

MENTAL HEALTH AND COVID-19 **IN SASKATCHEWAN ADULTS**

Report from a World Café Event

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Tom McIntosh, Nuelle Novik, Alanna DeCorby, Nazeem Muhajarine, Bonnie Jeffery, and Natalie Kallio



Mental Health and COVID-19 in Saskatchewan Adults: Report from a World Café Event

Authors

Dr. Tom McIntosh, SPHERU Co-Director (Politics and International Studies, University of Regina)

Dr. Nuelle Novik, SPHERU Researcher (Social Work, University of Regina)

Alanna DeCorby, SPHERU Research Assistant (Politics and International Studies, University of Regina)

Dr. Nazeem Muhajarine, SPHERU Director (Community Health and Epidemiology, University of Saskatchewan)

Dr. Bonnie Jeffery, SPHERU Researcher (Social Work, University of Regina)

Natalie Kallio, SPHERU Research Officer (University of Saskatchewan)

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Contents

Executive Summary ii

1) Introduction 3

2) Background: SPHERU, COVID-19 and Mental Health 3

3) Methodology..... 4

 What is the “World Café” Approach? 4

 Adaptations due to COVID 5

 Who attended? 6

4) Overview of the Presentation..... 7

 Mental health supports..... 8

 What the data could not tell us: Shaping the World Café questions..... 9

 The World Café questions 9

5) The Table Conversations..... 9

 Round One: Does the data square with your experience, and why is this happening? 10

 Demographics..... 10

 A clumsy mental health care system..... 10

 Intersectionality 11

 Round Two: What should change to meet the needs of diverse communities?..... 11

 Rethinking the system 11

 Collaboration 12

6) Key Themes and Messages That Emerged 12

 Theme One: The system was unprepared 13

 Theme Two: Mental health moves to the forefront..... 14

 Theme Three: Existing inequalities were made worse 15

 Theme Four: The informational challenges 16

7) A Post-COVID Saskatchewan 17

8) Next Steps 19

References 20

About SPHERU..... 21

Executive Summary

On May 26 and 27, 2021, researchers from the Saskatchewan Population Health and Evaluation Research Unit (SPHERU) convened a gathering of approximately 30 individuals from the mental health sector to discuss the impact of the COVID-19 pandemic on the mental health of Saskatchewan adults and begin to chart a research-informed course forward for post-pandemic mental health services in the province.

Using a World Café methodology, the discussion focused on the results of surveys of Saskatchewan residents carried out on behalf of Mental Health Research Canada (MHRC) and in partnership with the Saskatchewan Health Research Foundation (SHRF). Four key themes emerged from the discussions:

1. The system was unprepared for the extent and duration of the pandemic and could not easily adjust service delivery modes and this exposed gaps between community mental health services and the health care system.
2. Because of the attention given to mental health issues there may be an opportunity for changing public perceptions of mental health and its centrality to overall health.
3. Existing inequalities in society were made worse by the pandemic and how those inequalities reinforce and overlap in specific populations was more apparent.
4. The “pivot” to new ways of working, interacting with each other, and accessing public services meant there were significant issues in getting timely, accurate information to people.

In the end, consensus was reached on what needs to be learned from our experience with the pandemic as it relates to mental health and mental health service delivery.

1. There is a need to keep pushing to break down silos inside government (e.g., between departments) and between the government, the health system, and communities.
2. We need to sustain and nurture partnerships and initiatives that arose inside different communities during the pandemic.
3. The key elements of any service redesign should be *flexibility* and *innovation* to ensure the right service is in the right place for the right people.
 - a. This can only work with high levels of intersectoral cooperation and collaboration.
 - b. This requires focus on the patient/client rather than on the service provider/service organization.
 - c. This approach is better equipped to deal with the intersectionality of the economic and social determinants of health highlighted in the pandemic’s unequal impacts across communities, populations, and the province.

1) Introduction

On May 26 and 27, 2021, researchers from the Saskatchewan Population Health and Evaluation Research Unit (SPHERU) convened a gathering of approximately 30 individuals from the mental health sector to discuss the impact of the COVID-19 pandemic on the mental health of Saskatchewan adults and begin to chart a research-informed course forward for post-pandemic mental health services in the province.

Using a World Café methodology (see below), the discussion focused on the results of surveys of Saskatchewan residents carried out on behalf of Mental Health Research Canada (MHRC) and in partnership with the Saskatchewan Health Research Foundation (SHRF). Event discussions revealed a strong consensus: the pandemic created a heightened awareness of mental health issues—and may have opened a window of opportunity to make significant changes in the way services are delivered and integrated into our public health and health care services in the province. This report provides both a summary of those conversations as well as a preliminary guide to action derived from the themes and messages that emerged.

2) Background: SPHERU, COVID-19 and Mental Health

The COVID-19 pandemic—that began in late 2019 and immediately had a direct impact on Canada in early 2020—created a number of challenges for SPHERU as a research unit. For the first time, we were confronted with trying to continue our ongoing research in an environment that made traditional forms of community outreach and engagement much more difficult. At the same time, researchers were ‘inside’ a public health emergency upending not just the lives of the community members with whom they partnered, but their own lives as well.

Large parts of the economy shutdown, how and where one worked was fundamentally reordered, and the social connections and relationships on which we all relied were constrained and altered by the demands of the pandemic response. It became evident that, in addition to the challenge of defeating the virus, there was going to be a significant mental health challenge to be met. Dealing with COVID-19 was not just about combating the physical impact of the virus on individuals, but also the fear, anxiety, and uncertainty that was part and parcel of a global pandemic of indeterminate length and impact.

