CANADA AWARDS FOR EXCELLENCE
PRIX CANADA POUR L'EXCELLENCE
2020
ORDER OF EXCELLENCE RECIPIENT – MENTAL HEALTH AT WORK
RÉCIPIENDAIRE ORDRE DE L'EXCELLENCE – SANTÉ MENTALE AU TRAVAIL

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

COVID-19 and People Living With Serious Mental Illness

Policy Brief

Mental Health Commission of Canada
mentalhealthcommission.ca

Ce document est disponible en français

Citation information

Suggested citation: Mental Health Commission of Canada. (2021). *COVID-19 and people living with serious mental illness: Policy brief.* Ottawa, Canada: Mental Health Commission of Canada.

The views represented herein solely represent the views of the Mental Health Commission of Canada.

ISBN: 978-1-77318-263-6

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.

Acknowledgments

The Mental Health Commission of Canada operates primarily on the unceded traditional Territory of the Anishinabe Algonquin Nation whose presence here reaches back to time immemorial. The Algonquin people have lived on this land as keepers and defenders of the Ottawa River Watershed and its tributaries. We are privileged to benefit from their long history of welcoming many Nations to this beautiful territory. We also recognize the traditional lands across what is known as Canada on which our staff and stakeholders reside.

Our policy research work uses an intersectional Sex and Gender-Based Plus lens to identify, articulate, and address health and social inequities through policy action. In this respect, our work is guided by engagement with diverse lived experiences and other forms of expertise to shape our knowledge synthesis and policy recommendations. We are committed to continuous learning and welcome feedback.

The Mental Health Commission of Canada (MHCC) would like to thank the external reviewers and staff who provided important and valued contributions to this work.

Expert reviewers

- Eugène LeBlanc and members of the MHCC's Hallway Group and Youth Council
- Dr. Manon Charbonneau and members of the Canadian Psychiatric Association Public Policy Committee
- Tim Simboli, Executive Director, Canadian Mental Health Association, Ottawa Branch
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Introduction

Purpose

This brief provides an overview of issues faced by people living with serious mental illnesses (and their circles of care) during COVID-19, along with considerations for policy development as we move into the post-pandemic period. It builds on the Mental Health Commission of Canada's (MHCC's) preliminary scan on COVID-19 and mental health policy and draws on Canadian and international academic and policy literature, information gleaned from the media and key stakeholders, and contributions from the MHCC's Hallway Group and Youth Council. To amplify the voices of lived experience, some quotes — both anonymous and attributed — are included throughout the document.

Key messages

1. **COVID-19 has had a significant impact on the well-being of people living with serious mental illnesses.** People who were already living with serious mental illnesses prior to the pandemic were not only at higher risk for contracting COVID-19; social distancing protocols, service disruptions, and the nature of their illnesses also placed them at higher risk for poor mental health outcomes.
2. **Their needs have taken a back seat to other priorities.** The clinical and social support needs of people living with serious mental illnesses were subordinated to broader public health and mental health priorities during COVID-19.
3. **Services for people living with serious mental illnesses were significantly disrupted.** Services for people living with serious mental illnesses were significantly disrupted, and providers were challenged to meet their needs during the pandemic — especially for community-based services.
4. **Peer support has played a critical role.** There are some indications that virtual peer support services may have helped mitigate the impact of isolation and disruption in services, reinforcing the importance of social connections and strong social support systems in maintaining well-being.
5. **Pandemic impacts were compounded by layers of inequity.** People living with serious mental illnesses facing additional layers of inequities due to racialization, socio-economic status, and health status experienced additional challenges to their well-being during the pandemic.
6. **More research that engages lived experience directly is needed.** It is still too early to project the enduring impacts of the disruptions people living with serious mental illnesses faced during the pandemic. But research that engages lived experience directly should be prioritized to fully understand the scope of their challenges, address the systemic issues that exacerbated their experiences, and guide planning for future pandemics.

Background

Policy makers have been guided by a "whole of society" public health approach when addressing the impacts of the COVID-19 pandemic, with early recognition of distinct vulnerabilities in the population.[1,2] This orientation was in evidence when Health Canada asked the MHCC to prioritize vulnerable populations (including people living with mental health problems and illnesses) for policy research early in the pandemic.

