COVID-19 Impacts on the Capacity of the Mental Health and Substance Use Health Workforce in Canada

NOVEMBER 4 2021

Setting the Context

Mental Health & Substance Use Health (MHSUH) Workforce in Broader Context

- Immediate impacts of the pandemic
  - Higher rates of mental health symptoms, increased substance use, and greatest impacts where the two intersect
  - Reduction and disruption in service delivery and in-person capacity, significant pivot to virtual care
- Amplification of existing challenges
  - Shining a light on longstanding gaps, inequities, and stigmas
  - Compounded by the opioid epidemic
- Looking forward
  - History shows that we should also expect impacts that will be delayed, complex and long term.
  - Budget, election 2021 commitment to develop access standards, expand mental health transfer.
  - New Minister of Mental Health and Addiction; 2022 renewal of bilateral agreements.

Focus for TODAY? Capacity of the **MHSUH workforce** to respond to emerging needs.

Overview of Findings

Mental Health and Substance Use Health Workforce Capacity to Respond to COVID-19

$184k in CIHR funding through Mental Health and Substance Use Operating Grant

Overall purpose of this study:

- to assess the capacity of the full MHSUH workforce across the country to better match emerging population needs with MHSUH service capacity to prepare for longer-term shifts in service delivery.

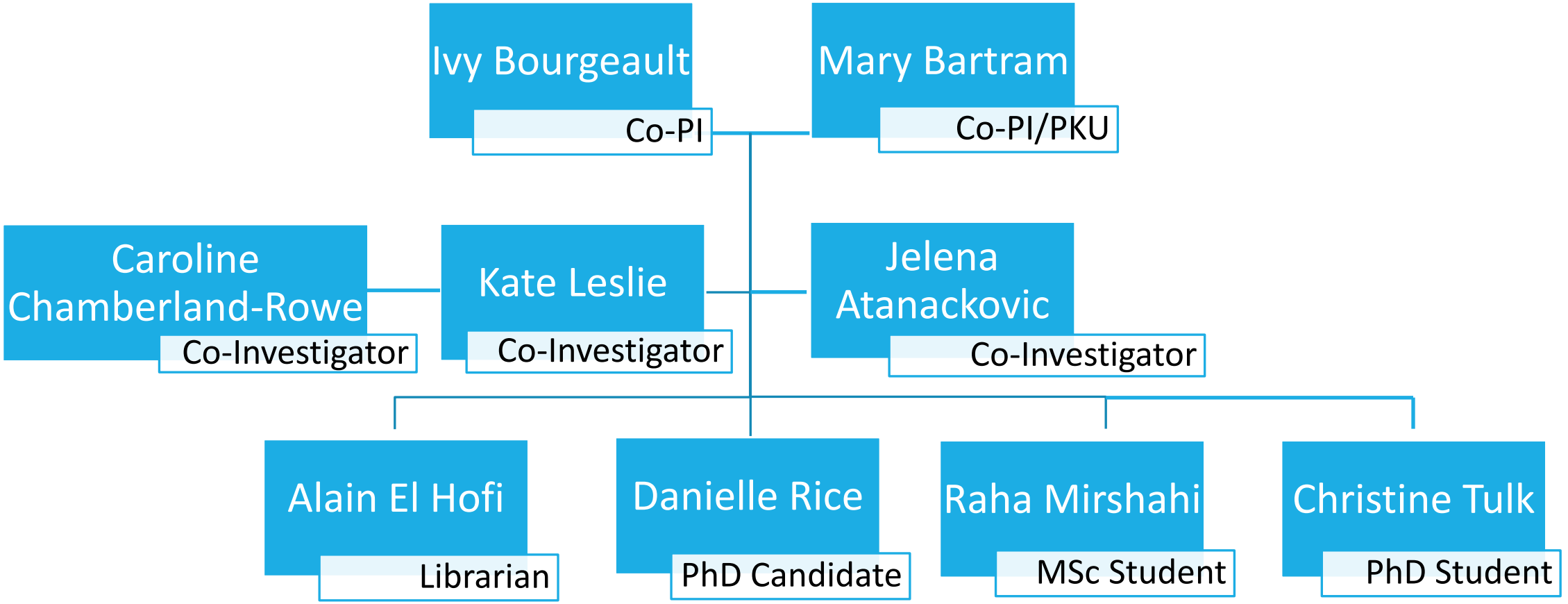
Even with significant financial investments, mental health and substance use services don't just magically appear.

- Bourgeault and Bartram, Hill Times Op-Ed, 2020

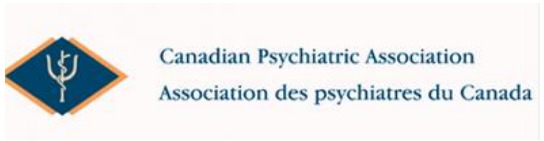
RCPS Réseau canadien des personnels de santé CHWN Canadian Health Workforce Network

