspiring Workforce's 'workplace know-how,' including everything from better understanding their human rights to improving the knowledge and understanding of the symptoms of their illness.
http://www.mentalhealthcommission.ca/English/system/files/private/document/Workplace_MHCC_Aspiring_Workforce_Report_ENG_0_0.pdf

Mental Health First Aid (MHFA)

MHFA is the help provided to a person developing a mental health problem or experiencing a mental health crisis. Just as physical first aid is administered to an injured person before medical treatment can be obtained, MHFA is given until appropriate treatment is found or until the crisis is resolved.

The MHFA Canada program aims to improve mental health literacy, and provide the skills and knowledge to help people better manage potential or developing mental health problems in themselves, a family member, a friend or a colleague.

Examples of groups that have taken MHFA:

- Families affected by mental health problems
- Secondary and post-secondary instructors, counsellors, and administrators
- Health service providers
- Corporations
- Emergency workers including fire, ambulance, and police services
- Frontline workers who deal with the public
- Volunteers
- Human resources professionals
- Employers and managers
- Community groups including new immigrants, homelessness advocates, and chronic disability support services

This is useful as it educates people who have contact with people who have a mental health problem – that is – the wider workforce.
http://www.mentalhealthcommission.ca/English/initiatives-and-projects/mental-health-first-aid

IKEN-MH

The goal of the IKEN-MH is to reduce the time from innovation to implementation to improve population mental health while focusing its efforts on:

- Building capacity & infrastructure;
- KE research and tool development;
- Utilizing technology to enhance connectivity; and
- Increasing the uptake of evidence informed knowledge.

http://www.mentalhealthcommission.ca/English/initiatives-and-projects/knowledge-exchange-centre/international-knowledge-exchange-network-mental-h

Opening Minds

This is the largest systematic effort in Canadian history focused on reducing stigma related to mental illness. Established by the MHCC in 2009, it seeks to change Canadians' behaviours and attitudes toward people living with mental illness to ensure they are treated fairly and as full citizens with opportunities to contribute to society like anyone else.

Two reports related to workforce are:

- Reducing the Stigma of Mental Disorders at Work: A Review of Current Workplace Anti-Stigma Intervention Programs
- Mental disorders and their association with perceived work stress: An investigation of the 2010 Canadian Community Health Survey

http://www.mentalhealthcommission.ca/English/initiatives-and-projects/opening-minds

Peer support

Peer support is a supportive relationship between people who have a lived experience in common. In the case of Peer Support, the experience that individuals or groups have in common is in relation to a mental health challenge or illness. The Mental Health Commission of Canada launched the Peer Project in 2010. The focus of this project was to learn from the experience of peer support workers across Canada and help recognize peer support as an essential component of the mental health services.

Guidelines of practice for peer support
Based on the recommendations of 2010's Making the Case for Peer Support report; the Peer Project is working to create guidelines of practice promoting the continued use of the grassroots, community-based peer support practices that have been so successful to date. Set to be released in 2013, these guidelines will outline the values, principles of practice, and skills and abilities of peer support workers—and provide much-needed insight and guidance to policymakers and program leaders on how to maximize the benefits of peer support programs.

Peer support training and workplace programs
The Peer Project is also bringing together organizations with experience in peer support training—and the desire to share their knowledge. Through this increased collaboration, the

Peer Project plans to establish not only national guidelines of practice but also competencies and training curricula for peer support workers. And as these communities of practice grow, focus will be able to shift toward the provincial/territorial policy level to ensure peer support is recognized as a key component of Canada's mental health system.

Changing attitudes toward mental illness
In addition to developing guidelines of practice, the Peer Project also seeks to encourage a change in societal attitudes toward mental illness through the use of peer-based education in our schools and workplaces. It is hoped these strategies will enable Canadians to better understand the realities of mental health issues, ultimately leading to a more supportive society.
http://www.mentalhealthcommission.ca/English/initiatives-and-projects/peer-project

Canadian State activities

Examples include:

- **Ontario**

Ontario Mental Health and Addictions Strategy: Strengthening the Workforce Theme Group Paper

> *"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."(p.4)*

This report notes:

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.
http://www.health.gov.on.ca/en/public/programs/mentalhealth/advisorygroup/docs/theme_workforce.pdf

The Executive Summary states:

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.
- 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 wellbeing.

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.
http://www.health.gov.on.ca/en/public/programs/mentalhealth/advisorygroup/docs/theme_workforce.pdf

Agencies & activities

Centre for Addiction and Mental Health (CAMH)

The Centre for Addiction and Mental Health (CAMH) is Canada's largest mental health and addiction teaching hospital, as well as one of the world's leading research centres in the area of addiction and mental health. CAMH combines clinical care, research, education, policy development and health promotion to help transform the lives of people affected by mental health and addiction issues. The website has many resources for staff.
http://www.camh.ca/en/hospital/about_camh/who_we_are/Pages/who_we_are.aspx

In 2014 the Centre for Addiction and Mental Health (CAMH) was named one of Canada's Best Diversity Employers for a fourth year in a row.

The Canada's Best Diversity Employers competition recognizes the nation's leading organizations when it comes to creating inclusive workplaces for employees from five diverse groups: women; visible minorities; persons with disabilities; Aboriginal peoples; and lesbian, gay, bisexual and transgender (LGBT) peoples.

Here are some of the reasons CAMH was selected as one of Canada's Best Diversity Employers for 2014:

- Manages "Employment Works!", a unique program to help those who have experience living with mental health or addiction problems to access meaningful employment. Since the program's inception, CAMH has hired over 300 individuals with histories of mental illness or addiction.
- Maintains an employment equity plan and diversity and inclusion strategy, reviewed on an annual basis, as well as a diversity and health equity strategy group, which meets quarterly and is comprised of employees from all levels of the organization
- Diversity goals are also included as a mandatory component of performance reviews and are integrated into interview questions for prospective employees
- Offers language interpretation services for clients in over 160 languages, available 24/7, and manages dedicated access service and care programs for a wide range of communities, including women's mental health, addictions programs for Aboriginal peoples, and is developing a refugee mental health training program.

CAMH Strategic Plan: vision2020: tomorrow.today
http://www.camh.ca/en/hospital/about_camh/mission_and_strategic_plan/Documents/StrategicPlan_Short_10May2012.PDF

CAMH also operates Portico, which is a network of addiction and mental health sites from across Canada. Portico offers clinical tools and evidence-based materials for health care providers, social service workers and others. While the resources on the core Portico pages are designed for professional use, they can be of equal interest to those with lived experience and their families. Portico hosts partner sites that are built and run by other groups and networks. They are editorially independent of the main site, with a variety of perspectives.
https://www.porticonetwork.ca/connect

Career Services Guide

May 26 2015

A new CERIC-funded *Career Services Guide* is seeking to improve the employment outcomes for people living with mental health problems and illnesses at a time when one in five Canadians experience a mental health issue.

Entitled *Career Services Guide: Supporting People Affected by Mental Health Issues*, the guide, along with supporting videos, has been developed by the Nova Scotia Career Development Association (NSCDA) along with project partners that include Great-West Life Centre for Mental Health in the Workplace, the Association, Healthy, Nova Scotia Certified Peer Support Specialist Program and Canadian Alliance for Mental Health and Mental Illness. The *Career Services Guide* was created in response to growing concerns from Canada's career professionals:

- An increasing number of clients disclosing mental illness as a barrier to employment
- Clients not thinking that practitioners had the specialized knowledge to support them if they have mental health concerns
- Practitioners unsure of how to handle stigma surrounding mental illness when helping clients access employment

The premise of the guide is that employment is a critical cornerstone of social inclusion, yet people living with mental illness face the highest unemployment rate of any disability group. It highlights that although individuals with mental health issues often want and are able to work, many find this a difficult goal to achieve.

This guide is intended for all career service workers, employment counsellors and career practitioners working in non-mental health specific employment settings. It builds on emerging best practices in employment support, recovery-oriented practices and draws on experts in the field of career counselling and the "experiential expertise" of people living with mental health problems and illness who access counselling services.
http://ceric.ca/?q=en/node/1063

Canadian Institute for Health Information (CIHI)

Care for Children and Youth With Mental Disorders, a new study by the **Canadian Institute for Health Information** (CIHI), shows that rates (defined as the number of patients per 100,000 population) of ED visits for mental disorders among children and youth (age 5 to 24)

increased by 45% from 2006–2007 to 2013–2014. Similarly, rates of inpatient hospitalizations that involved at least 1 overnight stay increased by 37% for Canadian children and youth over the same time period. Although the use of hospital services is increasing, there is no evidence to suggest that the prevalence of mental disorders in this age group has grown.

“The rising rates of hospital visits by young Canadians for mental disorders could be due to a number of factors,” said Jeremy Veillard, CIHI’s vice president of Research and Analysis. “We may be seeing more patients in the hospital because the stigma around mental disorders is decreasing, and young people are more willing to seek help. The question for the health system is whether those services are best provided in hospitals, or whether young people could be more effectively treated in primary care or community-based settings.”
This has workforce development implications.
http://www.cihi.ca/CIHI-ext-portal/internet/en/Document/types+of+care/specialized+services/mental+health+and+addictions/RELEASE_07MAY15

The following are NGOs that have some workforce development activities.

Canadian Mental Health Association

The Canadian Mental Health Association (CMHA), founded in 1918, is one of the oldest voluntary organizations in Canada. Each year, we provide direct service to more than 100,000 Canadians through the combined efforts of more than 10,000 volunteers and staff across Canada in over 120 communities.

As a nation-wide, voluntary organization, the Canadian Mental Health Association promotes the mental health of all and supports the resilience and recovery of people experiencing mental illness. The CMHA accomplishes this mission through advocacy, education, research and service.

CMHA branches across Canada provide a wide range of innovative services and supports to people who are experiencing mental illness and their families. These services are tailored to the needs and resources of the communities where they are based. One of the core goals of these services is to help people with mental illness develop the personal tools to lead meaningful and productive lives.
http://www.cmha.ca/cmha-national-strategic-plan-2012-2017/

Mental Health Works

This is an initiative of the Canadian Mental Health Association, Ontario. The core of Mental Health Works is the team of expert trainers in communities across the country who are certified to deliver a variety of workshops that address common mental health-related issues. Many resources and training types are available.
http://www.mentalhealthworks.ca/sites/default/files/free_resources/MHW_workplace_resource_web_June2012.pdf

The Mood Disorders Society of Canada

This agency has grown out of the vision and drive of a number of mental health consumer leaders from across Canada who in 1995 saw the need for a broad-based structure to bring consumers of mental health services together and who believe that consumers have a key role to play with regard to education and advocacy at the national level.

It was formally launched and incorporated in 2001 with the overall objective of providing people with mood disorders with a strong, cohesive voice at the national level to improve access to treatment, inform research, and shape program development and government policies with the goal of improving the quality of life for people affected by mood disorders. The MDSC's overall objective is to provide people with mood disorders with a strong, cohesive voice at the national level by:

- Raising the awareness of mood disorders as treatable medical disorders and working to eliminate the barriers to full community participation and reducing discrimination and stigma among the public, treatment and service providers, and governments.
- Building a national clearinghouse of information and resources related to mood disorders issues.
  Advocating for the creation of adequate and accessible, stigma free programs for those Canadians living with or suffering from a mental illness.
- Ensuring that the voices of consumers and family members are accurately understood and communicated on issues of national importance by building on existing networks and alliances.

http://www.mooddisorderscanada.ca/page/about-us

The Canadian Alliance on Mental Illness and Mental Health (CAMIMH)

This is a non-profit organization comprised of health care providers as well as organizations which represent individuals with lived experience of mental illness. Established in 1998, CAMIMH is a volunteer run organization that provides mental health education to the public. A fundamental objective of CAMIMH is to engage Canadians in a national conversation about mental illness. By starting this conversation, CAMIMH hopes to reduce the stigma associated with mental illness and provide insight into the services and support available to those living with mental illness.

One of CAMIMH's major annual initiatives is the Faces of Mental Illness campaign, a national education campaign that operates in conjunction with Mental Illness Awareness Week (MIAW). MIAW will reach more Canadians than ever before through their annual campaigns.
http://www.camimh.ca/

ENGLAND

National policy

Department of Health

Closing the gap: priorities for essential change in mental health

The document sets out 25 priorities for change. It details how changes in local service planning and delivery will make a difference to the lives of people with mental health problems in the next 2 or 3 years.

This supports the government's mental health strategy 'No Health without Mental Health'. across-government mental health outcomes strategy for people of all ages; has six shared objectives to improve mental health outcomes for individuals and the population as a whole. In this one objective is that 'fewer people will experience stigma and discrimination' (Department of Health 2011). A clear commitment is made to challenge stigma by supporting and working actively with the Time to Change program and others.

NHS

Five Year Forward View (October 2014)

The Forward View document sets out how the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and prevent ill-health.

A part of this document relating to mental health states:

> BOX 3.2: FIVE YEAR AMBITIONS FOR MENTAL HEALTH
>
> Mental illness is the single largest cause of disability in the UK and each year about one in four people suffer from a mental health problem. The cost to the economy is estimated to be around £100 billion annually – roughly the cost of the entire NHS. Physical and mental health are closely linked – people with severe and prolonged mental illness die on average 15 to 20 years earlier than other people – one of the greatest health inequalities in England. However only around a quarter of those with mental health conditions are in treatment, and only 13 per cent of the NHS budget goes on such treatments when mental illness accounts for almost a quarter of the total burden of disease.

Over the next five years the NHS must drive towards an equal response to mental and physical health, and towards the two being treated together. We have already made a start, through the Improving Access to Psychological Therapies Programme – double the number of people got such treatment last year compared with four years ago. Next year, for the first time, there will be waiting standards for mental health. Investment in new beds for young people with the most intensive needs to prevent them being admitted miles away from where they live, or into adult wards, is already under way, along with more money for better case management and early intervention. This, however, is only a start.

We have a much wider ambition to achieve genuine parity of esteem between physical and mental health by 2020. Provided new funding can be made available, by then we want the new waiting time standards to have improved so that 95 rather than 75 per cent of people referred for psychological therapies start treatment within six weeks and those experiencing a first episode of psychosis do so within a 27 fortnight. We also want to expand access standards to cover a comprehensive range of mental health services, including children's services, eating disorders, and those with bipolar conditions. We need new commissioning approaches to help ensure that happens, and extra staff to coordinate such care. Getting there will require further investment.

http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

The Mental Health Taskforce, 2015

This Taskforce brings together health and care leaders and experts in the field, including people using services, to lead a programme of work to create a mental health Five Year Forward View for the NHS in England.