Extensive polling throughout the course of the pandemic, in Canada and internationally, has highlighted the extent to which COVID-19 has contributed to increased stress among the general population.[3-8] However, less attention has been paid to how people living with pre-existing serious mental illnesses fared during the pandemic, with studies tending to include a broader range of pre-existing mental health conditions or else drawing on small samples and key informant reports.[9] In collaboration with Leger and the Canadian Centre on Substance Use and Addiction (CCSA), the MHCC has undertaken a series of polls that includes a focus on how people with a prior diagnosis of mental illness and substance use are faring during the pandemic. To date, moderate and severe anxiety have been among the most reported symptoms for these respondents.[10]

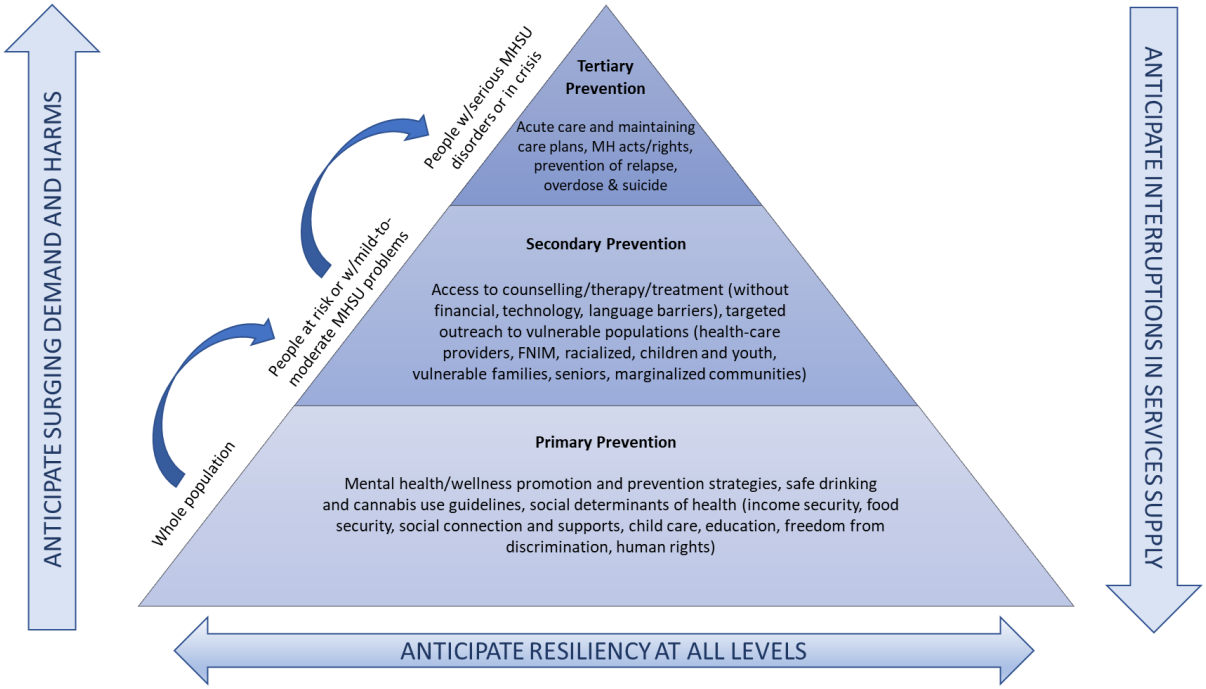
There are many types of mental illnesses, and an estimated one in five people in Canada are living with a mental illness at any given time. Still, less than five per cent of the population are living with what is usually thought of as a serious mental illness (based on the nature of the symptoms associated with a more severe impact on daily living for a longer period of time).[11] The U.S. National Institute on Mental Health defines serious mental illness "as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities" (para. 4).[12] These types illnesses include schizophrenia, bipolar disorder, chronic depression, eating disorders, and post-traumatic stress disorder (PTSD), among others.[13,14] People with serious mental illnesses can also experience concurrent physical illnesses such as diabetes.[15,16] Concurring substance use in individuals living with serious mental illness is also common,[17,18] and up to 49 per cent of adults with serious mental illnesses use non-prescription substances, compared to 16 per cent in the general population.[19]

Population health

The MHCC developed a population health model (Figure 1) to frame policy areas in need of attention in response to COVID-19. This triangle model conceptualizes how the stress from COVID-19 has created the potential for pressure increases across different levels of need for mental health and substance use in the population. In particular, and as expected, increases in demand have been coupled with disruptions in the supply of services.

For people living with serious mental illnesses, the focus is often on needs related to higher-intensity services (at the top of the triangle), which include acute and tertiary care as well as ongoing supports for secondary prevention. However, it is equally important to recognize the deep capacity for resilience, along with the fact that policies and services to meet people's needs are also encompassed in the first and second service tiers. Mental health promotion strategies, social determinants of health, access to primary care, psychotherapy, peer support, and other services that can be part of individual care plans in support of the journey of recovery are all important policy and service components for people living with serious mental illnesses.

