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# Healthy Professional Worker Partnership: *Nursing Case Study Survey Findings*

Examining the Pathway from Mental Health to  
Leaves of Absence & Return to Work and the  
Impact of the Pandemic



The Healthy Professional  
Worker Partnership

11/22/2023

## Table of Contents

Executive Summary .....	2
Introduction.....	5
Conceptual Framework.....	5
Case Studies .....	6
Overview of Methods .....	7
Key Findings.....	8
Background of Survey Respondents.....	8
Pathway from Mental Health, Leaves of Absence to Return to Work .....	11
Changes to Work.....	13
Taking a Formal Leave of Absence .....	14
Returning to Work After a Leave of Absence .....	15
Impact of the Pandemic on the Mental Health of Nurses .....	16
Mental Health.....	17
Psychological Distress .....	19
Presenteeism .....	21
Burnout .....	23
Summary & Next Steps .....	25
Acknowledgements.....	27
Endnotes.....	27

## Executive Summary

The Healthy Professional Worker (HPW) Partnership is an initiative that examines the mental health, leaves of absence and return to work experiences of different professional workers from an intersectional and comparative perspective. Between the end of November 2020 and early May 2021, a bilingual (French- English) online, self-administered survey employing crowdsourcing recruitment via our partner organizations, direct email and social media was undertaken as one component of this study. This report presents the key findings from the 1,005 nurses who participated in this survey component. There were three categories of nurses used in the analyses: registered nurse (RN), registered/licensed practical nurse (RPN), and advanced practice nurse (APN). RN included registered nurses and registered psychiatric nurses. Advanced practice nurse (APN) included CNS/clinical educators and nurse practitioners.

### **Pathway from Mental Health to Leaves of Absence and Return to Work:**

We found that most nurses (67%) reported experiencing a mental health issue over the course of their career or training:

- ✓ More RNs reported having experienced a mental health issue (70% of RNs, 59% of RPNs, 59% of APNs).
- ✓ There were no significant differences between part-time and full-time nurses or between RNs, RPNs, and APNs in terms of making changes to work, considering taking a leave of absence, or taking a leave of absence.
- ✓ Full-time nurses were significantly more likely to return to the work they were doing prior to their leave of absence compared to part-time nurses (78% of full-time, 66% of part-time).

For the 674 nurses who did report having a mental health issue:

- ✓ 65% made changes to their work.
- ✓ 59% considered taking a formal leave of absence from work.
- ✓ 38% took a formal leave of absence from work.
- ✓ 74% who took a formal leave of absence returned to the same work as prior to their leave.

What types of changes did nurses report making?

- ✓ The most frequently reported changes were retreating from work by taking sick days or vacation (41%), seeking help from a medical doctor (40%), and seeking help from an allied health professional (36%).
- ✓ Only a small percentage (11%) of nurses sought support from their union or formal accommodations from their employer (9%).
- ✓ More part-time nurses (27%) than full-time nurses (14%) reported reducing their workload.
- ✓ Compared to RNs and APNs, a significantly lower percentage of RPNs reported seeking help from an allied health professional or changing units.

What were the top reasons for NOT taking a leave of absence?

- ✓ 57% – Believed their mental health issue was severe enough

- ✓ 45% – Professional impact
- ✓ 44% – Financial Reasons
- ✓ Compared to RNs and APNs, RPNs were significantly more likely to report that financial reasons were a reason for not taking a leave.

What were the top facilitators of and barriers to taking a leave of absence?

- ✓ Top facilitators were having financial support while on leave (36%), having supportive colleagues (27%), and having a supportive supervisor (24%).
- ✓ The top barriers to taking a leave was having an unsupportive supervisor (27%).

What were the top facilitators of and barriers to returning to work?

- ✓ The top facilitator of returning to work was having supportive colleagues (42%).
- ✓ Having a supportive supervisor was important – 29% indicated having a *supportive* supervisor was a facilitator and 33% indicated having an *unsupportive* supervisor was a barrier to returning to work.

### **Impact of the COVID-19 Pandemic:**

Mental health declined and psychological distress, presenteeism, and burnout significantly increased during the pandemic for all sub-groups of nurses. Effect sizes for declines in mental health were large for all sub-groups of nurses.

- ✓ Full-time nurses reported better mental health prior to the pandemic as compared to part-time nurses, but there were no differences during the pandemic.
- ✓ APNs reported significantly better mental health both prior to and during the pandemic compared to RNs.
- ✓ RPNs reported the largest decline in mental health followed by RNs and APNs.

All sub-groups of nurses reported significantly more psychological distress during the pandemic, and effect sizes were large.