Mental Health Commission of Canada | Commission de la santé mentale du Canada

Project Team

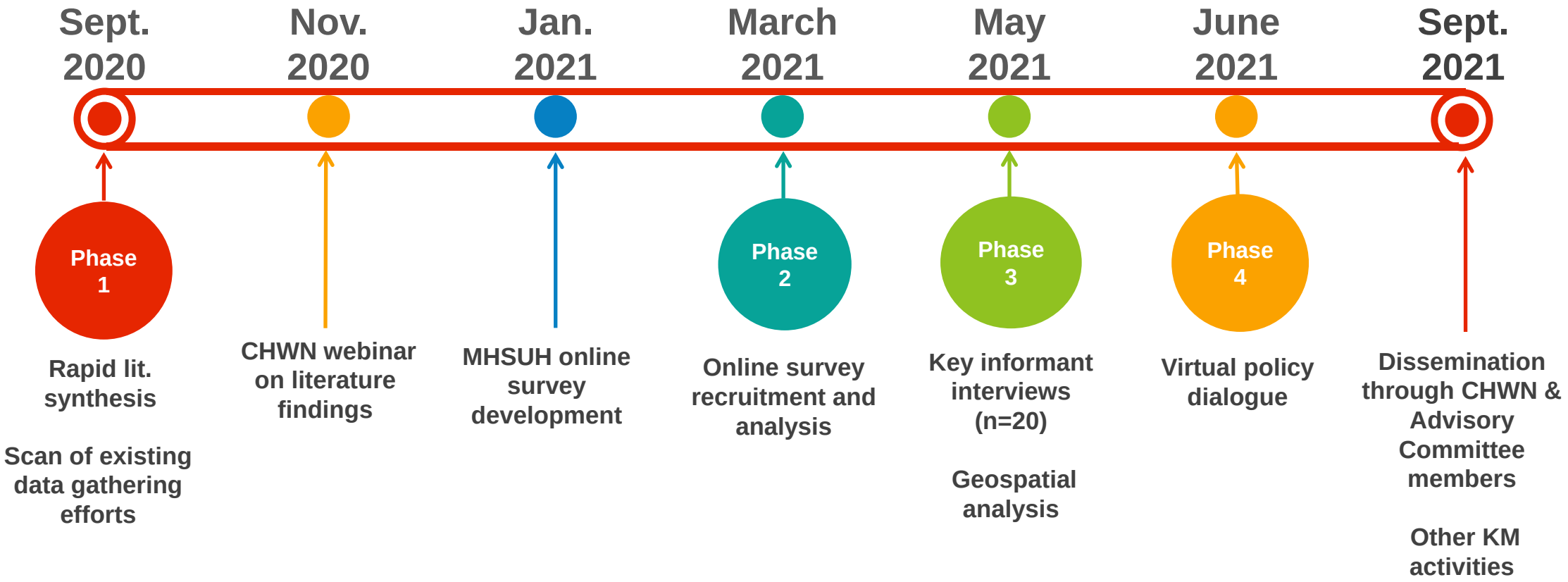


Advisory Committee



MHSUH Project Timeline

(Sept. 2020- Sept. 2021)



Phase 1: Literature Synthesis

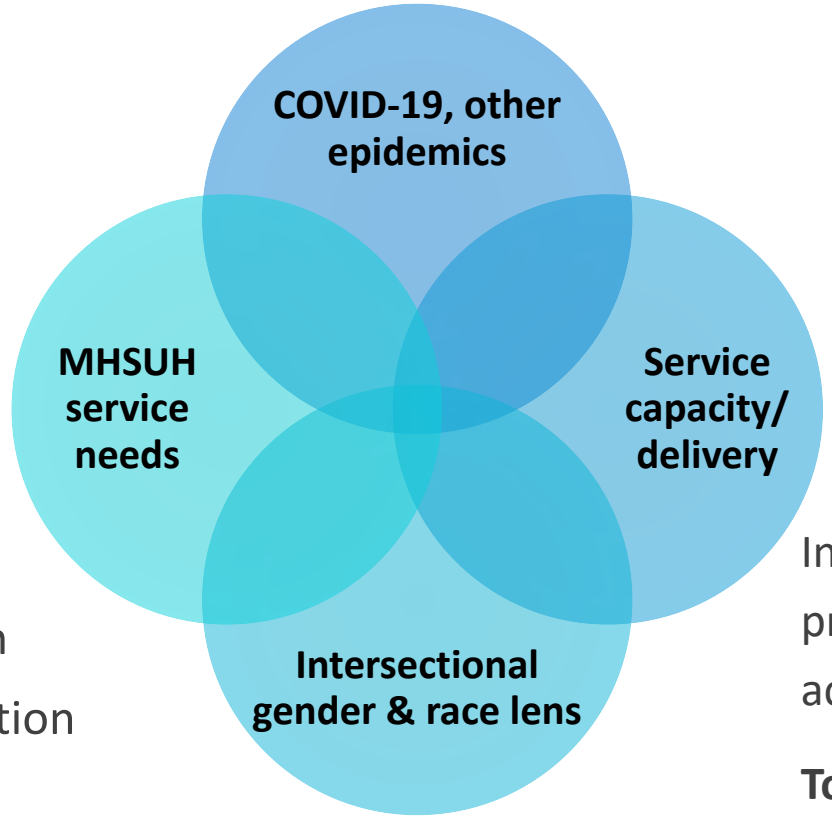
PUBLISHED LITERATURE

CINAHL: 23/271 selected for extraction

MEDLINE: 77/1178 selected for extraction

Google Scholar: 29/70 selected for extraction

Total extracted: 129



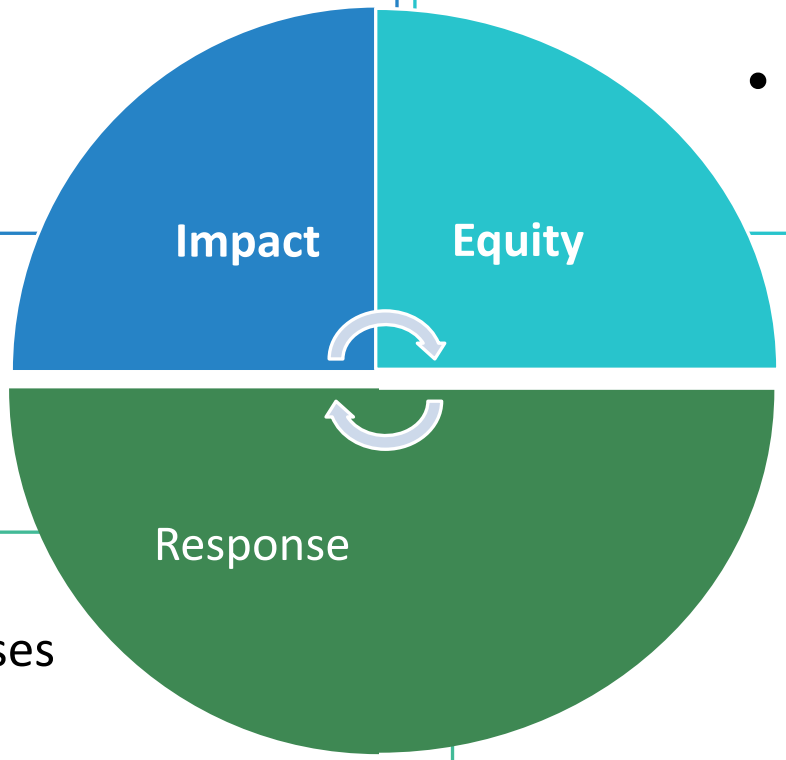
GREY LITERATURE

International, national, and provincial associations searched across 4 overlapping areas

Total extracted: 280

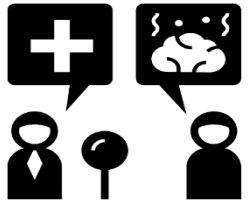
Emerging Themes

- Impact of pandemics/ disasters on MHSUH workforce capacity or service provision



- Impact of gender and other social identities

- MHSUH workforce responses (modifications to service provision)



Impact on MHSUH Capacity or Service Provision

- Negative impacts that COVID-19 or other pandemics/disasters have had on MHSUH workforce capacity or service provision (Auerbach & Miller, 2020; Johnson et al., 2020 Knopf, 2020; WHO, 2020).
- Most MH care systems were under-resourced and under-prepared, struggling to manage both existing and new clients (Rosenberg et al., 2020).
- International organizations (e.g. WHO) have considered the impact of COVID-19 on MHSUH service disruptions.

Examples: Johnson et al., 2020; WHO, 2020

→ "Reduced activity considerably exceeded those of increased activity, especially regarding inpatient admissions and new referrals to crisis services and community services."

