Exploring core competencies for mental health and addictions work within a Family Health Team setting

Brian Rush PhD
Centre for Addiction and Mental Health, Toronto; Dalla Lana School of Public Health, University of Toronto; Department of Psychiatry, University of Toronto, Toronto, Ontario, Canada

Catherine McPherson-Doe MSW
Hamilton Family Health Team, Hamilton, Ontario, Canada

Reneé C Behrooz MSc
Centre for Addiction and Mental Health, Toronto, Ontario, Canada

Alan Cudmore MA
Centre for Addiction and Mental Health, Toronto, Ontario, Canada

ABSTRACT

Approximately 200 Family Health Teams (FHTs) have been implemented in Ontario to improve access to primary healthcare, including mental health and addiction. The objectives of this project were to examine, through a focus group and qualitative methodology with three FHTs, the profile of patients’ mental health and addiction-related needs and to identify the implications for the development of core competencies in these innovative organisations. A spectrum of needs and service trajectories was identified, as well as the importance of a wide range of clinical skills and knowledge. The results indicate that ‘core’ competencies for mental health work in the context of an FHT go well beyond those required for an embedded mental health ‘programme’ or specialised mental health counsellors, but rather they relate to the core and discipline-specific competencies of members of the entire team. In addition to specific knowledge and skills, competencies include common attitudes and values relating to teamwork, good communication and collaboration. Challenges were noted with regard to working with some community service providers, especially addiction services. Implications for core competencies at the individual and organisational level were identified.

Keywords: addictions, collaborative care, core competencies, family health teams, mental health

Introduction

Significant primary care reform has been under way in Canada for about a decade, with a strong emphasis on inter-professional, team-based models.1 One of the most significant initiatives has been in the province of Ontario, with the development in 2005 of Family Health Teams (FHTs), now numbering some 200 sites. FHTs are intended to improve access to primary healthcare and related services,2,3 and to bring together different healthcare providers to give doctors support from other complementary professionals. Most FHTs bring together physicians, nurses/nurse practitioners and other professionals such as mental health workers and addictions counsellors to work on a collaborative basis.4,5 A body of research is slowly evolving on this innovative approach, and it is of great interest globally in part
because it models many features of the ‘medical home’, an emerging model of healthcare. This work also serves as a learning ground for understanding inter-professional collaboration and the role of professional culture.

Among the wide array of professionals working in this team context there are explicit requirements for involving mental health professionals, and many explicit and implicit expectations about improving access and quality of care for people with mental health challenges. Substance use/abuse is officially seen as part of the mental health portfolio, but often is not specifically highlighted in relevant policy documents and implementation and training initiatives. More research and performance monitoring is needed on the effectiveness of the mental health and addictions component of the FHT initiative. That said, the literature on collaborative mental healthcare suggests that it is an effective strategy for improving mental health-related outcomes. Although the research evidence does not point to the critical ingredients of collaborative mental healthcare, elements such as co-location, pairing with clinical guidelines and enhanced communication are seen as important contributing factors. These are all important elements of the mental health component of the FHTs.

The FHTs have incorporated mental health and addiction services in a variety of ways in response to a wide range of internal and external contextual factors, and many have distinct mental health programmes/professionals embedded in the larger team. However, unlike other areas of the larger and more specialised mental health and addictions service system, the scope of practice and core competencies for provision of mental health services in the FHTs, and within primary care generally, has yet to be defined. Within Canada, the Canadian Centre on Substance Abuse Treatment has developed a competency framework for substance abuse professionals. Health Canada’s Best Practices document on treatment and support for people with concurrent mental and substance use disorders includes a section that lists the best supported clinical interventions for specific concurrent disorders, and Goering and colleagues suggest a range of mental health system functions from which core competencies can be derived. In New Zealand, the Ministry of Health has developed a framework of skills and essential knowledge for mental health and addictions workers. This framework describes a set of values, attitudes, skills and performance indicators at different levels, recognising that various roles may have different requirements depending on when and where a person enters the workforce. In the UK, the Federation of Drug and Alcohol Professionals has developed a code of practice for all drug and alcohol practitioners.