Formed in March 2015, its principal task is to develop a new five-year national strategy for mental health covering services for all ages, which will be published in autumn 2015. This will be the first time there has been a NHS England-led strategic approach to designing mental health services for all ages spanning the health and care system. In order to develop the strategy, the taskforce will explore the variation in access to and quality of mental health services across England; look at outcomes for people who are and aren't able to access services and also consider ways to tackle the prevention of mental health problems. The views of people with mental health problems and their families and carers will be vital to this, as are the views of staff. The taskforce will ensure that people with personal experiences of mental ill health are engaged consistently in the delivery, monitoring and governance of the plan alongside other stakeholders with specific knowledge and interest.
http://www.england.nhs.uk/ourwork/part-rel/mh-taskforce/

Policy: Making mental health services more effective and accessible

These reforms of 2013 and 2014 describe information on strengthening skills in staff particularly in talking therapies.

https://www.gov.uk/government/policies/making-mental-health-services-more-effective-and-accessible--2

Transforming Primary Care Safe, proactive, personalised care for those who need it most

An excerpt from the executive summary relating to staff:

- Staff need to be given the time to focus on proactively caring for people. The Government and NHS England are working with the profession to free up time for GPs to provide proactive care and have already removed a number of task-based payments which had become overly bureaucratic.
- NHS England is working with the professions, patients and carers to further reduce bureaucracy and provide a clearer focus on outcomes and patient experience.
- Staff will be given the right training to ensure they can improve their skills to meet people's changing needs and work across traditional boundaries. Health Education England (HEE) will work with employers, professional bodies and education providers to ensure the workforce has the necessary skills to care for older people and those with complex needs and to support joint working.
- New ways of working also mean moving away from traditional professional boundaries and ensuring that staff are able to take on different roles where it benefits patients. Joint working will be further supported by improved information sharing, enabling staff to take decisions more effectively, and by timely access to GPs for staff in other health and social care settings.
- Finally, the Government will be working with NHS England, HEE and other system partners to embed the values and behaviours of the NHS Constitution.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/304139/Transforming_primary_care.pdf

Health Education England: Workforce Plan for England

HEE is a special health authority and has statutory responsibility for education and training of healthcare staff (and PH) which is mainly about commissioning the training/ education based on what's needed/ forecast.

In the first Plan In 2014/15 we published the first ever Workforce Plan for England, where we highlighted the fact that without a shared vision for the future models of care, our ability to commission the right workforce was considerably hampered.

This plan also included a workforce planning process that allowed us to bring together into one place decisions about:

- Planning the future medical workforce
- Planning the future non-medical workforce
- Investment in the education and training of existing staff
- Local needs and national priorities

- National workforce priorities alongside wider system/strategic goals.

http://hee.nhs.uk/wp-content/blogs.dir/321/files/2013/12/Workforce-plan-UPDATE-interactive.pdf

Proposed Education and Training Commissions for 2015/16

In the Executive Summary it states:

"HEE supports parity of practice for those with mental health and learning disabilities, and has a major programme of work covering the development and transformation of the multiprofessional workforce.

This year, our forecast for the mental health workforce describes a mixed picture. There are areas where significant increases have been made, for example, following a national policy commitment by the Government, we have produced a phenomenal increase in the Improving Access to Psychological Therapies (IAPT) workforce. We will commission an additional 190 this year (25% increase) which will contribute to a 1,548FTE growth in available supply (41%) over the next three years. We will commission an additional 100 training posts for mental health nurses in 15/16 (3% increase) contributing to a forecast growth in available supply of 2,630FTE (6.8%) over the next five years. This continued high level of training will allow for rapid growth over the next two years with more moderate growth from 2017, as a result of the ageing profile of this workforce.

Mental health service providers have forecast a reduced requirement for mental health nursing, but it is unclear to what extent this apparent reduction in 'demand' is the result of shifting employment patterns as opposed to affordability assumptions. The forecasts were collected from service providers before the recent policy announcements designed to ensure parity of esteem with physical health services. We have therefore chosen to endorse the overall rate of increase in mental health nursing proposed by our LETBs, rather than follow the more pessimistic demand line from providers.

The psychiatry workforce is divided into six specialties, and the main issue for all groups is that whilst the number of training posts should support significant growth, levels of low fill rate at Higher Specialist Training is now threatening this potential growth. Unless a different approach is taken, we will have insufficient supply to meet demand.

HEE has been working with the Royal College of Psychiatrists over the past year looking at how we can both encourage UK graduates into the specialty and how we improve the transition from core training into higher training in the specialties.

The picture for learning disability nurses is more mixed. Service providers are currently forecasting a decreased requirement, so at face value, the total additional supply needed to meet this forecast need is 0.4%. Some of this decreased demand may be accounted for by a shift of activity to non-NHS providers, but we are concerned that these forecasts may be overly influenced by affordability issues, and insufficiently aligned with the recent Bubb report. We therefore plan to increase commissions by 1.7% this year. In the context of historic growth, this should be more than sufficient to meet patient needs, but we will work with NHSE to understand their future service intentions, and to what extent any apparent 'decline'

actually represents changing sectors of employment (i.e. independent and social care sectors) rather than what is needed to deliver future models of care."
http://hee.nhs.uk/wp-content/blogs.dir/321/files/2012/08/HEE-investing-in-people-2015.pdf

15 year Strategic Framework

Health Education England (HEE) exists to improve the quality of care for patients by ensuring we have enough staff with the right, skills, values and behaviours available for employment by providers.

HEE produced Framework 15, a strategy based upon the needs of future patients to inform our long-term investment decisions, and more recently, we worked with the rest of the system to produce the Five Year Forward View.
http://hee.nhs.uk/wp-content/blogs.dir/321/files/2013/07/HEE_StrategicFramework15_2410.pdf

Public Health England (PHE)

Confidence, competence and commitment - building the skills of leaders and the workforce in public mental health

PHE is a government agency to provide support/ advice/ expertise/ leadership. PHE has published a national workforce development framework, launched at their annual summit in March 2015. The aim is to build the capacity and capability of leaders and a workforce that is confident, competent and committed to:

- promoting good mental health across the population
- preventing mental illness and suicide
- improving the quality and length of life of people living with mental illness

There are six ambitions for achieving this aim:

1. Advocacy - our leaders advocate for the mental health of citizens as a valuable resource for thriving communities and economies;
2. Expertise - a public health specialist workforce that has expertise to lead mental health as a public health priority
3. Community development - a local workforce working with communities to build healthy and resilient places
4. Mental health promotion - frontline staff are confident and competent in communicating with people about mental health and supporting them to improve it
5. Prevention - frontline staff are confident and competent in recognising signs of mental distress and supporting children, young people, parents and adults appropriately
6. Holistic practice - the health and social care workforce has the knowledge and skills to improve the health and wellbeing of people with a mental illness and reduce mental health inequalities

Each ambition outlines the key competencies required in the workforce and priorities for action. There are also 12 core principles that identify the common knowledge, beliefs and skills required by the entire workforce to address public mental health.

The framework is a practical document to guide the commissioning and delivery of local workforce development. It has been endorsed by 14 national partners who outline their commitment in the Call to Action. The documents can be downloaded at:
https://www.gov.uk/government/publications/public-mental-health-leadership-and-workforce-development-framework

Centre for Workforce Intelligence

The CfWI is a key contributor to the planning of future workforce requirements for health, public health and social care in England.

We are commissioned by the Department of Health, as well as Health Education England and Public Health England, to look at specific workforce groups and pathways, and to provide materials, tools and resources to inform workforce planning policy decisions at a national and local level.
http://www.cfwi.org.uk/

An example of one of their reports is: “My life, my support, my choice”. This document is jointly published by National Voices and Think Local Act Personal. It is endorsed by the national Children’s Health and Wellbeing Partnership as part of the Partnership’s work to support and enable integrated care and support for children and young people and families.
http://www.nationalvoices.org.uk/sites/www.nationalvoices.org.uk/files/tlapmylifemysupportmychoice_final.pdf

Agencies & activities

The Kings Fund

Workforce Planning in the NHS, April 2015 Report

Using national statistics, key publications and insights gained from interviews with expert stakeholders, this paper describes what is happening in the NHS workforce now in three key areas: mental health, general practice and community nursing. This analysis is presented alongside data that highlights providers’ reliance on agency staff. It looks at how workforce issues have been addressed across the system so far, explores the main challenges, and makes recommendations to improve workforce planning. There are major disconnects between strategic goals and workforce trends.

Key findings

- The greater strategic priority given to mental health has not translated into staff numbers on the ground.
- The rate of increase in the number of GPs has been dramatically outstripped by increases in the medical workforce in secondary care – a trend at odds with the ambition to deliver more care in the community.
- Despite long-standing ambitions to raise the level and range of community services provided, it is difficult to see any increases among key staff groups. Any such increases have been limited to areas with specific national targets.
- The information needed to guide workforce planning locally and nationally has not kept pace with the growing plurality of providers delivering NHS-commissioned services. There are large data gaps on primary and community care, use of agency and bank staff, vacancy rates, and independent and voluntary sector providers.

Policy implications

- Recent reforms have put Health Education England firmly in control of training the workforce of the future. But there needs to be a more joined-up approach to workforce planning today, with a national strategy that covers all NHS-commissioned services. This will avoid the current piecemeal approach to addressing workforce pressures.
- Building a national workforce strategy will require changes at national level to support providers as they develop strategies locally and across health systems, whether in relation to return-to-practice campaigns, international recruitment, making key professional careers more attractive to trainees, or other measures.
- Ensuring greater consistency between national strategy and the available workforce will also involve tackling questions of affordability. With pay overwhelmingly the biggest element of NHS costs, it is not credible for the recent trend of low real-terms growth to sustain any rapid increase in the NHS workforce.
- These considerations are vital in order for providers and the wider NHS to develop a workforce that is adaptable and able to deliver the new care models outlined in the NHS five year forward view.

http://www.kingsfund.org.uk/publications/workforce-planning-nhs

Nuffield Trust

"Nuffield Trust is an authoritative and independent source of evidence-based research and policy analysis for improving health care in the UK. We aim to help provide the evidence base for better health care. Our work programme focuses on a number of key areas in which we have expertise. These areas are outlined below – from these pages you will be able to access all our resources."
http://www.nuffieldtrust.org.uk/our-work

We are undertaking a series of projects looking at how we can adapt the workforce and health system to meet future needs. This includes research around future health care models, workforce planning, regulation and modernisation, education and training, and how performance can be improved.

Our research and analysis in this area aims to help policy-makers and organisations develop the health care workforce so that it better meets the needs of patients and society. Highlights of our work include:

- Research into the impact of technology on the health care workforce, and in particular the opportunities it offers to improve productivity.
- Identifying what the priorities are for the future health care workforce, including what opportunities there are to change the current skill mix, how the education and training budget should be invested, and how to develop the current workforce to better support new models of care.

http://www.nuffieldtrust.org.uk/our-work/health-systems-and-workforce

Mental Health Foundation

Starting today: The future of mental health services, 2013

Workforce (an excerpt from the summary)

“The mental health workforce of the future needs a balance of specialist and generalist staff, with clearly defined skills and roles, but able and willing to work collaboratively in support of individual patients. While we would urge an increased knowledge and understanding of mental health issues among generalist staff, and particularly GPs, as we would physical health issues among specialist mental health staff, it will be important not to water down the specialist skills that at times mentally ill people both need and want.

The very strong backing that peer support received during our Inquiry convinces us of the need to develop both formal and informal arrangements to increase opportunities for people with lived experience of mental illness to play a role within the future mental health workforce. We are not prescriptive about the precise role that trained peer support workers could play. This would need to be decided by local services, based on local expressed needs and choices.

Again without being prescriptive about the detail, and recognising the potential overlap with formal key workers and care coordinators, we strongly support the principle of a single individual within the future mental health workforce who can help people navigate their way through complex systems across health, social care, housing, employment and education (among other services) and access integrated care packages. In our view this would go a long way to ensuring that people not only receive the best support, but also play as full a role as possible in their community. This should be a priority area for research in terms of effectiveness and patient outcomes”. (p.4).
http://www.mentalhealth.org.uk/content/assets/PDF/publications/starting-today.pdf?view=Standard

Frontline First: Turning back the clock? RCN report on mental health services in the UK

Royal College of Nursing
This special Frontline First report Turning back the clock? Mental health services in the UK shows that mental health services are now under unprecedented strain, experiencing a steep fall in nurse numbers and available beds despite rising demand.

Recommendations:

1. Governments must ensure there is equal access to mental health services and that the right treatment is available for people when they need it.
2. Governments and NHS providers must ensure that the commitment to parity of esteem is directly reflected in the funding, commissioning of services, workforce planning, and patient outcomes.
3. Local commissioners and health boards must make available enough local beds to meet demand.
4. The principle of least restriction must be embedded across all mental health services. Detention under mental health legislation should always be based on clinical opinion and never be a result of local failures to provide appropriate care. Due to the significant increase in detentions under the Mental Health Act there should be a national objective set to reduce detention rates in England.
5. There must be a consistent shift across the UK from inpatient acute care to community-based services which recognises that prevention and early intervention results in better outcomes, reduces the pressure on acute services, and reduces the overall cost to the NHS in the long term.
6. Urgent action must be taken to address the workforce shortages. Resources must be committed to training and recruiting enough mental health nurses who are able to deliver specialist care in the changing health and social care landscape.
7. NHS providers must invest in the current mental health nursing workforce. Band 6, 7 and 8 mental health nurses should be developed to become advance practitioners to deliver effective recovery-led care in mental health services.
8. There must be a sustainable and long-term workforce planning strategy which acknowledges the current challenges facing the mental health nursing workforce.

https://www.rcn.org.uk/__data/assets/pdf_file/0004/600628/004772.pdf

Skills for Care

The care and support needs of people who use social care services can often indicate a heightened risk of poor mental health and wellbeing. Skills for Care estimate that 4–500,000 social care workers have regular contact with people who have a mental health problem. It is important that staff working in social care services know how to support and promote good mental health and overall wellbeing for everyone who uses those services.

With this in mind, Skills for Care has published the *Common core principles to support good mental health and wellbeing in adult social care*, based on work by the Mental Health Foundation. The common core principles and two key areas outlined in the

supporting *Practice guide* offer a comprehensive framework for the social care workforce to provide consistent high quality social care and support which promotes the mental health and wellbeing of people who need care and support. The guide to good practice is based upon real life examples from a range of social care settings, which demonstrate how each of the ten principles and two key areas can be applied in practice.

- Common core principles to support good mental health and wellbeing in adult social care
- Principles to practice - good mental health and wellbeing in adult social care

Skills for Health

Skills for Health major in workforce and organisational development. We are the employers' trusted provider of workforce solutions designed to improve healthcare, raise quality and improve productivity and financial performance. We are a not for profit organisation and the Sector Skills Council for the whole UK health sector, licensed by Government.
Our aim is to:

- Help you maximise the potential of your workforce
- Deliver workforce transformation
- Improve quality, productivity and health outcomes.
- Raise standards in skills and training delivery

Our expert staff work with employers helping them establish a more efficient and productive healthcare workforce that is fully sustainable.
http://www.skillsforhealth.org.uk/about/who-we-are

Skills for Health worked in partnership with the National CAMHS Workforce Programme (DH) to develop resources to support local CAMHS teams. The work of the Programme looked to ensure that children's psychological health and wellbeing services are effectively commissioned and provided by local services in England.

What this means for the workforce
As a part of the Workforce Programme a range of tools and materials were developed nationally to support the ongoing development of services, teams and staff within CAMHS.

Comprehensive workforce planning guidance is available on the CAMHS Workforce Hub.

