

CENTRE FOR ADDICTION AND MENTAL HEALTH
CORPORATE DIVERSITY REVIEW
REPORT

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Prepared by:

Usha George

Faculty of Social Work, University of Toronto

Jean Gilbert

Department of Anthropology, California State University Long Beach

Gurwinder Gill

Manager of Diversity Services, Trillium Health Centre, Mississauga

Table of Contents

Executive Summary

A. Introduction

B. Methodology

C. Findings

I. Status of Diversity Agenda

Successes

Challenges

Suggestions for moving forward

Recommendations by external reviewers

II. Diversity Programs Office Leadership

Suggestions for moving forward

Recommendations by external reviewers

III. CAMH Programs & Social Determinants Of Health

Successes

Challenges

Suggestions for moving forward

Recommendations by external reviewers

IV. CAMH Leadership

Successes

Challenges

Recommendations by external reviewers

V. CAMH and Community

Successes

Challenges

Suggestions for moving forward

Recommendations by external reviewers

VI. Public Education and Health Promotion Integration and Alignment

Steps CAMH can take to optimally address diversity across the province in an emerging regionalized structure

Other steps that can be taken to CAMH build on its successes

Recommendations by external reviewers

Appendix

List of Questions

Executive Summary

Introduction

In 2000 an external group of consultants reviewed the Centre for Addiction and Mental Health's (CAMH's) work in the area of diversity and developed a series of recommendations and Action Plan for moving the organization towards greater and more equitable inclusion in the areas of leadership, human resources, services and stakeholder relations. The Diversity Program Office (DPO) was designed in 2001 to provide leadership, expert consultation, strategic advice, planning and training support across the organization in addressing these diversity priorities through the Action Plan. CAMH's involvement has been reflected in the range of activities, commitment and structural changes in areas like strategic planning prioritization, change management leadership, program planning, clinical cultural competence delivery, performance management, resource development, public policy development, diversity training, sectoral leadership, and community relations.

This review is about CAMH's diversity work over the last four years. It is an assessment of the organization's successes and challenges in the implementation of the diversity agenda in order to provide directions for future work. The review gathered information on such themes such as Ontario's current health transformation agenda and diversity implications for CAMH's work, possibilities of revitalizing, refocusing and refreshing the diversity agenda, the role and place of social determinants of health considerations across all aspects of its work, evolving work of the DPO and enhancing our role with diverse communities.

Methodology

The external reviewers developed their analysis of the current status of the Centre for Addiction and Mental Health's (CAMH)'s Diversity Agenda through the triangulation of three types of data: focus groups, individual interviews with key management personnel, and a review of relevant archival materials.

Eight focus groups were conducted by the reviewers and these discussions were recorded and transcribed by CAMH staff. The eight focus groups included: two groups made up of Diversity Working Group, Caucuses and Committee members; one group of Clinicians; one of Clients and Family; one of Diversity Program Office (DPO) Staff; one consisting of Clinical & Research Directors and Managers; and two focus groups drawn from Community organizations which work in partnership with CAMH. Fifteen individual interviews were conducted by the reviewers. These interviews included discussions with board members, executive directors and managers of the various divisions within CAMH as well as corporate support personnel. Written materials included but were not limited to publications created by the Diversity Program Office and documentation/publications on CAMH that had relevance to the diversity agenda.

Recommendations by the External Reviewers

I. Status of Diversity Agenda

- **Review the ‘diversity agenda’ and incorporate the new directions- such as work on public policy issues and work with Local Health Integration Networks (LHIN)**
- **Work in the community should continue and ensure a balance between work inside CAMH and outside**
- **Work with VPs and directors of CAMH to have the required clout for broad impact.**
- **Clarify goals and objectives of the diversity agenda using a logic model, so as to ensure measurable outputs and impacts. This has to be designed for CAMH as a whole and for all program areas. Accountability mechanisms have to be in place.**
- **Annual diversity plans have to be based on the overall Diversity Policy Framework in order ensure consistency and coherence within the diversity initiative.**
- **The Diversity Program Office needs to create additional training resources for use within and outside the organization (videos, training modules, web-based training, Continuing Education modules) and level three and four training programs. These should be concrete, practice-oriented “how to” trainings (such as the “Asking the Right Questions” Intake and Assessment tool). At these levels, trainings need to be focused on special needs groups, for example, training for managers in how to manage a diverse workforce, trainings for non-clinical front line people in how to work with a diverse clientele.**
- **CAMH needs to extend training to include outside expert speakers, speakers from specific communities; attendance at conference and seminars.**
- **Since CAMH is a teaching hospital, the organization needs to extend training to the teaching function of the hospital by including cultural competence training to residents through Grand Rounds, case discussions and Objective Structured Clinical Examinations (OSCEs).**
- **Clinical services have to embrace and implement cultural competence measures and accountabilities.**

II. Diversity Programs Office Leadership

- **Align staff expertise in line with the multiple tasks to be accomplished by the Diversity Programs Office (DPO) including training, being a resource to diversity committees, clinical cultural competence and public policy work. This is essential as the diversity agenda at CAMH is entering a new phase of consolidation and expansion. It is important to have clinically oriented staff with expertise in cultural competence to provide resources to the clinical staff at CAMH.**
- **To work on better collaboration between Policy, Education and Health Promotion (PEHP), DPO and the Community Support and Research Unit (CSRU). From an operational perspective, for HR & Corporate Services to work more closely with the DPO to better reflect the community it provides services to, improved accountabilities of performance review processes, increased diversity training, and an enhanced relationship to better identify harassment complaints & grievances (ensuring there is a stronger component of due diligence and human rights training, especially for formal leaders)**

III. CAMH Programs & Social Determinants of Health

- Increase access to interpretation services, especially written translations and Language Line for emergency purposes
- Review and convey clear objectives priorities of the Diversity Plan/Agenda – internally and externally
- Improve cultural competency skills of all clinicians, particularly physicians and psychiatrists, as well as non-clinical staff, e.g. Security Services, Receptionists, Front-Line Administrative Positions that communicate with the community
- Re-word brochures, etc so that words such as “Institutionalize” and “stakeholders” are removed
- Ensure there is an enhanced focus on increasing accessibility for people with physical disabilities, including better access and standards at the new building
- Ensure there is a more welcoming atmosphere & more diversity information in the main lobby
- Ensure there is a staffing person at the reception area
- Ensure there is a specified budget that each unit allocates for investment in diversity services
- Create mandated data fields on clients’ race, ethnicity, and preferred language on information systems used to track clients.
- Ensure that the appropriate documents are translated into the languages of clients,