This framework of standards includes general standards, service provision, professional competence, consent, confidentiality, client relations, professional supervision and professional standards. In mental health, the Department of Health has prepared a framework of capabilities. In the USA, the Center for Substance Abuse Treatment has developed competencies for addiction counselling specifically. The Centre for Addiction and Mental Health (CAMH) has listed this and several other relevant competency frameworks on the Knowledge Exchange website. Since many of the competencies and functions identified in this body of work are highly relevant for FHTs, and for collaborative mental healthcare generally, it is important to explore mental health-related functions and competencies in the FHT context. For example, not all patients presenting with mental health or substance use concerns in these settings may have developed clinical symptoms, or meet the diagnostic criteria for specific disorders, but they may still be experiencing significant psychosocial difficulties and require specific intervention. Since the FHTs are likely to see a wider spectrum of problem severity than is encountered in specialised mental health and addiction services, the nature and scope of practice of mental health and addictions treatment and support within the settings will probably be different. It follows then that the required competencies for mental health and addictions-related work within the FHTs may be different as well.

The emerging literature on the FHTs is relevant for the development of core competencies for mental health and addictions work in these settings. Examples include the findings related to the required experience and maturity of the workers, the need for communication skills and clarification of scope of practice in a complex multi-disciplinary team environment, the need for inter-professional education, and the need for leadership and change management skills. However, the focus and language related to core competency development are absent from this and other literature on the FHTs.

In Ontario there is growing interest in developing core competencies for mental health work in primary care and the FHT setting. For instance, Pautler and Mahood prepared a report for the Ontario Ministry of Health and Long-Term Care in which they reviewed issues and best practices for the development of competency-based standards for mental health work in primary care. In another report prepared for the Ministry of Health and Long-Term Care, the Thames Valley Family Practice Research Unit conducted a focused literature review to identify best practices, and proposed recommenda-
tions for mental health work in the primary care setting. This report also included an environmental scan of what is currently happening in Ontario’s FHTs, and highlighted the importance of the unique characteristics of the practice and staff complement, as well as the unique community context in which the work takes place. Other reports cite organisational attributes such as a strong team leader, supportive environment and training, common vision and goals, up-to-date information and communication technology, and inter-disciplinary diversity among team members, in addition to individual attributes such as discipline-specific skills, respect for ideological differences, and communication skills.

One of the largest family health teams in Ontario had a major focus on mental health from the outset, and was a strong advocate and change agent for collaborative mental healthcare within the emerging FHT system across the province. However, the model of practice that emerged in this FHT was not rationalised on the basis of best practices or principles for FHTs, but largely on the basis of the expressed needs of individual GPs and the staffing complement at each of many sites that comprised the FHT. In other words, there may not be a direct correspondence between patients’ needs, the services that are being provided, and the competencies required. It is with this potential gap in mind that the present project was formulated.

The objectives of the present project were descriptive in nature and aimed to describe:
1. The profile of clients presenting to three Ontario FHTs with mental health and substance use concerns
2. How people with mental health and substance use concerns enter and move through the FHT, and the overall FHT response.

The focus of this paper and the overall goal of the project was to derive implications of this description for the development of core competencies for mental health and addictions work in the FHT setting. Importantly, it was not intended to develop a generic service model for mental health and addiction work in FHTs and related core competencies. The goal was to contribute to a subsequent process to develop core competencies for mental health and addiction work in the FHT setting.

**Methods**

**Study sites**

A total of four focus groups were held between October 2009 and February 2010 in three purposively selected study sites. Two focus groups were held in one large urban site supplemented by one group in each of two settings, both in more rural and northern jurisdictions.

**Site 1 (two groups)**

The first site is one of the largest family health teams in Ontario and serves approximately 235,000 patients. The FHT employs approximately 115 physicians, 101 nurses and nurse practitioners, 20 registered dietitians, 21 psychiatrists, 77 mental health counsellors and 7 pharmacists. The first focus group \((n=8)\) included four mental health counsellors and four mental health/addictions programme coordinators. The second focus group \((n=8)\) had a more diverse set of participants from different disciplines within the FHT, including two registered nurses, three family physicians, one receptionist, one pharmacist and one dietitian.

**Site 2 (one group)**

The second site, in Northern Ontario, includes ten family practices and serves over 16,000 rostered patients. The mental health service pre-dated the development of the FHT, but subsequently developed into a model of shared care. The focus group \((n=5)\), which was held by teleconference due to distance and resource limitations, included two family physicians, one social worker (mental health lead), one nurse practitioner and one registered nurse.