- ✓ Prior to the pandemic, there were no differences in distress between RNs, RPNs, and APNs, but this changed during the pandemic with RNs and RPNs reporting more distress compared to APNs.
- ✓ Effect sizes for the increase in distress were notably higher for RNs and RPNs as compared to APNs.

The pandemic increased how often nurses worked while ill (i.e., increased presenteeism).

- ✓ Effect sizes for increases in presenteeism were larger for full-time nurses compared to part-time nurses.
- ✓ Increases were largest for RPNs followed by RNs and APNs.
- ✓ Differences between full-time and part-time nurses were not significant prior to the pandemic, but greater increases in presenteeism resulted in full-time nurses reporting significant more presenteeism during the pandemic.

Average scores of burnout increased from close to 2 (*occasionally I am under stress and I don't always have as much energy as I once did, but I don't feel burned out*) up to 3 (*I am definitely burning out and have one or more symptoms of burnout, such as physical and emotional exhaustion*) on a 5-point scale from 1 to 5.

- ✓ Prior to the pandemic, there were significant differences between RNs, RPNs, and APNs, with RNs reporting the highest average level of burnout followed by RPNs and APNs.
- ✓ During the pandemic, larger increases in reported burnout for RNs and RPNs meant that APNs reported lower average burnout than both RNs and RPNs, but there were no longer differences between RNs and RPNs.

The survey findings we have presented offer an informative view of issues facing nurses with mental health challenges, for which we will next tap into the rich dataset provided by the in-depth interviews with stakeholders and nurses. By combining this survey analyses with the qualitative analyses of our in-depth interviews we can develop interventions specific to the nursing work context.

## Introduction

The Healthy Professional Worker (HPW) Partnership is an initiative that examines the mental health, leaves of absence and return to work experiences of different professional workers from an intersectional and comparative perspective.

MH issues experienced by professional workers are uniquely challenging because of the importance of their mental acuity in providing knowledge-based services to clients, patients or students. Both presenteeism despite significant MH concerns and MH-related absenteeism can lead to negative consequences for workers.<sup>i,ii</sup> Absences from work can also pose an increased burden on their co-workers and/or employees, in terms of increased workload and burnout, on their employers, in terms of productivity losses, and on society more broadly in terms of accessibility to and quality of services.<sup>iii</sup> Negotiating leaves of absence (LoA) and return to work (RTW) can be particularly difficult when stigmatizing MH issues are involved, and when work culture and structures constitute insurmountable barriers to short- or long-term leaves, generating essentially forced presenteeism.

Although the issues of MH-related presenteeism and absenteeism are areas of growing concern for professional workers, they are seriously understudied, particularly from a comparative perspective across sectors and workers. Although the issues of MH-related presenteeism and absenteeism are areas of growing concern for professional workers, they are seriously understudied, particularly from a comparative perspective across sectors and workers.

HPW focuses on the experiences of mental health at work, the decision to take a leave of absence from work (or not, what is called presenteeism), and how return to work is negotiated and facilitated. Its focus is inclusive of workplace stress, overload, and burnout to experiences of anxiety, depression, and other forms of mental illness along a trajectory. It seeks to understand how personal, familial, work, and organizational contexts influence the path from mental health to leaves of absence to return to work. This is informed by the following conceptual framework.

## Conceptual Framework

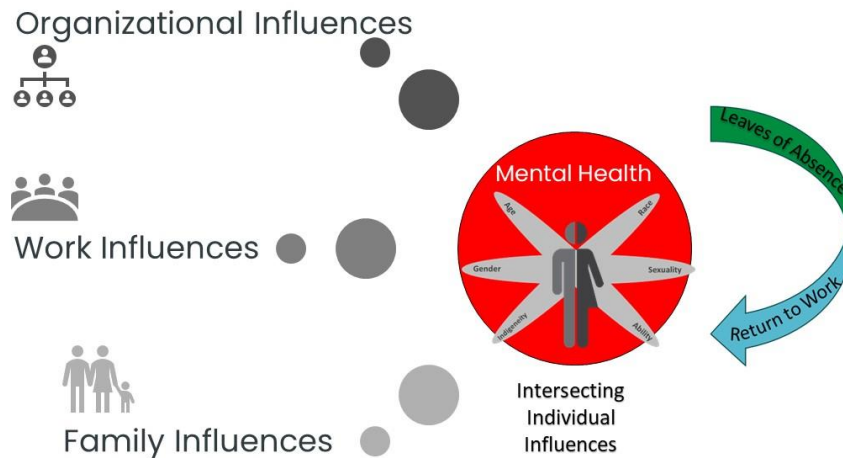
**Intersectional:** At the centre of the framework (see Figure 1) is an individual professional worker of a particular age with intersecting (non-binary) gender, racial, Indigenous, ability and sexuality identities affecting their experiences of mental health, leaves of absence and return to work.