IV. CAMH Leadership

- Senior management to better role model the value of diversity. HR practices are in line with the spirit of diversity
- Have accountability measures in place for themselves, as well as for their staff
- Create specific indicators to measure the success of diversity initiatives

V. CAMH and Community

Externally:

- Continue to share resources with community agencies
- Continue to share best practices, provide appropriate and timely information & educational material
- Discuss and implement innovative practices and/or workshops to meet unique needs of unique communities
- Better promote & extend the successful Spiritual & Religious workshops
- Extend its partnerships to ‘those that do not think like CAMH’ and outside of the traditional medical model way of thinking
- Compile a brochure that tracks, captures, highlights and promotes its successful partnerships, initiatives, advocacy work, and projects with various communities & agencies
- Share its findings of the review

- Increase & find ways to demonstrate CAMH's commitment to diversity outside of the DPO through the President, Vice-president, and Senior Management as a whole – internally as well as externally.
- The DPO to build on the relationship with the Aboriginal communities
- CAMH to allay fears of the smaller community agencies, to work in closer collaboration and through coalition versus outright leadership
- DPO could help “market” CAMH services to marginalized groups in order to achieve a closer population parity between client base and provincial population

Internally:

- Work on improving the relationships between the LGBTTTQQI community and the Clinic.
- The staff at the clinic need to be particularly sensitive to the issues facing the LGBTTTQQI community
- Revisit the criteria of the Clinic; its waiting list, its ‘rejection’ statistics, and relationships with the community
- Model on its successes, e.g. the Women’s Centre Therapy at Clark, the Client’s Council
- From a strategic perspective, for the DPO to remain a leader in diversity issues, but for other supports (HR, Corporate Support Services, Senior Management in other areas) to help with the integration of diversity practices within CAMH, thereby increasing accountabilities

VI. Public Education and Health Promotion (PEHP) Integration and Alignment

- To continue the introductory training across the province, and continue providing support across the GTA in relation to capacity building
- To advocate for cultural competency courses within colleges and post-secondary institutions
- To explore opportunities with foreign trained professionals
- To work more effectively with diverse communities on liaising with the LHIN's, ensuring they have a voice in the new restructuring, and for greater integration
- To develop diversity capacity within LHIN's managers
- To develop better partnerships with the hospitals in North Toronto

A. Introduction

In 2000 an external group of consultants reviewed the Centre for Addiction and Mental Health's (CAMH's) work in the area of diversity and developed a series of recommendations and Action Plan for moving the organization towards greater and more equitable inclusion in the areas of leadership, human resources, services and stakeholder relations. The Diversity Program Office (DPO) was designed in 2001 to provide leadership, expert consultation, strategic advice, planning and training support across the organization in addressing these diversity priorities through the Action Plan. CAMH's involvement has been reflected in the range of activities, commitment and structural changes in areas like strategic planning prioritization, change management leadership, program planning, clinical cultural competence delivery, performance management, resource development, public policy development, diversity training, sectoral leadership, and community relations.

This review is about CAMH's diversity work over the last four years. It is an assessment of the organization's successes and challenges in the implementation of the diversity agenda in order to provide directions for future work. The review gathered information on such themes such as Ontario's current health transformation agenda and diversity implications for CAMH's work, possibilities of revitalizing, refocusing and refreshing the diversity agenda, the role and place of social determinants of health considerations across all aspects of its work, evolving work of the DPO and enhancing our role with diverse communities.

B. Methodology

The external reviewers developed their analysis of the current status of the Centre for Addiction and Mental Health's (CAMH's) Diversity Agenda through the triangulation of three types of data: focus groups with staff, clients and community members, individual interviews with key management personnel, and a review of relevant documents.

Eight focus groups were conducted by the reviewers and these discussions were recorded and transcribed by CAMH staff. Focus group participants were assured that, though their remarks would be recorded, no specific remarks would be attributed to individuals. The eight focus groups included: two groups made up of Diversity Working Group, Caucuses and Committee members; one group of Clinicians; one of Clients and Family; one of Diversity Program Office (DPO) Staff; one consisting of Clinical & Research Directors and Managers; and two focus groups drawn from Community organizations which work in partnership with CAMH.

Fifteen individual interviews were conducted by the reviewers. These interviews included discussions with board members, executive directors and managers of the various divisions within CAMH as well as corporate support personnel. Again, in reporting data from these interviews, a non-attribution policy was followed.

Written materials included but were not limited to publications created by the Diversity Program Office, Levels 1 and 2 and other training materials, the KPMG Diversity Plan for CAMH,

Planning for Inclusion: Lessons and Challenges from the Diversity Project, the Diversity Policy, the Patient Bill of Rights, various past reviews of the Diversity initiative, the Patient Profile, Multicultural Resources (interpreter program/tracking, translated materials), A Review of Clinical Cultural Competence, CAMH Diversity Stakeholder Chart, 2002-2004 Annual Report, Human Resources (HR) Diversity Plan Draft, Diversity Performance Benchmarks, A Review of Diversity Integration in Research at CAMH, Canada's Socio-economic and Cultural Components of Health, the DPO Annual Plan, 2005, Diversity at CAMH since 2000: An Overview, and the CAMH Internet site, including the CAMH Population Studies e bulletin. Also included was the CAMH Research Section's Review of Diversity Integration in Research at CAMH, Phases I and II.

C. Findings

I. Status of Diversity Agenda

Successes

This theme was explored with the staff and clients of CAMH. Discussions included both the accomplishments and challenges of the Diversity Agenda. Three major themes emerged in the discussions of the accomplishments of the Diversity Agenda: leadership role external to CAMH; organizational change within CAMH and working with issues of marginalization.

The participants highlighted CAMH's leadership role in raising awareness of the issues of racism and other forms of discrimination in mental health and addiction services for both community members and stakeholders. CAMH has, in fact, demonstrated its commitment to these issues by working in collaboration with its stakeholders. This theme was discussed in detail by community members, who have been partners of CAMH in its diversity agenda.

The Diversity agenda was credited with introducing dramatic changes within CAMH since 2001, when the initial review was undertaken. The organizational change model embraced by the diversity agenda has had far reaching effects at all levels of the organization. It has been an especially empowering experience for the housekeeping staff, who felt that the diversity agenda enhanced their right to education.