**Site 3 (one group)**

The third site involved an FHT supporting a roster of 20,000 patients, and is located in a largely rural area of the province. It consists of family physicians, registered nurses, a pharmacist, a kinesiologist, a dietitian, a chiropodist, a mental health team, nurse practitioners and administrative staff. The focus group was held with eight participants (three social workers, a family physician, a secretary within the mental health department, a registered nurse, a mental health therapist and an information technology specialist).

**Structure of the focus groups**

Each semi-structured discussion was led by the first author (BR) and lasted between 2 and 3 hours. The structure of the focus groups was built around the first two objectives of the project concerning client profile and trajectory into and through FHT services.
To that end we first asked the following question: ‘Thinking about the various pathways to mental health and addiction services, what determines who goes where? And how might their needs differ for different pathways?’ This question was accompanied by a flowchart diagram that participants could also use to illustrate different pathways. The second question asked about client profiles: ‘Thinking about people with mental health and addiction problems in your FHT, how does their profile (strengths and needs) differ compared with people seeking help from other services in the community?’ The third structured question asked about the FHT response: ‘What is unique about the response to mental health and addiction concerns in the Family Health Team setting compared with other community services?’

Analysis

The results of each focus group were recorded on paper by a member of the project team. These results were then synthesised within each FHT and then separately for each of the three questions identified above and which were common to each group. The responses were subsequently analysed using inductive thematic methods. This qualitative process was conducted in two steps. First, two members of the project team reviewed the comments independently, documented the themes, and grouped the comments supporting those themes. The two analysts (RB and BR) then met to discuss their analysis, reconcile discrepancies and arrive at a common interpretation. Since there was a great deal of overlap in the themes that emerged under each of the focus group questions, we have not presented the results by individual question or FHT.

Results

Client profile

Across the four groups, four themes converged with regard to the nature of mental health, substance use and addiction-related problems, as well as other unique features of the client population in the FHTs. These themes are summarised below.

With regard to mental health concerns, although the full spectrum of mental disorders and severity/chronicity are seen, the most common were said to be depression and anxiety, in both adults and young people. People with personality disorders were also cited as being frequently seen, as well as young people with attention deficit hyperactivity disorder (ADHD) and adjustment disorders, and people with concurrent mental and substance use disorders. The comments regarding the range of presenting mental disorders reflected both the diversity of issues and concerns, and the gap that the FHTs seemed to be filling in the local system, a system that essentially focused on supporting people with severe and persistent mental disorders (SMI) and had limited capacity for people with complex concurrent disorders. The proportion of severe and complex mental health cases in the FHTs was considered to be low but still important, as the FHTs were seen as filling a need for monitoring, ongoing support and medication management for clients with SMI.

In terms of substance use problems, the focus group participants considered these problems to be less frequent than other mental health concerns, but still quite common and diverse. Marijuana was mentioned as a significant issue in each of the four focus groups, being linked most often to comments related to working with patients who were using cannabis to ‘self-medicate’, typically for anxiety, chronic pain or other chronic health concerns. Cannabis use tended to be viewed as ‘normal.’ Another common theme across all of the groups was concern about addiction to prescription opiates (usually Oxycontin) and the close link to pain management. Oxycontin was mentioned in connection with both the adolescent population and adults, as well as subpopulations such as obstetric patients (in that site, 25% of obstetric patients were considered to be dependent on Oxycontin). Gambling concerns were noted as a major problem by two of the four groups, with one of these sites being in close proximity to two casinos.

In addition to the specific types of mental health, substance use or gambling problems, an important theme emerged concerning the role of family members. In some cases this referred to the patient expressing a need for support concerning a mental health or addiction problem of another family member (e.g. parents’ concern about their child’s gaming addiction, adolescents’ concerns about their parents’ alcohol or drug use). Alternatively, the reference to family members related to the fact that the FHT had been the primary care provider for multiple generations and multiple family members, thus giving the FHT providers a unique inter-generational perspective.

Lastly, a theme emerged with regard to the importance of community context in determining the profile of clients with mental health and substance use concerns. On the one hand, the local service mix and gaps in the local continuum of care were said to influence who would access FHT services for their concerns. Examples included the lack of community
While the other two FHTs that were engaged in the project did not offer as complex an array of services and support for people with mental health and substance use challenges as Site 1, they each described unique internal pathways of engagement and service delivery. In short, the results from each focus group highlighted the fact that the issue of ‘core competencies’ was about the overall FHT response and capabilities for supporting people with mental health problems, and not just the capacity in the more circumscribed mental health service per se.