And while on one level, the initial message “the virus does not discriminate” was an important reminder everyone was susceptible to infection and needed to take precautions (e.g. frequent hand washing, masking, social distancing, etc.), it was soon evident some populations were going to be harder hit than others and the capacity to take the necessary precautions to protect oneself and one’s family was not equally distributed across the board.

In May 2020, SPHERU researcher Dr. Nazeem Muhajarine and infectious disease researcher Miles Fahlman from HACAN Consulting Ltd. launched the [Social Contours & COVID-19](#) surveys. These web-based surveys provided an important picture of how Saskatchewan residents were responding to the pandemic in terms of their changing social interactions, work and school environments, social activities, how they were protecting themselves, and what put them at increased risk. These results

pointed to some emerging mental health concerns as people dealt with the challenges of a pandemic that, by its very nature, meant dealing with changing public health guidelines, sometimes confusing government messaging, incomplete information for assessing risk, and uncertainty about how long the emergency would last.

Most recently, Dr. Muhajarine and Saskatchewan Health Authority and University of Saskatchewan psychiatrist Dr. Tamara Hinz, with funding from MHRC and SHRF, and Royal University Hospital Foundation have launched research into the mental health impacts of COVID-19 on children, youth, and families called [See Us, Hear Us](#). The study will provide useful data to enhance mental health services for children and youth and to support families by examining how common mental health problems like anxiety and depression are in younger residents; how well they are coping with these challenges throughout the pandemic, and whether current configurations of services are providing the supports they need.

In mid-2020, SPHERU was presented with a unique opportunity to also gain specific information about the mental health impacts of COVID-19 on Saskatchewan adults, through a partnership with the Saskatchewan Health Research Foundation (SHRF) and Mental Health Research Canada (MHRC). Beginning shortly after the pandemic took hold in Canada, MHRC engaged the polling firm Pollara Strategic Insights to survey and track mental health impacts of the pandemic on Canadian adults. With additional funding from SHRF, SPHERU, and the Office of the Vice-President (Research) at the University of Regina, a partnership was undertaken to ‘oversample’ Saskatchewan residents. This allowed a team of SPHERU researchers (Drs. Nazeem Muhajarine, Bonnie Jeffery, Nuelle Novik, and Tom McIntosh) to get statistically reliable samples of Saskatchewan adults out of these national surveys. To date, SPHERU has analysed two waves of data, collected in the province by Pollara on behalf of MHRC in August 2020 and February 2021. Three more waves of Saskatchewan data will be collected between June 2021 and early 2022. This will result in a time series of data spanning from the aftermath of the first wave of the pandemic through to what we hope will be the end of this public health emergency. These repeated, population level tracking data on mental health in Saskatchewan adults are an invaluable and timely resource to guide mental health services in the province.

SPHERU released a [Research Brief](#) and [Infographics](#) from the first wave of data in December 2020; [Infographics](#) and a [Research Brief](#) from the second wave were released in May 2021. At this point, SPHERU undertook to have a wider conversation about the survey data with a wide variety of people from across the province who could help provide context and nuance to the results and allow SPHERU researchers to better understand the import of the mental health challenges and service access challenges revealed by the data. This conversation was the focus of the World Café event held in May 2021.

3) Methodology

What is the “World Café” Approach?

The world café approach has been utilized as a strategy to generate dialogue and ideas in a wide range of settings through the engagement of diverse stakeholders. Recognized as an effective change management tool (Ritch & Brennan, 2010), this approach emphasizes strengths-based

learning and mutual creativity (Emlet & Mocerri, 2012; Hamilton-Wright et al., 2019). The world café method follows seven integrated principles in its design: context setting, creating a hospitable space, establishing meaningful and important questions to be explored, encouraging everyone's contributions, connecting diverse perspectives of participants, collective listening, and sharing ideas (Bazilio et al., 2020).

As originally designed, a world café is set up as a series of small group discussions held simultaneously; these *informal* conversations are established in a casual café setting. A world café is typically held as three rounds of discussion on questions of increasing complexity. The questions or themes to be discussed are usually established in advance and sometimes shared with participants prior to their attendance. Ideally, each café table has 6-8 participants with a facilitator and a note-taker, with each discussion block lasting 20-30 minutes. The facilitator of each group works with participants to “harvest” their thinking into a summary statement identifying patterns or themes that emerged from the conversation (Hite, 2020). These results are then fed back to participants as a summary before they resume and regroup at another table. By physically moving participants to different tables for each round, conversation is continued through threads of the previous discussion and is constantly added allowing a “cross-fertilization” of ideas in an inclusive and participatory way (Brown & Isaacs, 2001; Maloney & Harper, 2021).

Adaptations due to COVID

While Ferguson-Patrick and Jolliffe (2018) did describe world café occurring in an online as well as a face-to-face situation (as cited in EOSLHE, 2020), prior to the COVID-19 pandemic, few publications mention using the approach via an online forum. As a group of researchers, SPHERU recognized the importance of bringing together stakeholders in a timely manner to discuss the survey findings—especially given the evidence the pandemic was having a negative effect on the ability of Saskatchewan adults to access mental health services. Having experience incorporating face-to-face world café methodology in prior research projects, we were confident in our ability to effectively adapt the approach to deliver virtually using Zoom™. This platform was deemed to be an effective option for a virtual world café due to availability of breakout rooms, recording capabilities, and chat options.

As part of the planning process, a number of specific decisions were made. First, we chose to engage participants in two rounds of questions, instead of three (as we would in a face-to-face world café). Being very conscious of *zoom fatigue*, we made efforts to ensure everyone would be engaged through the process and would feel their time was well spent.

Second, we decided to split the process over two days. During the first morning, we facilitated an overview presentation of the survey data, as well as the two rounds of questions, during a three-hour span (including a short break). The final overview of discussion themes was scheduled for the following morning for a period of one hour. Given the very busy schedules of participants (many of whom had jobs directly related to dealing with the pandemic), we surmised the ability and commitment to attend would be higher by taking this two-day split approach.