**Contextualized:** Enveloping the worker are the different contextual influences at the family, work and organizational context, all situated within the broader system and societal level.

**Path:** The pathway from mental health to leaves of absence to return to work is depicted in a cyclical fashion. This recognizes that an individual worker experiencing mental health may or may not contemplate or follow through with a leave of absence from work and in turn may or may not return to work.

Figure 1. Conceptual Framework

## An Intersectional, Contextualised Path Model of Mental Health, Leaves of Absence & Return to Work Experiences



Depicting the pathway of mental health to leaves of absence to return to work and the influence of different factors and forces for professional workers with different identities can better enable the identification and development of targeted and more effective interventions to promote wellness and foster healthy return to work.

### Case Studies

HPW focuses on seven case study professions within and outside of health care that vary by gender composition: academia, accounting, dentistry, medicine, midwifery, nursing, and teaching. Leadership was identified as a key cross-cutting focus from the outset (see Figure 2). While Academia, Accounting, Dentistry, and Medicine are typically masculine professions that are slowly feminizing with time, Midwifery, Nursing, and Teaching are traditionally considered as more feminine professions. These case studies can be compared and broken down into unionized salaried positions, regular and irregular work schedules, group, or solo practice.

Figure 2. Case Study Professions



## Overview of Methods

The mixed methodological approach for HPW involved multiple phases and multiple methods. It began with a Partnership Development Phase, which involved a scoping review, pilot survey and interviews with workers, interviews with key stakeholders and a commissioned analysis of StatCan data on our case study professions. The full Partnership builds on this foundation and involves five key components: 1) Document Analysis; 2) Stakeholder Interviews; 3) Worker Surveys; 4) Worker Interviews; and 5) Intervention Toolkits. More information on each of these key components is included in the [Healthy Professional Worker Partnership: Preliminary Comparative Findings](#) report.

Between the end of November 2020 and early May 2021, a bilingual (French- English) online, self-administered survey employing crowdsourcing recruitment via our partner organizations, direct email and social media was undertaken. Participants were asked to choose their primary professional role from a list of professions (Academic-Professor, Professional Accountant, Dentist, Nurse, Midwife, Physician, Elementary/Secondary Education Worker). Other than this initial question, no other questions were mandatory to complete.

The remainder of this report presents the findings from the nurses who participated in the survey component of the study. Participants who selected the Nurse response option were directed to an initial set of questions about occupational characteristics specific to nursing. They then responded to several cross-cutting questions asked of all case studies, particularly focusing on the mental health, leaves of absence and return to work pathway, but also including a component which assessed mental health, distress, presenteeism and burnout during and prior to the pandemic. Finally, nurses responded to a set of customized questions specific to the nursing work context. The survey took approximately 20 minutes to complete. Data analysis for this report is based on the 1,005 nurses who responded to the question at the beginning of the final pathway component asking if they had ever experienced a mental issue over the course of their career.

Participants who selected Nurse as their primary work role were asked to indicate if they were a registered nurse (RN), registered/licensed practical nurse (RPN), registered psychiatric nurse, CNS/clinical educator, or nurse practitioner. To facilitate statistical comparison, we categorized registered psychiatric nurses as RNs. We also categorized participants who indicated CNS/clinical educator or nurse practitioner as advanced practice nurses (APNs). Participants who selected a combination of roles were classified as APN if any of the chosen roles were CNS/Clinical Educator or nurse practitioner (e.g., selecting registered nurse and nurse practitioner). Participants who chose “Other” and wrote “infirmière clinicienne” or “clinical nurse” were classified as RNs. Participants who chose RN and “Other” with a description such as Family Practice Nurse were classified as RN.

To date, descriptive analyses of the survey data have included frequency cross-tabulations with appropriate tests of significance undertaken at a  $p < 0.05$  criteria. Data from cells with fewer than 5 responses have been suppressed.



## Key Findings

### Background of Survey Respondents

As shown in Figure 3, the sample of nurse survey respondents predominantly identified as women (92%) as expected given the high percentage of women in the nursing profession. Because the number of nurses who identified as gender fluid, preferred to self-describe, or preferred not to answer was only 1% of the sample, we did not include these participants in statistical comparisons involving gender. Qualitative analysis of participants reporting non-binary gender identity will be included in future reports based on data from the interview components of our study.