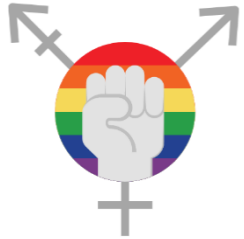
→ Pandemic has "disrupted or halted critical mental health services in 93% of countries worldwide, while the demand for mental health is increasing […]."

MHSUH Workforce Response

- MHSUH workforce has modified its service provision in order to better respond to the needs of population during crisis (Barney et al., 2020; Hames et al., Guan et al., 2020; Marques et al., 2020; Parker et al.,2020; Sharma et al., 2020).
- Strategies discussed are:
  - *Rapid implementation of virtual visits & consultations,*
  - *rotating shifts,*
  - *task shifting from specialized to less specialized,*
  - *temporary exemptions for prescriptions of controlled substances, etc.*

Example: Uscher-Pines et al., 2020

→ Several psychiatrists noted challenges affecting the quality of provider-patient interactions, such as **decreased clinical data for assessment, diminished patient privacy, and increased distractions in the patient's home setting**.



Equity considerations

- Impact that the *gender*, *race*, *ethnicity* and other social identities have on MHSU population needs, MHSUH service provision and MHSUH workforce capacity responses during COVID-19 crisis. (Auerbach and Miller, 2020; Novacek et al., 2020).
- Vulnerabilities among minorities and Indigenous groups during the pandemic and need for *gender specific and culturally specific* services (Le Va, 2020; Novacek et al., 2020)

Examples: Novacek et al.(2020); Government of Northwest Territories

→ To address the mental health needs of Black Americans that will arise as a result of COVID-19, "race-conscious and culturally competent interventions that consider factors such as discrimination, distrust of health care providers, and historical and racial trauma …are needed"(p. 449).

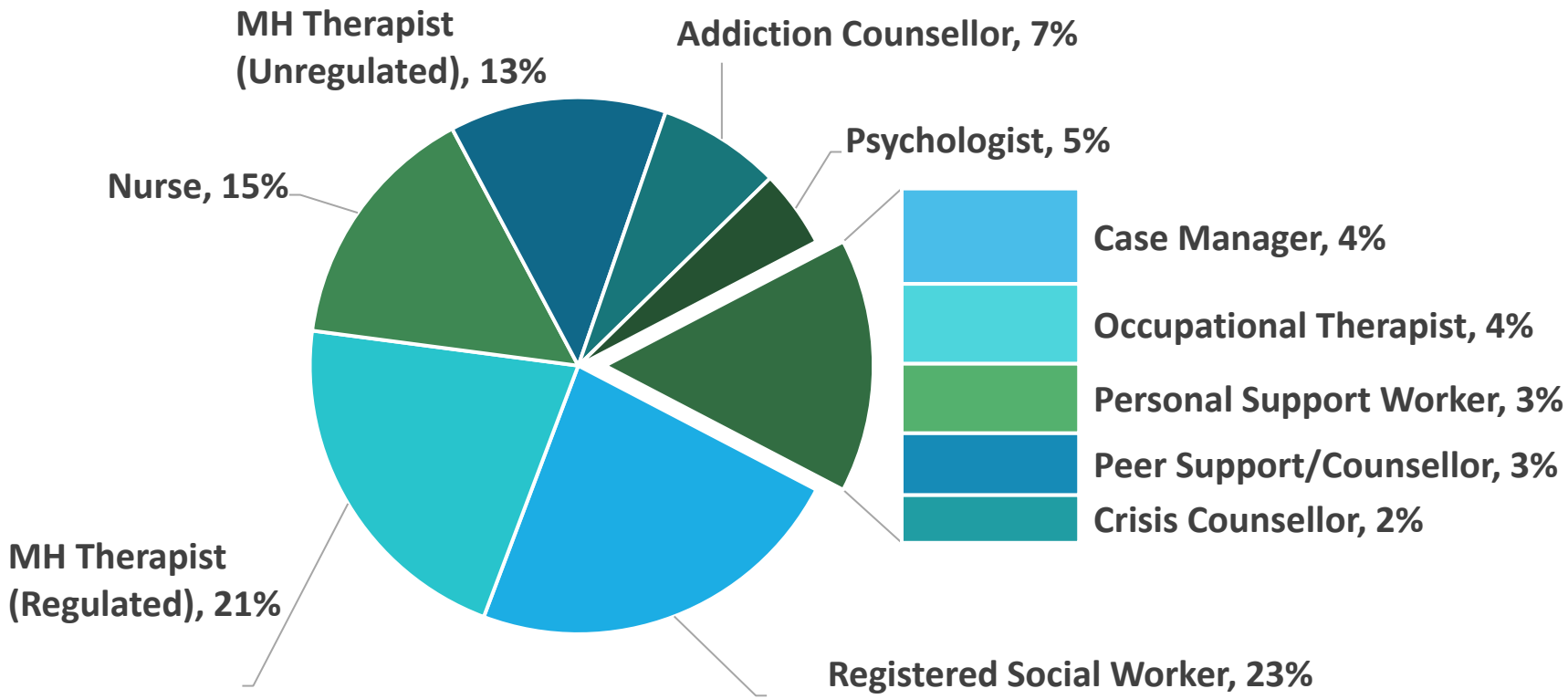
Conclusions and Gap Analysis

- The issue of MHSUH workforce capacity during COVID-19 crisis remains **largely unexplored**, especially in some areas:
  - *the impact of practice setting and service funding models on MHSUH workforce capacity during COVID-19*
  - *the mental health of MHSUH workforce during the pandemic and how it relates to capacity*

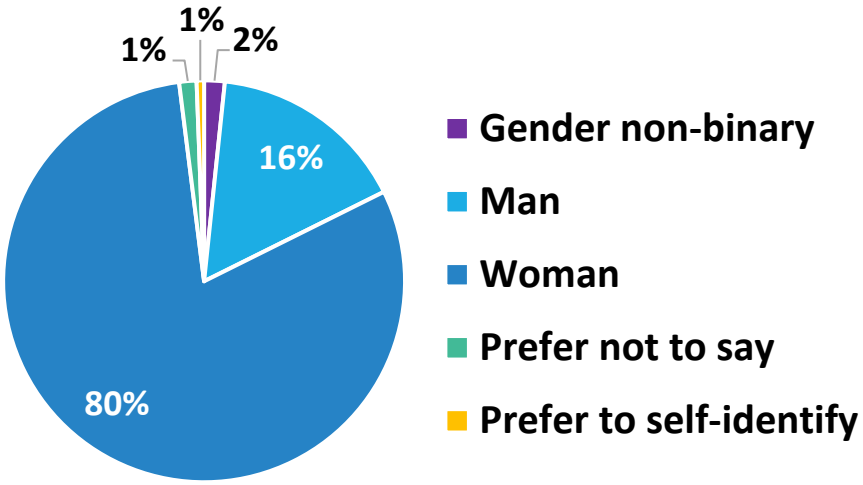
There is a need for:

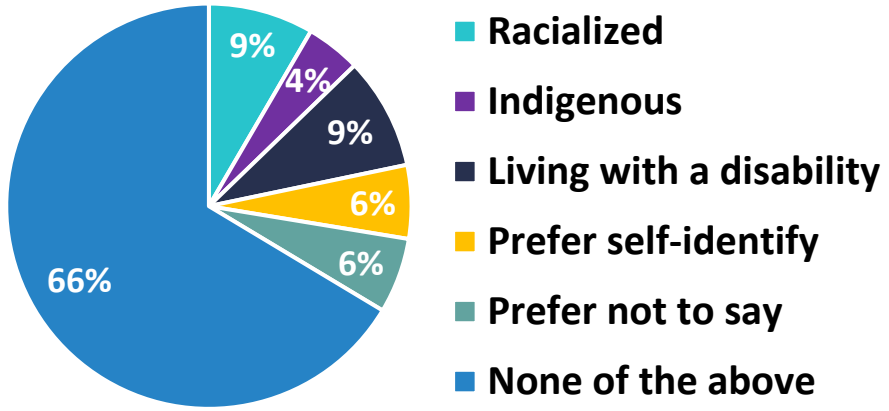
1. more **research**, and especially in some countries (e.g., Canada and UK)
2. **comparative** studies
3. research that focuses on the capacity of MHSUH professionals (e.g., peer support workers, addiction counselors) whose experiences have been **understudied**
4. **large-scale** studies with surveys that include bigger samples

Phase II: Participation By Occupation (*N* = 2169)



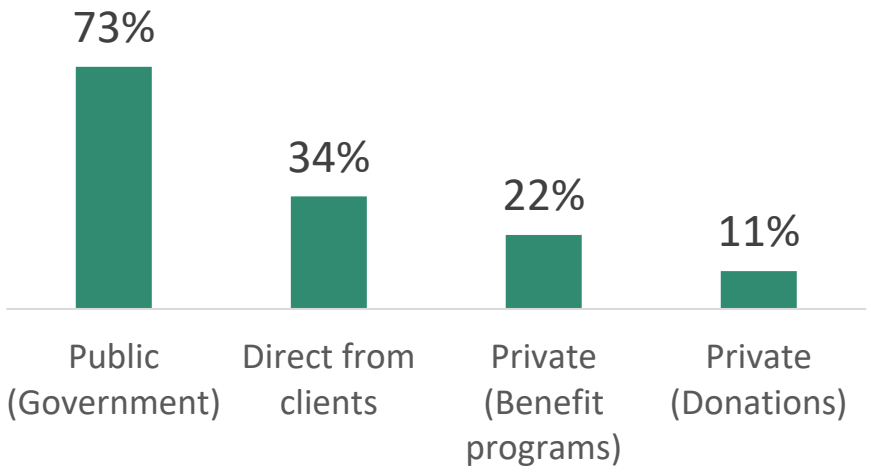
Demographics (*N* = 1507)

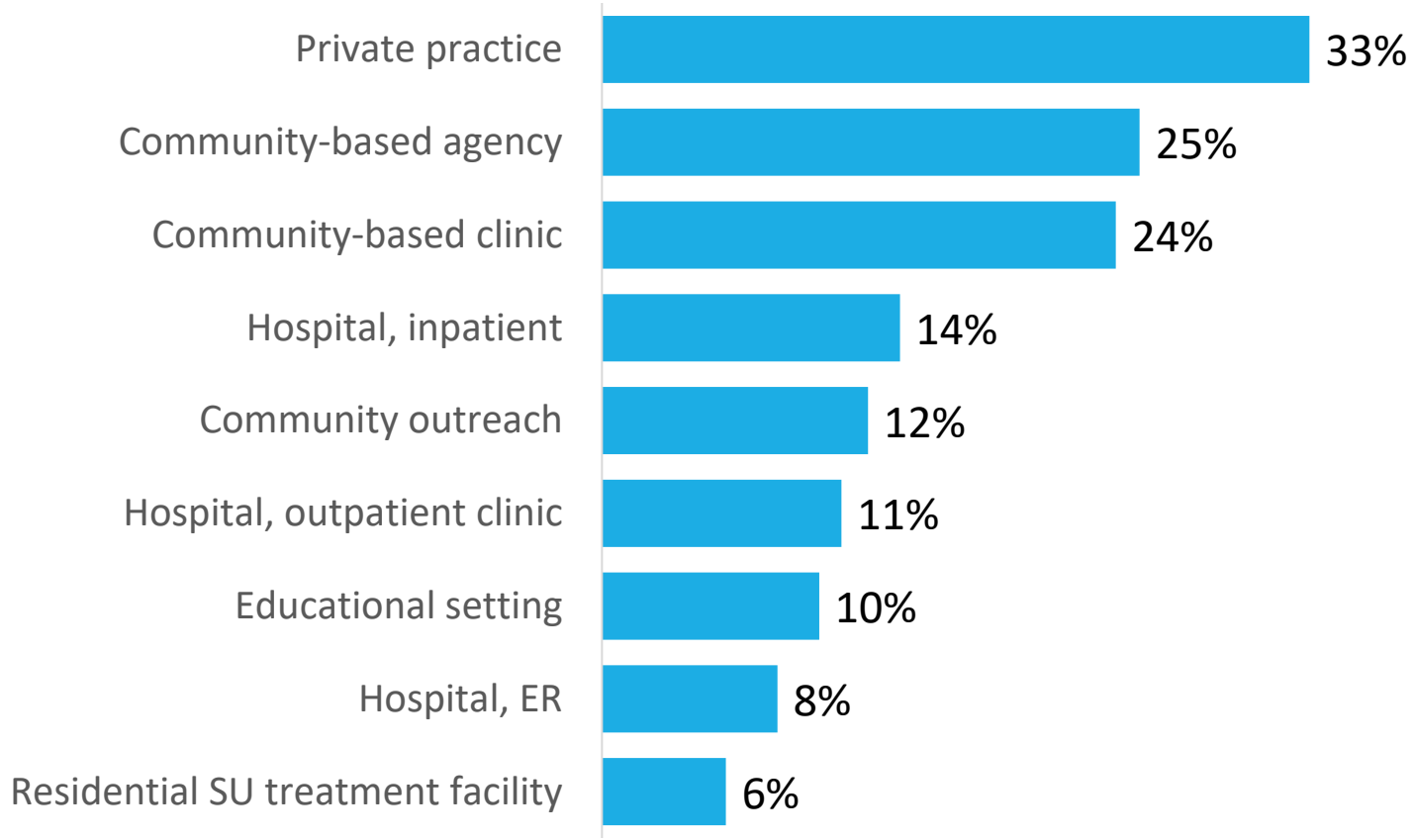




- 85% English, 15% French
- 40% ON, 14% QC, 30% rural/remote
- Mean age = 45.6 (*SD* = 12.89)