Internal programme response

In all of the FHTs, once enrolled in the internal mental health service, the process normally involved intake, assessment and treatment planning. However, a wide range of internal services and programmes may be accessed depending on the scope of mental health practice available. This included, for example, mood/anxiety-related programmes, insomnia groups and stress management, to name just a few of the options that were mentioned. As was noted earlier, some individuals with mental health and/or substance use issues remain under the care of a physician with little or perhaps no utilisation of the mental health service. In other instances, the referring physician ‘hands over’ major responsibility for the delivery of required mental health services and then assumes a monitoring role that was described as ‘support as needed.’

Apart from the differences across FHTs in the internal mix of professionals and the services they provide, the strongest theme that emerged concerning internal programme response was the need for a high level of role familiarity, communication and collaboration. The optimal FHT response was said to be holistic and systems-oriented, as evidenced for example by a thorough knowledge of internal roles and capabilities, team meetings, including group chart review, and group decisions for treatment planning. Although not all teams in each FHT were said to be working according to this team model, the team approach was described as ideal. Challenges were said to be at both the individual practitioner level and the structural level, for example, when the mental health or addiction counsellor is employed by the FHT office while the physician may own the practice and directly supervise nursing and office staff. It was noted in this situation that the physician may not understand the role of the mental health or addiction counsellor. One focus group emphasised that collaborative care has many incentives and disincentives, and that it is not easy to engage a physician who is carrying a caseload of, for example, 3500 patients and working 12 hours a day. Time...
constraints, willingness and accessibility were cited as challenges to good communication and collaboration. Related to an expressed need for a flexible, collaborative approach was the issue of constant change in a busy office environment that may not have sufficient infrastructure to support programmatic adaptations and ongoing quality improvement. The FHT was described as a dynamic environment with an ever-evolving team complement as well as patient composition. In terms of internal FHT response, the importance of viewing the individual in the context of their family was also seen as critical. This was said to be sometimes challenged by confidentiality concerns, but with the focus remaining on family-centred care. Lastly, there was the issue of prevention and health promotion. Although challenges were cited with regard to carving out time for prevention and health promotion, this was seen as clearly within the FHT mandate.

Community collaboration/coordination

The trajectory out of the mental health service was depicted as more dependent on community context than the in-flow and the internal FHT response. A common theme emerged regarding the need for improved communication with other local service providers. With regard to the general theme of community context, three sub-themes emerged.

First, the services provided by the FHT, and the way that they were coordinating with the local system, were clearly connected to the local availability of services for external referral. Community services were said to be unclear about ‘what FHTs do’, resulting in some instances in resistance to accepting referrals. ‘Don’t you do that?’ was said to be a common response from the community service providers who were being referred to. Role clarification and overall service coordination was seen as less of an issue in the focus groups in the predominantly rural setting, as the local systems were seen as less complex, and generally people knew each other on a personal basis.

Secondly, in virtually all of the focus groups, the issue of a challenging relationship with local addiction services was noted. These challenges included a lack of availability of a particular type of service that was needed (due to its being non-existent or having a long waiting list), concerns about the policy of the addiction agency that the person him- or herself must make contact and not the FHT professional, and/or concerns that post-referral feedback from the agency was typically not forthcoming, unlike that from most other service providers in the community to which the FHTs refer.

Lastly, there was a commonly repeated perception that patients within the FHT often resist referral outside the FHT as they often have an established relationship and high comfort level with their physician as well as with FHT staff.

Individual practitioner characteristics

In addition to themes and sub-themes concerning patient flow and the FHTs’ programmatic response, another strong theme emerged related to the required skills and other types of competencies of FHT practitioners working in the area of mental health and addiction. The majority of comments from the focus groups regarding skills and other characteristics related to the specialised mental health counsellor. However, other comments related to all FHT professionals working with people with mental health and addiction problems. Key characteristics cited included the following:

- skills in working with specific client subgroups, such as people with personality disorders, addiction problems or chronic conditions, including multiple co-occurring conditions
- skills and comfort level in working alone as well as in a team context, since although teamwork is emphasised, much of the work is done alone with long hours and a large caseload
- a high level of education and experience, including supervised hours, given the range of mental health and addiction issues encountered in daily practice
- the ability to introduce and manage change and to participate in change management at both a practitioner and an organisational level
- skills in communication and managing relationships, since ‘linkage’ is a key function of the work between patients, physicians, counsellors and psychiatrists, as well as brokerage of community resources and referral.