Figure 4 shows the number and percentages of participants who identified as racialized, Indigenous, or living with a disability.

Figure 3. Gender Identity of Nurse Survey Respondents

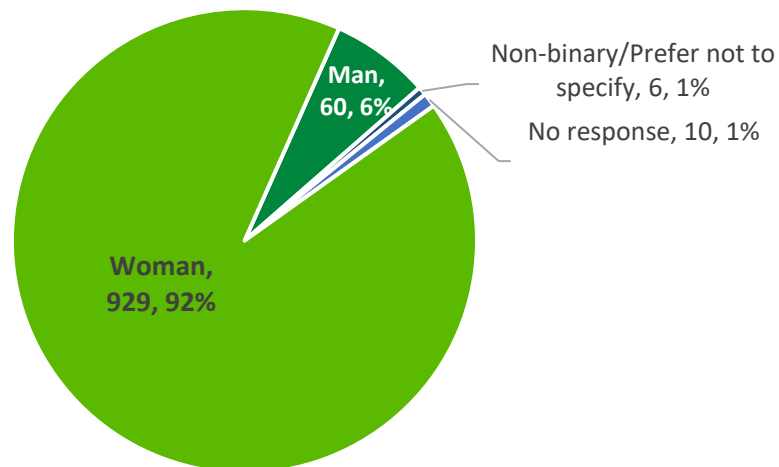
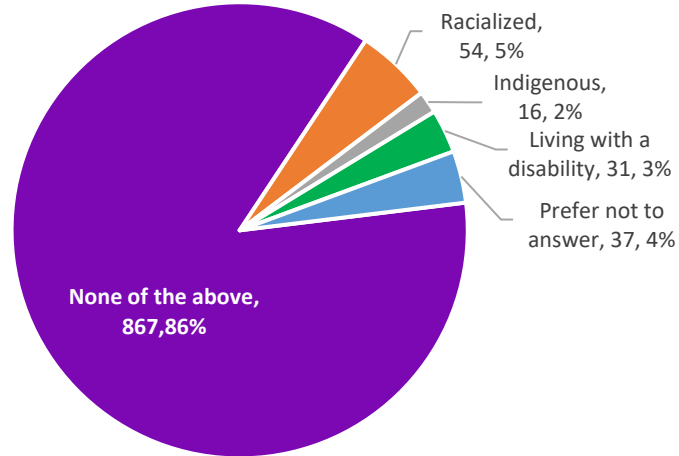


Figure 4. Percentage of Nursing Survey Respondents Who Identified as Racialized, Indigenous, or Living with a Disability



Information on the position and contract type of nursing survey respondents is shown in Figure 5 and Figure 6, respectively. More than three-quarters (77%) of the sample were RNs with smaller percentages of RPNs (12%) and APNs (11%). Most of the sample (66%) worked full-time with 34% reporting working part-time.

Figure 5. Position Type of Nursing Survey Respondents

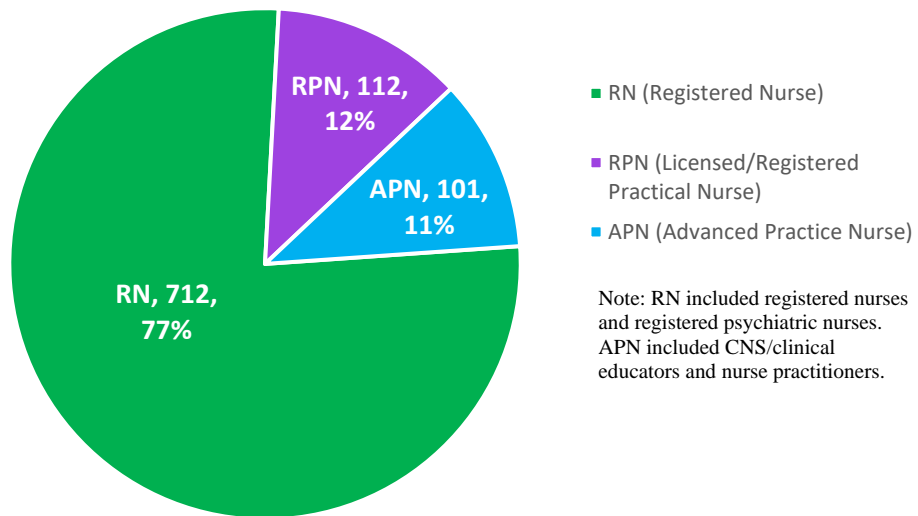
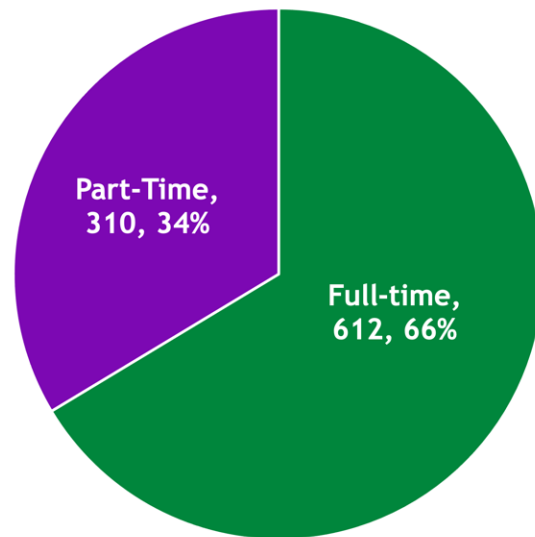


