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Catching Blind Spots in COVID-19 Health-Care Planning

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Ce document est disponible en français

Citation information

Suggested citation: Ungar, T., & Knaak, S. (2020). *Catching blind spots in COVID-19 health-care planning.* Ottawa, Canada: Mental Health Commission of Canada.

ISBN: 978-1-77318-184-4

Legal deposit National Library of Canada

Health Canada Santé Canada

The views represented herein solely represent the views of the Mental Health Commission of Canada. Production of this material is made possible through a financial contribution from Health Canada.

Catching Blind Spots in COVID-19 Health-Care Planning

In this time of emergency preparedness, health-care leaders at many levels are making important decisions about how to redeploy resources, what to consider an essential service, and how to ensure the best ethical judgment is used for difficult decisions. While the COVID-19 crisis is unquestionably bringing out some of the best of health-care provision, such a crisis also exposes the weak spots in our health-care systems. One example is the often "hidden in plain sight" aspects of mental illness-related structural stigma, which can create blind spots in decision making [1-3]. Like other quality risks, structural stigma is often enacted through implicit cognitive biases [2-3]. In the spirit of seeking to assist those working in health-care policy, ethical decision making, resource allocation, planning, and direct care in making the best quality decisions, below, we have highlighted some areas of potential risk.

- **Physical versus mental health care.** Many persons admitted to hospital with COVID-19 will have concurrent mental health conditions or need mental health services. Likewise, patients admitted to hospital for acute mental health conditions may develop COVID-19 while there, thus requiring physical treatments within the mental health service. Planning for integrated care, in which mental health is part of overall physical health care and physical care is an embedded component of mental health care, is the best way to ensure quality care for all patients [4-7].
- **Medically essential service decisions.** The medical need of electroconvulsive therapy (ECT) and other acute mental health treatments should be assessed using the same pandemic lens and triage principles as any other decisions on medical/surgical procedure during COVID-19 planning. Consideration should also be given to providing people with serious mental illnesses equitable access to COVID-19 testing, even though their symptoms may provide challenges for adherence to physical distancing and other public health directives [7-8].
- **Physical space allocations.** In redeploying mental health spaces to increase capacity for COVID-19 patients, it is crucial to protect appropriately triaged spaces for highly acute mental health patients [6-7]. For example, high-acuity bed capacity for mental health should not be discontinued for social service needs (e.g., as shelter) among persons who do not require acute admission or services. Nor should beds be used as safe housing for COVID-19 patients who are not complying with self-isolation directives, unless they also require acute mental health care.
- **Mental health provider roles.** With appropriate consideration for experience, previous training, and appropriate re-skilling/continuing education, many mental health clinicians (e.g., psychiatrists, psychiatric nurses) could be redeployed to help meet increased clinical capacity needs for physical care during COVID-19.
- **Mental health support for staff.** Asking mental health and addiction departments or clinicians to assume formal mental health roles to support organizational staff should not be encouraged, as the roles of care providers within a health-care organization are distinct from employee assistance programs, occupational health, and human resources departments. Doing so would also increase risks for dual-agency conflicts and privacy concerns. As well, mental health providers may themselves be in need of supports. While informal and emergency assistance among colleagues is

healthy and expected, arm's length support is the safest option for supporting the mental health needs of all staff, both during and post-COVID-19. One option for hospitals is to partner with another organization to provide rapid access for those in need. Another option is to implement formal peer support programs for health-care staff.

- **Ethical frameworks.** Given that implicit biases are a quality risk for ethical decision making, it would benefit ethics committees to consider including people who are aware of mental illness-related cognitive biases [9-10].
- **Vulnerable populations.** Since people with lived and living experience of mental health problems and illnesses and/or substance use have been identified as a vulnerable population [11], it is important to include them as a key target group in equity-based frameworks and other protective strategies [12].

We have seen many positive responses to mental health care from the COVID-19 pandemic. This includes increasing publicly available virtual care, moving service locations within hospitals, redeploying and mobilizing staff to align with the greatest need, and overcoming long-standing bureaucratic barriers (e.g., billing codes). Indeed, the decisions being made now will have long-lasting impacts. This is a key historical opportunity for decision makers and practitioners at every level to help ensure our health-care system responds to both protect and improve quality mental health care for all people in Canada.

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