Resources
Skills for Health has worked closely with the National CAMHS Workforce Programme to develop a CAMHS workforce that can tackle those challenges the service presents. These products include Core Functions – CAMHS Tier 3 & 4 (specialist targeted services) – which can act as the building blocks for a wide variety of workforce development processes. An evaluation document based on the experiences of three pilot sites that used the core functions is also available:

- Core functions
- Core functions evaluation guide

Developing a team approach for children
Skills for Health supported the development of a suite of resources Creating capable teams for children and young people, which is a team approach to support services for children and young people to improve quality and efficiency by exploring new, different and creative ways of working.

Capable Teams for Children and Young People (CTCYP): facilitator's handbook
Provides facilitators with a structured framework to enable them to deliver CTCYP. Includes http://www.skillsforhealth.org.uk/resources/service-area/23-child-and-adolescent-mental-health-services-camhs?highlight=WyJtZW50YWwiLCJoZWFsdGgiLCJoZWFsdGgnIiwiaGVhbHRoJ3MiLCInaGVhbHRoJyIsIndvcmtmb3JjZSIsIndvcmtmb3JjZSdzIiwiJ3dvcmtmb3JjZSciLCJ3b3JrZm9yY2UnIiwibWVudGFsIGhlYWx0aCIsIm1lbnRhbCBoZWFsdGggd29ya2ZvcmNlIiwiaGVhbHRoIHdvcmtmb3JjZSJd

Monitoring the Mental Health Act 2013/2014

Uses of the Mental Health Act have grown. At the end of 2013/14, there were 23,531 people subject to the act, either detained in hospital or under a community treatment order. This represents an increase of 6% from 2012/13. As the number of detained patients continues to increase, we continue to make sure that health and social care services provide them with safe, effective, compassionate and high-quality care.

During 2013/14, we carried out 1,227 MHA monitoring visits, meeting more than 4,500 patients, and our MHA Reviewers carried out 174 inspections with the mental health inspection teams. Our inspections highlighted the variation of care provided to detained patients. Too often we found services that are not routinely involving patients in their treatment. In addition, we are concerned with the issue of bed availability and the increasing number of patients being detained far away from home.
http://www.cqc.org.uk/content/mental-health-act-annual-report-201314

A positive and proactive workforce A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health

Department of Health, Skills for Health & Skills for Care, 2014

This report outlines some key points for organisations to ensure that any restrictive practice or intervention is legally and ethically justifiable and underpinned by following key principles which are shared with the DH guidance:

- Compliance with the relevant rights in the European Convention on Human Rights at all times.

- Understanding people's behaviour allows their unique needs, aspirations, experiences and strengths to be recognised and their quality of life to be enhanced.
- Involvement and participation of people with care and support needs and their families, carers and advocates is essential, wherever practicable and subject to the person's wishes and confidentiality obligations;
- People must be treated with compassion, dignity and kindness.
- Social care and health services must support people to balance safety from harm with freedom of choice.
- Positive relationships between the people who deliver services and the people they support must be protected and preserved.

http://www.skillsforcare.org.uk/Document-library/Skills/Restrictive-practices/A-positive-and-proactive-workforce-WEB.pdf

IRELAND

National policy

The implementation of *A Vision for Change* remains a priority for the Government. We are committed, in particular, to reforming our model of delivery so that more and better quality mental health care is delivered in the community. *A Vision for Change* details a comprehensive model of mental health service provision for Ireland. It describes a framework for building and fostering positive mental health across the entire community and for providing accessible, community-based, specialist services for people with mental illness.
http://health.gov.ie/future-health/reforming-social-and-continuing-care-2/mental-health-a-vision-for-change/a-vision-for-change/

In addition, the Government has provided ring-fenced additional funding to the HSE for mental health in line with the Programme for Government commitment. A new HSE Mental Health Directorate was established in 2013, with full financial and operational responsibility for the delivery of *A Vision for Change.*

Mental Health

In 2015 the Minister for Primary Care, Social Care & Mental Health have published the priorities for the Department of Health for 2015. The mental health ones included:

- Publish National Framework for Suicide Prevention
- Publish review of the Mental Health Act 2001
- Update Vision for Change Policy with a focus on implementation of key initiatives

The Government, the Minister for Health and the Department of Health are at the head of health service provision. The Department's main role is to support the Minister in creating and assessing policy for the health services. The Department also has a role in the future planning of health services, in consultation with the Health Service Executive (HSE), the voluntary sector, other government departments and other interested parties.

Each year, the Department of Health allocates funding to the Health Service Executive (HSE). Each HSE Area then makes decisions about how they will distribute available resources to the agencies in their area.
http://www.citizensinformation.ie/en/health/health_service_agencies/health_boards.html

Health Services Executive

It is estimated that one in four or five of us will experience some mental health problems in our lifetime. Mental health problems can range from a low or sad period to a more serious depression, with a small number of people going on to experience severe mental health problems. Most people with mental health problems can be treated by their GP, and are referred to HSE Mental Health Services when necessary.

The HSE provides a wide range of community and hospital based mental health services in Ireland, and these services have seen dramatic changes and developments over the past twenty years. These changes continue, as we move from the hospital model to providing more care in communities and in clients' own homes.
http://www.hse.ie/portal/eng/services/list/4/Mental_Health_Services/

The Department of Children and Youth Affairs

The Department of Children and Youth Affairs focuses on harmonising policy issues that affect children in areas such as early childhood care and education, youth justice, child welfare and protection, children and young people's participation, research on children and young people, youth work and cross-cutting initiatives for children.
http://www.dcya.gov.ie/viewdoc.asp?DocID=120

The Mental Health Commission

The main vehicle for the implementation of the provisions of the Mental Health Act, 2001 is the Mental Health Commission, which was established in April 2002. It is an independent statutory body, whose primary function is to promote and foster high standards and good practices in the delivery of mental health services and to ensure that the interests of detained persons are protected.
http://www.mhcirl.ie/

Agencies and activities

Psychology Briefing Paper for the HSE Mental Health Division

The psychology workforce in Ireland is well placed to lead on developing mental health services that are clinically excellent, recovery-oriented and service user-centred. This briefing paper outlines the evidence that psychological interventions are clinically effective, cost-effective, and valued by service users and their carers. The centrality of the recoveryethos to the work of psychologists and their role in fostering cultural change is discussed.

The means by which psychological work can embed the voice of the service user in mental health services is also set out, as are positive practice examples of how this is currently occurring in particular services in Ireland. How the psychology workforce can build on this and develop new practices and partnerships to further maximise its added value to our mental health services are presented in ten key recommendations.

Ten recommendations are made.
http://www.lenus.ie/hse/bitstream/10147/336949/1/HPSI2014PsychologybriefingpaperHSEMHDivision.pdf

The College of Psychiatrists of Ireland Workforce Planning Report 2013 – 2023 December 2013

This report looks at psychiatry in Ireland and one recommendation is:

> *"Following extensive consultation within the College of Psychiatrists of Ireland and review of the literature, this paper will recommend that we move to a mental health service with an adequate number of Consultants to both develop modern services, and be available to provide individual Consultant input for patients. We recommend that we move to a situation where we have 800 Consultants, and the number of psychiatric trainees required to meet future manpower planning needs for these 800 Consultants".(p.2)*

http://www.irishpsychiatry.ie/Libraries/PGT_Documents/CPsychI_Workforce_Planning_Report_2013-2023_Dec_2013.sflb.ashx

Current Education / Training Available for Professionals Working in Mental Health Services in the Republic of Ireland

This report funded by the Mental Health Commission was prepared by University of Dublin, Trinity College in 2010.

This report presents the findings of a scoping study that addresses the education/training available to professionals working in mental health services in the Republic of Ireland.

It focuses on the education of psychiatrists, nurses, social workers, psychologists, occupational therapists, and speech and language therapists. The research design was an exploratory, descriptive design using a combination of questionnaires and telephone interviews for data collection.

The report is presented in six parts. The first part provides a background to the study by reviewing literature on education for professionals working in mental health care. Information on the education of each professional group is considered separately, as the requirements and standards governing nurse education, for example, are very different to those required for psychology. This is followed by a review of the literature on interprofessional education.

Section three presents an outline of the methodology used in the study. In sections four and five, a standard format is adopted to present the findings of the study, and some examples of innovative practice in the area of education are presented. Section six summarises the findings, draws conclusions and makes a series of recommendations. In addition the limitations of the study are identified.
http://www.mhcirl.ie/File/CET.pdf

Mental Health Reform: Promoting improved mental health services

This agency comments on government activities and aims to improve services.
http://www.mentalhealthreform.ie/home/mental-health-in-ireland/

Recovery and Integration, Training and Education (R.I.T.E.)

This service offers effective and responsive training to the Mental Health and Substance Misuse workforce, service users and carers in Hertfordshire. To meet your training needs Herts R.I.T.E. offers flexible training solutions including:

- Courses aimed at staff across various disciplines at all levels
- Courses providing useful skills for service users and carers
- Calendared sessions at locations across the county
- e-Learning
- Bespoke courses created according to your requirements
- In-house sessions delivered at a time and location that suits you

We are commissioned by the **Hertfordshire Joint Commissioning Team** (PCT's and Adult Care Services) and delivered by a Consortium of three local charities; Druglink, Mind in Mid Herts & Herts Mind Network; underpinned by consultation with all stake holders directly and indirectly engaging service user and carer groups.

We carefully evaluate our services, report our findings and respond to the feedback we receive. We aim to constantly evolve and improve our service in order to deliver the most effective training possible.
http://hertsrite.co.uk/About-Us

NEW ZEALAND

Around 150,000 New Zealanders are treated by specialist mental health services every year. Most are discharged within two years. About 16,500 of these people, or 11 per cent, have contact with services for two or more years. As well as experiencing reoccurring mental illness, long-term users of services may also have issues with hardship, social isolation and difficulty in finding employment and housing.
Richard Woodcock, Te Pou; email communication, June 2015

National Policy and Workforce Centres

Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017

The Ministry of Health notes the aim of this Plan is to ensure that New Zealanders have better access to quality mental health and addiction services. Health service providers will work alongside individuals, families, whānau and communities so that people with mental health or addiction issues are able to get the help they need sooner and recover faster when they are unwell.

The plan includes 100 actions to:

- improve mental health and wellbeing, physical health and social inclusion for people with mental illness and addiction issues
- encourage more effective use of resources
- enhance integration of mental health and addiction services
- reduce disparities in health outcomes
- improve access to and reduce waiting times for mental health and addiction services

http://www.health.govt.nz/our-work/mental-health-and-addictions/rising-challenge

Robyn Shearer CEO of Te Pou explains New Zealand workforce development work:

Ministry of Health and Health Workforce New Zealand

New Zealand has invested in workforce development as a mechanism to improve the quality of services for people who use services and their families.

"Workforce planning and development is about ensuring an organisation has the right number of people, with the right skills, in the right place, at the right time, with the right attitude, doing the right work, at the right cost, with the right work output".
http://www.who.int/hrh/resources/observer3/en/

New Zealand's investment started in the late 1990s following a process of de-institutionalisation and to increase the capacity and capability of services to develop community care, recovery based treatment.

New Zealand has four workforce agencies funded by:

- the Ministry of Health http://www.health.govt.nz/our-work/mental-health-and-addictions/mental-health/mental-health-workforce
- Health Workforce New Zealand (an agency within the Ministry of Health). http://www.health.govt.nz/our-work/health-workforce

Te Pou (The national centre for mental health research, information and workforce development)

Te Pou's purpose is to enhance people's mental health and wellbeing by developing a sustainable workforce delivering quality services. Te Pou was established by the Ministry of Health in 2006 as a national centre that supports evidence based workforce development for mental health services. In 2008 Te Pou was contracted by the Ministry of Health to develop and deliver a Disability workforce programme. In 2012 Matua Raki and Te Pou merged to ensure a mental health and addictions focused workforce programme.

Te Pou links workforce, outcomes, service development and evidence based practice via four areas:

- Training and development
- Practice and leadership
- Information and Outcomes
- Workforce planning

Te Pou has developed a range of resources and information to improve services, support the workforce, inform outcomes and provide training and funding.

Resources are available to support workforce development via Te Pou's website www.tepou.co.nz

Let's get real

Let's get real is a Ministry of Health framework describing the essential knowledge, skills, values and attitudes required to deliver effective mental health and addiction services in New Zealand.
www.letsgetreal.co.nz

This framework has set a benchmark for the whole workforce to have a common language describing the work of the sector. The framework guides recruitment, training and development, leadership and practice. It aligns to professional competencies and is embedded in all mental health and addictions service contracts.

Te Pou's role has been to support the implementation of Let's get real.
http://www.primarymentalhealth.org.nz/section/10330/what-is-primary-mental-health/?tab=4515

Examples of Te Pou workforce initiatives:

From: http://www.tepou.co.nz/initiatives

- **Co-existing problems**
Organisations can access resources to improve the way they respond to people experiencing co-existing problems

- **Employment**
International evidence shows that for people experiencing mental health issues, having a paid job is a key part of getting and staying well.

- **Equally Well: Physical health**
Te Pou is a leading partner in Equally Well, a group of organisations committed to improving the physical health outcomes of people with mental health and/or addiction issues.

- **Leadership**
Te Pou is a source of resources, tools and support to develop leadership in the mental health, addiction and disability sectors.

- **NGO workforce development: On Track**
On Track is a road map for non-government mental health and addiction organisations.

- **Primary mental health**
People working in primary care play an important part in supporting people with mental health and/or addiction issues.

- **More than numbers workforce stocktake**
More than numbers is a project to gather data on New Zealand's adult mental health and addiction service workforce.

- **Service user, consumer and peer workforce**
Te Pou is a source of information, resources and research to help the sector develop and grow the peer workforce in a sustainable and measured way.

- **Talking therapies**
Te Pou provides tools and guidance to support organisations to establish or extend their talking therapy programmes.

- **Workforce planning**
Te Pou is a source of information and resources to support organisations to integrate workforce planning with service development.

Other key areas include:

- **Outcomes and information**

This work includes:

- Alcohol and Drug Outcome Measure (ADOM) which is a measure for community-based outpatient adult addiction services
- Knowing the People Planning: this process is a way for mental health services to assess how well they are meeting the needs and wants of people using their services
- Mental health outcomes measures: Te Pou provides tools, training and resources to strengthen outcomes and information use in New Zealand
- Mental health outcomes training
- PRIMHD: this is the Ministry of Health's national collection of activity and outcomes data. It is published by Te Pou in quarterly PRIMHD reports.

http://www.tepou.co.nz/outcomes-and-information

Skills Matter

People working in mental health and addiction can access Skills Matter funding to take part in postgraduate training.

Skills Matter provides funding for postgraduate training for new graduates and existing practitioners, including nurses, social workers, occupational therapists, psychologists and addiction practitioners.

There are six programmes funded in 2015. All programmes combine academic and workplace learning.

Te Pou manages Skills Matter funding on behalf of Health Workforce New Zealand. Skills Matter funded programmes are postgraduate level (levels 8 and 9 in the New Zealand qualifications framework).

For more information: http://www.tepou.co.nz/initiatives/skills-matter/46

Disability

Te Pou also provides a hub of workforce development for the disability workforce.
http://www.tepou.co.nz/initiatives/disability-workforce

Matua Raki within Te Pou

Matua Raki's programme emerged from the National Addictions Centre at Otago University. The original programme was focused on training and development for the addictions workforce.