Figure 6. Contract Type of Nursing Survey Respondents



The breakdown for age and years in profession for nursing survey respondents is shown in Figure 7 and Figure 8, respectively. Although age in profession was well distributed, years in profession was skewed with higher percentages of the sample in the under 10 years category and progressively smaller percentages as years in profession increases.

Figure 7. Age of Nursing Survey Respondents

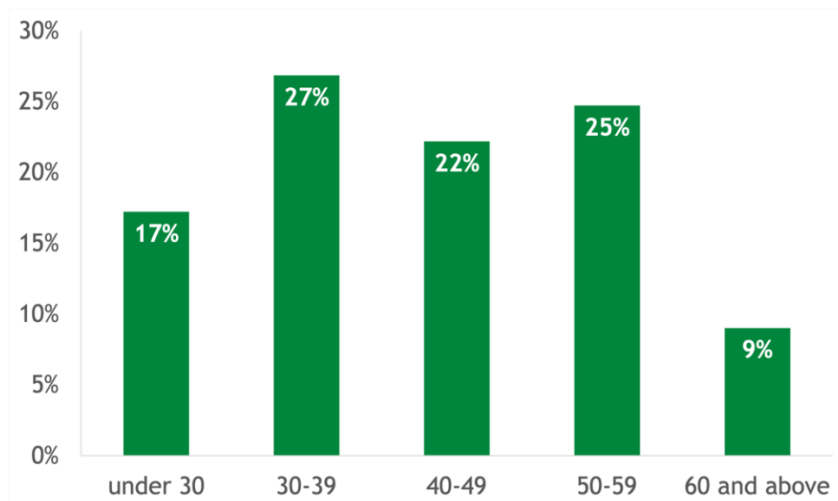
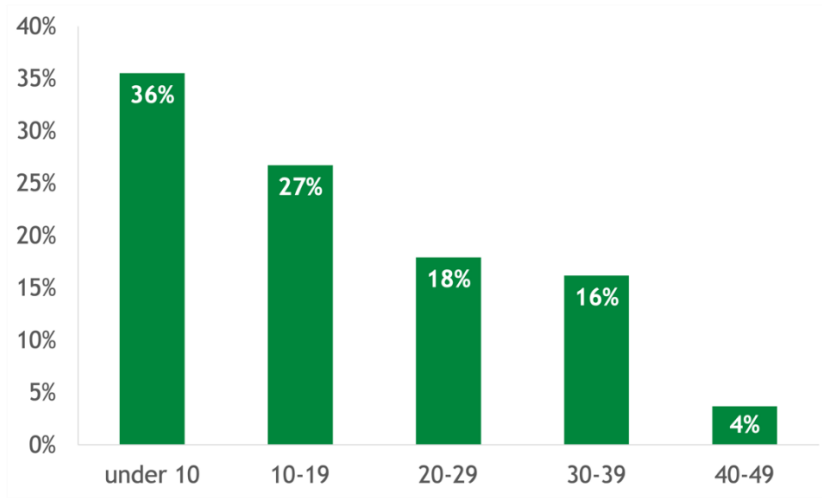