Figure 1. Population Approach to Addressing Mental Health and Substance Use During a Pandemic



Government responses during COVID-19

Canada's federal, provincial, and territorial (FPT) governments took steps early on to increase mental health services and supports, with a focus on the needs of people experiencing increased levels of distress or living with mild-to-moderate mental health problems. Mental health promotion messages directed at the general population, such as tips for mental health self-care, encouraging physical movement such as walking, and staying connected virtually, were integral to public health messages in most if not all jurisdictions. As part of its Safe Restart Agreement, the federal government provided the provinces and territories with $500 million to address needs and service gaps for people experiencing challenges during the pandemic related to mental health, substance use, or homelessness.[20] The federal Emergency Community Support Fund and Canada Emergency Wage Subsidy also provided relief and added capacity for community mental health services.[21-23]

Further, FPT governments invested quickly in e-mental health initiatives. At the federal level, Health Canada's Wellness Together Canada portal provided online mental health supports and access to free virtual counselling services to anyone living in Canada, with the intention of quickly filling gaps in access.[24] With programs such as Ontario Structured Psychotherapy and Bridge the gApp in Newfoundland and Labrador, provinces and territories were able to support shifts to virtual care by building on work begun over the past few years to improve access to psychotherapies, stepped care programming, and e-mental health services.[25]

Impact of COVID-19 on mental health and substance use services

Out of the spotlight, high intensity services for serious mental illnesses across most developed countries were required to adapt access so it could meet pandemic infection control protocols. Such adjusments had the effect of closing most in-person day programs and limiting the capacity of inpatient care.[26] In Canada, some of these responses required rapid policy making while addressing long-standing systemic

problems. One case in point was Nunavut, which quickly pivoted from a reliance on fly-in specialists and fly-out inpatient treatment to building capacity for assessing and providing inpatient care inside the territory.[27] Federal funding to shelters, community groups, and community mental health services provided some assistance with filling gaps at the community level.[28,29] However, outside these specific funding streams, the needs of people living with serious mental illnesses have not received policy attention.[30]

I am super proud of my colleagues across Canada working across various community non-profits who have been super creative, working long hours ramping up their efforts. I want to make sure that these efforts made by the non-profit sector are not overlooked or missed because we have been so innovative and creative in responding to the needs of people living with mental illness in real time. There are some great success stories, but we need more support from government including continuation of the targeted wage subsidy.

— MHCC Hallway Group Member

The pandemic has accentuated the extent to which the mental health system is under-resourced and the gaps that exist in health and social policies to meet mental health needs across the continuum, from mental health promotion and illness prevention to intensive specialized services.[31] Canadian mental health advocacy organizations have set out frameworks for tackling these gaps.[32,33] Some efforts were also undertaken to update guidelines, both in Canada and internationally, to support front-line services in addressing the impacts of COVID-19 at the clinical level.[34-36] Early in the pandemic, the Canadian Institutes of Health Research (CIHR) provided rapid knowledge-synthesis grants that yielded a degree of attention to serious mental illnesses, including a review that explored virtual care issues for people living with schizophrenia.[37] However, the pressures on the system to meet increasing needs across the population are likely to continue overshadowing the distinct high-intensity needs of people living with serious mental illnesses. To date, the Senate hearings on COVID-19 were one of the few policy-making arenas in which the needs of people living with serious mental illnesses were specifically and publicly explored.[38-40]

'People living with serious mental illness are an extremely marginalized group whose needs have been inadequately addressed by the mental health and social services systems for years. There is risk that with the focus on the negative mental health impacts of COVID-19 on other vulnerable groups and the general population that the needs of people living with serious mental illness will continue to be neglected. We must make sure that does not happen.' (p. 4)

— Centre for Addiction and Mental Health, 2020, Mental Health in Canada: Covid-19 and Beyond

Considerations

Risks and vulnerabilities for people living with serious mental illnesses

People living with serious mental illnesses are at increased risk for a range of poorer health, mental health, and social outcomes that in turn increase their risk of COVID-19 infection. Further, these risks are compounded by their intersection with other social determinants, including race, ethnicity, gender, income, age, and family caregiving responsibilities.

Comorbidities with physical health risk factors

The high rates of comorbidity between serious mental illnesses and common physical health conditions, including cardiovascular disease, diabetes, chronic respiratory disease, and chronic malnutrition, pose additional risks.[41] Among the more significant risk factors is the comorbidity between serious mental illness, substance use, and physical health conditions — in part due to lower access and adherence to medical care, as well the prevalence of risk behaviours such as smoking — which can increase the risk of disease progression and complications from COVID-19.[42,43] Due to its effects on respiratory and pulmonary health, COVID-19 can cause especially serious morbidity for people who smoke tobacco or cannabis and/or are using opioids and methamphetamines.[44]

Challenges of symptoms

The context in which symptoms associated with serious mental illnesses occur can alter a person's response to COVID-19, and there are distinct concerns related to different types of illness, including psychosis, eating disorders, prior PTSD, obsessive-compulsive disorder, and severe mood disorders. Psychiatric experts have pointed out that COVID-19 can be a catalyst for a new onset of psychosis or the exacerbation of symptoms.[45] A range of symptoms associated with serious mental illnesses could lead to a lower awareness of risk or a magnification of paranoid and anxious thinking, while certain symptoms such as disorganization can make it challenging to follow public health directives around social distancing and mask wearing.[46] For people living with serious mental illness, social distancing can lead to significant emotional distress that can trigger a relapse of psychotic symptoms as well as eating disorders and increase the risk of rehospitalization.[47,48]