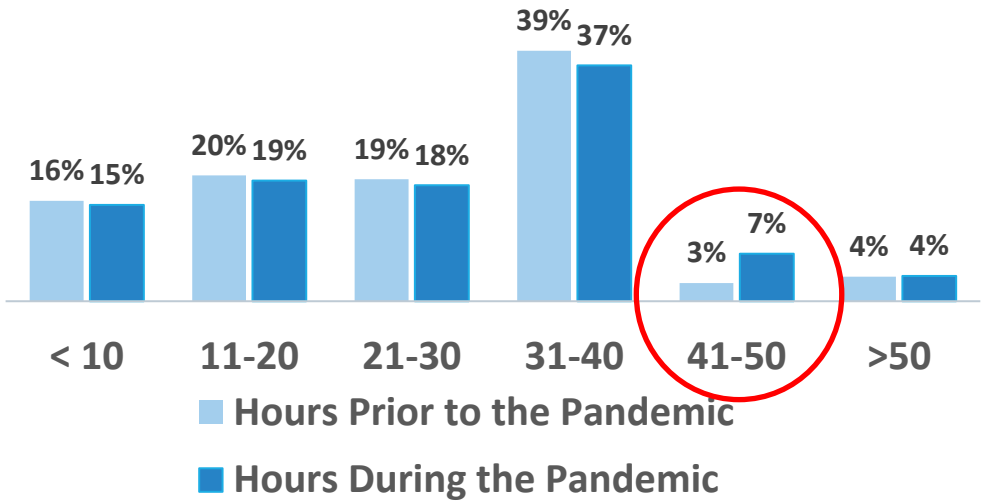
Funding and Service Delivery Setting (*N* = 1551)





Practice Information

	Prior to the Pandemic (*n* = 1511)		During the Pandemic (*n* = 1523)	
	M	SD	M	SD
Hours/week	28	15	29	15
Clients/week	22	38	24	33
Face-to-face (%)	89	21	36	35
Virtual (%)	11	21	64	35



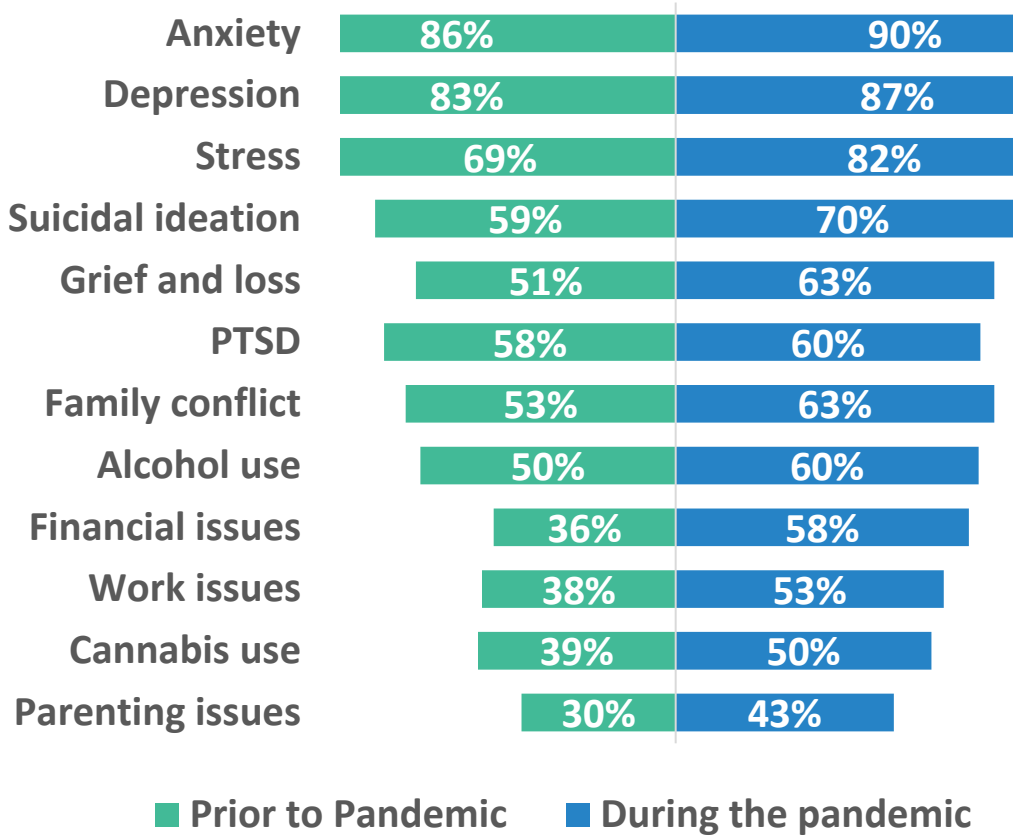
Main Presenting MHSUH Concerns

All categories increased during the pandemic

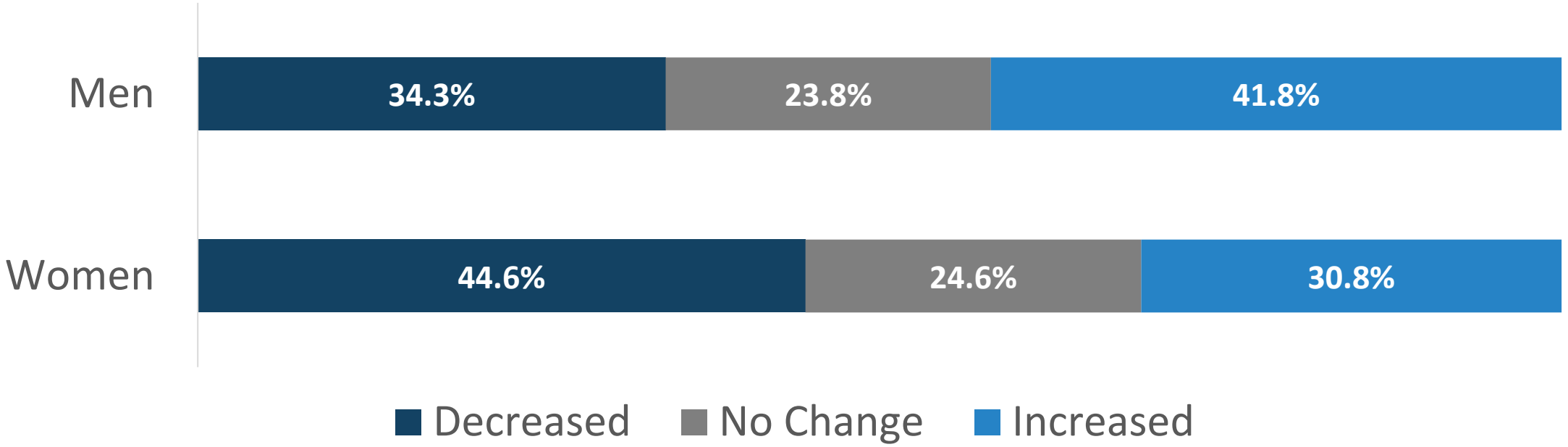
Largest increase: Financial Issues 36% → 58%