Third, there was an awareness the numbers of participants needed to be limited in order to best manage the process and create an inclusive discussion environment. As a result, we generated a participant list with a goal of confirming the attendance of 30 to 40 individuals. Once the number of

participants was confirmed, each individual was preassigned a discussion group for each of the two question rounds. As part of the planning process, experienced researchers were secured to serve as table hosts, along with students to serve as notetakers. Prior to the event, table hosts and notetakers were paired up (staying together for both discussions), briefed on the world café approach, and assigned to discussion groups.

Typically, in a face-to-face world café, a rapid content analysis occurs after the third discussion session and the identified themes and overall summary are presented to all participants immediately afterwards, with the intention of identifying specific goals for moving forward. By scheduling this part of the discussion for the second morning, more time was available to gather and review the notes and compile a concise overview of themes and highlights that emerged from the two discussion rounds. This approach also allowed for a robust large group discussion on the second day that we were able to audio record with the permission of participants.

During preparations for the World Café event, there was concern about the quality of discussions that could be generated using a virtual platform. However, participants all appeared to be very engaged in the discussion throughout the first morning and almost all logged back in for the second morning. Informally, participants provided feedback indicating they felt that the experience was worthwhile. By ensuring that the world café was well organized, and all information needed by participants was shared with them in advance, participant engagement did not appear to be inhibited by using an online forum. Also, by hosting the world café online, we were able to engage with participants from across the province; it is unlikely this would have been possible if everyone would have been required to travel to meet in a central location.

Similar to the accounts of experiences appearing in the research literature over the past year, our experience hosting this virtual world café was enhanced by the technology in a number of ways (Hite, 2020; McKimm, 2020). It appears the virtual format might have made it easier for participants to engage in discussions because they did not have to physically move around a room to get to another table. This format also prevented folks from staying with friends or colleagues instead of moving to the next assigned “table.” That participants’ names appeared below their pictures also may have helped participants connect more quickly with one another (Hite, 2020).

The virtual platform addressed sound quality issues that often arise during face-to-face discussions, due to room acoustics and large numbers of people talking in close proximity to one another. Splitting the event over two mornings also afforded us the opportunity to complete a more thorough content analysis of the notes taken during the two rounds of discussion. Finally, participants returned the second morning re-energized, having had time to process the discussions from the previous morning. As a result, the quality and depth of the final large group discussion was notable and generated a number of ideas for moving forward.

Who attended?

Invitations to participate in this world café event were sent to a range of individuals and organizations in an effort to bring together a diverse group with a vested interest in the topic. Participants included individuals representing community mental health agencies (Family Service Saskatchewan network, Canadian Mental Health Association), health organizations (Health Quality Council, Saskatchewan Association of Social Workers), front line service providers, patient

advocates, individuals working in policy and program development (Saskatchewan Health Authority, Ministry of Health), funders, and researchers. Those who agreed to attend were provided with an electronic copy of the *Infographics* and *Research Brief* in advance, as well as a schedule of the virtual activities planned for the world café over the course of two consecutive mornings.

4) Overview of the Presentation

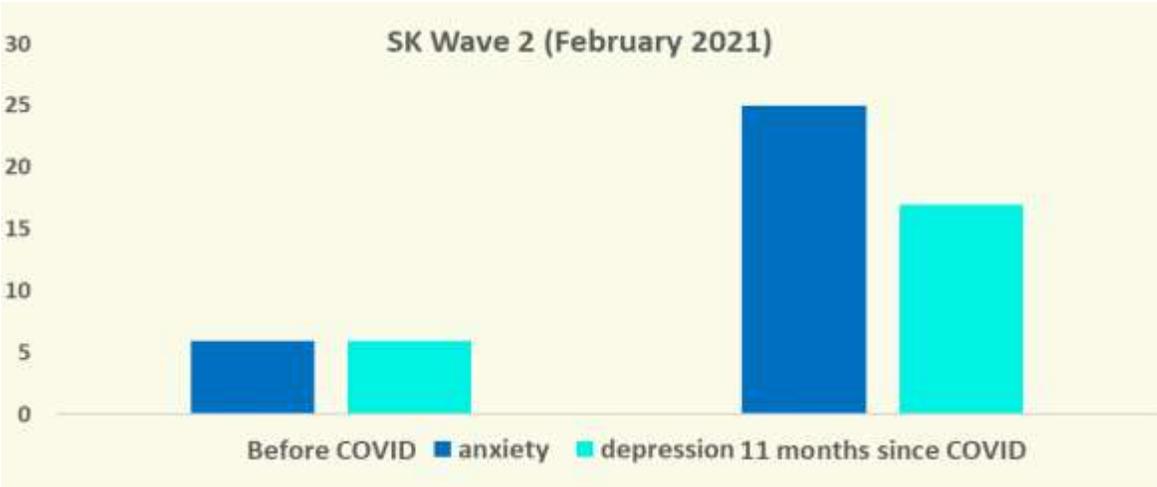
Even though all participants had been provided with copies of the *Infographics* and *Research Brief* in advance, we decided it was important to provide a short overview of the research prior to engaging in the World Café discussions. By taking this approach, all participants would be entering into their small discussion groups having had access to the same information.

As discussed earlier in this report, the data focused on for this world café event was from the summer 2020 and winter 2021 waves, with the data collected from 576 and 577 adult Saskatchewan residents (18-years and older) respectively. This is a stratified sample, with age, sex, and place weighted for analysis to ensure the total sample is representative of the Saskatchewan population as a whole. Anxiety and depression were measured using the Kessler-10 scale, a commonly used self-reported screening tool used in non-clinical settings.