The diversity training sessions have had excellent facilitators and provided extremely valuable learning opportunities. These have included comprehensive generalized training for entire organization with an especially well-conceived level 2 training program for nurses and clinicians;

According to the participants, some of the concrete benefits of the diversity agenda are:

- Cultural Interpretation Service established at CAMH
- Diversity plan for all departments at CAMH
- A number of initiatives on the way at Human Resources department including bias free hiring, mentorship, pay through performance system
- Prayer and spiritual groups

- Community Support and Research Unit (CSRU)

The diversity agenda at CAMH has also been instrumental in working with issues of marginalization at CAMH. Starting with an inclusive definition of diversity, the diversity agenda highlighted gender and sexual orientation issues, client employment and respectful treatment of clients. The formation of working groups and causes on various identity-based groups, such as the people of colour caucus and the disability working group, has brought staff together to work on common concerns. Diversity round table and diversity summit have been successful in improved communication between caucuses and working groups.

A significant success is the well-run interpreter program that does good tracking of the numbers of hours of interpreting, languages most used, departments using interpreters, amount of interpreter time used, and the use of telephonic interpreting. These data can be used going forward to determine translation and other language needs.

Other successful efforts have included the creation of Clinical Cultural Competence Guidelines; a very careful assessment of diversity-related activities by Research; a good benchmarking document for boards and committees, and several specialized diversity related programs: Geriatric Multicultural Memory program; Community Capacity Building by Research; though DPO has also developed good, though limited tools, internal marketing materials (policy statements, clients' rights materials).

Challenges

Participants listed a number of challenges facing the diversity agenda. These were further grouped into the following themes: lack of clarity of the diversity agenda, issues of discrimination, lack of accountability, Human Resource issues and program issues.

Perceptions about the lack of clarity of the diversity agenda revolved around the notion of 'agenda.' To some participants, apart from the diversity training they had, diversity did not seem to have an agenda and definitely not as having concrete goals and objectives. While recognizing that diversity is a moving target, some participants felt that implementation is a problem and that political correctness goes too far within the organization. Communication within the organization was identified as a challenge.

Another area of concern was related to Aboriginal issues. Although listed as separate from the diversity agenda, Aboriginals are included in the discussions of diversity even at the regional level. Diversity agenda's approach to Aboriginal issues is somewhat ambiguous.

Participants pointed out that in spite of the workings of the diversity agenda over the last four years, classism and other forms of discrimination are rampant and very evident on a day to day basis. While there are too many discussions on 'recovery,' people with mental health histories are discriminated against and there is still stigma around employing former clients. Clients are still excluded from the operations of power and privilege. Client perceptions of harassment still persist.

The diversity agenda suffers from lack of accountability. Diversity program planning is at best uneven in various program departments. There seems to be tension between corporate diversity agenda and program agenda. The culture of risk management is all pervasive; and this prevents departments from fully embracing the diversity agenda. Some participants identified procurement process at CAMH as not having an equitable and inclusive orientation.

The Human resource department was identified as having some challenges in the implementation of its diversity plan- to the extent of asserting that HR is not on board with the diversity agenda. HR is under resourced; there is a great deal of staff turn over in HR and as a result, HR is always doing catch up. HR is driven by collective agreement and it is described as often reactive and not proactive. HR practices vary with managers, who are more and more invested with the responsibility for diversity through the Performance Recognition System (PRS) Questions were raised about the preparedness of the middle management to handle the responsibilities in relation to the diversity plans of their programs. At the operational level it was suggested that performance reviews are not carried out on a regular basis; implementation of the Employment Related Harassment and Discrimination policy is uneven; and that there are no enforcement mechanisms for those who have been identified by the complaints procedures. Moreover, significant number of staff is still reluctant to lodge complaints

Participants listed a number of challenges in relation to programs. Particularly noted was the great variation between programs in their approach to diversity. For example, research is not impacted by the diversity agenda. Most debilitating is the challenge posed by the clinical staff, as clinical directors find it impossible to hold them accountable. There is still no process to follow up on the implementation of the diversity plans designed by the clinical staff. Some staff members are unaware of the diversity agenda and policies, and, staff from minority communities, who do not speak English face many challenges at the workplace. Diversity working groups do not meet on a regular basis, as staff does not get time to attend the meetings, as there are no mechanisms to back fill positions. In the context of downsizing, many members of the staff are reluctant to be identified in relation to their identities. There is still a culture of fear and lack of safety among staff. While some of the work with the Lesbian, Gay, Bisexual, Transgendered, Transexual, Two-Spirited, Queer, Questioning and Intersexed (LGBTQQI) communities is laudable, some others do not get any favourable mention; and a great deal remains to be done. It was also pointed out that when funding issues dominate the service delivery system, implementation of diversity initiatives is not a priority.

Some DPO issues were also identified by the participants in the context of this question. These are, however, included under separate question on the DPO.

“CAMH Workplace climate has changed appreciably over the last four years. There is more openness and willingness to confront and challenge troublesome issues of racism, homophobia, sexism and ableism. This varies somewhat depending on the site/location. There are still too many areas of CAMH that are plagued by stigma, silence, discomfort and oppressive climate. Still, too many staff feel isolated diminished and unappreciated. Class issues are very prominent in the workplace”

-The status of the diversity agenda as summarized by a participant

Suggestions for Moving Forward

The participants were also asked to provide suggestions for moving forward. These fall mainly into two categories: HR related and program related. Many of the HR related suggestions revolved around the need to have clear expectations of leaders, directors and managers with regard to diversity. Appropriate tracking mechanisms are to be in place and tracking is to be carried out in a transparent manner. Middle management has to be supported and assisted with HR training for bias-free hiring. Leadership is to work towards nurturing relationships. Staff is to have time to attend diversity working group meetings and staff should feel that their work with diversity is valued. At the program level, the main suggestion was to align department practice with diversity and to have all departments implement their diversity plans. An overall diversity plan for the whole organization was deemed important. Another set of suggestions revolved around issues of breaking down silos, promoting communication, building capacity and more collaboration and partnerships. Finally, suggestions were made for further training.

Based on the feedback from the participants and review of documents, the external reviewers felt that CAMH has taken pioneering steps in initiating and promoting a diversity agenda within the organization. The diversity agenda is a unique initiative in a large mental health setting. CAMH has made its commitment to diversity known to the external community agencies through its partnerships and other initiatives. The Diversity Agenda has had a great deal of successes to be proud of, yet a lot more remains to be done, as the integration of diversity is an ongoing task.