Addictions affect a significant number of New Zealanders, and contribute to social and economic harm to individuals, their families and whanau, and the wider community. Around

115,000 people have a substance use disorder in any year, yet only around 30,000 people receive specialist treatment.

Matua Raki leads the development of New Zealand's addiction workforces through developing a broad range of evidence-based workforce development solutions that contribute to welcoming, hopeful and effective services.
http://www.matuaraki.org.nz/

Their work is currently focused in the following areas.

- **ADOM implementation project**
The Alcohol and Drug Outcome Measure (ADOM) is a brief outcome measure relevant to New Zealand alcohol and other drug (AOD) services. Te Pou and Matua Raki have formed an ADOM implementation team whose role is to assist addiction services to implement ADOM.

- **Addiction nursing**
Matua Raki supports the development of addiction nursing expertise and recognition of the specialist knowledge and skills of nurses in the addiction sector.

- **Co-existing problems**
The aim of the co-existing problems project is to ensure that 'any door is the right door' for people with co-existing addiction and mental health issues to access services.

- **Compulsory assessment and treatment**
Matua Raki is working with the Ministry of Health on the development of legislation, which will allow for the compulsory assessment and treatment of substance addiction.

- **Consumer workforce**
We are working to develop and support the capacity and capability of the addiction treatment consumer workforce.

- **Cultural competency**
With an over representation of Māori and Pasifika people in all addiction statistics it is important the addiction workforce is specifically equipped to respond to the needs of Māori and Pasifika. Our work in the area of cultural competency aims to support this goal.

- **Research workforce**
Matua Raki actively supports the addiction research workforce and the dissemination of research considered relevant to the addiction workforce.

- **Service development**
Matua Raki has a continuing role in partnership with the National Committee for Addiction Treatment (NCAT) to support service development through national and regional events.

- **Workforce surveys**
  Regular workforce surveys gather information about the capacity and capability of the addiction sector workforce and services, and help to inform workforce planning across the sector.

- **Working with family and whānau**
  Matua Raki works with a variety of stakeholders to ensure the addiction workforce is capable of meeting the needs of family and whānau of people with addiction issues.

http://www.matuaraki.org.nz/supporting-workforce

Te Rau Matatini (TRM)

Established in 2002, TRM coordinate a range of national programmes that contribute to health, Māori (the indigenous people of New Zealand) mental health, primary health and public health workforce priorities. These programmes aim to increase responsiveness to Māori health needs, expand the Māori workforce, extend training opportunities, enhance career pathways and advancement, promote rewarding career opportunities for Māori in health and mental health, and support Māori health leadership development.

They provide a strategic focus for workforce development solutions and advancement of indigenous wellness. It aims to improve the quality, utility and relevance of workforce development and training programmes, strengthen Māori health leadership development and, in doing so, strengthen the responsiveness of services for Māori.

Mental Health and Addictions

Their focus is to:

- Foster the strength of Māori health leadership through the implementation of the Henry Rongomau Bennett Foundation Leadership Programme
- Implement dual-competencies into training curricula, career pathways, scope of practice and professional development programmes
- Promote the early recognition and appropriate intervention of mental health in other health and broader whānau ora and primary health sectors
- Extend health training and career pathways for Māori in nursing, whānau ora and primary health sectors
- Promote and award workforce scholarships and bursaries for Māori mental health and addictions workforces
- Support Māori Health research and development
- Ensure all Te Rau Matatini workforce solutions are accessible at the front-line, in areas where it is challenging to recruit or retain, and areas that are regionally responsive
- Work with the other key sector organisation to encourage networking and collaboration both nationally and internationally.

Suicide prevention

Waka Hourua is a four-year national suicide prevention programme for Māori and Pacific communities funded by the Ministry of Health. Te Rau Matatini is leading this four-year programme, in partnership with Le Va. Waka Hourua will provide a clear focus for suicide prevention in Māori whānau, hapū, iwi, Pacific families and communities. It invites Māori and Pacific communities to enhance resilience and build capacity to prevent suicide and to respond safely and effectively when and if suicide occurs. The programme also seeks to build leadership and knowledge through education, training and resources that are relevant and effective among Māori and Pacific whānau, families and communities. Waka Hourua aligns with the New Zealand Suicide Prevention Strategy 2006–2016, and the New Zealand Suicide Prevention Action Plan 2013–2016.
http://www.matatini.co.nz/suicide-prevention

Supporting Māori Public Health Workforce Development

Te Uru Kahikatea: The Public Health Workforce Development Plan has a clear objective to strengthen the Māori public health workforce and the capability of the non-Māori workforce to improve Māori health and reduce inequalities.

As part of the plan, the Ministry of Health included actions to:

- develop a planned and strategic approach, and an implementation plan to strengthen the Māori public health workforce
- increase the capability of the non-Māori workforce to improve Māori health and reduce inequalities
- identify appropriate advice and strategies to support the public health workforce to more effectively address the health needs of Māori.

Te Rau Matatini has continued to support the development of the Māori Public Health workforces through the provision of training and the promotion of Māori Public Health as a career.
http://matatini.co.nz/M%C4%81ori-public-health-workforce-development

Training

The overarching visions of Te Hau Māia are “ To strengthen and further equip the Māori workforce through applied, relevant and accessible training programmes to maximise health gains for whānau.” Programmes and courses offered by Te Hau Māia will be informed and underpinned by the following:

- Dual Competency - clinical and cultural domains are integrated to provide a comprehensive and relevant service to tangata, their whānau and the communities in which they live.
- Theory and Evidence - knowledge is gained through theory, knowledge, evidence-based research and practice. This recognises the interaction between theory and

knowledge and, within a Māori health context, the cyclical interdependence of knowledge growth based on the theory, research and practice interface.

- Whānau Ora – a whānau-centric model, which encourages whānau to identify and develop their own solutions.
- Te Tiriti o Waitangi – an integral part of the development, delivery and assessment of all Te Hau Māia wānanga.

Training Programmes

- Māori Suicide Prevention Training
- Kaitaki Ahurea – Cultural Competency Course
- Tuhono Tuara – Māori Public Health Training Programme
- Te Pātaka Uara Training
- Kaumātua Training

http://www.matatini.co.nz/training

Research

The research and evaluation portfolio utilises the following kaupapa Māori framework to ensure research addresses the learning needs of Māori:

- Kotahitanga, a unified vision aimed at improving the health needs of Māori whānau assisted by sports and traditional recreation activities at the community level. Rangatiratanga, development of leadership by the guiding mechanisms within all the organisations.
- Mātauranga Māori, utilisation of Māori values, beliefs and practices.
- Whānaungatanga, collaborative partnerships with participatory evaluation processes. Awhi mai awhi atu, a reciprocity process that allows information and knowledge to be transferred in an ethical and safe way.
- Tino rangatiratanga, clarifying the individual roles within the monitoring and evaluation process that aligns with self-determination and autonomy.
- Whakakao, a purposeful system for thinking through the issues, monitoring, analysis, recommendations and dissemination of information.

Current research and evaluation projects include:

- Tomo Mai
- Te Tomokanga
- Te Ipu Whakahaua

http://www.matatini.co.nz/research

The Werry Centre for Child and Adolescent Mental Health

The Werry Centre is a national centre for infant, child and adolescent mental health, led by Dr Sally Merry, Child and Adolescent Psychiatrist and situated within the Department of Psychological Medicine at the University of Auckland. It has three areas of focus: research, teaching and workforce development. The centre is involved in the development and promotion of evidence-based approaches to healthcare as well as supporting clinical staff and services working with infants, child and adolescents throughout New Zealand.
http://www.werrycentre.org.nz/about-us/staff

Teaching

Mental health problems in children and adolescents are a major concern. The Ministry of Health has stated that 4% of young people in New Zealand need access to mental health services. Barriers to meeting this need include the serious lack of child and adolescent mental health clinicians, and the limited training available; few health professionals have undergraduate or specialised training in the area.

The Werry Centre delivers postgraduate and undergraduate teaching through the University of Auckland's Faculty of Medical and Health Sciences. Although the Werry Centre is part of the University of Auckland, it has a national focus and strong role in supporting educational institutions across New Zealand in their provision of training in child and adolescent mental health. In addition to this, it has been a trial site for the delivery of postgraduate training using e-learning and flexible teaching methods.
http://www.werrycentre.org.nz/professionals/publications-and-resources/teaching-programmes

Workforce Development

Projects led by the Werry Centre in collaboration with the other workforce centres (Te Pou, Matua Raki and Te Rau Matatini) are:

Drivers of Crime
"Drivers of Crime" are the underlying and interrelated causes of criminal offending and victims' experiences of crime, recognising that certain life circumstances are associated with a greater likelihood of offending and victimisation. Training in parenting programmes, behaviour support, and care delivery systems aim to build effective responses including early prevention with vulnerable children and their families/whānau, and development of training for specific needs related to offending.

COPMIA: Children of parents with mental illness and/or addiction
Whilst many children of parents who have mental health and/or addiction problems fare well, a proportion are vulnerable to a range of poor outcomes, including increased risk of developing mental health issues. This project aims to increase the capability of health professionals to identify and attend to the needs of these children and their family/whānau.

Projects led by the Werry Centre include:

Online platform
The Werry Centre website hosts a large array of training and research information for mental health and primary health professionals, and has been updated to include information for young people and their families/whānau. Online learning modules such as an introduction to child and adolescent mental health and undertaking HEEADSSS assessments are also available.

Real Skills Plus ICAMH/AOD
This project builds on the specialist infant, child and youth mental health and AOD sector competencies known as Real Skills Plus CAMHS, developed in alignment with the government's Let's get real framework of essential skills and attitudes for effective mental health and addiction services. The new revised version (Real Skills Plus ICAMHS/AOD, 2014) includes a primary level relevant to the primary level workforce. The E-Skill Plus tool, which is currently under development, will identify areas for workforce development both for individuals and teams and plan service delivery.

Choice & Partnership Approach (CAPA) CAPA is a service redesign model offering choices to young people and their families in their dealings with mental health and addiction services, and partnership with clinicians during treatment. Integrated into CAPA are the 7 Helpful Habits (7HH) to enhance service delivery and efficiency. This project focuses on CAPA training, implementation support, and helping services to monitor impact through data collection.

HEEADSSS training in primary health
The HEEADSSS assessment tool is a key instrument for primary health care workers to identify mental health and AOD concerns early. Expanded use of the HEEADSSS assessment is one of 22 initiatives recommended by a cross-agency project, led by the Department of Prime Minister and Cabinet, on improving services for young people with, or at risk of, mild to moderate mental health disorders.

Incredible Years® Parent Management Training and Primary Care Triple P
The Werry Centre has built a sustainable workforce development model in Incredible Years® Parent Management Training for the CAMHS sector over the past eight years. We provide training, follow-up supervision and support for accreditation, as well as training and supporting Peer Coaches who coach new group leaders in developing their delivery skills.
A suite of Incredible Years® resources (Ngā Tau Miharo) has been developed for Māori group leaders and we are currently developing resources for Pacific group leaders.

Research
Projects include:

TrACY study (Treatment Approaches for Children and Young people)
The main objective of the TrACY study (Treatment Approaches for Children and Young people) is to improve the clinical outcomes for those attending child and adolescent mental health services (CAMHS) in New Zealand, thus impacting on the burden to society of long-term mental illness.

E-therapy for depressed adolescents
We have developed SPARX - a computer program that helps young people with mild to moderate depression. It was developed with the help of young people and is based on a type of 'talking therapy' called Cognitive Behavioural Therapy (CBT). SPARX received two international awards for digital innovation.

IDEAL study
3-year follow-up study of infants exposed antenatally to methamphetamine. This is the study of infant development, environment and lifestyle where the children are born to mothers using methamphetamine. The Werry Centre has been funded to study a cohort of infants, which can be compared to others from Los Angeles, Honolulu, Des Moines and Tulsa.

Youth2000 survey series: National youth health and wellbeing surveys
The Youth2000 survey series ask a large, representative sample of secondary school students from over approximately a third of all high school in New Zealand a wide range of questions that contribute to health and wellbeing of young people in New Zealand. These include questions about ethnicity & culture, physical health, food & activities, substance use, sexual health, injuries and violence, home and family health, school achievement and participation, neighbourhood environment, spirituality and access to healthcare. Over the past eleven years the Adolescent Health Research Group (AHRG) has collected data on these topics from a total of 28,000 students.
http://www.werrycentre.org.nz/research/about-werry-centre-research

Le Va – Pacific workforce development within the Wise Group

Le Va's purpose is to create opportunities for Pacific families and communities to flourish through embracing Pacific solutions. Le Va takes a holistic perspective to flourishing and wellbeing - encompassing the physical, mental, social, environmental and spiritual dimensions of wellbeing. This is reflected in Le Va's diverse portfolio across Pacific mental health, addiction, disability, public health, general health, suicide prevention, and education, as well as in sport and with local government. Le Va is proud to be valued as New Zealand's national hub for Pasifika mental health and addiction workforce development. It's important to ensure quality mental health and addictions services for Pacific people because the Pacific population has higher rates of mental illness and substance abuse than the general New Zealand population.
http://www.leva.co.nz/

Mental health
We enhance the quality of services received by Pacific families by developing the workforce in the areas of:

- systems transformation – translating policy into practice and leading advocacy roles
- recruitment and retention – promoting mental health as a career to Pacific populations and supporting the current mental health workforce
- training and development – providing scholarships and grants to Pacific people to enhance relevant skills and grow new people into the Pacific workforce

- leadership – growing Pacific leaders through the Le Tautua emerging leaders and alumni programme
- enhancing responsiveness – cultural competency training for the workforce to effectively engage with Pacific people and their families.

http://www.leva.co.nz/mental-health-and-addiction/mental-health-workforce-development

Addiction

Addiction-related harm has a significant impact on Pacific families in New Zealand. Pacific people have high prevalence rates across the addictions continuum but low (and often late) access to help and treatment. Effective treatment works when we have a capable and competent workforce that can meet the needs of Pacific families.

Le Va is focusing on growing and upskilling the Pasifika addiction workforce, as well as enhancing the responsiveness of the non-Pacific addiction workforce, by:

- providing Pasifika scholarships and mentoring through our Futures that work programme
- supporting Pasifika emerging leaders to grow through our Le Tautua leadership programme (and gain accredited training points with the Drug and Alcohol Practitioners Association of Aotearoa New Zealand)
- delivering our Engaging Pasifika cultural competency programme to the addictions workforce, by the addictions workforce (and gain accredited training points with the Drug and Alcohol Practitioners Association of Aotearoa New Zealand)
- supporting Drua, our Pasifika addiction network
- working in collaboration with Matua Raki to develop tools and resources for the Pasifika addiction workforce. E.g. our Engaging Pasifika cultural competency programme is part of Te Whare o Tiki - the Co-Existing Problems framework, outlining the knowledge and skills required by the mental health and addiction workforce to be able to effectively respond to the needs of people with co-existing problems (mental health and addiction).

http://www.leva.co.nz/mental-health-and-addiction/addictions

Training and careers

Le Va is committed to enhancing the quality of health and disability services for Pacific peoples. We aim to grow a qualified, flexible and sustainable Pacific health workforce, as well as support the mainstream health workforce to be more responsive to the needs of Pacific people. Our work in training and careers is designed to support this aim.