Social determinants

The social determinants of health play an important part in elevating the risk of contracting COVID-19 and/or experiencing poorer outcomes over the medium and long term. If people living with serious mental illnesses are living independently, they are more likely to be living in poorer or crowded housing or be part of the significant percentage living in group home or residence settings — both of which present challenges for infection control. In addition, many do not have access to the internet services, computers, or cellphones needed to avail themselves of virtual services.[49,50]

Mental health experts have increasingly argued that more attention should be paid to the social underpinnings of mental distress.[51] Strong evidence highlights how higher rates of poverty, limitations in social supports, and poor physical health among people living with serious mental illnesses place them at increased risk of developing comorbid illnesses, mortality through suicide, injury through self-harm, and self-neglect. In addition, while limited U.S. data (and no Canadian data) exists on COVID-19

outcomes among people living with serious mental illnesses, we know that social stressors and conditions can increase the risk of relapse, recurrence, or increased severity of symptoms during the COVID-19 pandemic.[52-56]

Reviewers emphasized the impact of social determinants on people living with serious mental illnesses during COVID-19, which was exacerbated by the pre-pandemic lack of social housing and the insufficient implementation of Housing First approaches. Such approaches, recommended in the At Home/Chez Soi study, highlight the importance of appropriate supports as a key determinant of an individual's success in retaining housing.[57,58]

FPT governments and non-governmental organizations have taken measures to address COVID-19 income support and safe housing needs for individuals experiencing homelessness or housing precarity, food insecurity, and income precariousness, which are all risk factors disproportionately experienced by people living with serious mental illnesses.[59] At the start of the pandemic, many provinces offered homeless people and people living in shelters emergency temporary housing in empty hotels and apartment buildings; for example, in April 2020, Toronto's city council approved $47.5 million in spending to develop 250 units of modular housing by the fall of 2020.[60,61] However, COVID-19 has placed even more strain on the social housing system and shelters, and the emergency municipal, provincial, and federal response has not met the needs of people experiencing precarious housing and homelessness. Further, persistent homelessness can raise the risk of infection and make it harder to identify, follow up, and treat people who are infected.[62-64]

As soon as COVID-19 began and places started shutting down, people who are already marginalized are falling through the cracks and continue to do so compared to the general population. In Moncton, we have seen a rise in homelessness and there is a greater need for community supports.

— Eugène LeBlanc, MHCC Hallway Group

Racialization

People living with serious mental illnesses from racialized communities, who experience layered forms of stigma, discrimination, and racism, also face increased risks from the impacts of COVID-19. Yet this situation has just recently become part of the national conversation, and it continues to go unrecognized by many governments and organizations in Canada, in part because of the lack of race-based data collection, which is only now beginning to change.[65,66] As an MHCC report on the 2016 census highlights, racialized groups experience high levels of discrimination that can have an impact on mental health and well-being.[67] The map used by Toronto Public Health to track the COVID-19 infection rate (by neighbourhood) in the Greater Toronto Area, underlines the extent of such disparities and areas where racialized individuals live in cramped quarters, lack programs and services, are dependent on public transit, and have higher rates of infection.[68] There is also growing evidence that the use of involuntary detainment and restraint is higher for racialized populations with serious mental illnesses who come into contact with the law.[69,70,71] During COVID-19, racialized communities and individuals continue to face varying forms of discrimination, prejudice, stigma, and hate crimes, which are linked to increased stress and other negative impacts on mental health.[72-77]

I am also concerned about the populations most vulnerable to COVID-19 as I have been seeing the pandemic lead to increased racism and I am concerned about the impact that that has on mental health and access to mental health services and care that people receive.

— MHCC Hallway Group Member

Gender

Mothers and pregnant women have experienced a greater impact from COVID 19 on their mental health compared with men in their peer group.[78,79] An increased risk of gender-based domestic violence has also been associated with public health restrictions during the COVID-19 pandemic.[80,81] Earlier studies have indicated that women with schizophrenia experience additional risks of sexual exploitation, domestic abuse, and random violence.[82,83]

Life span dimensions

The pandemic has had distinct impacts on children and youth as well as on older adults living with serious mental illnesses.[*,84,85]

In general, children and youth have had the critical anchor of a sense of normalcy and routine stripped away, while having their socializing opportunities limited and access to school and specialized programs interrupted.[86] A 2020 report from the MHCC and Headstrong, called *Lockdown Life: Mental Health Impacts of COVID-19 on Youth in Canada*, found that young people (especially marginalized youth) are particularly vulnerable to the breakdowns the pandemic has caused across Canada. In an Ontario survey by the Centre for Addiction and Mental Health (CAMH), 50 per cent of youth who had previously sought help for mental health concerns reported disruptions in their access to care since the pandemic began.[87]