For the purpose of the presentation in advance of the word café discussions, it was decided specific elements of the data were important to highlight, including rates of self-identified anxiety and depression, reported alcohol and cannabis use, feelings of resilience and the ability to recover, and access to mental health supports.

Saskatchewan has seen a four-fold increase in the levels of anxiety since the pandemic (25% compared to 6% before) and a three-fold increase in levels of depression (17% compared to 6% before). Younger Canadians (18-34 years) and women are experiencing the highest levels of anxiety and depression. Social isolation remains a leading stressor negatively impacting mental health; time outdoors continues to be identified as the best activity to support good mental health.

Table 1: Saskatchewan Adults Experiencing Anxiety and Depression Before & During COVID (%)

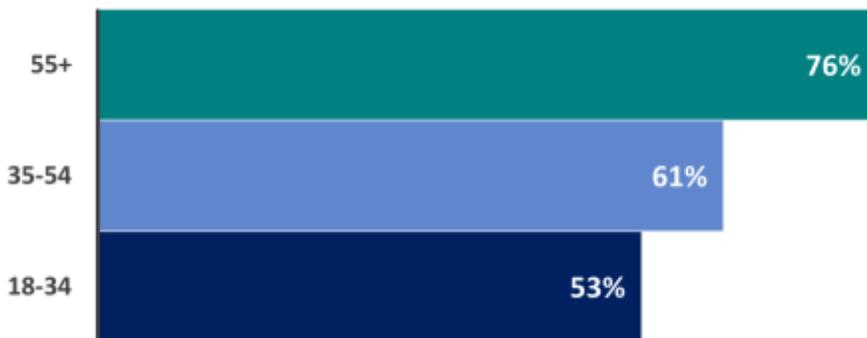


The data also highlighted changes in alcohol and cannabis use amongst Saskatchewan adults. Those under 55 years (18-34: 26.4%; 35-44: 22.9%; 55+: 11.1%), specifically males (22.3% vs. 17% of females), indicated increases in alcohol consumption during the pandemic.

Indications of increased alcohol consumption are more likely among those with higher levels of anxiety (moderate [5-7 rating]: 22.2%; high [8-10 rating]: 30%) and depression (moderate: 24.7%; high 31.9%). Saskatchewan adult males under 35 years of age (17.8% vs. 35-54: 5.5%; 55+: 1.1% and 9.2% of males vs. 6% of females) are more likely to indicate increases in cannabis consumption. Indications of increased cannabis consumption are also more likely among those indicating higher levels of anxiety (moderate [5-7 rating]: 7.4%; high [8-10 rating]: 19.3%).

As the pandemic has worn on, the data has indicated that three-fifths of Saskatchewan adults continue to feel confident about their ability to bounce back. However, younger respondents (under the age of 55 years) are not as confident in their ability to bounce back from the challenges the pandemic has caused. In particular, respondents from Regina (65%) and Central Saskatchewan (64%) feel less confident in their ability to bounce back, compared to respondents from the North (74%), South (76%) and Saskatoon (76%). 34% of respondents say they are doing well managing feelings of stress, anxiety, and depression (compared to 47% before COVID-19). Those who reported they are most likely to handle stress well are those with no children, respondents in the 55+ age group, and men.

Figure 1: Ability to bounce back from difficulties (by age)



Mental health supports

The data has shown 59% of Saskatchewan adults who were receiving mental health supports pre-pandemic are still receiving those supports. These are mostly likely to be younger adults (40% in the age group 18-34 years, 46% aged 35-54, as compared to 14% of those 55 years and older). One-to-one in-person support with a mental health professional (i.e., counsellor, psychologist, or psychiatrist) has decreased from 25% before COVID-19 to 8% since. This is not particularly surprising, due to the physical distancing and other restrictions put in place. Accessing support through a family doctor or general practitioner has also decreased, from 12% before COVID-19 to 7% since.

According to the data, adults opting for one-to-one support virtually via online (i.e., video chat) with a mental health professional has seen a very slight increase, from 3% to 4%; one-to-one verbal phone call sessions with a mental health professional has seen a marginal increase, from 4% to 6%.

Saskatchewan adults who needed mental health supports but did not access any such supports since the pandemic has nearly doubled since the pandemic (12% since COVID vs. 7% before COVID). Saskatchewan adults indicate they would like information about mental health supports—16% want information about supportive activities they can complete on their own and 11% are interested in information about accessing one-on-one counselling support.

What the data could not tell us: Shaping the World Café questions

The presentation ended with a series of questions we felt were raised, but left unanswered, by the data. While the data was clear on what was happening during the pandemic when it came to adult mental health, it was unable to tell us why it was happening. Nor did it unambiguously point us in the direction of specific policy choices or changes that could be made to alleviate the challenges to accessing services identified in the surveys. These questions were instrumental in shaping the specific questions for the Table Discussions at the World Café:

- Why are some groups at greater risk of developing severe difficulties?
- Are adequate mechanisms for surveillance, reporting, and intervention services for substance abuse, domestic violence, etc. in place?
- How can the uptake of mental health services, especially among the vulnerable population, be increased?
- As COVID-19 and its effects on mental health will last for some time, what are some long-term, system-wide response plans?
- How can we effectively provide mental health support and not overwhelm the already burdened health care systems?

This led us to the two questions we focused on during the world café event.

The World Café questions

1. We are seeing increased levels of depression, anxiety, and substance use during the pandemic while also seeing decreased rates of individuals accessing mental health supports at the same time. Does this square with your experience, and why is this happening?
2. In a post-COVID Saskatchewan, what do we need to change in order to increase access to mental health and addictions supports province-wide? How do we meet the needs of specific populations (Indigenous, immigrant, rural, northern, etc.) as we make those changes?