Recommendations by the External Reviewers:

- **Review the ‘diversity agenda’ and incorporate the new directions- such as work on public policy issues and work with Local Health Integration Networks (LHIN)**
- **Work in the community should continue and ensure a balance between work inside CAMH and outside**
- **Work with VPs and directors of CAMH to have the required clout for broad impact.**
- **Clarify goals and objectives of the diversity agenda using a logic model, so as to ensure measurable outputs and impacts. This has to be designed for CAMH as a whole and for all program areas. Accountability mechanisms have to be in place.**
- **Annual diversity plans have to be based on the overall Diversity Policy Framework in order ensure consistency and coherence within the diversity initiative.**
- **The Diversity Program Office needs to create additional training resources for use within and outside the organization (videos, training modules, web-based training, Continuing Education modules) and level three and four training programs. These should be concrete, practice-oriented “how to” trainings (such as the “Asking the Right Questions” Intake and Assessment tool). At these levels, trainings need to be focused on special needs groups, for example, training for managers in how to manage a diverse workforce, trainings for non-clinical front line people in how to work with a diverse clientele.**
- **CAMH needs to extend training to include outside expert speakers, speakers from specific communities; attendance at conference and seminars.**
- **Since CAMH is a teaching hospital, the organization needs to extend training to the teaching function of the hospital by including cultural competence training to**

residents through Grand Rounds, case discussions and Objective Structured Clinical Examinations (OSCEs).

- **Clinical services have to embrace and implement cultural competence measures and accountabilities.**

II. Diversity Programs Office Leadership

There was general consensus on the successful role of the Diversity Programs Office (DPO) in the diversity transformation that is taking place at CAMH. DPO has supported working groups and all diversity related forums at CAMH. DPO has also developed impressive partnerships with community groups. As a result, DPO has supporters within and outside CAMH.

Integrating the feedback from question # 1 on the DPO with the responses to this question, some of the challenges facing the DPO are summarized below:

DPO's separate identity, as opposed to integration throughout CAMH was discussed by participants. Fear was expressed that this amounted to showcasing diversity rather than integrating diversity into the everyday workings of the organization. Concerns were raised about the sustainability of the DPO in the context of budgetary constraints. It was also felt that DPO was stretched too thin; access to DPO was not equitable and that DPO's commitment to committees was not honoured on an ongoing basis. In spite of the sweeping changes at CAMH, introduced by the DPO, a great deal of work remains to be done. There seems to be a loss of momentum for the DPO.

DPO's staffing situation was the subject of more detailed feedback. Much of it had to do with the observation that the staffing situation of DPO does not provide for optimal functioning. The DPO revolves around one strong leader. In the context of increasing demands on DPO's time, there are doubts about the DPO being capable of meeting its expectations.

In Short:

Participants felt that while the DPO was seen as being successful in the implementing the diversity agenda of CAMH there were concerns raised about the advantage of the separate identity of the DPO, and about the sustainability of the DPO in the context of budgetary constraints and its repercussions on the staffing situation.

Suggestions for Moving Forward

DPO related

Expand the DPO. The DPO's separate existence is problematic; Diversity needs to be interwoven in the organization; i.e.; 'Move it out of the office to through out the organization'. DPO needs to enter a new phase; to support departments rather than championing. There is a need to move diversity from being owned by DPO. Move away from "what is DPO doing as opposed to what are we doing" about diversity. Diversity should be championed throughout the organization.

The DPO needs to identify priorities for the coming years. It is not just a planning strategy that's needed but also a key device for accountability based on bench mark then achievability. Issues around communication for diversity need to be addressed. Coordinated communication is needed around issues. Balance of diversity and aboriginal needs to be addressed. Welcoming of Aboriginals should be done by more than the Aboriginal program itself. There is a need to ensure that Level 2 training materials clearly identify intersectionality of oppressions. There is a need to build on Big 3 training re racism, homophobia and ableism with managers

HR related

Expectations of leaders, managers, directors etc with regard to diversity should be made clear. There is a need for consistency of expectations. Tracking should be done in a transparent manner. Multiple means of communication are needed. Leadership should work towards nurturing relationship. There is a need to support middle management and for HR training. There needs to be more accountability from the HR and there is a need to improve internal communication. Time should be given for diversity group meetings. Staff should feel that their work with diversity is valued.

Program Related

There is a need to include collaboration and assistance and resource with for example with the Research Division. All CAMH departments have to still be aware of the need for implementing the diversity plan. There is a need to align department practice with diversity and to raise partnership to higher-level e.g. Capacity building. There is a need to find way to make the development of partnerships easier and more effective. Broader organizational plan seems to be missing, even if everyone has submitted their plans. There is a need for interdepartmental and divisional collaboration on the importance of the diversity agenda. This will help to break down silos.

The External Reviewers felt that the DPO is a unique initiative that embraces the whole organization and has been instrumental in making tremendous changes within the organization. It could be argued that the DPO now has to enter a second phase of consolidation and expansion in light of the challenges facing not only CAMH, but the healthcare delivery system, and, therefore there is a need to increase the impact of DPO as is detailed in the recommendations below.

Recommendations by the External Reviewers:

- **Align staff expertise in line with the multiple tasks to be accomplished by the DPO including training, being a resource to diversity committees, clinical cultural competence and public policy work. This is essential as the diversity agenda at CAMH is entering a new phase of consolidation and expansion. It is important to have clinically oriented staff with expertise in cultural competence to provide resources to the clinical staff at CAMH.**
- **To work on better collaboration between Policy, Education and Health Promotion (PEHP), DPO and the Community Support and Research Unit (CSRU). From an operational perspective, for HR & Corporate Services to work more closely with the DPO to better reflect the community it provides services to, improved accountabilities of performance review processes, increased diversity training, and an enhanced relationship to better identify harassment complaints &**

grievances (ensuring there is a stronger component of due diligence and human rights training, especially for formal leaders)

III. CAMH Programs & Social Determinants Of Health

Successes

There is strong board support for programmatic implementation of Social Determinants of Health (SDOH)-related actions. An excellent interpretation system is in place. A cultural competence assessment tool is being used to review and inform clinical programs about many of the social determinants. Clinicians found it useful when integrated with training. A Multicultural Memory Clinic has been implemented to better treat language minority elders. Community Research Capacity Enhancement partner projects have been implemented by Research. A number of the SDOH are used as research foci or variables in the studies conducted by the research division. There has been an integration of SDOHS related variables in some research studies, researchers plan for more. A Client Council for patient input has been put in place. CAMH consistently seeks input from community agencies.