Figure 8. Career Stage of Nursing Survey Respondents, Years in Profession



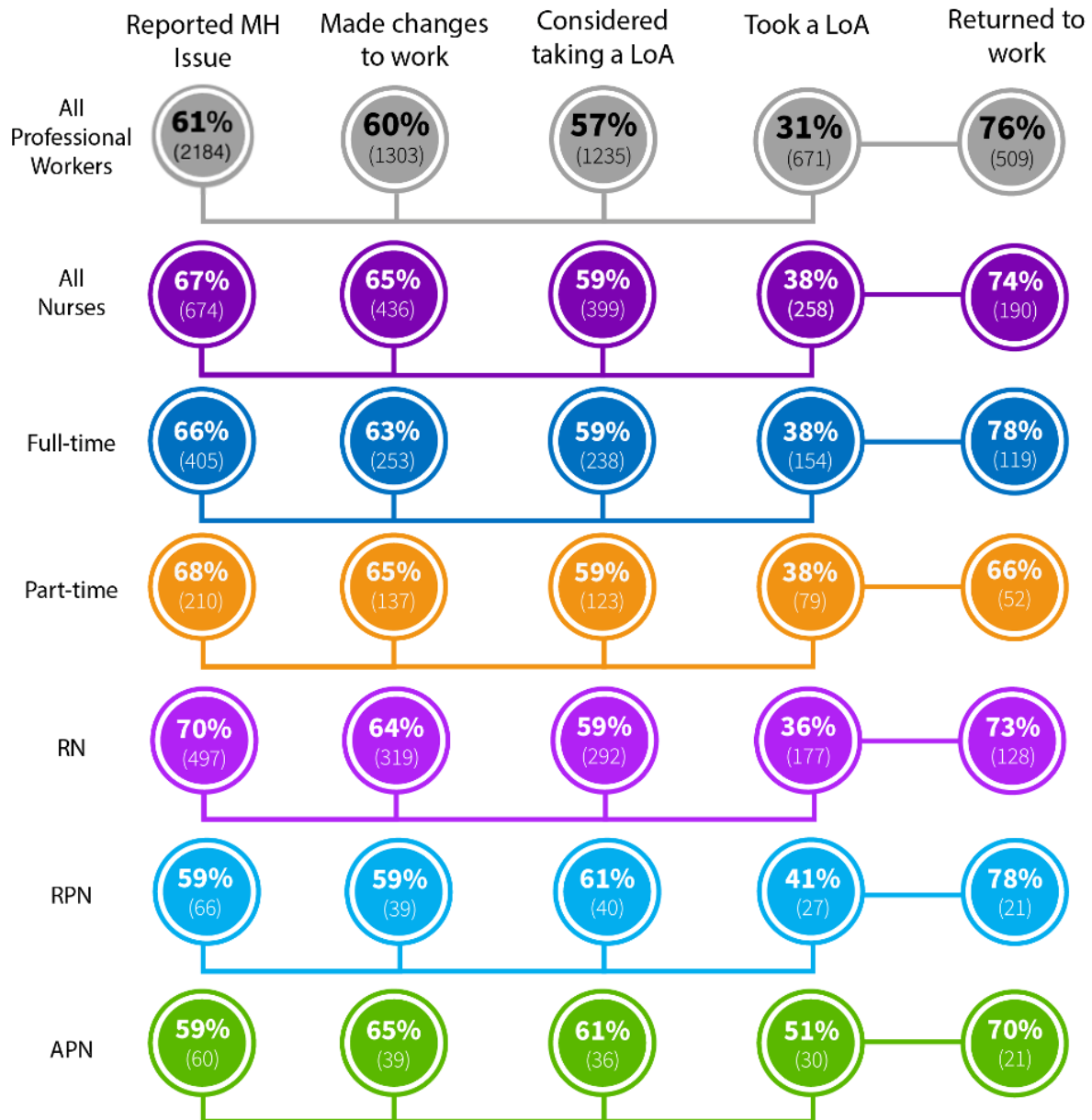
### Pathway from Mental Health, Leaves of Absence to Return to Work

The main purpose of this study was to understand the pathway from experiencing mental health issues, making changes to work in response to mental health challenges, considering or taking a formal leave of absence for mental health reasons and returning to work. These pathways are complex with nurses who experience mental health issues making use of none, some, or all these options. We have used the survey to get a broad view of the steps on this path.

*In the context of this study, mental health issues include mental or psychological stress or distress, burnout, anxiety, depression, other mood disorders, substance use or dependence, post-traumatic stress disorder, or serious thoughts of suicide. It includes both short term mental health problems that temporarily limit our ability to function as well as more persistent and severe medical health disorders that require medical intervention.*

Figure 9 shows a comparison between all our survey respondents and nurses who embarked on this pathway. Comparisons between nurses who worked either part-time or full-time revealed no significant differences in terms of reporting a mental health issue over the course of their career (66% of full-time, 68% of part-time),  $\chi^2(1) = 0.23, p = .63$ . There were, however, significant differences between RNs, RPNs, and APNs with a higher percentage of RNs reporting having experienced a mental health issue (70% of RNs, 59% of RPNs, 59% of APNs),  $\chi^2(2) = 8.46, p = .02$ . There were no significant differences between part-time and full-time nurses or between RNs, RPNs, and APNs in terms of making changes to work, considering taking a leave of absence, or taking a leave of absences. Full-time nurses, however, were significantly more likely to return to the work they were doing prior to their leave of absence compared to part-time nurses (78% of full-time, 66% of part-time),  $\chi^2(1) = 3.84, p = .05$ .