5) The Table Conversations

As mentioned above, the World Café event revealed a strong consensus that the pandemic created a heightened awareness of mental health issues, which may have opened a window of opportunity to make significant changes in the way services are delivered and integrated into our public health

and health care services in the province. This section will provide a brief overview of the conversations that took place during the World Café event. The themes that emerged are discussed in more detail later in this report.

Round One: Does the data square with your experience, and why is this happening?

Demographics

There were three threads running through the responses to Question 1. The first revolved around demographics and how different groups were experiencing results similar to what was found in the surveys (i.e., increased levels of depression, anxiety, and substance use during the pandemic, while also seeing decreased rates of individuals accessing mental health supports at the same time), while some groups were not experiencing similar results. In particular, participants were surprised younger adults (aged 18 to 34) were being affected quite negatively. Upon further reflection, participants agreed it is understandable this group is being affected negatively when taking into consideration that individuals in this age group are typically less financially secure, often have small children, and often rely heavily on social groups. Participants also mentioned social media as a possible exacerbating factor for why individuals in the 18 to 34 age group are being more negatively affected; social media was noted as a factor that can spread misinformation, fear, and, ultimately, could increase anxiety throughout the pandemic.

Another demographic discussed by participants as being particularly affected was racialized groups in the province. Many participants observed that the pandemic exacerbated the impact of racism and discrimination for Indigenous populations and people of colour who already experience barriers to accessing mental health supports based on identity, language and culture. It was also noted that the pandemic reinforced and increased gender, social, and economic inequities in our society and exacerbated the north/south and urban/rural divides in the province.

A clumsy mental health care system

The second thread in response to Question 1 was around the ‘why’. Many participants agreed the reason we are seeing these results (i.e., increased levels of depression, anxiety, and substance use during the pandemic, while also seeing decreased rates of individuals accessing mental health supports) is because of the public mental health care system’s inability to pivot and effectively deliver services at-a-distance. Further, there was significant discussion around the lack of access to services for rural and remote citizens of Saskatchewan as well as Indigenous peoples. Reasoning behind this decreased access for these groups of citizens was chalked up to lack of technology, lack of internet access, lack of financial stability to access technology and/or internet connection, stigma around accessing mental health services in these areas and communities, as well as lack of information on how to properly access the services that may have been available.

Similarly, many participants noted the difference in service delivery between the public mental health care system and the private health care system. Those who could access private mental health services found their experience to be generally positive in terms of “the pivot,” while many felt the same could not be said for the public system. Additionally, participants reported that individuals who already had a relationship built with a mental health professional had much more trust and success in the system.

Again, there was consensus that information provided by the mental health care system was lacking and the system struggles to give information to citizens in the ways they want to receive it. Most importantly, many participants held that the mental health care system in Saskatchewan was not performing well before the pandemic and, therefore, the pandemic aggravated these gaps in service, the lack of information, and the lack of coordination of services.

Intersectionality

The third thread throughout all of these conversations was intersectionality. It appears there were multiple exacerbating factors at play that caused individuals to experience and/or observe increased levels of depression, anxiety, and substance use during the pandemic, while also seeing decreased rates of individuals accessing mental health supports at the same time.

Overall, the majority of participants agreed these results were not surprising. Many found these results somewhat fit their experiences as well as what they were witnessing firsthand during COVID-19. It should also be noted there were a few participants who held that these results did not properly match their experience. These participants were practicing health care and mental health care professionals (e.g., doctors, nurses, social workers, psychologists) who expressed that demand for their services, and mental health services in particular, has been increasing. Many of the frontline workers who were participating in the World Café event expressed feeling overrun with calls and demands for services while having to be creative in how to meet this demand.

Round Two: What should change to meet the needs of diverse communities?

The second round of discussion was also characterized by perceptions of a heightened awareness of mental health issues—and the impression such awareness may have opened a window of opportunity to make significant system changes.

Rethinking the system

The responses to our second question can also be divided into two overarching themes, the first of which revolved around rethinking the mental health care system. There were three changes participants agreed needed to take place within the system for it to better meet the needs of all Saskatchewan residents. First, there was discussion around the role the provincial government plays in creating and sustaining the system. Participants expressed the need for more collaboration within and between government departments to breakdown the policy silos—in order to recognize the interconnectedness of social and mental health policy and account for the intersectional aspects of the response. In other words, it should be recognized that health care and mental health care cannot be seen as a separate entity from social services or from economic and labour markets, as these all play a large role in how COVID-19 affected the mental health of Saskatchewan residents.

Second, there was discussion around how to better meet clients where they are at. Participants strongly supported putting *community* back into *community mental health care*. Participants also discussed various strategies and resources that could make a huge impact on accessibility. This included the need for secure and reliable internet infrastructure across the province and acknowledging and addressing the reality of racism in Saskatchewan, as well as the stigma that still follows mental health. Some of the strategies are more straightforward, like building internet infrastructure or addressing the lack of access in rural and remote communities through a review

and reboot of the [Saskatchewan Mental Health Action Plan](#) (completed in 2014). Others, such as addressing systemic racism, are more complicated and complex.

Third, there was in-depth discussion around the need for better data collection throughout the province. For instance, despite most participants experiencing less-than ideal support and access to the system, Saskatchewan is meeting nationwide benchmarks for wait-times for counselling services. This could be indicative of a disconnect between need and the perceived assessment of need on the part of the mental health care system. For example, if a client requests one-on-one counselling but is instead put into small group counselling, this client may not feel as though they accessed the services they needed, but from the perspective of the system, the patient was delivered services quickly and efficiently. There are two ways participants felt data collection could be improved. The first is to collect data in a way that captures the client experience. This could mean clients have opportunities to express whether or not they feel their needs were met. Additionally, there was a discussion of the need for data on community-based services in addition to data from the formal mental health care system.