Challenges

There is still a perception on part of some clients that a medical model, rather than SDOH, is being used for assessment, treatment planning, and outcome/prognosis. The Medical model is tied to academic model, and focuses on the individual. SDOH factors are not given emphasis. The “*whole person*” is not seen to be important to psychiatrists.

In forensic units, the emphasis is on medication, not SDOH variables. Mental health concerns are still subject to stigma. Clients feel that the Organization is run like a business. There is a strong perception of connection between psychiatry and pharmaceutical companies. There was concern expressed about programs being closed with no input from clients. Gender roles, other cultural practices, life experiences and norms are perceived as being construed only from a “*European*” perspective. Clients feel that there is extensive classism at CAMH, with clients seen as uneducated and “*less than*” the staff. Clients perceived that it was a “*Horrendous*” situation if you don’t speak English”. Not enough translated information was available.

Some community members feel that CAMH is failing miserably with SDOH or is silent on SDOH issues. Some feel there is failure to walk the talk at CAMH in relation to the SDOH. This is a challenge to the organization to communicate explicitly on how the Diversity Agenda is addressing these issues within the CAMH organization and philosophy of care.

Extensive diversity in the community requires continual need for seeking solutions for dealing with its diversity. Education for empowerment is not seen to be done by CAMH in marginalized communities.

There is no global accommodation money to address SDOH issues. There is the perception that only DPO staff and Social Work seem to know what the issues are. There seems to be no broad dissemination or utilization of the research findings or projects involving the social determinants

of health. Language barriers and access issues of the clients are not always taken into account by staff.

There is a need to gather more accurate internal measures of how SDOH are affecting outreach practices, client base, patterns of service utilization, drop-puts, recovery, recidivism, length-of-stay, forensic services. There is also a need to have specified and mandated language and ethnicity/race fields on data systems so that systematic analysis of the above can be regularly performed. The Patient Profile Report does not provide insights into the ethnic breakup of the patients being serviced by CAMH. People can't be held accountable for what they don't know, and if data on CAMH services as they relate to diverse clients are not collected and analyzed, it will be difficult to refine services to meet the needs of these groups. The Language Line service is not widely used or understood by staff. Interpreters must be booked in advance; therefore interpretation facilities are not available at reception or in an emergency or contact phone lines. "Right to a CAMH supplied interpreter is not part of Patients' Rights document. Limited translation of important forms and documents such as consent forms, posted Patient's Rights, etc. continues to marginalize non-English speaking populations.

In Short:

Participants felt that while lip service is given to considering and integrating the social determinants of health into client-centered services at CAMH, much work still needs to be done in examining how integration of these factors can be operationalized in assessing and treating clients. Clients and some community members feel that the medical model completely drives the services and philosophy of CAMH. Gaps in infrastructure, which reduce information about the client base, are problematic and limit assessment of the effects of SDOH on diagnosis and treatment outcomes. Language barriers still prohibit access by linguistically marginalized groups.

Suggestions for Moving Forward

Clients and Community related

The Client Empowerment Council is essential and should continue. Minutes of Council meetings should be taken and the issues brought forward during these meetings should be discussed in staff and clinician meetings. A non-attribution policy should be followed in these minutes.

The interpretation of SDOH factors by community groups should be regularly sought and brought back for discussion within CAMH. Speakers from community groups should be utilized in clinical trainings within the organization.

Internal functioning related

Discussions of the social determinants should be the focus of trainings and an attempt should be made to prioritize understanding of those determinants most important to addictions and mental health assessments and treatment modalities. The findings resulting from research studies utilizing social variables should be widely disseminated to clinical staff. A laminated pocket card on how to use the Language Line should be produced and broadly disseminated. The numbers

associated with Language Line use should be posted in all departments. If the clients' right to have an interpreter supplied by CAMH is not included in the Patient's Rights poster, a separate poster informing clients of their right to interpretation should be created and posted in every department. Additionally, some attention to signage or a map of the campus in the most frequently preferred language of clients should be considered.

Infrastructure related

There is a need to gather more accurate indicators of how SDOH are affecting outreach practices, client base, patterns of service utilization, drop-outs, recovery, recidivism, length-of-stay, and forensic services. In order to accomplish the analyses outlined above, the organization must have specified and mandated data fields for language, ethnicity/race and other SDOH variables so that these analyses can be regularly performed. A committee should be formed and within six months have determined which SDOH information fields should be added to the data information systems and determined a strict time line for these data elements to be added.

A lack of translated critical documents, e.g. informed consent documents, program descriptions, Patients Bill of Rights, Signage, Rx labels, continues to marginalize non –English speaking clients and outreach to potential clients. In order to meet these translation needs of the clients, a working committee should be formed to prioritize the documents that need to be translated and set a timeline for the translation of necessary documents. Prioritizing the languages most used by CAMH clients can begin by analyzing the data collected by the interpreting department. This committee should also study state-of-the art medical translation procedures and determine how to implement a program that will assure accurate and culturally sensitive translated materials.

The external reviewers feel that CAMH has taken initial steps to advance the SDOH agenda. SDOH issues have to be integrated more clearly into the clinical and research areas. More needs to be done to increase access of services to persons from diverse backgrounds.

Recommendations by the External Reviewers:

- **Increase access to interpretation services, especially written translations and Language Line for emergency purposes**
- **Review and convey clear objectives priorities of the Diversity Plan/Agenda – internally and externally**
- **Improve cultural competency skills of all clinicians, particularly physicians and psychiatrists, as well as non-clinical staff, e.g. Security Services, Receptionists, Front-Line Administrative Positions that communicate with the community**
- **Re-word brochures, etc so that words such as “Institutionalize” and “stakeholders” are removed**
- **Ensure there is an enhanced focus on increasing accessibility for people with physical disabilities, including better access and standards at the new building**
- **Ensure there is a more welcoming atmosphere & more diversity information in the main lobby**
- **Ensure there is a staffing person at the reception area**
- **Ensure there is a specified budget that each unit allocates for investment in diversity services**
- **Create mandated data fields on clients' race, ethnicity, and preferred language on information systems used to track clients.**

- **Ensure that the appropriate documents are translated into the languages of clients**
- **More outreach is needed to marginalized and ethnic communities in the GTA and beyond**

IV. CAMH Leadership

Successes

CAMH has very significant support, resource allocation and commitment from the very top management. The CEO has approached other organizations around issues of diversity. There is good commitment to diversity issues from most of the Vice President (V.P) level. Diversity has been anchored in the mission, vision, and values of CAMH and has been identified as a strategic goal of the organization. There is also good support for diversity issues from most managerial levels and from clinical practice leaders.