Among children with pre-existing mental health conditions, researchers at Sick Kids Hospital in Toronto found that children and youth experienced relatively similar overall mental health impacts no matter what their clinical history said.[88] However, those with autism spectrum disorder (ASD) reported the greatest deterioration in depression, irritability, attention span, and hyperactivity. Among the intersecting factors believed to be behind this deterioration were closures of school-based services, challenges with online learning, reduced care services, and disruptions to daily routines. The study also found that, for some children with certain pre-existing conditions, the stay-at-home directives may have provided relief from sources of stress and improved symptoms of anxiety or irritability. By contrast, children with diagnoses such as ASD or attention deficit hyperactivity disorder experienced a negative impact due to the loss of structure, consistency, and familiar social interactions.[89]

Within the older adult population, despite histories of a shorter life expectancy, one segment has been living with serious and complex mental illnesses for many years. While the distinct needs of older adults living with serious mental illnesses are rarely explored, the pandemic has impacted their lives on several layers, including disruptions in access to services for maintaining their well-being and reductions in their quality of life from imposed isolation.[90] One expert reviewer shared a personal observation that, in various settings, elderly clients living with serious mental illness were particularly affected by the

[*] The MHCC has separate briefs underway for each population group that explore these issues more fully.

restrictions imposed on visits by close family members and friends, with some making a request for medical assistance in dying.[91]

There is increasing evidence that isolation measures compounded the pandemic's impact for people living with dementia and mental illness in long-term care (LTC) settings.[92,93] A meta-analysis of 74 studies on LTC populations concluded that certain serious mental illnesses are more widespread in LTC settings than in the community. The most prevalent among LTC residents was dementia (median prevalence: 58 per cent) and major depression (median prevalence: 10 per cent), yet the median prevalence of depressive symptoms was 29 per cent.[94] In Ontario, 40 per cent of older adults in nursing homes need psychiatric services, but less than five per cent receive the care they need.[95] Further, emerging anecdotal evidence indicates an increase in the use of anti-psychotics and restraints in LTC settings.[96]

Family caregiver dimensions

The increased load carried by family caregivers of people living with serious mental illnesses, due to service disruptions and isolation measures, has been difficult and overwhelming for some. Concerns have been raised by some experts regarding a substantial decline in families' capacity to address these needs because of public health restrictions and the deterioration of caregivers' own physical and mental health.[97] A 2020 study found caregiver burden to be especially high in some circumstances, a situation it associated with "poor social support, high negative expressed emotions, [and] domestic violence" by an intimate partner toward their family member. It also found that "financial strain, social isolation, low emotional support, negative social interactions, and psychological distress" increased caregiver burden (p. 4).[98] In addition, while social distancing measures required family peer support services to pivot to virtual modalities, no studies have yet been found on the outcomes or challenges of this experience.

Recovery, resilience, and self-determination in the COVID-19 context

The importance of focusing on the strengths and resiliency of individuals and communities rather than on weaknesses and vulnerabilities is a critical aspect of the recovery-oriented approach in mental health. This approach integrates the principles of hope, person-centred care, human rights, and social connectedness within recovery-oriented programs and services for people living with serious mental illnesses. Implementing this approach necessarily means paying attention to the factors that maintain well-being and build resilience, which in turn require that systemic inequities are addressed.[99,100] An early commentary in *Nature* highlighted this point by noting that, while it was encouraging to see strong attention to mental health as part of the COVID 19 response, it was disappointing that the focus was on only half the equation: it was ignoring how mental ill-health increases a person's exposure to economic shocks and the need to attend to the social needs of those with pre-existing mental-health conditions who are most at risk of "social drift."[*,101]

Just as recovery does not necessarily mean cure, resilience does not equate with any ideal level of mental health; rather, it is constantly developed by engaging in life's challenges and opportunities, including the challenges associated with serious mental illnesses. There are multiple pathways to

[*] The social drift hypothesis proposes that people living with mental illness "drift"; in other words, they have downward social mobility into lower income and/or socio-economic status during the course of their lives due to a number of factors that could include stigma, increased health expenditures, or reduced earning potential.

resilience, but they are all built on the need for social support and sufficient resources, which serve as the underpinnings for dealing with challenges, including a pandemic.[102]

As part of fulfilling fundamental social needs (a home, a job, a friend), recovery-oriented principles reinforce the importance of paying attention to opportunities for social connectedness. Early concerns were raised within the mental health sector that social distancing requirements would lead to poor psychiatric outcomes during the pandemic for people living with serious mental illnesses. These concerns included increased social isolation and loneliness, which are already common experiences for these individuals[103] and are associated with a lower quality of life, depression, paranoid thinking, and suicide ideation.[104] Social isolation and loneliness can also lead to significant emotional distress and recurrences of psychotic symptoms, resulting in increased risk of rehospitalization in this population.[105]