Notable Increases in MHSUH concerns:

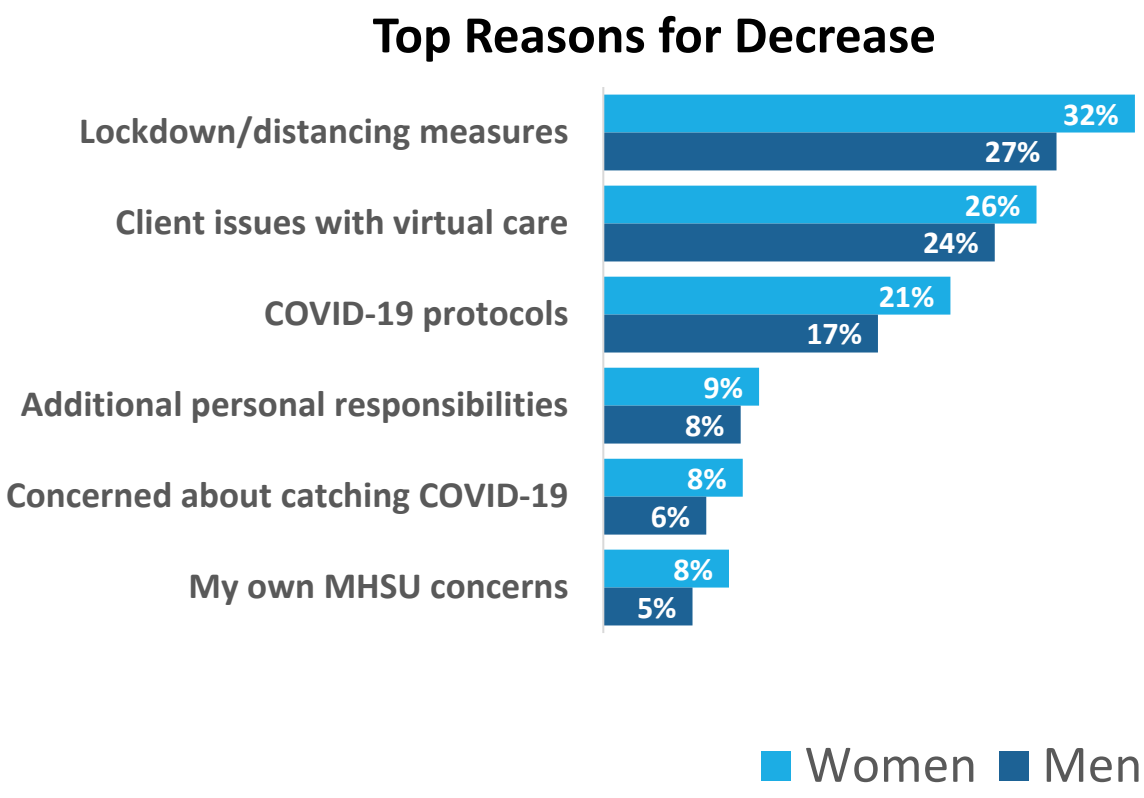
Cannabis Use	39% → 50%
Alcohol Use	50% → 60%
Suicidal Ideation	59% → 70%
Grief & Loss	51% → 63%

