RCPS Réseau canadien des personnels de santé

CHWN Canadian Health Workforce Network

Summary Report

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Toward a Mental Health and Substance Use Health Workforce Strategy for Canada

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- Canadian Addiction Counsellors Certification Federation
- Canadian Association of Occupational Therapists
- Canadian Association of Social Workers
- Canadian Centre on Substance Use and Addiction
- Canadian Counselling and Psychotherapy Association
- Canadian Federation of Mental Health Nurses
- Canadian Institute for Health Information
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INTRODUCTION

"The mental health and substance use health (MHSUH) impacts of COVID-19 and the overdose crisis have increased the gap between what the population needs and what the service system can provide".[3]

Opioid overdose deaths increased dramatically at the beginning of the COVID-19 pandemic.[4] Rates of meeting screening criteria for depression, anxiety, and bipolar disorder nearly doubled between 2012 and 2022, and even more so among youth.[5] At the same time, the capacity of the MHSUH workforce has decreased, particularly in the public sector.[6]

The MHSUH workforce is the backbone of the critical response but has been woefully overlooked in research and policy.

This neglect of the MHSUH workforce has deep roots in stigma, criminalization of substances and untreated mental illness, colonization, and the exclusion of MHSUH from public health insurance and the Canada Health Act.[7,8]

Gaps in data and regulation are undermining equitable access to services and the capacity to undertake workforce planning to meet population needs.

MHSUH workforce data is much more limited than data available for the broader health workforce. This is particularly true for occupations not regulated by statute, including many psychotherapists and counselling therapists, addiction counsellors, and peer support workers.

"Now more than ever, Canada needs a MHSUH workforce strategy to coordinate planning across jurisdictions, provider types, and public and private sectors."[3]

Many developed countries, including the U.K.,[9] Australia,[10] New Zealand,[11] and the U.S.[12], have significant MHSUH workforce plans. This study proposes five priorities and 16 actions for a made-in-Canada MHSUH workforce strategy.

POLICY DIALOGUE

WHO WAS INVOLVED

Our virtual policy dialogue was conducted over four hours on February 9, 2024. Approximately 40 people from across the country participated, bringing a diverse cross-section of MHSUH workforce expertise and perspectives. Participants included representatives from the public and private sector, MHSUH provider associations, research institutions, MHSUH practitioners, and individuals with lived experience.[13]

DIALOGUE DESIGN

The dialogue started with a keynote presentation from Dr. Sandra Diminic, Principal Research Fellow and Lead of the Mental Health Services Research stream at the Queensland Centre for Mental Health Research, who inspired participants by describing how Australian mental health workforce data gathered through comprehensive needs-based planning has played a central role in the development of the Australian National Mental Health Workforce Strategy.[10,14]

The research team then provided an overview of key pillars and promising practices, drawing on a preliminary scan of international and national best practices.[3] Participants worked in facilitated break-out groups to identify and rank priorities for action for each pillar and refined these priorities in plenary discussions with the whole group. Online software was used to record and rank priorities in line with the nominal group technique, a structured method used for generating ideas, identifying solutions, and building consensus for priorities and directions among groups of stakeholders.[15-17]

The policy dialogue closed with a discussion of a draft call to action to create momentum for a pan-Canadian MHSUH workforce strategy. The research team further refined the priorities identified in the policy dialogue and call to action in consultation with Advisory Committee members.

TOWARD A MENTAL HEALTH AND SUBSTANCE USE HEALTH WORKFORCE STRATEGY FOR CANADA

PRIORITIES	ACTIONS
Collect data for planning	• Create a standardized census of the MHSUH workforce across jurisdictions and sectors. • Align census data on the workforce with population needs and service outcomes for better planning.
Support the workforce	• Promote psychological health and safety in MHSUH workplaces. • Provide fair compensation across provider groups. • Expand access to upskilling and micro-credentialing. • Ease cross-jurisdictional licensure.
Target recruitment	• Leverage data and digital innovation for targeted recruitment by provider type. • Co-design recruitment strategies with under-represented groups. • Improve pay scales in rural and remote communities.
Optimize and diversify roles	• Clarify and optimize roles and scopes of practice. • Recognize lived experience in teams, leadership, and regulatory models. • Re-imagine “right touch” regulatory approaches across Canada.
Close policy gaps	• Strengthen integration of MHSUH into primary care teams. • Expand public insurance to cover all qualified MHSUH providers. • Strengthen policy supports for peer support and parity for substance use health workers. • Train the MHSUH workforce in culturally appropriate and trauma-informed care.