- The Futures that work programme has a pipeline approach from training right through to employment, tailored to the needs of our communities.
- The Le Tautua emerging leaders programme is designed to support new and emerging Pacific leaders to develop and enhance their leadership and management skills.
- The Engaging Pasifika programme focuses primarily on the basic and essential cultural skills and knowledge required to work effectively with Pacific service users and their families.

http://www.leva.co.nz/training-careers

Suicide Prevention
The team at Le Va is honoured to be leading New Zealand's first Pasifika suicide prevention programme – FLO. FLO is a national programme that aims to build strong, resilient Pacific families and communities, address at risk groups within Pacific communities and assist those Pacific families who have been part of the impact of suicide. FLO is part of Waka Hourua - national suicide prevention programme for Maori and Pacific communities delivered by Te Rau Matatini and Le Va.

Engage	Inform	Equip	Lead
Enhancing understanding of suicide and suicide prevention through safe talking	Supporting the implementation of Pasifika research through Te Ra o Te Waka Hourua research agenda	Cultural competency training for people working with Pasifika to enhance responsiveness	Provide a voice and centralised hub for Pasifika suicide prevention
Empowering communities to lead initiatives	Promote best practice and innovation to build knowledge base	Suicide prevention education for Pasifika communities	Support Pasifika suicide prevention ambassadors
Engaging ethnic specific, youth and rainbow (LGBTIQ) Pasifika communities	Provide access to information and research for Pasifika suicide prevention	Effective resources for ethnic specific, youth and rainbow (LGBTIQ) Pasifika communities	Ensure ethnic specific, youth and rainbow (LGBTIQ) Pasifika leadership

http://www.leva.co.nz/suicide-prevention

Other Agencies that support workforce development

Platform

Platform Trust is a peak provider organization that supports a national network of non-government community mental health and addiction organisations (NGOs). Platform provides advocacy and support for the community sector.

In 2012/2013 over 50,000 New Zealanders accessed support from NGO services.
Platform's current foci:

- Support Fair Funding for NGOs ***Read more...***
- Equally Well - access to physical health care for people with mental health and/or addiction issues needs to be improved. We encourage you to endorse the The Equally Well consensus position paper. This consensus position paper is based on the findings of an evidence review undertaken by Te Pou (2014), which summarises the drivers of this health disparity and importantly how to tackle it.

- On Track - the development of a guidance document (in conjunction with Te Pou). This is for the mental health and addiction NGO sector for service delivery in 2020 and the predicted impact on the NGO workforce. PDF now available for download (4.28MB). (Cited earlier in this report)
- Housing - Accommodating people with serious mental illness is a challenging topic for the community and a difficult area for policy makers. Read the latest research from Supporting Families in Mental Illness.
- Mindful Employer – supporting employers and raising awareness and understanding of mental health issues in the workplace
- NZ Navigator – free online tool for community organisations to self-assess ongoing development. This tool now has multiple participant assessment and branch assessment modules.
- Productivity Commission - more effective social services - The draft report is now available and submissions are invited by 24 June 2015.

http://www.platform.org.nz/

Blueprint for Learning

Blueprint for Learning is New Zealand's leading provider of learning and development for people working in the mental health and social service sectors. Our dream is to enhance the wellbeing of people and communities through inspirational learning.

Blueprint is best known for our comprehensive range of mental health training. Our programmes cater for both government and non-government providers from one-day workshops to comprehensive mental health leadership training. We are NZQA accredited and ISO 9001 registered. This demonstrates our commitment to quality, productivity and customer satisfaction.

Browse our wide range of programmes throughout New Zealand, or contact us and ask us to customise a programme specifically for your organisation.
http://www.blueprint.co.nz/

- **Mental Health 101**

  Blueprint operates MH101 which is a mental health learning programme which has been developed to give you greater confidence to recognise, relate and respond to people experiencing mental illness.

  This is similar to Mental Health First Aid but has been customised to fit the New Zealand context (e.g. less medically focused, more recovery focused and culturally appropriate to New Zealand).

http://www.mh101.co.nz/home

PeerZone

PeerZone consists of twenty-three hour peer led workshops for small groups of people with mental distress or addiction. We are adding new workshops soon. After groups have completed the workshops in the ‘Understanding Ourselves’ series they can pick and choose any or all of the optional workshops in the other series.

Foundation workshops	
Understanding ourselves series	Understanding our distress Understanding our alcohol and drug use Leading our recovery Exploring our stories

Optional workshops	
Empowering ourselves series	Dealing to self-stigma Finding our voices Empowering ourselves in services - mental health Empowering ourselves in services - alcohol and drug Dealing with crisis
Working on our wellbeing series	Coping with stress Understanding trauma Minding our lifestyle
Connecting with the world series	Enhancing our relationships Maximising our income Finding and keeping a home Finding and keeping work
Exploring our unique identities series	Toku Oranga (Wellbeing for Maori) Wellbeing for young people Wellbeing for men Wellbeing for Pacific people (part 1 and 2)

http://www.peerzone.info/workshops

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http://www.blueprint.co.nz/

Mind and Body Learning and Development Ltd

Mind and Body Learning and Development Limited are the training and education arm of Mind and Body Consultants Limited, a well-established New Zealand consumer-run provider of mental health services.
www.mindandbody.ac.nz

Mental Health Education and Resource Centre (MHERC)

The Mental Health Education and Resource Centre (MHERC) is a registered Charitable Trust which provides information, a free public library, and professional development about mental health, wellbeing, mental illness and addiction.
www.mherc.org.nz

The Mental Health Foundation of New Zealand

This is a charity that works towards creating a society free from discrimination, where all people enjoy positive mental health & wellbeing.

While it is not a workforce development agency pre se, it has resources and training available to all. We work to influence individuals, whanau, organisations and communities to improve and sustain their mental health and reach their full potential.
http://www.mentalhealth.org.nz/

SCOTLAND

National strategy

Mental Health Strategy for Scotland: 2012-2015

Scotland's Mental Health Strategy is the successor document to Delivering for Mental Health and Towards a Mentally Flourishing Scotland. It builds on that work as well as on policy and service improvements taken forward alongside those main policy documents.

In August 2012, the Scottish Government's mental health division introduced the Mental Health Strategy for Scotland 2012-15. It sets out a range of key commitments across the spectrum of mental health improvement, services and recovery to ensure delivery of effective, quality care and treatment for people with a mental illness, their carers and families. Prior to its launch, NHS Health Scotland's work in mental health improvement had been in response to ´Towards a Mentally Flourishing Scotland´.

The strategic direction for mental health improvement and public mental health has evolved from a number of policy areas including:

- mental health
- public health
- social justice and social inclusion
- education
- enterprise and life long learning
- arts, sports and culture

The public health policy in Scotland has increasingly identified mental health as an integral part of the wider agenda for health improvement.
http://www.healthscotland.com/mental-health-background.aspx

NHS - Developing the Workforce for Mental Health Improvement: A Strategic Approach, 2011

There are three main challenges facing mental health improvement workforce development:

- the workforce is wide and broadening, staff can sometimes be unsure of their new or developing role and how to undertake it;
- the integration of learning on mental health improvement into other agendas whilst combating stigma through specifically focused work;

- the current constraints on resources, especially staff time to attend training and money for courses.

These issues are explored in more depth below. This document will clarify these issues and suggest solutions to these problems.
http://www.healthscotland.com/documents/5545.aspx

NHS Scotland

Details of related programmes of work being taken forward by NHS Health Scotland and our partners.

Our mental health improvement work has been developed to raise its profile and support its application in Scotland. Much of the work supports the implementation of the Scottish Government´s health improvement policy in terms of mental health. For more information you can read our background and policy page.

The key areas of work being taken forward are:

- mental health indicators
- mental health data
- mental health and wellbeing training
- Mental Health Improvement Outcomes Frameworks
- Evidence for Action (EfA)
- mental health research
- Policy reviews
- mental health and wellbeing in later life
- mental health in the workplace (external link)
- Choose Life and self harm national strategy (external link)
- mental health and race equality
- publications
- evaluation of mental health improvement
- understanding mental health improvement
- Steps for Stress (external link)
- children and young people

Policy review – public mental health
NHS Health Scotland´s Policy Evaluation and Appraisal Division coordinates the evaluation of health improvement policies in Scotland as set out in, ´Improving Health in Scotland: The Challenge´ (2003) (external link).

Developing the Workforce for Mental Health Improvement: A Strategic Approach

In 'Towards a Mentally Healthy Scotland' the Scottish Government committed to produce a workforce development strategy for the mental health improvement workforce. This strategy

was to guide planners and the workforce themselves to ensure that they have the skills needed to further mental health improvement in Scotland.
19018-LWD Strategic Approach for Mental Health Improvement.doc

NHS Scotland notes:

Learning and development of the workforce is essential for health improvement in Scotland. This section will help you find the support you need to gain new skills and knowledge and develop as a professional.

This year (14/15), Learning and Workforce Development's work to reduce health inequalities has been split across the following project areas:

- Assessing Needs and Resources to Address Health Inequalities
- Systems, Processes and People
- Health Inequalities Learning Resources Review
- Workforce Development Support and Delivery

http://www.healthscotland.com/learning/index.aspx

Terminology

Recent research suggests that mental health consists of two dimensions: mental health problems (mental illness, psychiatric morbidity) which includes, for example, depression and anxiety; and, positive mental health (mental wellbeing) which includes, for example, life satisfaction, positive relationships with others and purpose in life. Good mental health is therefore more than the absence of mental illness.

The terms mental health, mental health problems and mental wellbeing have been agreed as the terms which will be used by NHS Health Scotland.

Mental Health
There are many definitions of mental health, however, in NHS Health Scotland mental health is used as an umbrella term to refer to both the concepts of mental health problems and mental wellbeing.

Mental Health Problems
This refers to symptoms that meet the criteria for clinical problems: diagnosis of mental illness, or symptoms at a sub-clinical threshold which interfere with emotional, cognitive or social function. Examples include common mental health problems such as depression and anxiety, and, severe and enduring mental health problems such as schizophrenia. The term mental health problems is often used interchangeably with mental health, negative mental health, mental illness, mental ill-health and mental distress.

Mental Wellbeing
There is greater variety in definitions of mental wellbeing; however, most tend to emphasise that mental wellbeing includes aspects of subjective wellbeing (affect and life satisfaction), and psychological wellbeing (which covers a wider range of cognitive aspects of mental

health than affect and life satisfaction such as mastery and a sense of control, having a purpose in life, a sense of belonging and positive relationships with others) and covers both the hedonic and eudaimonic perspectives of wellbeing. The concept of mental wellbeing is less well established and the term is often used interchangeably with mental health, positive mental health or wellbeing.
http://www.healthscotland.com/uploads/documents/13619-Terminology%20and%20Working%20Understandings%20-%20Final.pdf

Welcome to the Learning and Workforce Development area

- Choose Life
- Scotland's Mental Health First Aid
- Scotland's Mental Health First Aid: Young People
- Health Behaviour Change - which includes alcohol, drugs, smoking, sexual health, physical activity, food and health, and child healthy weight
- Improving Health Developing Effective Practice - more details will follow shortly.

Please take a look at our information booklet for more information.

Virtual Learning Environment (VLE)

The Virtual Learning Environment (VLE) is the learner management system used by NHS Health Scotland to deliver online learning to internal and external colleagues.

As the website is open source and free to use by internal teams, we have managed in recent years to use the VLE to develop trainer networks, support project working groups and host fully online conferences for hundreds of delegates.

The VLE is a dynamic and flexible resource with pages for blended and online courses.

http://www.healthscotland.com/learning/index.aspx

Information Services Division, NHS National Services Scotland

Vision

- To work in partnership with organisations and working groups to ensure that services are relevant to key stakeholders (e.g. policy makers, practitioners, academics, media) to help improve mental wellbeing
- To generate high quality technical advice on uses of information and its generation
- Broadcast the information produced by ISD in a way that is intelligible, intelligent and in the medium appropriate to customers

Aims

- Support the implementation of the National Information Strategy in relation to mental health information
- To work in partnership with organisations and working groups to ensure that programme services are relevant to key stakeholders (e.g. policy makers, practitioners, academics, media) to help improve mental wellbeing
- To generate high quality technical advice on uses of information and its generation
- Broadcast the information produced by the programme in a way that is intelligible, intelligent and in the medium appropriate to customers

Workstreams

Child and Adolescent Mental Health Access Target

The Scottish Government has set a target for the NHS in Scotland to deliver a 26 week wait from referral to treatment for specialist CAMH services from March 2013, reducing to 18 weeks by December 2014.

The above link will direct you to the Child and Adolescent Mental Health home page where you can access the latest publication of the Child and Mental Health Services Waiting Times in Scotland report.

Dementia Post-diagnostic Support Target

The Scottish Government has set a HEAT target 'To deliver expected rates of dementia diagnosis and by 2015/16, all people newly diagnosed with dementia will have a minimum of a year's worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan'. The target goes live in April 2013.

The above link will direct you to the Dementia Post-diagnostic Support home page where you can access further information on the target and measurement support.

Mental Health Benchmarking Project

The principle objective of the Mental Health Benchmarking project is to improve Mental Health Services by using benchmarking to understand and compare services and their outcomes and to promote best practice.

Psychological Therapies Mental Health Access Target

The Scottish Government has set a target for the NHS in Scotland to deliver an 18-week wait from referral to treatment for Psychological therapies from December 2014.

Psychology Workforce Planning Project and the Child and Adolescent Mental Health Services Workforce Project
National workforce statistics relating to NHS Scotland Psychology and CAMHS workforce are published quarterly and can be viewed on the webpage above.

Scottish Suicide Information Database (ScotSID)
By linking data on deaths from 'probable suicide' with health service and other records, a fuller picture can be obtained of the lives of people who have died by suicide and their contact with services before death. This will help identify factors, which may increase or decrease the likelihood of suicide, and assist in suicide prevention.
http://www.isdscotland.org/Health-Topics/Mental-Health/

NHS Education for Scotland

From NHS Education for Scotland (a separate Government Department) comes the following:

Values Based Practice

The 10 Essential Shared Capabilities for Mental Health Practice Learning Materials (Scotland)
The main emphasis of the learning materials is supporting cultural change in services by promoting values-based, person-centred and recovery-focused practice. The learning is relevant to people in all roles and settings who are involved in mental health work. The materials, facilitators Toolkit and evaluation of the dissemination of the learning can be accessed in our publications section.

Mental Health Recovery

NES/SRN Realising Recovery: A National Framework for Learning and Training in Recovery Focused Practice
The Framework was published and launched in September 2007. As well as providing guidance regarding the development of training mental health workers in recovery focused practice the document aims to highlight to people who use mental health services and their friends, families and carers what they should expect from mental health workers.