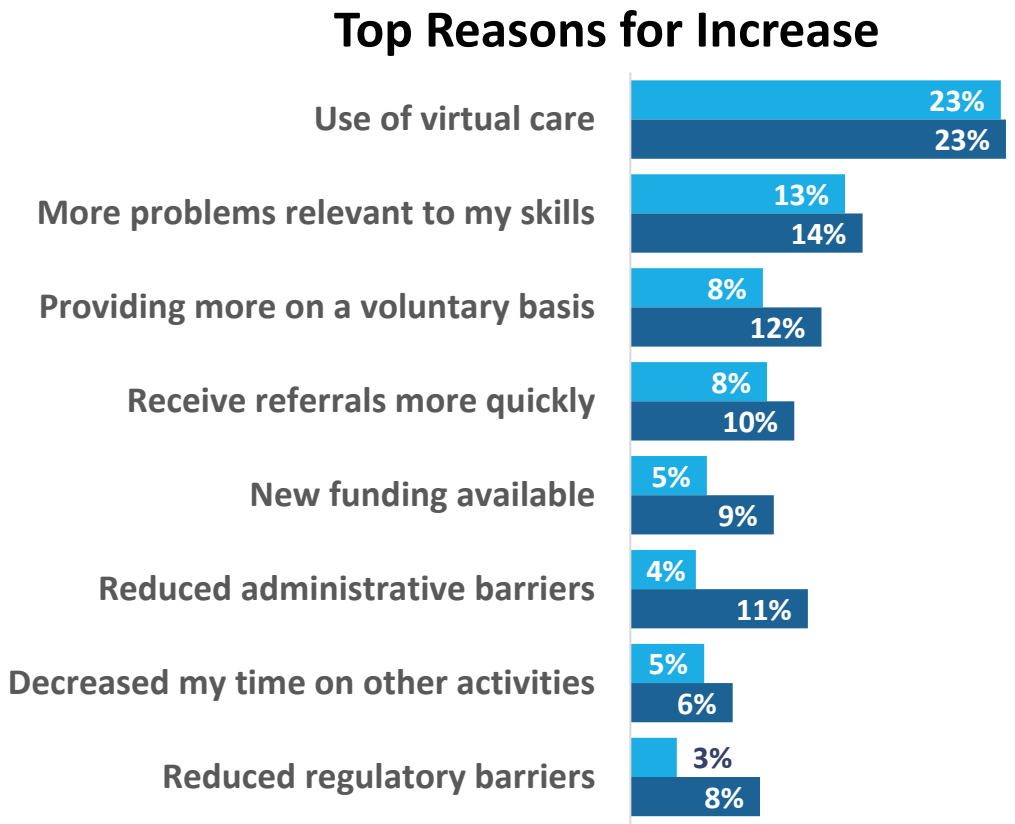


Impact of the Pandemic on Direct Services By Gender

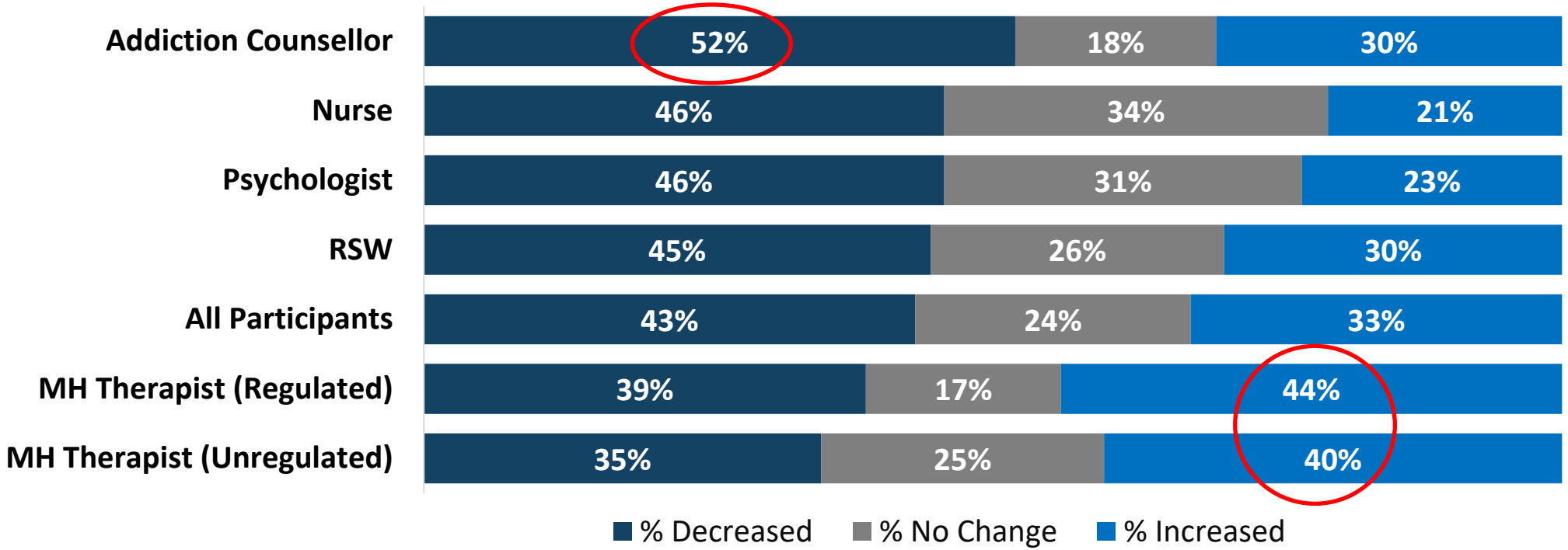


Reasons for Impact on Direct Services By Gender

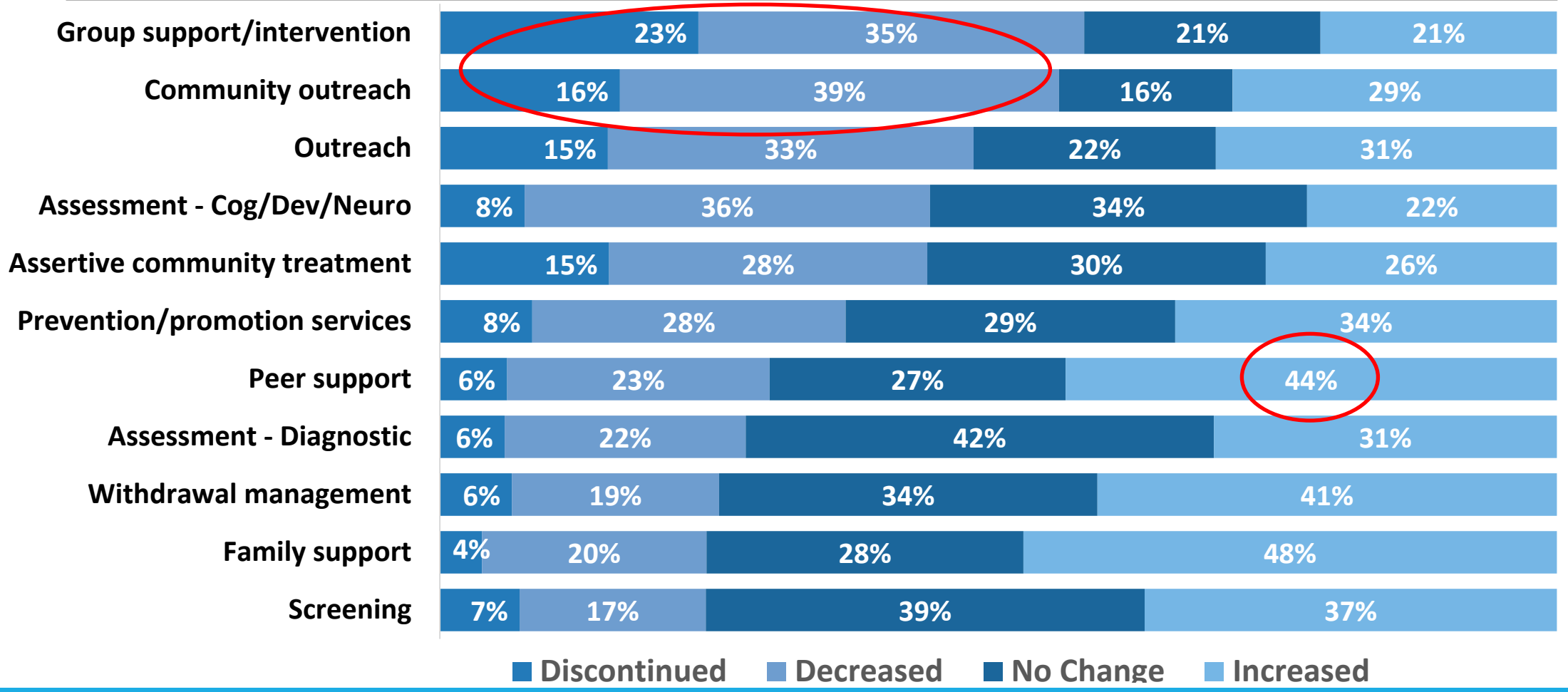




Impact of the Pandemic on Direct Services by Occupation (*N* =1523)



Impact of the Pandemic by Type of Service (*N* = 2120)



What would enable provision of more services?

- Funding/pay reported by all occupations, more so by regulated mental health therapists
- Additional coping resources and supports higher for RSWs, regulated mental health therapists
- Regulatory barriers and scope of practice higher for addictions counsellors, nurses

			Mental Health Therapist			
	RSW	**Addiction Counsellor**	**(Regulated)**	**(Unregulated)**	**Nurse**	**Psychologist**
Funding/Paid	41%	38%	**49%**	37%	37%	37%
Support	**35%**	28%	**30%**	22%	29%	17%
Optimal scope	28%	**34%**	18%	18%	**37%**	13%
Regulatory barriers	26%	**38%**	22%	20%	**33%**	3%

Which factors contribute most to increased capacity?

- Respondents who **only receive private funding** were 3x more likely to report increased capacity than those who only receive public funding

- **Regulated MH therapists** were 3.5x and 2x more likely to report increased capacity than psychologists and nurses.