PRIORITY 1: COLLECT DATA FOR PLANNING

MHSUH workforce data in Canada is limited, significantly constraining opportunities for MHSUH workforce planning.[8] The Canadian Institute for Health Information (CIHI) collates record-level data on physicians, nurses and occupational therapists but presently collates only aggregate data on psychologists, social workers, regulated psychotherapists and counselling therapists, and no data (as yet) on addiction counsellors and peer support workers.[18] Data on demographic representation and critical competencies such as trauma-informed care, working with children and youth, and cultural safety is needed. MHSUH workforce planning is also limited by gaps in data on MHSUH service utilization, particularly as there is no administrative data on uninsured non-physician MHSUH services, and as MHSUH claims data from private benefit programs are not publicly available.[8]

WHAT WE HEARD:

Data is collected in different ways on different measures. So just having a more systematic approach among agencies, but also among jurisdictions like provinces and territories.

How many folks are working in private practice? What populations are they serving? Is it mostly through their insurance that they're accessing those services? Are they paying out of pocket? Versus, what kind of services are provided by practitioners more on the public side?

There's no data being collected on outcomes. And as a result of that, there's no lifetime need data. And you don't have lifetime need data, you don't have workforce data to drive that.

PROMISING PRACTICES:

In the U.S., a federally-funded health workforce research network includes a dedicated Behavioural Health Workforce Research Centre.[19] The National Center for Health Workforce Analysis in the U.S. also maintains MHSUH workforce forecasts through dashboards,[20] including projections of MHSUH workforce supply and demand, by discipline and at the state and national levels.[21]

In Australia, needs-based planning data has guided the National Mental Health Workforce Strategy 2022-2032.[10,14] In Canada, the capacity for needs-based MHSUH planning is growing, and psychology is part of the minimum data set research.[22]

RECOMMENDED ACTIONS:

1.1 Create a standardized census of the MHSUH workforce across jurisdictions and sectors.

1.2 Align census data on the workforce with population needs and service outcomes for better planning.

PRIORITY 2: SUPPORT THE WORKFORCE

Coming through the pandemic, the need to better retain and support the MHSUH workforce is often crowded out by the pressing mental health and retention crisis in the broader health workforce.[23,24] Rates of burnout and vacancies in the MHSUH workforce are on a par with higher-profile healthcare professions such as nurses.[25,26] Further, in Ontario, there is a 30% pay gap between MHSUH positions in the community compared to the hospital sector.[27] As for the broader health workforce, supporting and retaining MHSUH providers requires a multi-pronged approach.[28]

WHAT WE HEARD:

Ensuring psychologically safe workplaces is absolutely a retention strategy. So I think that's a tremendous point to mention, and include here.

For retention, we need to compensate people within the public forms of service delivery equitably compared to what they earn, if they were offering those services privately.

From a retention training perspective, in terms of people with lived experience who are acting as peer support workers, they can perhaps engage in micro credentials to upskill and contribute even more significantly.

In terms of retention, making it easier for licensing across provinces.

PROMISING PRACTICES:

The Australian National Mental Health Workforce Strategy 2022-2032 sets out a clear plan for supporting and retaining the workforce as required to meet current and future demands.[10]

A national MHSUH workforce development centre Te PoU,[29] funded by the Ministry of Health in New Zealand, provides funds and access to grants and specialized training for MHSUH providers.