Realising Recovery Learning Materials
The Realising Recovery materials have been developed by NHS Education for Scotland and the Scottish Recovery Network and have been designed to support mental health workers to develop their recovery focused practice. They build on The 10 Essential Shared Capabilities (Scotland) learning materials and are designed to provide further learning to enable mental health workers to work alongside service users as they create their own unique recovery journeys.
http://www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/mental-health-and-learning-disabilities/our-work/mental-health.aspx

The HEAT target 'Deliver faster access to mental health services by delivering 18 weeks referral to treatment for Psychological therapies from December 2014'

This target was approved by the Scottish Government in November 2010 for inclusion in HEAT from April 2011.

Psychological therapies refer to a range of interventions, based on psychological concepts and theory, which are designed to help people understand and make changes to their thinking, behaviour and relationships in order to relieve distress and to improve functioning. The target applies specifically to psychological therapies for treatment of a mental illness or disorder.

What is included in the target?
Psychological therapies as defined above are counted. These include psychological therapies listed in the Matrix and also those not listed but which clinicians decide are the most appropriate treatment to meet a patient's needs. This will mean that at national and local level we have the information that will allow us to develop services to meet the need that exists. The inclusion of therapies in the Matrix is dependent on the evidence base, particularly as currently defined in SIGN and NICE guidelines. The absence of evidence in literature does not mean that approach should not be used, or that it does not count towards the psychological therapies target - it may be that not enough relevant research has been carried out to develop an evidence base. Such treatments can still be recognised as being of benefit to patients. Irrespective of the evidence base, Boards should be providing services which meet local and individual need. What is delivered will to some extent be dependent on what services Boards already have and the expertise available locally.

The target applies:

- where the therapy is for treatment of a mental illness or disorder
- where the therapy is delivered to individuals or groups, in person, on the telephone or by videolink, in real time, by staff trained to recognised standards, operating under appropriate supervision, in dedicated/ focused sessions;
- where the therapy is delivered through family, health and/or care staff who are being trained or supported to deliver a particular intervention to a named patient/client;
- to all ages (including CAMH services);
- in community settings;
- in inpatient settings;
- in physical health settings where there is associated mental illness such as depression or anxiety, for example chronic pain and cancer;
- for substance misuse where there is associated mental illness;
- for learning disabilities where there is associated mental illness.

http://www.isdscotland.org/Health-Topics/Workforce/Psychology/Psychological-Therapies/

Well Scotland

Well Scotland is the national mental health improvement website for Scotland. It is a resource intended for professionals who currently work in, or have an interest in the mental health improvement field. Working in partnership with Scotland's national agencies, its purpose is to provide up to date information on recent developments in the mental health improvement area.
http://www.wellscotland.info/

Current priorities are:
A mental health strategy for Scotland includes commitments for mental health over the life-course. There is an increased focus on self-help approaches in order to reduce common mental health problems.
The strategy identifies priorities relating to

- infants and early years
- children and young people
- mentally healthy adults
- later life
- Dementia
- improving the quality of life of those experiencing mental health problems
- preventing suicide and self harm
- Addressing common mental health problems

In this section

- How to measure mental wellbeing
- Case Studies
- Mental Health Improvement Outcomes Framework
- National indicators for mental health in Scotland
- Evidence briefings
- Publications
- Research and evaluation

http://www.wellscotland.info/guidance

Agencies and activities

Child & Adolescent Mental Health Services in NHS Scotland Workforce Information as at 31st December 2014

This publication is a collaborative piece of work between the Information Services Division (ISD) of NHS National Services Scotland and NHS Education for Scotland (NES).
The publication contains information about the workforce in NHS Scotland Child and Adolescent Mental Health Services (CAMHS) as at 31st December 2014.

Key points:

In 2009, the Scottish Government committed central funding to expand the CAMHS workforce of NHSScotland. This has resulted in a steady increase in the CAMHS workforce from 764.6 WTE (883 headcount) in 2009 to 942.4 WTE (1096 headcount) as at 31st December 2014.

- The most significant staff increases have been in Psychology (72% since 2009), and Nursing (22% since 2009).
- The headcount has remained relatively stable over the past year. At 31st December 2014 there were 1096 clinical staff (942.4 WTE). Nationally, this represents a staffing level of 17.7 WTE clinical workers per 100,000 of the population of Scotland.
- An additional 48.8 WTE posts throughout NHS Scotland CAMHS were between being advertised and being filled. A further 11.2 WTE posts were approved for recruitment but not yet advertised.

https://isdscotland.scot.nhs.uk/Health-Topics/Workforce/Publications/2015-02-24/2015-02-24-CAMHS-Report.pdf?64724367857

Psychology Services Workforce in NHSScotland Workforce Information as at 31st December 2014

This publication is a collaborative piece of work between the Information Services Division (ISD) of NHS National Services Scotland (NSS) and NHS Education for Scotland (NES). It is an example of the workforce reports available from ISD.

The publication presents information on NHSScotland Psychology Services workforce as at 31st December 2014.

Key points:

The group ‘Clinical Psychologists’ is composed of staff whose professional group is Clinical Psychology. This is the largest staff group within NHSScotland Psychology Services. ‘Other Applied Psychologists’ comprises staff from professional groups Counselling Psychology, Health Psychology, Forensic Psychology and Neuropsychology. ‘All Applied Psychologists’ refers to the total of Clinical Psychologists plus Other Applied Psychologists. As at 31st December 2014:

- The total number of clinical staff employed in NHSScotland Psychology Services continues to rise, with 1253 staff (1057.2 WTE) including 905 (756.8 WTE) Clinical and Other Applied Psychologists in post as at 31st December 2014.
- There has been a significant increase over time in the number of Clinical and Other Applied Psychologists employed in NHSScotland from 426 (371.0 WTE) in 2003 to the current level of 905 (756.8 WTE) as at 31st December 2014.
- This total of 905 (756.8 WTE) equates to 844 (705.3 WTE) Clinical Psychologists plus 61 (51.5 WTE) Other Applied Psychologists. This represents a national staffing level of 14.2 WTE Applied Psychologists per 100,000 of the general population of Scotland.

- The total of 1253 staff also includes Graduates of the MSc in Psychological Therapies in Primary Care (64.2 WTE), Graduates of the MSc in the Applied Psychology of Children and Young People (37.1 WTE), Cognitive Behavioural Therapists (47.8 WTE), Counsellors (26.8 WTE), other therapists (17.2 WTE), and other clinical staff (20.1 WTE).
- As at 31st December 2014, an additional 49.0 WTE posts throughout NHSScotland Psychology Services were between being advertised and being filled with start dates commencing in January 2015. A further 13.5 WTE posts were approved for recruitment but not yet advertised.

Mentally Healthy Workplace (MHW) Training

One worker in six in the UK will be experiencing depression or anxiety right now. From research commissioned by the Scottish Association for Mental Health, the estimated cost of sickness absence due to mental health problems for Scotland's employers is £360 million a year - it makes good business sense to promote positive mental health in the workplace.

'Mentally Healthy Workplaces' eLearning course - for employees
Everyone has a role to play in promoting mental health and wellbeing in the workplace. This online course aims to increase awareness of mental health at work. The course is for anyone who wants to learn more about mental health, whether it is how to look after your own mental health, or advice on supporting a colleague.

It takes about one hour to complete and can help your organisation in working towards their Healthy Working Lives Award. To complete the course you'll need to register on Health Scotland's Virtual Learning Environment, this will only take a few minutes.

'Mentally Health Workplace' training - for managers
Line managers have a crucial role in supporting the health and wellbeing of employees. From communication, to clarity of job role, managers can influence the success of a team. This training includes good practice in promoting positive mental health and wellbeing, as well as offering practical examples of how to support employees experiencing mental health problems. Courses are delivered across Scotland by local Healthy Working Lives teams.

'Mentally Healthy Workplace' training - in-house training for managers
If your organisation has over 50 managers, there's always the option to deliver the course in-house. Your organisation will be able to have the training tailored to their needs and be part of the organisation's workforce development.

Your organisation will be offered a 'train the trainer' session so that you can deliver the course as part of your internal training programme for managers. The course can be offered as a one-day face-to-face course or a blended learning package (online and face-to-face). For more information on this option contact your local Healthy Working Lives team or the Adviceline on 0800 019 2211.
Find out how Glasgow Caledonian University implemented the in-house training.
http://www.healthyworkinglives.com/advice/workplace-health-promotion/mental-health/mhw-training

SWEDEN

The following is a brief description information relating to mental health care and the workforce. Few documents are available in English so this information is sparse.

What is the role of government?

The three independent levels of government are all involved in the health system. The state, through the Ministry of Health and Social Affairs, is responsible for overall health and health care policy. In addition, there are eight national government agencies directly involved in the areas of health, health care, and public health. Local self-government has a long tradition. At the regional level, 17 county councils and four regional bodies (regions) are responsible for financing and delivering health services to their citizens and for operating regional transportation and cultural activities.

At the local level, 290 municipalities are responsible for matters relating to the immediate environment of their citizens, including care of older people and disabled people. The regional and local authorities are represented by the Swedish Association of Local Authorities and Regions (SALAR).

Coverage is universal.

People with minor mental health problems are usually attended to in primary care, either by a GP or by a psychologist or therapist, and patients with severe mental health problems are referred to specialized psychiatric care in hospitals.
http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2012/Nov/1645_Squires_intl_profiles_hlt_care_systems_2012.pdf

Myths and Realities about Mental Health and Work (OECD, 2012)

These are being tackled in a number of OECD countries.

For Sweden:

Executive summary
Throughout the OECD, mental ill-health is increasingly recognised as a problem for social and labour market policy; a problem that is creating significant costs for people, employers and the economy at large by lowering employment, raising unemployment and generating productivity losses. The Swedish Government has embarked on various policies and strategies that seek to combat the negative consequences of mental ill health. Nonetheless, a number of barriers persist, including insufficient resources, lack of awareness and tools to identify and, hence, help those with a mental disorder. Above all, it is important to recognise that problems related to mental ill health cannot be solved without strong co-ordination

between policy areas and institutions. A systematic and sustained effort is required across different government departments (including, Education, Health, Social Insurance and Employment) and workplaces to improve labour market inclusion of people with a mental illness and prevent large social and economic losses incurred by the Swedish society as a whole.

The OECD recommends to Sweden to:

- Increase resources available for school health services to identify and provide support to pupils with mental health problems early on.
- Provide adequate support to early school leavers and NEET with mental health problems to promote their transition into higher education and employment.
- Reform the disability benefit scheme for those aged 19-29 who tend to access the system with a mental illness, with much greater focus on active measures to avoid an early exit from the labour market.
- Provide greater support to small employers to retain workers with mental health problems; to prevent them from moving onto sickness benefits; and to reintegrate sick employees.
- Ensure that adequate employment and health services are given to sickness benefit recipients with mental health problems at an early stage of the sickness spell to facilitate their rapid return to work.
- Develop employment-oriented mental health care and experiment with ways to integrate health and employment services.

http://www.oecd.org/els/emp/MHW_SwedenES.pdf

USA

Behavioral Health Concerns in the United States
Alcohol: 60.1 million aged 12 or older were current (past month) binge drinkers.
Illicit Drugs: 24.6 million aged 12 or older were current users.
Marijuana: 19.8 million aged 12 and older were current users.
Mental Illness: nearly one in five adults had a mental illness.
Source: 2013 National Survey on Drug Use and Health

Our best estimate of the number of adults with any diagnosable mental disorder within the past year is nearly 1 in 5, or roughly 43 million Americans. Although most of these conditions are not disabling, nearly 10 million American adults (1 in 25) have serious functional impairment due to a mental illness, such as a psychotic or serious mood or anxiety disorder. Fully 20 percent—1 in 5—of children ages 13-18 currently have and/or previously had a seriously debilitating mental disorder. By comparison, 8.3 percent of children under age 18 have asthma and 0.2 percent have diabetes.
http://www.nimh.nih.gov/about/director/2015/mental-health-awareness-month-by-the-numbers.shtml?utm_source=govdelivery&utm_medium=email&utm_campaign=govdelivery

National policy

As indicated in SAMHSA's Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015-2018, SAMHSA will efficiently focus its work to increase the awareness and understanding of mental and substance use disorders, promote emotional health and wellness, address the prevention of substance abuse and mental illness, increase access to effective treatment, and support recovery.

One of the six strategic initiatives (SI) is:

Workforce Development
This SI will support active strategies to strengthen and expand the behavioral health workforce, including those health care workers not considered behavioral health specialists. Through technical assistance, training and focused programs, this initiative will strengthen the capabilities of an integrated, competent behavioral health workforce that enhances the availability and quality of prevention and treatment for substance abuse and mental illness.

The Administrator Pam Hyde states:

Working with federal partners such as the Health Resources and Services Administration, and professional associations and other stakeholders, SAMHSA has four main goals with the workforce initiative:

- **Develop and disseminate workforce training and education tools and core competencies.** One key element is to train both behavioral health and other types of practitioners to work in the growing number of settings in which behavioral health services are integrated with primary care services. Finding ways to recruit, train, and retain a culturally sensitive workforce prepared to serve an increasingly diverse nation is also crucial. This workforce includes preventionists, psychiatrists, psychologists, social workers, addictions and mental health counsellors, marriage and family therapists, and other specialty behavioral health workers. It also includes practitioners in primary care, emergency care, health specialty care, and other settings where addressing behavioral health is critical.
- **Increase the number of peer practitioners.** We cannot just rely on behavioral health professionals. Peers can supplement what professionals do by engaging, supporting, and providing supportive services for those with behavioral health conditions. SAMHSA supports efforts to increase the number of peer practitioners, as well as to enhance the evidence base about what works best when it comes to peer and paraprofessional services.
- **Develop ways to track behavioral health workforce needs.** SAMHSA is working to develop consistent data collection methods and identify gaps. Programs are also in place to promote the behavioral health professions to students by providing them with training and financial assistance.
- **Increase funding for the behavioral health workforce.** The behavioral health workforce deserves to be compensated appropriately. SAMHSA is identifying barriers, exploring best funding practices, and working to improve reimbursement rates and pay incentives.

Building on existing efforts, these strategies will help ensure our nation has enough well-trained behavioral health specialists, health practitioners with understanding of behavioral health issues, and peer practitioners to treat mental illness and addiction, prevention substance abuse and mental disorders, and improve health throughout the country.

In its 2013 Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, SAMHSA outlines how these laws are reshaping the workforce and delivery of services by moving the field toward improved coordination and integration of behavioral health care with other health care in primary, specialty emergency, and rehabilitative care settings, and, with that, the need to apply team approaches to address an individual’s health concerns.

Anne Herron, SAMHSA's lead for the new Workforce Development Strategic Initiative, says, “The inclusion of behavioral health services which are covered by health insurance means people will have greater access to the help that they need. But right now, 55 percent of U.S. counties do not have any practicing behavioral health worker and 77 percent reported unmet behavioral health needs. It’s clear our robust effort in promoting relevant professions, building skills, and making sure that communities in need have support will have a positive effect on many.”

Because people see their primary care physician more often than specialists, the integration of behavioral health screens and supports into primary care will help to address concerns more quickly. It may also make recovery more accessible by providing the alternative of a general doctor for those who may feel uncomfortable seeking out a behavioral health specialist. This effort also encourages primary care providers to look at whole health of their patients – not just a symptom that may have prompted a visit to the doctor.