According to leaders, diversity has been integrated in performance reviews, policies and procedures. Training of leaders (Board, management) has introduced diversity concepts, language, conflict/mediation skills. Leaders perceive that a variety of trainings are available: managing diverse teams, team development, management of staff returning from long-term disability, racism, anti-homophobia.

Assessment of management and board diversity has been conducted. The HR committee is “looking at” how to conduct bias-free hiring/interviewing. Organizational development is addressing issues such as cultural competency and harassment.

Challenges

A few top managers show a weak commitment or “lip service” commitment. Senior management has changed, not all are now bought into the diversity agenda as completely as prior leaders. There is a breakdown at middle management level because of workload/stress. Initiatives related to diversity breakdown because of discomfort of managers with the topic, and due to manager turnover.

Some leaders fail to hold people accountable for performance indicators, or are unclear about the meaning of performance indicators. Top leadership, in conjunction with DPO, needs to review performance indicators and re-set priorities more frequently. Leadership Development isn’t mandatory for leaders. HR accomplishments on Diversity Agenda need to be more closely monitored by leadership.

In Short:

According to the participants, CAMH has a senior management leadership that is committed to the diversity agenda. Diversity has been anchored in the mission, vision, and values of CAMH and has been identified as a strategic goal of the organization. Diversity training is accessible to all leaders. The management is aware of the importance of diversity in plan and action. Workload /stress are hindrances to the implementation of diversity initiatives by middle

management. There is a need to review performance indicators and reset priorities more frequently. HR accomplishments related to diversity need to be monitored more closely by the leadership.

The participants' feedback suggests to the external reviewers that the leadership of CAMH is deeply committed to the diversity agenda and has provided a great deal of support to the DPO's operation. There is still room for improvement, especially by the implementation of better accountability measures for management and staff.

Recommendations by the External Reviewers:

- **Senior management to better role model the value of diversity. HR practices are in line with the spirit of diversity**
- **Have accountability measures in place for themselves, as well as for their staff**
- **Create specific indicators to measure the success of diversity initiatives**

V. CAMH And Community

This section summarizes the information shared by focus groups with community agency representatives, the Community Advisory Council, and clients & families in relation to the links between CAMH and the community.

Successes

CAMH is seen as having a great leadership. The leadership displayed by CAMH and the DPO is a bold move, a unique initiative, the first of its kind in a very large health care setting in Ontario, and possibly Canada. There have been great initiatives such as the Diversity Health Practitioners Network (DNHP) and the list serves that connects healthcare practitioners. The DPO has been generous in sharing best practices with the community. The Director believes in the work and is very positive. The diversity strategy at CAMH is perceived to have has a clear, well-defined mandate. The DPO, its staff & leadership is a prototype to other healthcare providers. An example of CAMH's leadership is that this organization is the only one doing this assessment/review. CAMH's DPO has innovative ways of dealing with people effectively. External agencies look to the CAMH model for organizational change. The DPO has been instrumental in highlighted issues of racism, homophobia, & ablesim, principles of equity at work

The DPO has demonstrated its resourcefulness to build capacity in various ways, such as being instrumental in establishing the DHPN, its List serve, its sharing of information and knowledge transfer the assistance it provides to community education, and the great initiatives for sharing best practices & new knowledge. CAMH is perceived as being rich and well resourced. The Diversity Training program is very useful with educational materials on diversity & discrimination. The DPO organizes many workshops in the community. It recently organized a valuable Health Diversity Conference on Equity (jewel) as well as providing an exchange of in-

services/workshops e.g. Canadian National Institute for the Blind (CNIB). CAMH offers valuable Spirituality Workshops within the organization, open to all. The Diversity Consultants are very willing to share knowledge and connect with others in the community CAMH has visible scholarly work.

The non-defensive manner of the President & Vice – President was observed and appreciated at a recent meeting in the community. There was open discussion of problems & issues. Most are satisfied with community partnerships, processes, collaboration, consultation and community relations. Partnerships, networking, and workshops in the community have been instrumental in getting people together. There has been good visibility of diversity posters, materials, and positive messaging. The DPO helps to connect with other internal resources within CAMH. There has been success of the Consultation, Assessment, Triage and Support Program (CATS) committee thanks to the DPO. The community agencies were happy to see a recent invitation sent by CAMH's President for an upcoming breakfast meeting. CAMH's DPO provides great support to the Aboriginal communities

Letters of support from the DPO have been appreciated as they have helped with projects & research proposals. Support has helped with land for Aboriginal people. There have been valuable discussions within the community. The Cultural Interpreter Service has increased language access. There have been significant advances for targeted programs (e.g. Rainbow Services, gay, lesbian, black community, building bridges, where mental health is taboo, newcomers, refugees). A positive example of increasing access for clients is the Client Council in CAMH where caseworkers are allowed to go into the hospital; it has been the only experience that has kept some clients going. CAMH helped some clients deal with trauma and helping them come to terms with their sexuality. There were some very positive comments about the Women's therapy center at Clark. There was a noticeable difference of an increase in staff of visible minority background. Many were grateful for programs for the lesbian community. Many were grateful for the services they received. Some thought the 'professional look' and feel of the organization was good

Challenges

Some were unsure of the actual workings of the diversity plan from the 'outside', how things differ, and would like to find out more. Some felt the plan was ambitious and seemed disjointed. They felt that important priority setting could have been done earlier. Some were seeing the paper/review sent by CAMH for the first time. There was a great deal of suspicion in the smaller community organizations about CAMH's agenda. There were questions about staff especially senior staff, 'walking the talk'. Many did not know of the policy work undertaken within the DPO. Many felt that more people of colour were needed, especially at the Queen Street site. Many recommended greater accountability, tracking & evaluation. There needs to be a clearer funding process which outlines criteria for funding reflecting work that needs to be done.

There was more awareness of the framework at the start of the Diversity programs than there is currently. Some did not know of the DPO until recently and felt that more promotion needed to be done. Many recognized that it was a challenge dealing with traditions that it would take time to change. Several examples were given of the trans community's very negative experiences with CAMH and the Clinic in particular. The reputation of the clinic was felt to be seriously

undermining the commitment to the trans community, they felt the criteria being used was very dated, it seemed to be the strictest in the world, the clinic was not very responsive or friendly. Some gave examples of being on a waiting list for a year or more, after which 70 – 80% were rejected, staff not getting back to clients, that the traditional medical model was undertaken of the assessment. These negative experiences were felt to be poisoning the relationship, creating suspicions by the LGBTTTQQI community, affecting their openness about their sexual orientation, resulting in feel unsafe to disclose their sexual identity.