Collaboration

The other overarching theme that was followed throughout discussion and responses about change to the system was the need for better collaboration. Collaboration is needed between clients who are actively receiving mental health care, those seeking mental health care, mental health care providers, government officials, and community-based organizations, as well as other stakeholders. Collaborative entities that emerged during the pandemic, such as the Saskatoon Inter-agency Response, should continue to receive provincial support. For these community-based partnerships and collaborations to work, the mental health care system needs to have a genuinely open dialogue with stakeholders about what is working and not working from each perspective. This is important, especially when taking into consideration the amount of knowledge community organizations have about the needs of their community members. Nonetheless, participants were adamant that collaboration between *all stakeholders* would improve the quality of mental health care for all in Saskatchewan while ensuring the already over-loaded health care system is not further burdened.

6) Key Themes and Messages That Emerged

As noted above, the World Café reconvened on the second day to respond to and validate a presentation on the key themes across table discussions the previous day. The result was an in-depth and engaged discussion that added nuance and detail to the broad themes that emerged from the initial conversations. There was a strong desire to push the conversation towards finding solutions to the shortcomings in mental health care highlighted by the and to envision the pandemic as an opportunity to rethink the organization, financing, and delivery of mental health services, especially for those populations that had the biggest problems accessing and navigating the system as it existed during the pandemic. What follows is a discussion of four key themes that emerged from both the table discussions on the first day and the plenary discussion on the second. This is followed by a discussion of what a post-COVID Saskatchewan can look like in terms of rethinking mental health supports in the province.

Theme One: The system was unprepared

Despite Canada's experience in the relatively recent past with pandemics—including the Severe Acute Respiratory Syndrome (SARS) pandemic from 2002-04 and efforts made to learn lessons from our response to that episode (Canada 2003)—it was clear both the country and, by extension, the provinces were simply not prepared for a pandemic on the scale of COVID-19. This had a number of immediate impacts on health services:

1. The health care system could not easily adjust service delivery modes in the way as some businesses and schools.
2. This exposed gaps between community mental health services and the health care system including:
 - a. Linkages that could refer clients needing services to existing or newly created remote/online services were not robust.
 - b. Online and telephone services worked for some segments of the population but not for others.
 - i. Some were not comfortable with online services, some resisted changes in the mode of the therapy offered (e.g., from one-on-one to group), and some simply could not access online/remote services because of the lack of technology or the lack of internet infrastructure in some parts of the province.

As one of the participants noted:

We have taken many, many calls in the last year and a half and we set up our separate phone lines [but] it was very difficult for people ... to access the usual kind of services, because they would usually have to phone a number and then wait an indeterminate amount of time for somebody to phone them back. And sometimes they didn't get phoned back. And so, it made a situation where I think access generally, even in the cities, is sometimes very slow and there's a real need for systems navigation, to help people in the first place, but with this all happening and it just got multiplied many times ... it was clumsy, and I think it's still clumsy.

At the same time, it has to be recognized the system, and those that staff it, also worked hard to sustain access to services:

[We] retained all intake staff onsite and maintained enough clinical staff onsite to respond to emergencies. Access is an important area to improve upon, and we have plans to do so in both cities. As well, not all staff have worked from home, many of our frontline [staff] have continued to provide care, as well as increased care ... I think it's important to recognize those staff as they showed up every day.

It was also clear the public health restrictions (e.g., work from home, self-isolation, physical distancing, etc.) exacerbated the challenges in ways that could not be easily predicted. This became a double-edged sword in some respects: blaming the restrictions for the mental health problems rather than acknowledging restrictions as necessary to public health and identifying strategies to cope with them. Indeed, one participant noted “mental health impacts” were used by some political leaders, in his view, as “an excuse” to not impose more strict public health measures, despite evidence such measures lower “the overall burden of harm to society writ large, both in terms of

health and economics.” This often became a contest over how these issues are framed for the public and, importantly, who gets to do the framing.

Finally, it cannot be ignored that, as the pandemic progressed, there was also a growing sense of a mental health crisis within the health care system for frontline service providers—who were suffering unprecedented levels of stress, anxiety, and exhaustion coupled with a frustration with those who denied or would not recognize the crisis. The personal mental health care needs of these workers were often not prioritized, as they tended to focus their attention on providing the best possible services for others.

Theme Two: Mental health moves to the forefront

Because of, in the words of one participant, the “generalized trauma” the pandemic created for all citizens in all walks of life, there was also an awareness it made mental health issues, the need for services and the challenges of accessing services in a timely and appropriate manner, more visible to the general population. While the extent and severity varied, everyone had to deal with new sources of stress, anxiety, and uncertainty brought on by a situation over which they had little to no control—a possible opportunity to undercut mental health stigma.

At the same time, it is important that we be cautious in not portraying COVID-19 as the *source* of the crisis in mental health services—that crisis existed long before the pandemic. As one participant said:

I'm happy that [COVID-19] shines a light on mental health and no doubt will help move things forward but, at the end of the day, this issue is a pre-existing issue and really COVID has sort of created a variant by generalizing it to other populations that hadn't been affected in the past. So, the political agenda behind this is a very relevant agenda and it may in the end, serve as an equalizer ... this is not something new and that's been ongoing and more lives have suffered from the impact of mental health for much longer than just in this COVID age.

This led to two key conclusions about the opportunities identified in the discussions:

1. There is a likelihood of greater empathy for people with mental health conditions because of this shared experience and, thus, this may reduce stigma.
2. There is now an opportunity to use that shared experience to better integrate mental health services into the community health and health care sectors.