Summary and implications

This project set out to describe the mental health work (including addiction services) and the population served by a small number of FHTs in Ontario, as a preliminary step towards the development of core competencies for mental health and addictions work in these innovative healthcare settings. Mental healthcare, including that delivered in FHTs, is not the only domain of health that is interested in identifying and then enhancing competencies of
the workforce. As in other domains, there are many uses to which core competencies can be put, including staff recruitment, performance reviews/monitoring and other human resource-related functions, supporting quality improvement processes aimed at improving client care and outcomes, and setting concrete targets for training and education, including both continuing education and curriculum development. Goldman and colleagues cite a framework that categorises different types of inter-professional interventions (organisational, practice based and educational), and core competencies for mental health work in the FHT context would provide a common set of targets for this diverse set of interventions.

Workforce competencies have received attention in many other areas, including public health, health promotion and many specific subspecialties, such as social work and addictions treatment. Across this broader body of work there is no universal definition of ‘competencies’ or ‘core competencies’. In public health, core competencies include the knowledge, skills and attitudes of the workforce that are required to achieve organisational or system-level goals. The distinction between ‘core’ and ‘specific’ competencies is important in this wider literature, whereby the ‘core’ reflects the common required skills, knowledge and attitudes across all of those working in a given domain. This is distinct from the competencies that are also required to fulfil role functions within various subspecialties and disciplines who may be working together towards common goals. For mental health, these specialties would include psychiatry, psychology, nursing, addiction counselling and addiction medicine, social work, nutrition, occupational therapy, and administration and programme management, to name just a few areas. As noted earlier, the results of the present project indicate that ‘core’ competencies for mental health work in the context of an FHT go well beyond those required for an embedded mental health ‘programme’ or specialised mental health counsellors, but rather they relate to the core and discipline-specific competencies of members of the entire team.

The following discussion and implications of the present findings for core competencies are organised into two categories, namely the individual level (separating knowledge and skills from attitudes and values) and the organisational level. The findings are also integrated with the results of other qualitative studies of the Ontario FHTs, some but not all of which focused on mental healthcare specifically.

Individual-level competency requirements

Knowledge and skills

There are many themes which arose in the focus groups that relate to specific mental health and addiction-related knowledge and skills. Specific knowledge and skills are required in order to treat a wide range of mental and addictive disorders as well as problems and/or symptoms that are at sub-threshold levels from a DSM-based, diagnostic perspective. The variety of disorders and sub-threshold concerns is in part related to their high prevalence in the community (e.g. mood/anxiety disorders, substance use disorders), with the FHT providing an open-access option for rostered clients. On the other hand, the wide variety of disorders that is being seen is also influenced by lack of available or effective options in the community (e.g. services for people with personality disorders and adults or young people with ADHD). Regardless of the underlying reasons, the wide variety of disorders that is being seen calls for a highly developed set of clinical competencies in the overall FHT.

Ability to manage a high level of comorbidity is also suggested by the focus group results (e.g. co-occurring pain management, mental health challenges and prescription opioid abuse), as are skills in clinical supervision and working with families, including confidentiality-related issues. Previous studies have also highlighted the complexity of the case presentations in the FHT context. This complexity, combined with the often challenging work conditions vis-a-vis caseload, space limitations and overlapping scopes of practice, calls for an experienced and mature cadre of professionals engaged in mental health and addictions work.

The findings reported here are the first to highlight the range and complexity of challenges related to substance use, particularly prescription opioid dependence and cannabis use, but no doubt also including alcohol, tobacco and less frequently used substances. Core competencies in these areas are critically needed and would include those required for implementation of guidelines and resource material for screening and brief intervention for individuals at low to moderate risk related to their alcohol use, and skills related to addictions assessment, medication management and psychosocial interventions for more severe addiction problems.

Familiarity with guidelines and related challenges concerning cannabis use are also needed. In addition, knowledge about available addiction services in the community, and skills in working with them, are required, as there appear to be challenges in these working relationships compared with mental health services generally.
Other areas of core knowledge and skill-related competencies noted here and/or in other work include communication skills, ability to adapt one's practice to a complex team-based environment, basic skills in the use of technology (e.g., shared electronic health records) and, for senior staff, a high level of project development and management skills. Communication skills relate not only to working with other team professionals but also to working with patients (e.g., supporting and encouraging clients to take advantage of other community services, and referral and linkage to these services).