There was a comment made that some people have been misdiagnosed. Some external partners infrequently hear criticism and see negative body language when CAMH is mentioned. There was an example given of a research project that nearly happened two years ago but did not transpire – this was in regards to transgendered and transsexual people who had issues in accessing services. Different minorities felt left out. An example was given of staff/clinicians having very little knowledge about the Rastafarian community (e.g. smoking marijuana). Some felt that CAMH partnerships tended to be with those who also only seem to believe in the medical model. Some asked if CAMH was partnering with people for the ‘wrong’ reasons, i.e. Because they think they should be/obliged to partner with marginalized communities. Some felt that leadership, communications, and co-ordination could be improved, e.g.: to raise awareness of Aboriginal issue.

There needed to be greater advocacy, e.g. some felt that there were not enough people of colour or females in universities/colleges which reflect the current staff mix of organizations such as CAMH.

Many felt that staff within CAMH needed to be better informed of the diversity plan, that there is a need for better internal communication. There were wide-sweeping changes but some participants were unsure if the rest of the organization was aware of the changes. One comment was made about how people have said they have schizophrenia but they had not been treated. Some felt that the person’s race and background played a role in how they were treated or diagnosed. Some felt that in support groups “*although you are encouraged to say how you feel, it was not the same when you leave the room*”. The relationship with staff was perceived as being strained. Some felt that the organizational climate was not friendly, and that there was usually nobody at reception. An example was given of how a client was treated. The client was big, from the black community, and although gentle, security called out for five more people to ‘help’.

Some were unsure of the process for employee complaints. The wording in the literature was not very sensitive, e.g. Stakeholders, Institutionalization. The second floor (Administration Offices) were referred to as the ‘*Cruise Ship*’ (carpeted, etc, compared to the other floors).

In Short:

Organizations in the community have a very positive image of CAMH's and its top management's role in pioneering diversity initiatives. However, there were doubts expressed about CAMH's agenda and whether the organization practices what it preaches with respect to diversity. The LGBTTQQI community in particular had many negative experiences regarding accessing of services. The organizational climate was seen as unfriendly and non welcoming.

Suggestions for Moving Forward

Innovation/Leadership related

It was felt that continued commitment was needed from the senior team, and to have accountability measures in place.

Capacity Building related

More documentation was needed to record issues as well as best practices. Learnings were encouraged to be shared of the review and diversity training. Training needed to be more than soft skills alone; it needed to be combined with human rights training. Data collection/specific demographics of staff were needed, and employment equity measures need to be in place. There needed to be more doctors of different cultural backgrounds, as well as female doctors. Some felt that the DPO needed to be separate, but that the diversity work needed to be more integrated. CAMH should continue being a resource. The workings of policies of harassment needed to be better assessed. Some needed more clarity around the measures of success.

Partnerships/Relationships related

CAMH could be better connected to university research projects for students. CAMH needed to build up the trust in the Trans Community. The organization needed to continue providing support and pro-active engagement. There needed to be increased transparency and accountability. The diversity policy needed to be reviewed and updated, with better tracking and accountability mechanisms.

Advocacy related

CAMH has a strong role to play for advancing communities and advocacy.

Access & Perception related

The DPO needs to have a mandate/policy to help those who are suffering, have grievances, etc. There were issues that although a new building has been designed and being constructed that access issues remain. There needed to be a more welcoming reception area. There needed to be frequent information tables at the front. Simple things could be done e.g. staff taking the time to listen.

On the whole it was clear that the community in general, and agencies in particular, appreciate CAMH's leadership role in the diversity agenda. CAMH should continue balancing the external role with internal work pressures. There is a lot more that CAMH can do externally and

internally to increase its efficiency in working collaboratively with the community and community agencies, as have been spelt out in the recommendations below.

Recommendations by the External Reviewers:

Externally:

- **Continue to share resources with community agencies**
- **Continue to share best practices, provide appropriate and timely information & educational material**
- **Discuss and implement innovative practices and/or workshops to meet unique needs of unique communities**
- **Better promote & extend the successful Spiritual & Religious workshops**
- **Extend its partnerships to ‘those that do not think like CAMH’ and outside of the traditional medical model way of thinking**
- **Compile a brochure that tracks, captures, highlights and promotes its successful partnerships, initiatives, advocacy work, and projects with various communities & agencies**
- **Share its findings of the review**
- **Increase & find ways to demonstrate CAMH’s commitment to diversity outside of the DPO through the President, Vice-president, and Senior Management as a whole – internally as well as externally.**
- **The DPO to build on the relationship with the Aboriginal communities**
- **CAMH to allay fears of the smaller community agencies, to work in closer collaboration and through coalition versus outright leadership**
- **DPO could help “market” CAMH services to marginalized groups in order to achieve a closer population parity between client base and provincial population**

Internally:

- **Work on improving the relationships between the LGBTTTQQI community and the Clinic.**
- **The staff at the clinic need to be particularly sensitive to the issues facing the LGBTTTQQI community**
- **Revisit the criteria of the Clinic; its waiting list, its ‘rejection’ statistics, and relationships with the community**
- **Model on its successes, e.g. the Women’s Centre Therapy at Clark, the Client’s Council**
- **From a strategic perspective, for the DPO to remain a leader in diversity issues, but for other supports (HR, Corporate Support Services, Senior Management in other areas) to help with the integration of diversity practices within CAMH, thereby increasing accountabilities**

VI. Public Education And Health Promotion (PEHP) Integration And Alignment

Steps CAMH can take to optimally address diversity across the province in an emerging regionalized structure

The Diversity Training, Community Enhancement and Collaborative Program, and the Aboriginal Culturally Safe conference were provided as examples of successes and the participants recommended they continue. CAMH should welcome internationally educated professionals. It was suggested that the presence of CAMH should be extended to other roundtables. CAMH should share this review and feedback. More attention and advocacy is needed for disability issues. CAMH can play a role to aid the Metis through the Local Health Integration Networks (LHINs) restructuring. Smaller agencies have a fear of being ‘swallowed’ by the bigger players (CAMH), thus better collaboration and coalition is needed. CAMH should allay fears re: ‘unfair share/allocation’ of resourcing/ funding allocation. Smaller partners also need to be at the LHIN’s table. Community agencies were looking to CAMH to be the champions, but through a coalition format ensuring that all voices are heard. An observation was made that outside of Toronto, there was no person of colour on the LHIN’s.