Access to peer support is considered an especially important facilitating contributor to supporting well-being for people living with serious mental illnesses.[106] Reports through the MHCC's Hallway Group provide some evidence that maintaining peer support services virtually can help to mitigate the impact of isolation for some people living with serious and chronic mental illnesses, a portion of whom were able to tap into federal funding for community groups and wage subsidies to refocus their work in a virtual context.[107] Peer support groups, community mental health programs, and psychiatric services may all consider playing a role in undertaking more robust research to better understand the experience of social isolation during the pandemic among people living with serious mental illnesses.

Another key principle of recovery-oriented mental health practice is self-determination and rights, which may come under threat as health systems prioritize infection control. While Britain moved to loosen criteria and protections for involuntary treatment and confinement in its mental health acts during the pandemic,[108] no such policies have been uncovered in Canada. Nevertheless, the extent to which infection control measures have led to an increase in the use of seclusion and restraint in inpatient settings in the Canadian context (i.e., that mirror the anecdotal reports of increased use of antipsychotics in LTC settings) is still unclear.[109] However, PSR Canada reviewers observed pullbacks of recovery-oriented services with especially concerning impacts on in-hospital units. Members reported that people in the units lost their rights to go on walks even if public health guidelines were followed: "Years of advancement towards the rights of people with mental illness and substance use seemed to be eliminated in some settings due to the pandemic."[110] This is also an area warranting further research.

Impact on mental health services

COVID-19 has accentuated the extent to which mental health has been poorly resourced in Canada and across the world.[111] According to a United Nations report, internationally, the vast majority of mental health needs went unaddressed during the first wave of the pandemic.[112] In Canada, an MHCC-CCSA-Leger poll found that, as of December 2020, access to services had not kept up with need: only 22 per cent of respondents with mental health symptoms reported accessing treatment services since the pandemic began.[113] Regarding people living with serious mental illnesses, the UN found that many countries' mental health policies did not sufficiently address their needs in community, outpatient, or inpatient settings — nor did most COVID-19 risk management and lockdown measures align with human rights conventions.[114] Additional studies are needed to better understand how much the Wellness Together Canada and provincial and territorial government virtual services, special provisions for high-

intensity services, and mental health promotion efforts mitigated service disruptions and social isolation measures during the pandemic.

Inpatient settings

Several reports in 2020 indicated that inpatient settings and psychiatric units within mental health centres and hospitals around the world were unprepared for the sudden onset of the COVID-19 pandemic and did not have the proper policies, guidelines, and resources to respond. [115-121] Other reporting has found instances of wards and programs having to close in the wake of COVID-19, sending people living with serious mental illnesses to settings with limited support.[122-124] Further, staff at those inpatient settings had to advocate both on behalf of people living with serious mental illnesses and to get support from governments and other organizations.[125] Inpatient settings that stayed open restricted visits and quickly redeployed staff. But these actions led to difficulties in maintaining essential treatments — such as medications, electroconvulsive therapy, cognitive behavioural therapy — and in addressing the needs of people living with serious mental illnesses who had contracted COVID-19.[126,127] While a systematic analysis was not undertaken, a quick scan identified services that were publicly sharing updated status reports related to the outbreaks they experienced and the measures they were taking.[128] Yet other reports indicated that peer support services in some institutions were deployed to mitigate the impact of COVID-19, and that others had opened alternative clinical services. [129-132]

There are various documented reports of COVID-19 affecting patients and staff at mental health centres in countries around the world, including China, South Korea, Italy, and others.[133-137] In Canada, the most publicized case was at the Douglas Mental Health University Institute in Montreal, which experienced an outbreak of COVID-19 in its mood disorders clinic arising from the transfer of LTC residents to the institute.[138] In the aftermath, people living with serious mental illnesses were refused admittance and discharge while hospital staff were lacking resources and strong guidelines to address the outbreak in this setting.[139]

Inpatient settings are at increased risk of COVID-19 outbreaks because

- they are not set up for aggressive infection control
- staff and patients don't typically wear protective gear
- wards are crowded
- people living with serious mental illnesses are ambulatory, interactive, and may find it hard to follow some social distancing protocols.[140-142]

The public health response to the pandemic has also limited the programs inpatient settings are able to offer (such as recreational activities and visitation), which has also led to delays in admissions and transitions back to the community.[143] While it is still unclear how the implementation of pandemic protocol plans for psychiatric inpatient settings have unfolded, there are likely differences across settings; for instance, in hospital psychiatric ward versus a psychiatric centre or a child mental health centre. In general such unique challenges make it more difficult to quickly put measures in place to address the COVID-19 pandemic and maintain safety, continuity of care, and a recovery-based approach.