In addition, changes in healthcare legislation and delivery have increased the use of health information technology for billing, elevated the importance of prevention and recovery-oriented systems and principles that include individual choice and self-directed care, and focused attention on the value of using peers and paraprofessionals in behavioral health care delivery.

SAMHSA and the Health Resources and Services Administration (HRSA) are working to address the integration of behavioral health in primary care settings. A number of these joint workforce efforts develop models that support integration, technical assistance, and training.

SAMHSA Programs

SAMHSA has a number of its own new and emerging programs that will improve behavioral health knowledge and capacity. The following is abbreviated information from the website.

Center for Substance Abuse Prevention (CSAP) Prevention Fellowship Program (PFP)
Launched in 2006, the two-year fellowship program provides 10 participants with the education and training to build the needed skills for success in the substance abuse prevention and behavioral health fields. Fellows spend a required 32 hours each week during their fellowship building their skills in substance abuse prevention. They are supported by mentors from participating states and territories to establish or assess the performance of substance abuse prevention efforts.

The cooperative agreements with the Historically Black Colleges and Universities initiative build interest in behavioral health, expand campus-based services, and facilitate workforce development. This funding also helps address disparities among racial and ethnic minorities by employing strategies that ease access, making services uniformly accessible, and improving outcomes.
Project Lift. *"Through the presentations, the support, the education, the experiential activities, and the goal-setting, I've really gained a lot of momentum. I have begun to concretely think about my career in ways that I did not know were possible."* – Jordanna Burkett Crist, Navajo, Participant in Project LIFT and Clinical Supervisor with Native American Connections
Designed as a leadership development academy, Project LIFT began in 2013 to enable emerging leaders to work with individuals with behavioral health needs in marginalized or underserved communities. Those participating in this program participate in monthly web or phone meetings, to learn more about behavioral health and how the Affordable Care Act covers such services. At the end of six months, teams give presentations to demonstrate their knowledge and understanding and ability to bring new learnings back to their communities. Emerging leaders apply for and are selected to Project LIFT.
http://liftleaders.org/files/project_lift_faqs.pdf

Center for Mental Health Services (CMHS) Minority Fellowship Program
The Minority Fellowship Program provides specialized training and mentoring relationships to address health disparities. Fellowships are given to individuals who have a history of working with underserved communities and are committed to continuing the work to lessen disparities and make behavioral health supports accessible. Fellows are given the opportunity to provide leadership on the development and implementation of culturally specific and patient-centered programs for underserved communities with behavioral health needs. Additional federal funding was provided in 2012 to increase the number of culturally competent mental health professionals.

Although the fellowship program is managed by CMHS, it is jointly funded by CMHS, CSAT, and CSAP. The fellowship is offered in one of the three domains: substance abuse prevention, substance abuse treatment, or mental health treatment.

Peers: The "Nontraditional" Workforce
SAMHSA is also committed to developing supports within a "nontraditional" workforce by including peers, or people in recovery from mental and substance use disorders. According to CMHS Director Paolo del Vecchio, "One area that provides a lot of promise is the use of peers as providers." SAMHSA supports clarifying competencies for peers and family members to accomplish this work and the development of a peer professional career ladder that will include training and supervision of peers by peers.
http://www.samhsa.gov/samhsaNewsLetter/Volume_22_Number_4/building_the_behavioral_health_workforce/

Core competencies

The Annapolis Coalition on the Behavioral Health Workforce (www.annapoliscoalition.org), under the auspices of CIHS, created the Core Competencies for Integrated Behavioral Health and Primary Care. Divided into nine categories, these competencies provide organizations and individual professionals a "gold standard" for the skill set needed to deliver integrated care. They represent the long-term goal of workforce development for professionals with careers in integrated care. The core competencies provide a reference for the vision of an integrated workforce, and the six categories of workforce development provide practical and logistical assistance to building that vision.

The full report and other key teachings from the Core Competencies for Integrated Behavioral Health and Primary Care can be found below.

CORE COMPETENCIES:
I. Interpersonal Communication
II. Collaboration & Teamwork
III. Screening & Assessment
IV. Care Planning & Care Coordination
V. Intervention
VI. Cultural Competence & Adaptation
VII. Systems Oriented Practice
VIII. Practice Based Learning & Quality Improvement

IX. Informatics
http://www.integration.samhsa.gov/workforce/core-competencies-for-integrated-care

As indicated in SAMHSA's Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015-2018, SAMHSA will work to ensure that the behavioral health workforce has access to the information needed to provide successful prevention, treatment, and recovery services. SAMHSA also will support the workforce to engage people with mental and/or substance use disorders and empower them on the path to recovery. As identified in the Workforce Development Strategic Initiative, SAMHSA is committed to:

- The development and dissemination of training and competencies
- The deployment of peer providers in all public health and health care delivery settings
- Increasing the capacity to address behavioral health in all prevention, treatment, and recovery settings
- Assuring adequate funding and payment structures.

http://www.samhsa.gov/workforce/development-competencies-capacities

Additional resources include:

- Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice
- Knowledge Application Program (KAP) - online learning
- Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues
- Workforce Development á la Webinar

National Association of State Mental Health Program Directors (NASMHPD)

The National Association of State Mental Health Program Directors (NASMHPD), is home to the only member organization representing state executives responsible for the $37.6 billion public mental health service delivery system serving 7.1 million people annually in all 50 states, 4 territories, and the District of Columbia. NASMHPD operates under a cooperative agreement with the National Governors Association.

NASMHPD (pronounced "NASH-bid") operates under a cooperative agreement with the National Governors Association and is the only national association to represent state mental health commissioners/directors and their agencies.

While NASMHPD's primary members are the commissioners/directors of the 55 state and territorial mental health departments, the NASMHPD structure also includes 5 divisions comprised of directors of special populations/services (Children, Youth & Families; Financing and Medicaid; Forensic; Legal; and Older Persons) as well as a Medical Directors Council. The purpose of these entities is to provide technical assistance and expert consultation to the Commissioners/Directors on issues specific to those populations. Each of the Divisions and

the Medical Directors Council has a Commissioner Division Advisor.
http://www.nasmhpd.org/About/about.aspx

Examples of the work undertaken:

Peer workforce

In an effort to assist State Mental Health Authorities, in close collaboration with Single State Authorities, in planning and implementing activities to foster increased employment opportunities for people with mental health and/or substance use disorders, the Substance Abuse and Mental Health Services Administration (SAMHSA) and its Center for Mental Health Services (CMHS) created the Employment Development Initiative (EDI).
http://www.nasmhpd.org/TA/EmploymentDevInitiative.aspx

Technical Assistance for State Mental Health Agencies

As a part of an umbrella project funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), NASMHPD is coordinating activities to support the provision of high-quality training and technical assistance to representatives from the state mental health system and other designated stakeholders in order to implement, improve, and expand mental health services and supports in communities across the nation, while simultaneously advancing critical SAMHSA goals and priorities.

State and Regional On-Site Training and Technical Assistance

On-site training and technical assistance (T/TA) is provided to states and regional clusters of states to aid these entities in their efforts to plan, implement, and expand quality services within the public mental health system. Within the parameters of available resources, such T/TA may be provided in a variety of formats, such as: site visits; policy review and recommendations; strategic planning; and staff training. A range of topics might be covered via such T/TA, including, for example: financing; implementing evidence-based program models; improving treatment practices to be more conducive to recovery; training and certification of peer specialists; cross system collaboration; implementing programs for persons in early stages of psychosis; and leadership development, to name a few.
http://www.nasmhpd.org/TA/NTAC.aspx

CMHS's National Center for Trauma-Informed Care (NCTIC)

This Center is beginning its fourth year of activities to promote trauma-informed practices in the delivery of services to people who have experienced violence and trauma and are seeking support for recovery and healing. They may or may not have a diagnosis of mental health or substance use disorders, and may experience traumatic impacts from the experiences of violence that have strained social connections in the family, in the workplace, in childrearing, in housing – and that may have led to consequent health problems – all of which need to be addressed in a trauma-integrated manner. NCTIC is guided by the following fundamental beliefs.

- People with lived experience of trauma can and do recover and heal;

- Trauma-Informed Care is the hallmark of effective programs to promote recovery and healing through support from peers, consumers, survivors, ex-patients, and recovering persons and mentoring by providers; and
- Leadership teams of peers and providers charting the course for the implementation of Trauma-Informed Care are essential.

Over the last four years, NCTIC has provided on-site training and technical assistance to nearly every state in the country to develop and improve trauma-informed environments across the spectrum of public health programs. Training and technical assistance has been provided to residential programs; criminal justice and homeless programs; networks of training, educational, and learning collaboratives; community-based agencies; and less formal gatherings of people seeking trauma support. Integrating peers and providers in all aspects of planning, training, and development of Trauma Informed Care is a hallmark of NCTIC. NCTIC receives over *thirty* (30) requests for training and materials per month.
http://www.nasmhpd.org/TA/NCTIC.aspx

A state response: Texas

The Mental Health Workforce Shortage in Texas - Department of State Health Services September 2014

In addition to a shortage of providers, other sociodemographic factors contribute to the state's inadequate mental health workforce. For example, providers are not distributed evenly across the state resulting in differential access to care by region, especially in rural areas and along the border. Further, the provider workforce does not reflect the state's growing ethnic diversity resulting in the continued need for culturally competent mental health care.

The Department conducted a literature review and sought out information from stakeholders, including: the Statewide Health Coordinating Council, mental health care providers, advocacy organizations, and professional organizations. These efforts revealed five possible key themes for state consideration in policymaking:

- Increasing the size of the mental health workforce – At its core, the mental health workforce shortage is driven by factors that affect recruitment and retention of individual practitioners. Chief among these factors, as studies and stakeholders suggest, is that the current payment system fails to provide adequate reimbursements for providers, especially in light of the extensive training necessary for practice. Furthermore, more students may be attracted to the mental health professions by strengthening graduate medical education and by exposing them to opportunities in the mental health field earlier in their education. Finally, maximizing the capacity of the mental health workforce could benefit from expanding roles of providers responsibly within their scope of practice, with appropriate treatment tools available to them.
- Improving the distribution of the mental health workforce – Access to care is differentially distributed across the state. Often, rural and border populations experience greater impacts from the mental health workforce shortage than do urban

populations. One approach to consider is increased focus on targeted development and recruitment of rural mental health providers that may be expanded to address these needs. Additionally, the state could consider methods to increase the practice of tele-mental health services.

- Improving the diversity of the mental health workforce – Due to Texas' diverse population, it is important that the workforce include sufficient providers to address the cultural, ethnic, and linguistic needs of the individuals receiving care. Evidence suggests that educational pipeline programs and the state's Joint Admission Medical Program have been successful. The expansion of such programs, aimed at producing mental health providers, is a possible consideration. Additionally, the state may consider policies that encourage international medical graduates to practice in the state, and educational institutions to equip providers with the necessary tools to treat the state's diverse population.
- Supporting innovative educational models – Recent health care system changes have challenged providers to be more innovative and efficient in their practice. These concepts include team-based care, patient-centered medical homes, and other innovations. The educational system will need to adapt its curriculum, produce more faculty with expertise in these new delivery models, and students with related clinical experience.
- Improving data collection and analysis – Projects aimed at innovative delivery of mental health care have already been initiated as part of the Medicaid 1115 Waiver Delivery System Reform Incentive Payment (DSRIP) program and as a result of Senate Bill 58, Legislature, authored by Senator Jane Nelson. These projects may shed light on mental health workforce implications and potential scalability. There is also a gap in knowledge about the mental health care needs of the state's population and the actual capacity and productivity of its workforce. Additional data would help inform policymaking decisions.

http://www.dshs.state.tx.us/legislative/2014/Attachment1-HB1023-MH-Workforce-Report-HHSC.pdf

Agencies & activities

As there are many agencies in the US this section focuses mainly (but not solely) on peer workforce development.

The Annapolis Coalition

The Annapolis Coalition is a non-profit organization dedicated to improving the recruitment, retention, training and performance of the prevention and treatment workforce in the mental health and addictions sectors of the behavioral health field. As part of this effort, we seek to strengthen the workforce role of persons in recovery and family members in caring for themselves and each other, as well as improving the capacity of all health and human services personnel to respond to the behavioral health needs of the individuals they serve.

There is broad consensus that there is a crisis regarding the nation's behavioral health workforce. This crisis is characterized by a range of problems including the following:

- Difficulty finding or recruiting interested or qualified providers.
- Difficulty keeping or retaining employees once hired. Turnover rates in behavioral health organizations typically range from 20-70% annually.
- The existing workforce is aging and there is an inadequate flow of new workers to fill the jobs held by those who will retire over the next decade.
- A lack of providers qualified to care for children, adolescents and the elderly.
- Severe shortages of behavioral health providers in rural America.
- The use of ineffective training techniques and a reduction in the amount of overall training being delivered due to financial constraints in provider organizations.
- Decreased levels of supervision of direct care staff.
- The absence of training in management and leadership skills for the next generation of leaders in the field.
- The absence of training and supports for persons in recovery and families who care for them.
- Inadequate preparation of the workforce for treatment approaches involving integrated care.

http://annapoliscoalition.org/who-we-are/

To achieve its mission, the Annapolis Coalition has focused on a set of functions that aim to build awareness and consensus and promote change at the local, regional and national level. These functions include:

- Synthesizing published recommendations on strategies for improving the quality and relevance of workforce recruitment, retention, education and training.
- Convening expert panels to identify best practices in workforce development.

- Identifying innovation in workforce development through national searches for innovative workforce practices, with reviews of these practices by panels of workforce experts.
- Identifying strategies and tactics for overcoming the obstacles to improving workforce development practices.
- Creating and maintaining a network of stakeholders concerned about the future of this workforce.
- Routinely disseminating information to stakeholders about best practices, innovation and change strategies.
- Linking stakeholders who have similar interests or those who can be of assistance to each other in implementing workforce best practices.
- Organizing educational events for stakeholders.
- Providing state agencies and non-profit organizations technical assistance on workforce development.
- Advising federal agencies and commissions on workforce development best practices.
- Conducting strategic planning on workforce issues on behalf of federal agencies.

http://annapoliscoalition.org/our-work/

For more information about their work:
http://annapoliscoalition.org/wp-content/uploads/2013/11/AC-Overview-of-Workforce-Activities.pdf
http://annapoliscoalition.org/?portfolio=publications

The National Council for Behavioral Health (National Council)

This agency is the unifying voice of America’s community mental health and addictions treatment organizations. Together with our 2,000 + member organizations employing 750,000 staff, we serve our nation’s most vulnerable citizens — more than 8 million adults and children living with mental illnesses and addiction disorders. We are committed to ensuring all Americans have access to comprehensive, high-quality care that affords every opportunity for recovery and full participation in community life.

The National Council, along with the Maryland Department of Health and Mental Hygiene and the Missouri Department of Mental Health, pioneered Mental Health First Aid in the U.S. and has trained approximately 280,000 individuals to connect youth and adults in need to mental health and addictions care in their communities.

PREMIER BEHAVIORAL HEALTH ASSOCIATION
A not-for-profit 501(c)(3) association, the National Council for Behavioral Health’s mission is to advance our members’ ability to deliver integrated healthcare.