Attitudes and values

It is evident from work in other health domains that competencies involve more than knowledge and skills related to task completion. The inclusion of an attitudinal element is important in that it recognises that psychological attributes of the workforce can have a significant impact on the nature and quality of services provided. In mental health and addictions, this is particularly critical given how stigma and discrimination challenge people's access to and receipt of appropriate services, and the importance of client engagement strategies and therapeutic relationships as a determinant of outcome. In the FHT context these core values should include an open-minded approach to, and acceptance of, working with people regardless of the severity and challenges of their illness (e.g., people with personality disorders).

Other attitudinal factors relate to working in a collaborative, interdisciplinary team context as well as engaging with other community service providers. Within the context of team-based care in the FHTs, Beales and colleagues discuss the role of professional culture and practice style in developing effective collaborative care. Many elements of professional culture relate to attitudinal competencies, for example, not all FHT professionals will share the same attitudes towards people with substance use problems, and expectancies with regard to working with community addiction providers who require ‘self’ versus provider or family member referral. The meaning of the term ‘recovery’ is also quite different in the mental health sector compared with the addictions sector. Professional cultures also differ in the comfort level and value placed on a non-hierarchical work environment.

The broader literature on healthcare collaboration distinguishes various forms of integration (e.g., structural versus functional, vertical versus horizontal), but increasingly emphasises ‘normative integration.’ Hollander and Prince have identified ‘shared belief’ in their best practice framework for collaborative care. Essentially these terms mean getting everyone on the same page with regard to core values and modus operandi, which in the FHT context is a recovery-oriented approach to mental health and addictions work in a family-centred care model. High value must also be placed on the unique skills, competencies and world view of each team member. Future efforts with regard to core competencies for mental health and addictions work in the FHTs need to articulate the desired norms and principles of collaboration in this organisational context.

Organisation-level competency requirements

In addition to considerations of competencies at the individual level, it is important to note that workforce competencies play out in the context of overall organisational capacity for the achievement of the core mission. The work of Greenhalgh and colleagues and other organisational theorists illustrates the reciprocal and very complex interplay between individual and organisational competencies and assessment of the impact of competency improvement strategies. On the one hand, competencies at the individual level can evolve or ‘spread’ to become an organisation-level competency (e.g., when the training of one key person, or the cumulative impact of training several staff, contributes to shifts in organisational culture, infrastructure or policy which then have an impact on the majority of the workforce in that organisation). On the other hand, predisposing factors such as processes for performance review or management structures of the person's home organisation can influence their ability to action and sustain new knowledge or skills that are being learned in various skill-building situations or training events. This interplay at the organisational level would emerge in efforts to improve mental health and addictions-related core competencies within an FHT (e.g., efforts to incorporate and share a new or innovative evidence-based practice).

Our findings highlight many organisation-level competencies that are required to support the work of the overall team as well as individual professionals. Again our findings resonate with previous qualitative studies of the Ontario FHTs. The most salient theme is the requirement for strong organisational leadership and, based on that leadership, ensuring that processes and structures support team-based care. This can include the following:

- infrastructure for electronic sharing of patient information
- support for education and staff development


- co-location and space planning to facilitate teamwork, informal sharing and relationship building
- well-facilitated team meetings and case conferences that help to define who is responsible for what
- expertise in strategic planning and engagement of staff and stakeholders to craft a common vision
- human resource policies and procedures that facilitate a healthy work climate that supports staff self-care and wellness, and reduces turnover
- opportunities for team-based inter-disciplinary learning.

Other organisation-level competencies relate to the uniqueness of the mental health work in the family context and often with multiple generations of the same family. Although this brings a unique opportunity to work in a broad family systems context, it also presents unique challenges from an organisational confidentiality perspective. The findings also highlight the many pathways into and through an FHT, thus calling not only for strong engagement and motivational skills and attitudes among individual team members, but also for a strong organisational ‘systems’ response, including defining and supporting the front-end receptionist role and staff at other key triage points. In addition, given the wide age range that is seen in the FHT setting, and the many opportunities for primary and secondary prevention, the FHT leadership and the overall FHT organisational plan should endorse a strong prevention and health promotion component and action it accordingly.