Key Informant Interviews: Initial Impact

Hard pivot to virtual at first:

- *At the beginning of the pandemic was a frustration with **flipping their whole day onto a computer**. They needed to figure out how to deliver their programming virtually and there were a lot of clients who did not have the digital literacy themselves to receive care.*

Loss of capacity:

- *What it meant was that **some staff went into retirement early**. Or some went on **indeterminate leave** because medically it was contraindicated for them to be in acute care facilities – some departments were operating at 50% capacity. We were having to redeploy residents in psychiatric services.*

Key role for peer support:

- *Peer support moved very fast to re-start services. **Because I know what it is like to live with a mental health condition and to suddenly be alone and afraid and terrified**. I know that we as a program had to provide services.*

Key Informant Interviews: Public← →Private

Emerging needs driving recognition:	• *We have had a number of advocacy successes with regard to third party recognition by insurers and benefit plans.* ***Simply because the need is there.***
Expanded eligibility for third party payment:	• *Yes, expanded eligibility for RSWs and psychotherapists is a trend. Ten years ago no – but as psychotherapist have been regulated, they've started to be added.* ***Insurers are much more comfortable, especially if there's a regulatory body.***
Public and private system divide increasingly problematic:	• ***Both the public and private systems are patchworks****. There will need to be some kind of reckoning between the two systems. Especially as we expect to see more mental health and substance use issues coming forward.*

Key Informant Interviews: Burnout

Stress up, morale low:

- *Stress level going up, knowing you have kids you are trying to protect or families you are trying to support **but not having the ability to do so**…. The morale for social workers is fairly down at this point.*

Supporting colleagues:

- *MHSU staff also being called on to **support their colleagues**, healthcare providers with burnout in other sectors. It adds strain – providing an extra level of care **on top of navigating the pandemic** on a human personal level.*

Exiting the public system:

- *Staff make decisions – just today two excellent psychiatrists announced they were **going into private practice**, if the pandemic wasn't here they'd be in the public system.*

Key Informant Interviews: Data gaps

SU data gaps:

- *We know so little about the substance use side.* ***It's just a huge chasm. We don't have a damn clue.*** *It's literally a ground zero piece of the puzzle.*

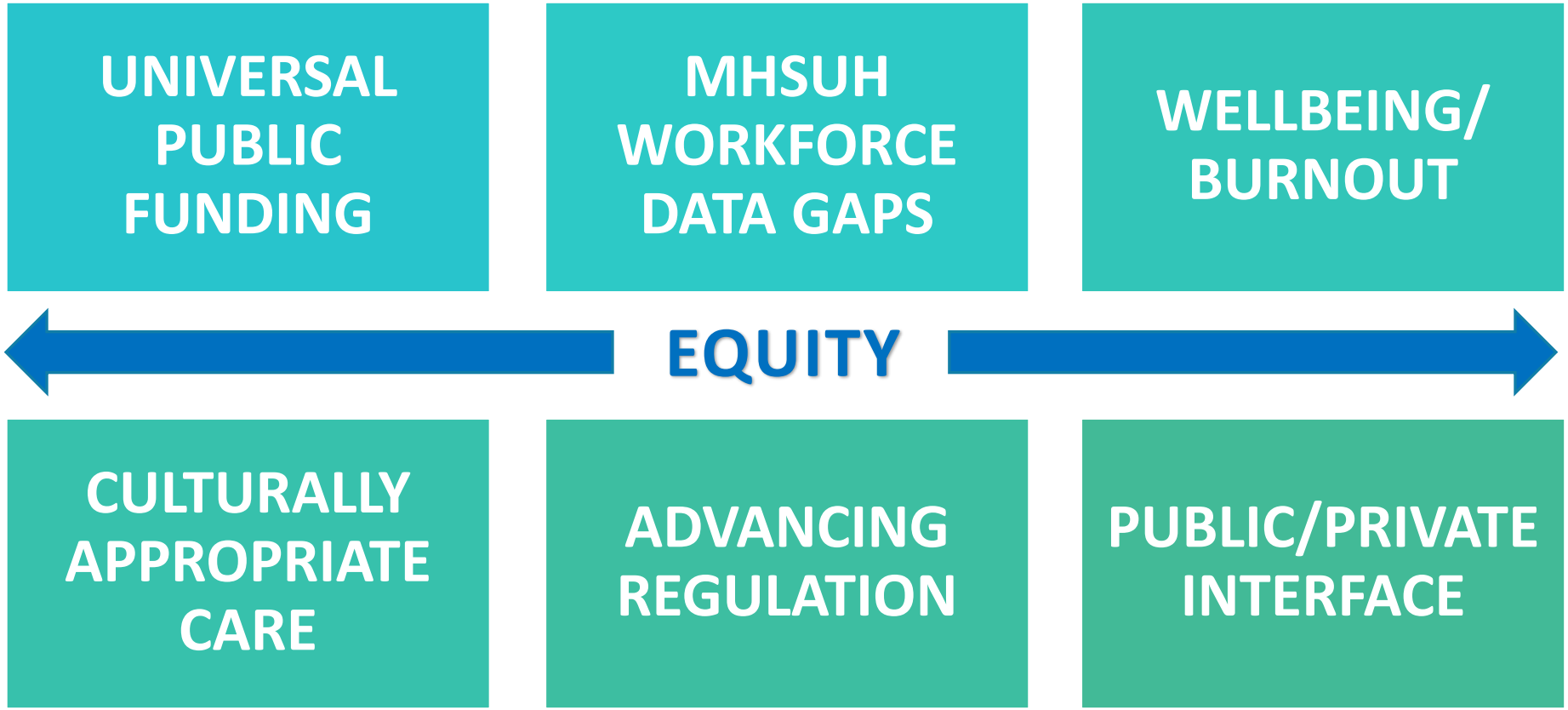
Data siloes:

- ***Sick leave, turnover data?*** *it would be HR and senior management that would have that – we do have data on population/community needs but not the workforce data.*

Common repository:

- *Get the heads of every MHSU provider association and deans of any kind of training,* ***lock them up in a room*** *until they've reached consensus on a* ***common repository of information*** *down to postal code level – searchable and public. Without this information, any solution that you propose will be* ***disconnected from the capacity of the system*** *to deliver.*

Priorities from policy dialogue



Key findings and policy implication

KEY FINDINGS	POLICY IMPLICATIONS
Capacity decreased overall: most for women, addiction counsellors	**Gender/equity lens:** for both providers' and population needs
Hidden workforce playing key role: peer support, counsellors/therapists, RSWs.	**Further recognition in policy:** overshadowed by mental health needs of health workforce
Need driving recognition: regulation and eligibility, but risk of shift to private sector	**Leverage momentum re regulation:** addictions counsellors, psychotherapy, peer support
Inequitable impacts of COVID-19: amplifying need for culturally-specific, barrier-free services	**Overall picture & plan needed:** data and planning gaps across public & private sector

Our panelists

Kim Hollihan, EdD, Chief Executive Officer, Canadian Counselling and Psychotherapy Association

Gord Garner, Vice President, Strategic Partnerships, Community Addictions Peer Support Association

Bonnie Wong, Executive Director, Hong Fook Mental Health Association