Participants were also quick to note that, because of the pandemic, local organizations in particular were pushed to restructure how they delivered services and to collaborate in new ways. There was a strong feeling we should not lose sight of those innovations and, as the pandemic wanes, to focus on how to best replicate and scale up those creative solutions and creative collaborations that arose and/or became relied upon. Three such examples are:

1. Saskatoon Inter-Agency Response to COVID-19: <https://saskatooninteragencyresponse.ca/>
2. The collaboration between the Family Service Saskatchewan partners in creating Counselling Connect Saskatchewan: www.counsellingconnectsask.ca.
3. The formation of Be SaskWell out of the University of Saskatchewan: <https://besaskwell.memotext.com/>

That the pandemic made the long-standing issue of the marginalization of mental health within discussions of health and health services visible was seen as something of a silver lining. While recognizing these issues predate the pandemic, there was also a strong sense this visibility may, for a time, make it easier to build upon awareness and draw more widespread attention to those long-standing challenges while also highlighting the creative and collaborative innovations the pandemic response helped generate.

Theme Three: Existing inequalities were made worse

While many leaders and governments favoured the public position “the virus doesn’t discriminate” to convey the seriousness of the situation and potential risk to everyone, it was painfully obvious to many that COVID-19 disproportionately impacted certain populations.

Further, it was also apparent to the World Café participants—from frontline workers to patient/client advocates to policy makers—that the social and economic factors that defined particularly vulnerable populations not only interacted with each other to exacerbate people’s vulnerability, but often limited individuals’ ability to respond to the pandemic.

For example, low-paid service sector workers (who tend to be younger, more likely to be members of racial minorities and new immigrants who may already face language and other barriers to accessing support) could not work from home. Keeping their jobs when their children were required to learn remotely at home (also imposing cost of specific technology and internet and access) proved challenging. Even when able to work from home, women disproportionately bore the burden of organizing and accommodating their children’s educational needs, often to the detriment of their employment.

All of this was happening at moment when, for obvious reasons, traditional modes of accessing social support and the capacity of the various social systems to offer support were themselves compromised by the pandemic. Agencies struggled to pivot to online and other options for service delivery while government support programs were being hastily implemented with confusing eligibility criteria. In short, the lives of those already in precarious or marginalized situations were made more so by the pandemic.

Population health and social justice researchers, practitioners, and advocates have long demonstrated health outcomes and access to health-sustaining resources is unevenly distributed along key cleavages in society. Thus, it comes as little surprise this particular group of participants noted how the pandemic’s impacts were differentiated along particular axes:

1. Geographic Divides

- a. Urban areas were hit harder and keeping to some public health orders was more difficult (e.g., the need to restrict contacts), but also had more resources and resiliency to respond.
- b. By contrast, rural areas had fewer access points for services.
- c. Northern areas were also hit hard, and distance made responses more difficult.
 - i. Rural and northern Indigenous communities often responded on their own (e.g., imposing their own community lockdowns) out of necessity.

- d. This further highlighted the challenges of providing adequate services to small and isolated population groups.
- 2. A Racial Divide
 - a. Systemic racism made the situation worse for Indigenous peoples, racialized minorities, and new immigrants.
 - i. These groups have fewer resources in their communities and multiple barriers to access good mental health services.
- 3. An Economic Divide
 - a. The working poor, essential workers in sectors and businesses that remained open, people who were homeless or living in substandard and crowded homes were all at greater risk and had fewer resources to access services and mental health care.
- 4. A Gender Divide
 - a. Women took up much of the increased work at home—including schooling of children and caregiving while simultaneously trying to work “outside the home from inside the home” –and returned to work at a slower pace than men.
 - b. The health care system’s gender divide was also reinforced nurses and frontline workers in health and mental health are more likely to be women.
- 5. A Health Divide
 - a. People with prior physical and mental health issues, including those with substance use and addictions issues, had a harder time gaining or maintaining access to services and struggled more to abide by public health guidelines.

Again, we need to understand and approach these divides not as discreet categories but as interconnected and often mutually reinforcing threads of people’s lives that can build webs of risk and marginalization that are difficult to untangle. Unless these are approached both intersectorally and intersectionally, we cannot begin to counter their impacts.

Many people were impacted by the pandemic and many of those people may have reached out and received services virtually, which is most often the way that it has been available. But there’s a whole group of people—racialized people, newcomers—that might have been receiving fewer services because [the] mode of delivery changed or the pressures and challenges of life were exasperated ... it takes time to receive support.

Theme Four: The informational challenges

The pandemic posed massive communication and informational challenges for governments, service providers, community organizations, and citizens. The sheer size and speed with which we were all expected to “pivot” to new ways of working, interacting with each other, and accessing public services meant there were significant issues in getting timely, accurate information to people and uncertainty about how to best get information into the hands of those who needed it. Getting reliable and trustworthy information about accessing services and minimizing risk was made more difficult by a number of factors:

- 1. Confusing government messaging that complicated individual responses:
 - a. Being told, on one hand, to “stay home” and, on the other, “to support local businesses” created public confusion what to do and how to behave.

2. It was difficult to keep up with the ever-changing science and knowledge about COVID-19 and the changes in public health orders that stemmed from them.
 - a. This may have contributed to a greater sense of distrust of scientific evidence and to suspicion as to the severity of the pandemic and efficacy of public health restrictions.
3. The system was clumsy and called on navigation skills people did not feel they had.
 - a. Participants frequently talked about how many people felt discouraged while trying to access services and many who may have abandoned attempts to get help.
 - b. New media and social media may have worked as a vehicle for a significant portion of the population, but it was not always accessible to those who need services the most.
4. At the system-wide level, it was also noted that we still lacked a lot of basic information about what services were available and where.
 - a. This was especially true on the on the community mental health side.