More than other qualitative studies of Ontario FHTs, the present findings highlight organisation-level process and structures needed to work with external service providers and system planners. This can include joint educational sessions, service agreements, and participation on regional planning committees. Strong links are required with the local community network of mental health and addiction services to effectively manage the full range of mental health and addictions challenges. That said, there appears to be a strong preference among FHT patients for receiving as much service as possible, if not all of it, in the FHT. This probably reflects many factors (e.g. the patient may have come to the FHT because of a particular cultural/linguistic competence, they may have ‘exhausted’ local services, or the services may not be available locally). Mulvale and colleagues\(^1\) have highlighted the importance of FHT planning according to local population health needs, an observation that is supported by our findings (e.g. the regional variation in prevalence of specific addictive disorders, such as prescription opiate dependence). The variability in community resources and the need to attract experienced professionals such as psychiatrists and psychiatric nurses calls for organisational competency in recruitment coupled with resources and experience in offering incentives to work in rural/remote areas of the province.

The data collected in the present project illustrate the important role that the FHTs are playing in their respective communities in the delivery of mental health and addiction services. However, there is a disconnect between the planning and implementation of these FHT-based services and that of the mental health and addictions services being provided through the specialty agencies funded through the Local Health Integration Network (LHIN). These specialty agencies are involved in local/regional planning processes and also participate in various provincial information systems and system enhancement initiatives. There is a need to better connect the mental health and addictions work of the FHTs to this broader network of providers with regard to planning, professional recruitment and performance measurement systems, so as to ensure optimal coordination and maximum benefit for community members who are seeking help for mental health and addiction problems. Collaborative work on core competencies is needed, and would probably be a helpful collaborative activity to build bridges between the FHTs and other community service providers.

**Limitations**

A significant limitation of the present project is that, due to resource constraints, only three of the 200 FHTs now in existence in Ontario were included in the study. In addition, due to resource constraints we were not able to undertake a state-of-the-art qualitative analysis (e.g. working from taped proceedings to yield detailed transcripts, coding and iterative theme development with the support of qualitative software, and member checking). Although our methods were limited in these ways, and it is not possible to generalise the results across the entire provincial network, many of the themes that were identified triangulate with those found in previously published qualitative studies of FHTs that were also based on very small samples.

**Going forward**

Notwithstanding these limitations, it is important to identify some of the next steps towards identification of core competencies for mental health and
addiction-related work within the FHT system provincially. These steps should include the following:

- identifying key champions to further this work and develop an action plan
- securing agreement on the importance of further work on core competencies among key stakeholders (e.g. the Ontario Ministry of Health and Long-Term Care, the Association of Family Health Teams of Ontario)
- securing the support and potential engagement of other mental health and addiction services in Ontario
- proposal development to secure funds for dedicated project management resources
- further analysis of mental health and addiction practice in the FHT context (e.g. with a broader survey of a representative group of FHT physicians, managers and professional and administrative staff)
- a functional analysis of their mental health and addictions work to identify the core functions and group them into a functional map, followed by identification of tasks and competencies required for these tasks.

This would be followed by drawing up competency statements that would then be disseminated for feedback and consultation. This can be done with questionnaires, focus groups or a consensus process such as the Delphi technique. Multiple rounds of feedback are encouraged to arrive at a point of consensus.

Conceptual frameworks that articulate different types of competencies (e.g. knowledge, skills, attitudes, values and organisational versus individual levels) need to be reviewed and one of them adopted. The conceptual framework advanced by Mulvale and colleagues, which articulates the critical role of internal and external context, may also be helpful, as some competencies may not be weighted equally in some situations (e.g. rural versus urban jurisdictions). It will also be important to have a well-defined implementation and evaluation plan going forward. There will not be universal agreement on the potential benefits and challenges of a set of core competencies for mental health and addiction work in the context of the FHT. Although a programme logic model and the objectives for which the competencies are being developed can serve as a starting point for evaluation planning, a developmental evaluation and complexity-based approach to the overall evaluation plan is encouraged. The plan should track the success of key aspects of the development process, implementation strategies and outcomes being achieved. Implementation should also involve one or more pilot projects in which the implementation of the competencies can be tried out and evaluated in terms of both process and outcomes achieved. Competencies can be revised on the basis of these pilot experiences. The final stage would be broader implementation and evaluation with a view to potential revision and updating of the competencies.

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CONFLICTS OF INTEREST

None.

ADDRESS FOR CORRESPONDENCE

Brian Rush, Centre for Addiction and Mental Health, 33 Russell Street, Toronto, Ontario M5S 2S1, Canada. Tel: 416 535 8501 ext 36625; email: Brian_Rush@camh.net

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