The National Council advocates for policies that ensure people who have mental health and substance use problems can access comprehensive healthcare services. We also offer state-of-the-science education and practice improvement consulting and resources to ensure mental health and addiction services are efficient and effective.

The National Council coordinates the Mental Health First Aid program across the U.S. and operates the SAMHSA-HRSA Center for Integrated Health Solutions to provide nationwide technical assistance on integrating primary and behavioral healthcare. We offer the annual National Council Conference featuring the best in leadership, organizational development, and excellence in mental health and addictions practice.

National Council Magazine, National Council Live webinars, and our Journal of Behavioral Health Services and Research offer in-depth perspectives on current trends and hot topics in mental health and addictions — suicide prevention, trauma-informed care, the future of behavioral health, treating addictions as a disease, care for children and youth, integrated health and wellness, criminal justice and mental health collaboration, and more.
http://www.thenationalcouncil.org/about/national-mental-health-association/

MAJOR HEALTHCARE LEADERSHIP & WORKFORCE DEVELOPMENT INITIATIVES

Examples include:

Executive Leadership Program
The National Council for Behavioral Health's Executive Leadership Program nurtures executives with policy acumen who will excel in a dynamic healthcare environment and build a strong workforce that embraces change. The program offers coaching, training, performance improvement, and networking opportunities to strengthen each participant as a leader, community problem solver, and futurist. An expert team of policy and practice improvement principals forecasts how the healthcare payment and delivery system landscape will change and give participants best practices and tools to navigate this changing landscape.

Middle Management Academy
The National Council for Behavioral Health's Middle Management Academy helps managers at all levels enhance their ability to lead in increasingly complex environments characterized by tighter budgets, policy changes, and evolving clinical and business practices. The Middle Management Academy offers interactive learning opportunities on the full spectrum of critical management skills — role of the middle manager, moving from clinician to manager, how to run meetings, team building, recognizing and analyzing financial trends, staff skills and strengths development, conflict management, performance improvement, data-driven decision making, and more.

Addressing Health Disparities
Eliminating disparities in health requires leadership, vision, teamwork and an understanding of the issues from like-minded leaders. The need is critical in the light of the rapid growth in racial and ethnic minorities in the U.S., projected to account for 90 percent of the increase in national population by 2050. The Addressing Health Disparities Leadership Program is designed to mentor culturally diverse mid-level managers into executive positions, nurturing leaders who can represent and serve our nation's diverse communities.

Moving Case Management to Care Management
As healthcare reform advances and as more states move to health home models, the evolving healthcare marketplace will rely on case managers' existing knowledge and skills in

new ways. The National Council for Behavioral Health's Moving Case Management to Care Management in-person, 1-day training helps case managers step into the role of care managers prepared to meet the demands of the new healthcare marketplace. Care managers are able to develop strategies to build strong partnerships with primary care providers, help prepare patients for primary care appointments, increase patient self-management, and apply basic chronic care principles to managing heart disease and diabetes.

Whole Health Action Management
The National Council for Behavioral Health offers 2-day in-person trainings in WHAM — Whole Health Action Management — built on a science-based curriculum from the SAMHSA-HRSA Center for Integrated Health Solutions. The training prepares persons with mental illness and addiction disorders, employed in behavioral health organizations, to facilitate WHAM groups that help their peers reach whole health, wellness, and resiliency goals through effective self-management. WHAM teaches participants to set and achieve whole health goals through weekly action plans and 8-week support groups. The training also teaches basic health screens for prevention and encourages shared decision making with health professionals.

Community Health Worker Training
The National Council for Behavioral Health's 2-day in-person Community Health Worker training is designed to expand the skills of existing community health workers in providing services to people with behavioral and physical health challenges. The training includes introduction to mental and substance use disorders; introduction to counseling, cognitive behavioral therapy, and motivational interviewing; referrals and supports for mental health services; and mental health promotion, including stigma reduction and recovery.
http://www.thenationalcouncil.org/areas-of-expertise/leadership-and-workforce-development/

California Institute for Behavioral Health Solutions - CIBHS (formerly the California Institute of Mental Health)

The **California Institute for Behavioral Health Solutions (CIBHS)** is a non-profit agency that helps health professionals, agencies and funders improve the lives of people with mental health and substance use challenges through policy, training, evaluation, technical assistance, and research.

CIBHS was established as the **California Institute for Mental Health (CiMH)** in 1993 to promote excellence in mental health services. Local mental health directors founded CiMH to work collaboratively with all mental health system stakeholders. The commitment to collaboration has led the board to expand board membership to include consumers, family members, and other interested persons representing the public interest.

On July 1, 2014, CiMH merged with the **Alcohol and Other Drug Policy Institute (ADPI)** to form the California Institute for Behavioral Health Solutions.
http://www.cibhs.org/about-cimh

CIBHS is dedicated to helping California's mental health and substance use professionals through a variety of training methods. The left side bar includes links to:

- Conferences/Trainings
- Online learning
- Technical assistance and consulting
- MHSA trainings funded by the California Department of Health Care Services

Work includes:

The California Institute for Behavioral Health Solutions customizes numerous support services including training, technical assistance, research and evaluation, and policy development services to the mental health professional community.

- CIBHS's Workforce Development team supports a range of statewide, regional and local county efforts, focused on public mental health workforce development. This includes strategies to develop the future workforce along with current staff working in public mental/behavioral health and integrated settings. Our statewide efforts include Mental Health Services Act (MHSA) Workforce Education & Training (WET) funded contracts under the Office of Statewide Planning & Development (OSHPD) for consumer and family member employment technical assistance.
- The California Institute for Behavioral Health Solutions customizes numerous support services including training, technical assistance, research and evaluation, and policy development services to the mental health professional community.
- An CIBHS eLearning Web site. You can easily view and track all of your coursework, and access this information at your convenience 24/7. Now it is easier than ever to increase your knowledge, stay more informed, and access new training.
- CIBHS offers a wide variety of conferences and trainings.

http://www.cibhs.org/training-and-services

White Paper: US Peer Leadership & Workforce Development, 2014

Peer providers bring their own experiences of living with mental illnesses, addictions and/or community health problems to light the path to recovery for others. Creating a recovery based peer driven and delivered workforce creates training and employment opportunities providing peers with a stronger role and voice in integrated care plus the opportunity to break the cycle of poverty with employment in this emerging new healthcare field.

Creating a national Lived Experience Workforce Development plan can establish and legitimize the lived experienced service provider as a healthcare occupation and should be recognized by the United States Department of Labor (DOL) as a billable healthcare provider category through the Centers for Medicare and Medicaid Services (CMS) and managed care organizations (MCO).
http://bha.dhmh.maryland.gov/POPULATION_BASED%20BEHAVIORAL%20HEALTH/Documents/OWDT/WhitePaperUSPeerLeadershipandWorkforceDevelopment_Idenhandout.docx

A Report on Colorado's Behavioral Health Peer Provider Workforce

Current Status and Recommendations for Workforce Development, 2014

The main goal of this document is to outline the evolving peer workforce and a suggested direction for workforce development in Colorado. It includes:

- A description and brief history of the different behavioral health peer professions in Colorado as they currently exist,
- The progress that has been made in establishing a cohesive workforce,
- A summary of state and national findings and examples of best practices,
- And suggestions for moving forward with development of the peer workforce. Peers helping peers, individuals who have experienced a similar condition or circumstance, supporting and mentoring others; this type of mutual understanding and support occurs in a vast array of situations from cancer survivors to recovering alcoholics.

The peer behavioral health workforce is made up of three distinct groups:

- Peer Supporter Specialists – individuals who are in recovery from a mental illness.
- Recovery Coaches – individuals who are in recovery from addiction.
- Family Systems Navigators and Family Advocates – individuals who are the parent or family member of someone affected by a behavioral health issue.

http://static1.squarespace.com/static/53ec0294e4b02b8554865818/t/54b003b3e4b0ce916d667680/1420821454847/CMWN+Peer+Workforce+report

Peer Specialist Training and Certification Programs A National Overview – 2014 Update

Texas Institute for Excellence in Mental Health

The certified peer specialist workforce is relatively new in the behavioral health field, with state recognized certification programs first emerging in 2001. Within this short timeframe, states have recognized the potential of peer specialists to improve consumer outcomes by promoting recovery. A nearly universal definition of a peer specialist is: an individual with lived experience who has initiated his/her own recovery journey and assists others who are in earlier stages of the recovery process. As of March 2014, 38 states and the District of Columbia have established programs to train and certify peer specialists and 8 states are in the process of developing and/or implementing a program.

A review of the components of these state peer specialist training and certification (PSTC) programs is needed so that states developing training/certification programs may look to those that are more established for advice and guidance, while established programs may benefit from understanding the similarities and differences between existing programs.

This information may also be useful to policymakers and program developers as they create the infrastructure necessary to support the peer specialist workforce to remain relevant and financially sustainable in a changing healthcare environment. Providers employing, or considering employing, peer specialists may also find the information useful in developing appropriate guidelines and expectations for these employees. Peer specialists themselves, or those interested in becoming peer specialists, should also find the report useful in determining requirements necessary to become certified and the competencies of their peers in the field. http://sites.utexas.edu/mental-health-institute/files/2014/07/Peer-Specialist-Training-and-Certification-Programs-A-National-Overview-2014-Update.pdf

2012 Update: Status of the Developing Mental Health Peer Workforce in Massachusetts

Purpose: This paper reports on progress made and lessons learned since Transcom's* 2006 position paper, "Developing a Mental Health Peer Specialist Workforce in Massachusetts". The authors hope that people will be inspired and deepen their commitment to valuing and promoting the role of peer workers, who share their lived experience of mental health recovery throughout Massachusetts mental health services.

This paper describes key opportunities and advocates for recovery-oriented change. It is intended to be used as a reference for people who make decisions about the strategies, policies, practices, and resources related to mental health recovery which support and guide communities across the state.
http://transformation-center.org/wp-content/uploads/2014/06/Transcom-Peer-Specialist-Position-Paper-April-2012.pdf

Peer Specialist Training and Certification Programs: A National Overview, 2012

As of September 2012, 36 states had established programs that train and certify individuals with lived experience who have initiated their recovery journey and are willing to assist others who are in earlier stages of the recovery process. The information presented is a compilation of existing peer specialist training and certification (PSTC) programs in the United States based on review of and direct excerpts from online resources from states, email exchanges between the authors and contacts from some states, as well as published literature examining peer specialists and PSTC programs.
http://www.dbsalliance.org/pdfs/training/Peer-Specialist-Training-and-Certification-Programs-A-National-Overview%20UT%202013.pdf

Recovery Innovations

Recovery Innovations offers statewide services in Arizona, California, Delaware, North Carolina, Washington State as well as in Auckland, New Zealand. Recovery Innovations has developed an international reputation for service-based programs that demonstrate repeatedly that recovery from mental illness is possible. Using an exceptional peer support delivery model, Recovery Innovations offers strengths-based, wellness-focused approach

includes Recovery Response Centers (RRC)/Crisis, Wellness City/Outpatient, Transitions/Bridgers, Recovery Navigation, Housing Supports and Education.

In addition, Recovery Opportunity Center provides training and consultation, including Peer Employment Training, Facilitating Learning, Leading and Coaching a Recovery Organization and many other trainings including online training.
http://www.recoveryinnovations.org/

For the past 15 years, Recovery Innovations (RI) has engaged in changing the world through recovery education, focusing their efforts on three different target populations:

- Individuals with Serious Mental Illness
- Behavioral healthcare leaders/administrators
- Recovery Innovations employees
- Three departments within RI are responsible for delivering this education.

Recovery Opportunity Center (ROC)
Founded in 2005 as an RI subsidiary, the Recovery Opportunity Center has graduated more than 6,000 individuals from Peer Employment Training, certifying them to serve in Peer Support roles. As a result, RI has boasted one of the largest peer supports workforces in the world, and has used this experience in recruitment, training, support, management and retention of peer workers to create trainings that support other organizations in making similar transformations.

Recovery Education Center (REC)
Author Malcolm Gladwell's Ted Talk on Capitalizing Human Potential focuses on two key drivers: what others expect of us and what we are trained to achieve. Often, individuals with serious mental illness are told that they have a disabling illness, and as a result they will not be able to work.

Since 2002, the Company has offered alternatives to historic day programs, including vocational certificates and personal growth workshops, bringing an important "Peer Career Ladder" to thousands of individuals served by RI's Wellness City. This empowers individuals to choose career options beyond Certified Peer Supports.

RI Learning Team
Chris Martin leads the Learning Team of three master learning specialists and an education coordinator, which supports RI sites and programs across the US and in Auckland, New Zealand. They also focus on the professional and career development of staff and the advancement of the four balanced score card areas of the company.
http://davidwcovington.com/2015/03/05/igniting-hope-with-recovery-education/

The Child Health and Development Institute of Connecticut

THE INFANT MENTAL HEALTH WORKFORCE: Key to Promoting the Healthy Social and Emotional Development of Children

The Child Health and Development Institute of Connecticut (CHDI), a subsidiary of the Children's Fund of Connecticut, is a not-for-profit organization established to promote and maximize the healthy physical, behavioral, emotional, cognitive and social development of children throughout Connecticut. CHDI works to ensure that children in Connecticut, particularly those who are disadvantaged, will have access to and make use of a comprehensive, effective, community-based health and mental health care system.

BEST PRACTICES FOR HEALTHY DEVELOPMENT

CHDI is helping to build a competency-based, trained workforce that actively promotes infant and early childhood mental health in the settings where young children receive services.

This work is being done in partnership with the **Connecticut Office of Early Childhood** (OEC) and the **Connecticut Association for Infant Mental Health** (CT-AIMH) and includes the following.

Training for Early Care and Education Providers

- **In-person training**
  CT-AIMH is offering a series of trainings for early care and education providers in infant and early childhood mental health. Training focuses on understanding the importance of brain development, how temperament affects each child's personality, the importance of play, understanding the importance of healthy social and emotional development, how to identify social and emotional developmental delays, and how to work with parents. It also provides resources to refer parents to appropriate interventions.
- **Online training**
  The **KidsMentalHealthInfo.com** website is being updated to include online training resources for health and early care and education providers specific to infant and early childhood mental health and maternal depression.

Training for Health Providers (EPIC)

Educating Practices In the Community (EPIC) is CHDI's training initiative to inform pediatricians and their staff about critical children's health issues – right in the comfort of their own offices. Two new EPIC modules have been developed and are being delivered through CHDI's EPIC program across Connecticut on:

- Infant Mental Health
- **Maternal Depression**
  As part of these two new EPIC modules, **Maintenance of Certification** will be offered to those pediatric providers who complete the training module and want to participate in a quality improvement initiative related to Infant Mental Health and Maternal Depression.

Infant Mental Health Competencies

CHDI is helping the CT-AIMH build a system for Connecticut to support a competency-based early childhood workforce. This effort is based on the CT-AIMH Endorsement (IMH-E®).

The intent of the Endorsement is to recognize and document the development of infant and family professionals within an organized system of culturally sensitive, relationship-based, infant mental health learning and work experiences.

http://www.chdi.org/our-work/early-childhood/infant-early-childhood-mental-health/workforce-development/