In the US, a 2022 National Mental Health Strategy set out an investment of $135 million over three years into training and an awareness campaign to promote self-care in the MHSUH workforce.[30]

In Canada, the First Peoples Wellness Circle has introduced virtual initiatives to support the Indigenous mental wellness workforce. Manitoba's Health Human Resources Action Plan also commits to creating a psychiatry resident retention program and increasing psychology and psychiatry residency positions.[31,32]

RECOMMENDED ACTIONS:

2.1 Promote psychological health and safety in MHSUH workplaces.

2.2 Provide fair compensation across provider groups.

2.3 Expand access to upskilling and micro-credentialing.

2.4 Ease cross-jurisdictional licensure.

PRIORITY 3: TARGET RECRUITMENT

Recruitment is a core challenge for the MHSUH workforce, a longstanding trend that was compounded during the COVID-19 pandemic. In 2022-23, vacancy rates were at 18% for psychologists, social and social service workers, and counsellors, compared with 23% for nurses.[25,33] Further, targeted recruitment is urgently needed to increase representation within the MHSUH workforce, to better meet the needs of underserved populations in urban, rural, and remote communities.[34]

WHAT WE HEARD:

We don't have any incentives to recruit people. And again, it's around funding [but] it's not all about funding. I'm training people to be full scope of practice…[but] there's no funding to pay for training, even if it was online or virtual.

We should be leveraging some kind of digital solution to recruit individuals nationally… [a] centralized hub for hiring, centralized hub for job postings, whatever the case may be.

It's both about trauma-informed capacity and so on in non-Indigenous, non-racialized workforce, but it's also about trying to increase representation of under-represented groups in the workforce itself through recruitment.

PROMISING PRACTICES:

In the UK, the National Health Service (NHS) Mental Health Implementation Plan specifies the number of providers that need to be incorporated into the workforce to promote recruitment, including 600 psychiatrists, 600 social workers, 4,000 nurses, 5,000 peer support workers, and 8,000 psychologists, psychotherapists and psychological professionals.[35]

In Australia, the state of Victoria hosts a *Jobs that Matter* hub to ease entry into the MHSUH workforce.[36]

The National Mental Health Strategy in the U.S. is funding a Minority Fellowship program that aims to increase racial and ethnic minorities in the MHSUH workforce in return for a commitment to practice in rural and other underserved communities.[30]

In Canada, Prince Edward Island's Mental Health and Addiction Strategy 2016-2026 includes recruitment as part of its collaborative MHSUH workforce pillar.[37]

RECOMMENDED ACTIONS:

3.1 Leverage data and digital innovation for targeted recruitment by provider type.

3.2 Co-design recruitment strategies with under-represented groups.

3.3 Improve pay scales in rural and remote communities.

PRIORITY 4: OPTIMIZE AND DIVERSIFY ROLES

The MHSUH system capacity gap cannot be closed only by adding more highly trained specialists - psychiatrists, addictions medicine specialists, and psychologists.[38] It is equally important to ensure that all providers are working to their optimal scope and to diversify roles across a fuller range of MHSUH providers, including peer support. A re-imagined approach to right-touch regulation is needed that places as much emphasis on minimizing undue barriers to practice as on matching regulation to the level of risk.[7]

WHAT WE HEARD:

You could have psychologists, psychotherapists, mental health, peer support workers, lived experience, under one kind of regulatory sphere. And then what would happen, of course, is you would have your scope of practice, defined according to those competencies, the knowledge, skills, training, kinds of categories.

Some of the traditional forms of regulation or quality assurance may preference certain educational qualifications. Or, may not have a great way of recognizing and legitimizing the expertise that can come from lived experience.

Almost a lighter touch regulatory model, maybe there are ways to provide some regulatory quality assurance mechanisms that may not require the full spectrum statutory regulation.

PROMISING PRACTICES:

In Victoria, Australia, the Strategy for the Alcohol and Other Drug Peer Workforce supports resourcing and planning for the substance use health peer workforce.[39]

In the U.S., 39 states reimburse MHSUH peer support services through Medicaid.[40]

In Canada, competency and certification frameworks include new Behavioural Competencies for the Substance Use and Mental Health Workforce,[41] Canadian Addictions Counselling Certification,[42] Peer Support Certification,[43] and Psychosocial Rehabilitation Recovery Practitioner Certification.[44]

RECOMMENDED ACTIONS:

4.1 Clarify and optimize roles and scopes of practice.

4.2 Recognize lived experience in teams, leadership, and regulatory models.

4.3 Re-imagine “right touch” regulatory approaches across Canada.

PRIORITY 5: CLOSE POLICY GAPS

The MHSUH workforce has been shaped by long-standing policy gaps and inequities. The intergenerational impacts of colonial policies have shaped gaps in access to Indigenous-led and culturally competent MHSUH services.[45,46] Stigma and discrimination have contributed to policy neglect across the MHSUH workforce, and criminalization has had a particularly strong impact on SUH service providers.[7] It is also difficult to achieve parity with physical health care when most MHSUH services are excluded from public health insurance funding and the Canada Health Act.[47]

WHAT WE HEARD:

The barriers are issues around the right resources, remuneration, to get addiction work, social work, navigators, peer supports, embedded into primary care…Stigma limits involvement of healthcare providers doing the work, of policymakers supporting the work.