Other steps that can be taken to CAMH build on its successes

CAMH had a moral obligation to make mental health an everyday word, to build trust. It was felt that CAMH should play a navigator’s role, stop the silo effects, be advocates with the agencies who know their communities very well, and help build capacity. CAMH as a whole should be making the effort to conduct outreach in the external communities. CAMH should continue to provide support related to capacity building around the Greater Toronto Area. CAMH could help communities better address stigma as mental health problems were so stigmatized in some communities that people were afraid to seek help within their communities. CAMH needed to advocate for cultural competency courses in community colleges. CAMH should help keep diversity issues on agendas. There needed to be better promotion & advocacy to others outside of the usual, to the broader communities.

CAMH and the DPO should work with diverse communities on liaising with the LHIN’s as mental health issues of diverse communities were not clearly articulated; better integration of diversity is needed in the new structure. Better communication is needed between PEHP & LHIN’s. In line with its provincial mandate for diversity, CAMH should develop diversity capacity within LHIN’s managers. CAMH needs to be consistent in providing treatment for everyone and being responsive to all communities equitably. CAMH commercials are good anti-stigma to reach all communities; stigma affects getting funding as well as getting services. There need to be stronger partnerships with the hospitals in North Toronto. It was felt that CAMH needed to increase accessibility. There needed to be more partnerships – joint collaborations, not just having the community help with CAMH projects

In Short:

Participants expressed a need for better communication between the DPO, CSRU, and the rest of PEHP, research, & clinical areas. It was felt that CAMH should continue and expand its leadership role with other organizations in relation to diversity issues but should find ways to allay fears/doubts of these smaller organizations regarding CAMH’s agenda. CAMH needed to increase accessibility through increased partnerships and joint collaborations and to increase its reach to all communities.

CAMH had demonstrated good leadership role on the diversity agenda and should continue to do this in future. Specific suggestions that CAMH can implement to improve the integration and alignment of the PEHP program are given below.

Recommendations by the External Reviewers:

- **To continue the introductory training across the province, and continue providing support across the GTA in relation to capacity building**
- **To advocate for cultural competency courses within colleges and post-secondary institutions**
- **To explore opportunities with foreign trained professionals**
- **To work more effectively with diverse communities on liaising with the LHIN's, ensuring they have a voice in the new restructuring, and for greater integration**
- **To develop diversity capacity within LHIN's managers**
- **To develop better partnerships with the hospitals in North Toronto**

APPENDIX

CAMH Corporate Diversity Review: Questions for Reviewers

PEHP integration and alignment

Policy Education and Health Promotion (PEHP) is currently finalizing an extensive internal reorganization. At the same time the division is providing leadership to refreshing CAMH's strategic planning process.

PEHP is also providing strategic and organizational impetus and leadership in respect to CAMH's role -and the role of the mental health and addiction sector- in the current provincial health transformation agenda, particularly in terms of the emerging Local Integrated Networks (LIHNs). There are many questions and issues about implications for marginalized populations who are usually not significantly engaged or represented in a process like this.

- **How could CAMH position its diversity agenda to provide effective leadership in the new environment – internally and externally?**

In addition to corporate diversity in CAMH's Toronto offices, PEHP is also responsible for leadership in diversity work across the province. Diversity is one of three provincial priorities identified, the others being concurrent disorders and youth. The management position for this provincial priority is currently vacant. There is a strong commitment to engage diversity as an integrated, coordinated, consistent and strategic whole across the province, as opposed to two fairly separate agendas (as is currently the case for the most part).

- **How could this be best done?**

Service Delivery

Health Canada's *Social Determinants of Health* currently informs some of CAMH's work. However, this application is uneven and inconsistent, particularly in areas like clinical, health promotion, the work of Community Support and Research Unit (CSRU), public policy, etc. These determinants have significant implications for diversity and cultural competence (analytically and in terms of actual service delivery).

- **How strategically could the diversity agenda be positioned to assertively advance this priority across CAMH?**

Clinical

The lead for integrating cultural competence across CAMH's clinical programs rests with the Deputy Chief of Nursing Practice. A recent client satisfaction survey indicates significant concerns by clients in terms of diversity, including concerns about CAMH not being a safe place for them (based on their particular diverse identity) and secondly, that there are concerns that CAMH is not being culturally responsive or culturally competent in terms of treatment. The most significant concerns are on the mental health side.

- **How can the diversity agenda have a stronger, more effective role in influencing clinical practice (for example, the development of Cultural Competence Practice Standards and performance accountability)?**

Leadership

While more informed and capable, CAMH's diversity leadership and accountability (especially from Directors and Senior Managers) is still uneven and inconsistent. The performance accountability process with respect to diversity is still a challenge.

- **How can the organization move leaders more consistently to the level of support, accountability and high performance necessary, given the importance of diversity in CAMH's Mission, Vision and Values?**

DPO Leadership

The Diversity Programs Office (DPO) currently provides expertise, leadership and support to CAMH's diversity agenda through coordinating activities, initiating special events, providing specialized advice to all parts of CAMH, training, community capacity building and partnership and the development of tools and resources.

There is currently a greater shift towards integration and alignment of priorities and activities across Research, Clinical and PEHP. Additionally CAMH's strategic future must take into account imperatives like:

- Improving access to mental health and addiction services and improving our cultural competence capacity in delivering care, particularly in an environment that is increasingly diverse, multilingual, multi-racial and assertive about rights as health consumers. Additionally the health care system continues to be highly pressured in terms of resources.
- Working with the increased expectations of communities about partnerships and supports given the changing healthcare landscape.

- Making Employment Equity and Bias-free hiring, mentoring, leadership support and talent management real and concrete organizational priorities given the changing demographics of the workforce

- Should the mandate and role of the DPO change given this reality and if so, how?

Organizational Culture

CAMH is undergoing much change fatigue. The most recent Staff Satisfaction Survey indicated a still-too high level of distrust of management, poor communication, and high level of stress and burnout. In an environment of increasing demands for performance accountability, on-going systems transformation, scarcer resources, downsizing and job uncertainty, staff members are being asked to ensure that diversity remains an important planning, strategic and service delivery priority. While this is a reality, diversity has received good staff support in terms of working group and caucus participation. However the creativity and work need to maintain this support becomes more onerous as time goes on.

- **How could the diversity agenda be repositioned in light of this organizational reality?**
- **What innovative recommendations would you make about maintaining an important presence, continuing to have impact while being flexible and creative?**

Prepared by Kwasi Kafele
Director, Corporate Diversity
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