As an occupational therapist, I am familiar with how COVID has impacted in-patient settings and so there are a lot more barriers to resources. One example is the limits on use of communal areas like cafeterias, rec and fitness. It has forced people to be more creative to meet restrictions but still offer services/social support face-to-face. It has been difficult to be in inpatient settings, specifically around not having visitors. . . . Also, in hospital settings there is the barrier of not being able to do transitional meetings with folks who are about to integrate back into the community. In the past we were able to provide transitional programs such as providing opportunities to be in the community, connecting with folks prior to discharge that could have implications for long-term recovery.

— MHCC Hallway Group Member

In response to these COVID-19 public health measures, researchers have pointed out the risk of increased seclusion and involuntary detention rates in inpatient settings.[144,145] In addition, mental health review tribunals became less accessible, which put people living with serious mental illnesses at increased risk of being deprived their human rights.[146] With a lack of access to usual support services in inpatient settings, inappropriate hospitalizations, delayed discharge, and seclusion "clearly falls into the category of risk management, rather than treatment" (p. 10).[147] Yet such "risk management" violates the human rights of people living with serious mental illnesses. Not only can it make them unable to advocate for themselves, it can worsen health and mental health outcomes.[148]

At the June 3, 2020, meeting of the Senate Standing Committee on Social Affairs, Science and Technology, Dr. Georgina Zahirney, president of the Canadian Psychiatric Association (CPA), highlighted the issues exacerbated by the long-standing lack of appropriately resourced acute inpatient mental health care beds:

> Outside of Quebec and Nunavut, there are 7,242 designated mental health beds, yet the estimated daily mental health occupancy is over 8,300 in that jurisdiction alone. Extended stays for people who no longer require the intensity of inpatient care but who cannot be safely discharged back to their housing situation also further impedes access to acute hospital resources.[149] (p. 8)

Among CPA's recommendations were better resourcing of intensive mental health services as well as stronger and more unified guidelines and policies for inpatient settings across Canada.

Community-based services

COMMUNITY MENTAL HEALTH SECTOR

While most mental health care in Canada is delivered in the community, this already under-resourced sector faced significant challenges in adapting to specific COVID-19 public health restrictions.[150] As one reviewer said, while acute care services were largely maintained during the pandemic, "it was really the cut-off from community services that support and help maintain recovery and well-being that [was] the most devastating for people living with serious mental illnesses."[151] The continuum of community mental health care is wide-ranging and includes programs offered by the Canadian Mental Health Association (CMHA), a growing network of integrated youth hubs, hospital outpatient services (e.g., assertive community treatment and housing support), and extensive specialized mental health services across the lifespan and for population needs.

The sector is made up of many small agencies, whose reliance on grants and community funding was severely hampered during the pandemic. As CMHA has pointed out, they expect that the federal funds needed to enable community groups to transition to online services would not be sufficient.[152] While certain federal measures, such as community grants and the wage subsidy program (combined with resources added by provinces), appear to have helped bridge some of the gaps, no comprehensive analysis of the sector's overall ability to meet care needs has yet been undertaken.

Social distancing measures also placed numerous challenges on maintaining access to community health services for people living with serious mental illnesses, including day programs, peer support, counselling on housing and income support issues, simply because some services became more difficult to access due to public health measures and the challenges in maintaining adequate social distancing.[153,154] CMHA has pointed out that

> Many mental health and addictions sector organizations have had to limit or suspend in-person programs and services at a time when requests for support are increasing. Consequently, many people with mental health problems and mental illnesses have lost access to the supports and programs, and the routines and connections that support their well-being and recovery.[155] (p. 3)

These additional challenges impacted the ability of community mental health services to meet the mental health needs of the public, and particularly the needs of people experiencing serious mental health problems or illness.

International poll data from April and May 2020 suggests that people living with serious mental illnesses experienced challenges in accessing a psychiatrist and/or a prescriber as well as prescription medication during the early stages of the COVID-19 pandemic.[156,157] Further, for a complex array of reasons, certain population groups including racialized individuals and people with low incomes used fewer second tier services such as psychologists, and people living with serious mental health problems were often overlooked for distinct needs for first and second tier community based and health promotion programs.[158]

I have a friend who lives with severe bipolar disorder, who relies on liquid medication for management. A week or so ago he dropped a prescription as he was coming out of the pharmacy, so it was not usable. So, he went back to get it refilled but apparently the particular medication he is on is in such shortage due to COVID that he had to wait almost 4 weeks to get it refilled. He went from being medicated to completely stopping medications for a month and that is having huge effects on his personal life, job and professional life, as well in terms of his ability to function.

— MHCC Youth Council Member

In some ways [COVID-19] has increased accessibility to services but conversely there are lots of people who don't benefit from virtual services.