I think we need to advocate for counselling to be added to the insurance services across Canada.

If the funding doesn't come through on the addiction side for the staff, then it always causes 'the poor cousin in the system to mental health' type of thing.

There's just generally a bit of lack of support and integrating within organizations, for peer support workers to have the consistent training to be able to deliver on their work, and also opportunities for growth.

There's a huge need for Indigenous mental health services, or culturally appropriate and competent services, which is something that we've included a whole section on in our standards of practice, and code of ethics.

PROMISING PRACTICES:

New Zealand's Mental Health and Addiction Workforce Development Action Plan 2017-21 prioritized an integrated and connected workforce to provide a 'one team' approach to health.[11]

The U.S. National Mental Health Strategy doubled funding to integrate mental health and substance use treatment within primary care services.[30]

In Canada, the federal government recently exempted GST/HST for psychotherapy and counselling therapy; Nova Scotia has also added mental health and addiction services to the definition of insured services under its Health Services and Insurance Act.[48,49]

RECOMMENDED ACTIONS:

5.1 Strengthen the integration of MHSUH into primary care teams.

5.2 Expand public insurance to cover all qualified MHSUH providers.

5.3 Strengthen policy supports for peer support and parity for substance use health workers.

5.4 Train the MHSUH workforce in culturally appropriate and trauma-informed care.

CALL TO ACTION

HELP OUR MENTAL HEALTH AND SUBSTANCE USE HEALTH WORKFORCE NOW!

Canada's mental health and substance use health (MHSUH) workers are a critical resource to people living in Canada. The MHSUH impacts of the COVID-19 pandemic compounded by the overdose crisis in Canada have only increased the gap between population needs and service system capacity.

Canada needs a MHSUH workforce strategy now more than ever, to improve and coordinate planning across jurisdictions, provider types, and the public and private sectors. This call to action is to ensure better care, better work, and better data for planning.

We, the following practitioners, family members, people with lived and living experience, educators, researchers, leaders, and representatives of MH and SUH provider associations, regulators, and unions are united in our gratitude to Canada's MHSUH workforce and our grave concern about the future of this workforce in Canada and its capacity to meet the needs of the population.

We call on the Government of Canada to support this critical workforce by making significant and immediate investments into developing a MHSUH workforce strategy for Canada, in collaboration with provincial and territorial governments and diverse MHSUH organizations and groups. Many developed countries including the U.K., Australia, New Zealand, and the U.S. have significant MHSUH workforce plans. Canada should follow their lead.

This strategy should focus on the following key priority areas:

- ✔ **Collecting data for planning:** Create a census of the MHSUH workforce across jurisdictions and sectors, and align workforce data with population needs and outcomes for better planning.
- ✔ **Supporting the MHSUH workforce:** Promote psychological health and safety in MHSUH workplaces, provide fair compensation across provider groups, expand access to upskilling and micro-credentialling, and ease cross-jurisdictional licensure.
- ✔ **Targeting recruitment:** Leverage data and digital innovation for targeted recruitment by provider type, co-design recruitment strategies with under-represented groups, and improve pay scales in rural and remote communities.
- ✔ **Optimizing and diversifying roles:** Clarify and optimize roles and scopes of practice, recognize lived experience, and re-imagine "right touch" regulatory approaches across Canada.
- ✔ **Closing policy gaps:** Strengthen the integration of MHSUH into primary care teams, expand public insurance coverage to cover all qualified MHSUH providers, strengthen policy supports for peer support and parity for substance use health workers, and train the MHSUH workforce in culturally appropriate and trauma-informed care.

We can and should do better. A strong MHSUH workforce strategy is needed to improve wellbeing in Canada. We need to invest now to create impact for the future.

Please join our call to action!

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