In general, getting information to people in a way they can easily access it is a perennial problem for the health system. Too often, decisions about what information to share and how to share it are made in a top-down manner, rather than starting from the needs and preferences of the intended recipients. The pandemic experience drove home the importance of accurate, timely, and accessible information *and* the need to ensure the trustworthiness of that information. As platforms for disseminating information multiply and the number of dubious sources of information proliferate, this is an issue that is only going to grow in importance.

7) A Post-COVID Saskatchewan

In pulling together the broad themes from the World Café discussions, it became apparent many of the questions the surveys on mental health did not answer were, at least partially, answered in the conversations about the data (meeting an objective of this world café event). Clearly, inequalities and inequities evident in the mental health system before the pandemic were heightened and exacerbated by this public health crisis. There was consensus that we still lack the mechanisms to both monitor and intervene in the often personally harmful behaviours that increased during the pandemic.

If we don't take account of those kinds of things and plan in the future for them, we're never going to get out of this particular mess that we're in ... let's not pretend that when the pandemic is over everything's just going to go back to normal and we'll do a few little changes and everything will be okay. Because I don't believe that's the case at all, nor should it be, we should be taking this opportunity to really learn.

In the end, consensus was reached on what needs to be learned from our experience with the pandemic as it relates to mental health and mental health service delivery to adults in the province.

1. There is a need to keep pushing to break down silos inside government (e.g., between departments) and between the government, the health system, and communities.

This is not a new proposition, but the pandemic has made it even more urgent. The challenge is that, to be effective, this needs to be done from the bottom up, not top down. Participants

spoke about the need to put the *community* back into community mental health—rethinking mental health services needs to start with communities defining and articulating their service needs. Cognizant this will vary according to both the geography and the composition of the community, we need to build that flexibility into the design and delivery of mental health services. Participants repeatedly returned to the idea of a system that was “*person-centred*” not provider-centred.

2. We need to sustain and nurture partnerships and initiatives that arose inside different communities during the pandemic and how to scale and replicate those in other places. In doing so, we need to rigorously evaluate the effectiveness of these innovations.

The health system, broadly speaking, is often not really good at translating success stories to other places. We get programs that work and [are] effective and we're really not good at either scaling those up or adapting them and moving them into other places in other contexts and this I think heightens the need to think through those challenges.

3. The key elements of any service redesign should be *flexibility* and *innovation* to ensure the right service is in the right place for the right people. Governments need to understand different people in different places will want or need different services.
 - a. This can only work with high levels of intersectoral cooperation and collaboration.
 - b. This requires focus on the patient/client rather than on the service provider/service organization.
 - c. This approach is better equipped to deal with the intersectionality of the economic and social determinants of health highlighted in the pandemic’s unequal impacts across communities, populations, and the province.

As Kingdon (2011) notes, policy change takes place when problems, politics, and policies align to open a window of opportunity for change. The pandemic may have opened that window for mental health, but it may not stay open for very long and certainly not forever. The challenge, then, is to move quickly but to also with deliberation and thoughtfulness. Coming to the table with concrete proposals we are confident will work is integral to taking advantage of the system’s open window for change.

This will take resources, and those are hard to come by in the health care system, but there was also consensus that mental health services have long been starved for resources and even recent increases in investment have done little to change the overall proportion of health spending for mental health.

Policy change of the kind envisioned constitutes a clear political agenda, one that will challenge the status quo in important ways. As World Café participants noted throughout, governments have long ignored mental health as both health system priority and a public health/social service priority because there was little political cost to their position. The hope is the nature and extent of mental health as a post-COVID concern may make ignoring it much harder to do now. And, as a few participants noted, the relative cost of scaling up “what works” in mental health services is relatively low for the big return on that investment—and that itself can make it an attractive policy option for governments.

8) Next Steps

For its part, SPHERU's work on these issues is continuing even as the pandemic slows in Canada and Saskatchewan and vaccination programs continue. In addition to the ongoing work on Social Contours of COVID-19 and emerging work on children's mental health noted earlier in this document, we also have three more waves of Saskatchewan-specific data to come before Spring 2022. Each of those iterations will present a changing picture of the situation in the province and clarify where we will come out of the crisis and what the state of mental health needs and service access actually are on the ground. With each wave of data, we will continue to provide the interested public, stakeholders, and policymakers with results in the form of Research Briefs and Infographics.

As those waves of data become available and the picture of post-COVID Saskatchewan comes into focus, it will be important not to lose the ideas and energy evident in the World Café event. The pandemic has highlighted and strengthened the argument that the organization and delivery of mental health services has to change in the province. Further conversations like the World Café will be integral to fueling that commitment. The new data and a better sense of the policy and political landscape for change will provide an opportunity to focus in more concretely on both the successes and challenges that emerged from the pandemic and, thus, to sketch in more detail what a community-based, person-focused system of mental health services could look like in a post-COVID Saskatchewan.

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About SPHERU

The Saskatchewan Population Health and Evaluation Research Unit (SPHERU) is a bi-university research centre located at both the University of Regina and the University of Saskatchewan. Established in 2000, SPHERU's mandate is to engage in interdisciplinary, community-based population health intervention research aimed at reducing health inequities across various populations in the province, including, but not limited to, those created by race, age, geography and socio-economic status. Its work is focused on children's health, rural health, Northern and Indigenous Health and the history of health inequality in the province and in recent years has also pursued a particular focus on senior's health and international maternal health.

The full history of SPHERU's research can be found at www.spheru.ca and on a special 20th anniversary website (www.spheru20.ca) that combines videos, animation, and testimonials to illustrate how SPHERU's two decades of collaboration and cross-sector partnerships bridged gaps between disciplines, organizations, and communities. SPHERU has catalyzed transformations through innovative research methods, engagement, knowledge creation, and intervention. Its researchers work directly with Saskatchewan communities, organizations, and community partners to make a real difference in the health of Saskatchewan people.