— MHCC Youth Council Member

VIRTUAL CARE

Since the onset of the COVID-19 pandemic there has been a tremendous shift to virtual service delivery. While this has spawned important and likely long lasting innovations for the second tier of care, telemedicine or online approaches may not meet the needs of people living with serious mental illnesses who may not be able to access these resources, struggle with computer literacy, or may have needs that go beyond virtual sessions.[159] Experts stress that for people living with serious mental illness, face-to-face appointments with a mental health service provider are essential to make ongoing assessments, to receive services and treatments as well as to monitor overall well-being.[160,161] Continuing face-to-face appointments throughout the COVID-19 pandemic is essential and psychologist and psychiatrists will need the proper resources and supports to be able to maintain continuity of care for people living with serious mental illnesses.

It (isolation) is the worst for a person's mental health. The telephone does not replace eye to eye contact. I can't see the end of the tunnel. I miss my peer support groups. I would like to know why this has happened to us.

— Nadia, Our Voice/Notre Voix, September/Septembre 2020
English translation of French Original

PEER SUPPORT SERVICES AND ENGAGING LIVED EXPERIENCE

As noted earlier, peer support programs offer important sources of support for people living with serious mental illnesses. They also make up an increasingly important component of the community mental health sector. Social distancing and barriers in accessing these services exacerbated isolation and loneliness for people living with serious mental illness.[162] In MHCC's consultations with people with lived experience, 29% of participants described barriers to creating communities of care as a high concern, while 43% noted that the shift to virtual services, although beneficial, also accentuated the digital divide and left some people behind.[163]

[There has been] uneven access to capacity building for people to build their own communities of care and advocacy…And with an ongoing pandemic, these barriers are amplified.

— Eugène LeBlanc, MHCC Hallway Group

Beyond peer support services and advocacy, our consultations and research found no evidence of the extent to which the perspectives of people with lived experience were considered, consulted, or directly engaged in the changes institutional and community mental health services had to make to respond to COVID-19 protocols. Yet there were calls early on by advocates to engage lived experience in research on the impact of COVID-19 on people living with mental illnesses, service delivery and planning responses.[164] A reviewer pointed out that overlooking the opportunities to engage people living with serious mental illnesses can also be attributed to the lack sufficient attention and implementation of person-centered mental health care approaches.[165]

COVID-19 has put into place more stumbling blocks for how people can access help, and thus the call on how the mental health system can transform itself and still maintain relevant should be at the forefront of this agenda. I think that the call for a new kind of street-level mental health workforce is at hand, otherwise many people will fall on the wayside. For some, help by means of social distancing is not a form of contact that can sustain one's mental health.

— Eugène Leblanc, MHCC Hallway Group

FRONT-LINE MENTAL HEALTH SERVICE PROVIDERS

Front-line mental health care professionals (FMHPs) are the core of high-intensity services which are often emotionally charged and highly stressful environments.[166,167] The onset of the COVID-19 pandemic has increased the amount of stress placed on FMHPs in relation to the increase in the use of virtual technology and impacts on capacity, as was expressed by 43% of participants with lived experience in consultations.[168.169] Stress, burnout, and compassion fatigue can often impact the mental health services that patients receive and their level of satisfaction, leading to somewhat of a cyclical pattern.[170,171] A CIHR-funded study of the mental health workforce is currently underway in a collaboration between the MHCC and the University of Ottawa, that may indirectly provide some additional insights about the impact on services through the lens of individual providers as well as on their own mental health.

Priority Recommendations for Further Policy Development

1. Work with researchers and funders to evaluate the impact of COVID-19 formally and systematically on people living with serious mental illnesses, starting with the development of a shared policy research agenda, identifying partners, and collaborations.
2. Fund and support peer support groups to collect, publish and disseminate stories of lived experience during the pandemic.
3. Coordinate across peer support groups, community mental health programs, and psychiatric services to undertake robust research to better understand the shared experience of social isolation among people living with serious mental illnesses during the pandemic.
4. Develop, strengthen, and integrate pan-Canadian guidelines for upholding and integrating a strengths-based, people-centered recovery-oriented practice to reduce the impact of future pandemics on people living with serious mental illness. These guidelines need to address policies and practices in institutions, regional/provincial mental health systems, and public health authorities.
5. Meaningfully involve people with lived experience of serious mental illnesses in post-pandemic mental health system and services planning and policy development. As well as in developing mental health promotion strategies at the community, provincial, and national levels.
6. Fund and support a separate initiative that focuses on addressing virtual care gaps and issues for people who need high intensity specialized services.

7. Assess from both a health equity and sex and gender-based analysis the intersecting social determinants of health faced by people living with serious mental illnesses across various policy with the goal of reducing inequities experienced during the pandemic, including housing, anti-racism, and income and food security policies.
8. Support and strengthen communication efforts to profile the impact of lack of resources devoted to mental health, the importance of mental health parity, and to share lessons learned during the pandemic.

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