Figure 9. Pathway from Mental Health to Leaves of Absence and Return to Work



### Changes to Work

Nearly two thirds (65%) of the 674 nurses who reported experiencing a mental health issue over the course of their career also reported making changes to their work or training in response to a mental health issue. Figure 10 shows the types of changes made by all nurse survey respondents and the breakdown by full-time or part-time work status. The most frequently chosen responses were to retreat from work by taking sick days or vacation (41%), seek help from a medical doctor (40%), or to seek help from an allied health professional (36%) such as a psychologist, social worker, counsellor, psychotherapist, or other nurse. Relatively small percentages of nurses sought support from their union (11%) or formal accommodation from their employer (9%). The only significant difference between full-time and part-time nurses was with respect to reducing workload or amount of work, with more part-time nurses (27%) reporting that they had reduced workload compared to full-time nurses (14%),  $\chi^2(1) = 14.96, p < .001$ .

Figure 10. Changes to Work, By Full-time or Part-time

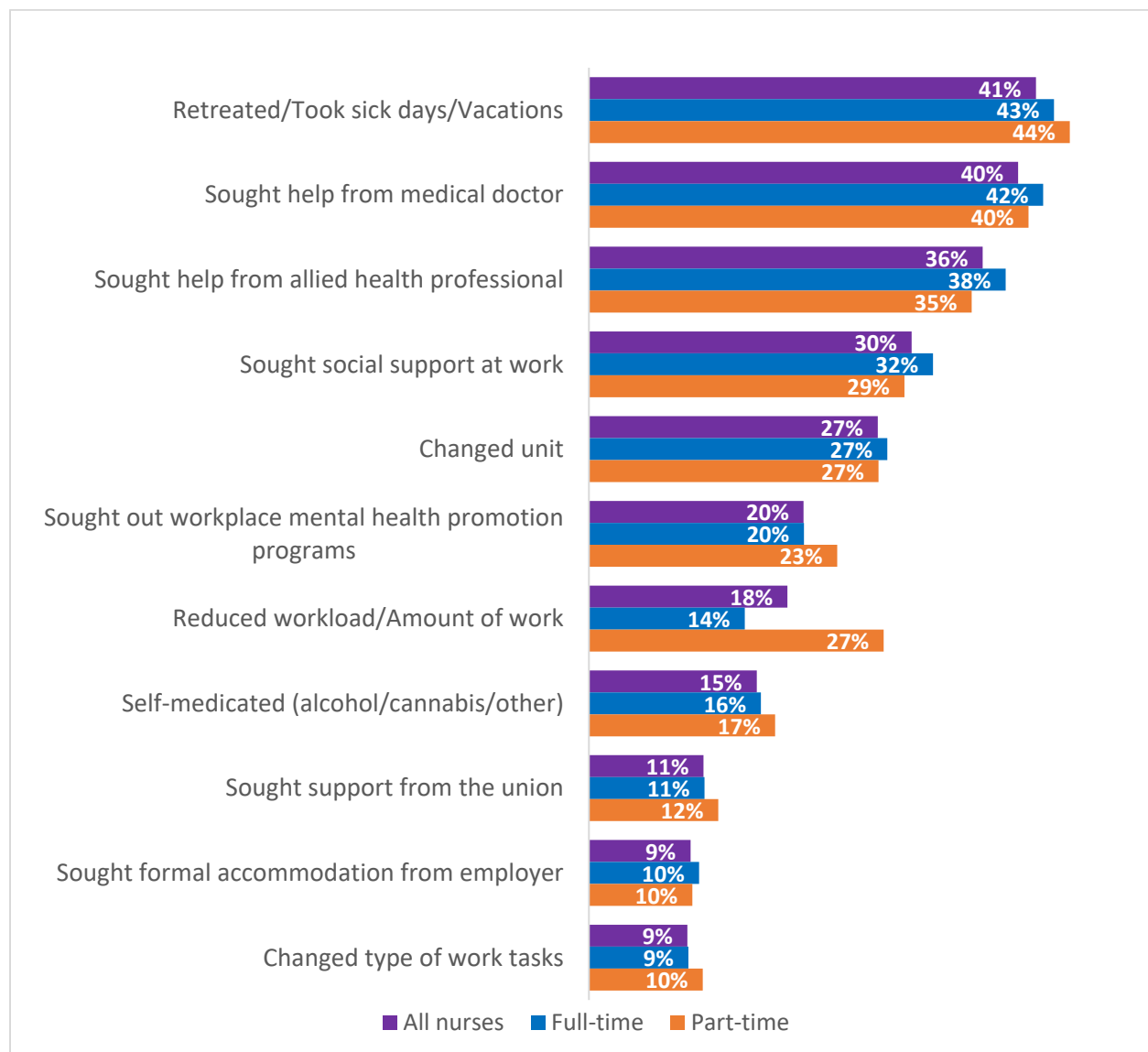
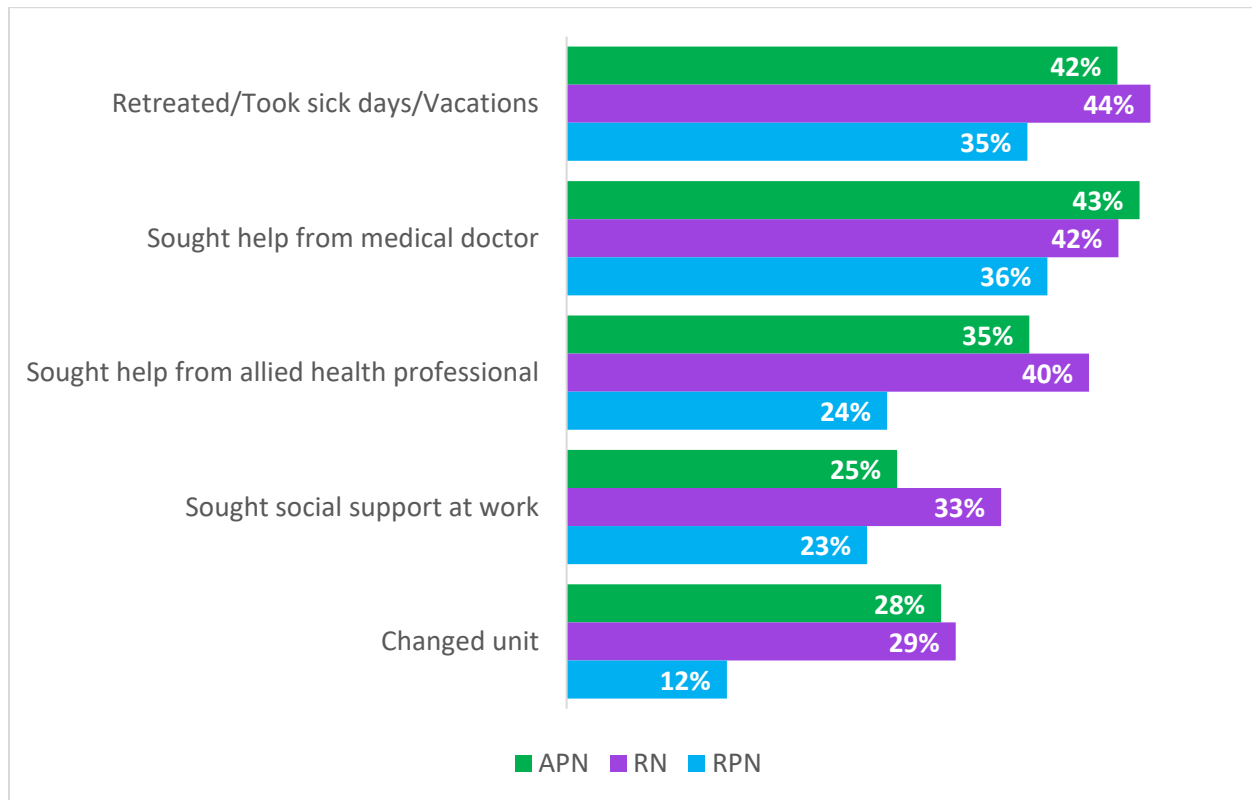


Figure 11 shows the top five changes made by nurses according to their position type. Only the top five are shown because some cells sizes for other changes were less than 5. Compared to RNs and APNs, a significantly lower percentage of RPNs reported seeking help from an allied health professional,  $\chi^2(2) = 5.91, p = .05$ , or changing units,  $\chi^2(2) = 8.74, p = .01$ .

Figure 11. Changes to Work, by Position Type



#### Taking a Formal Leave of Absence

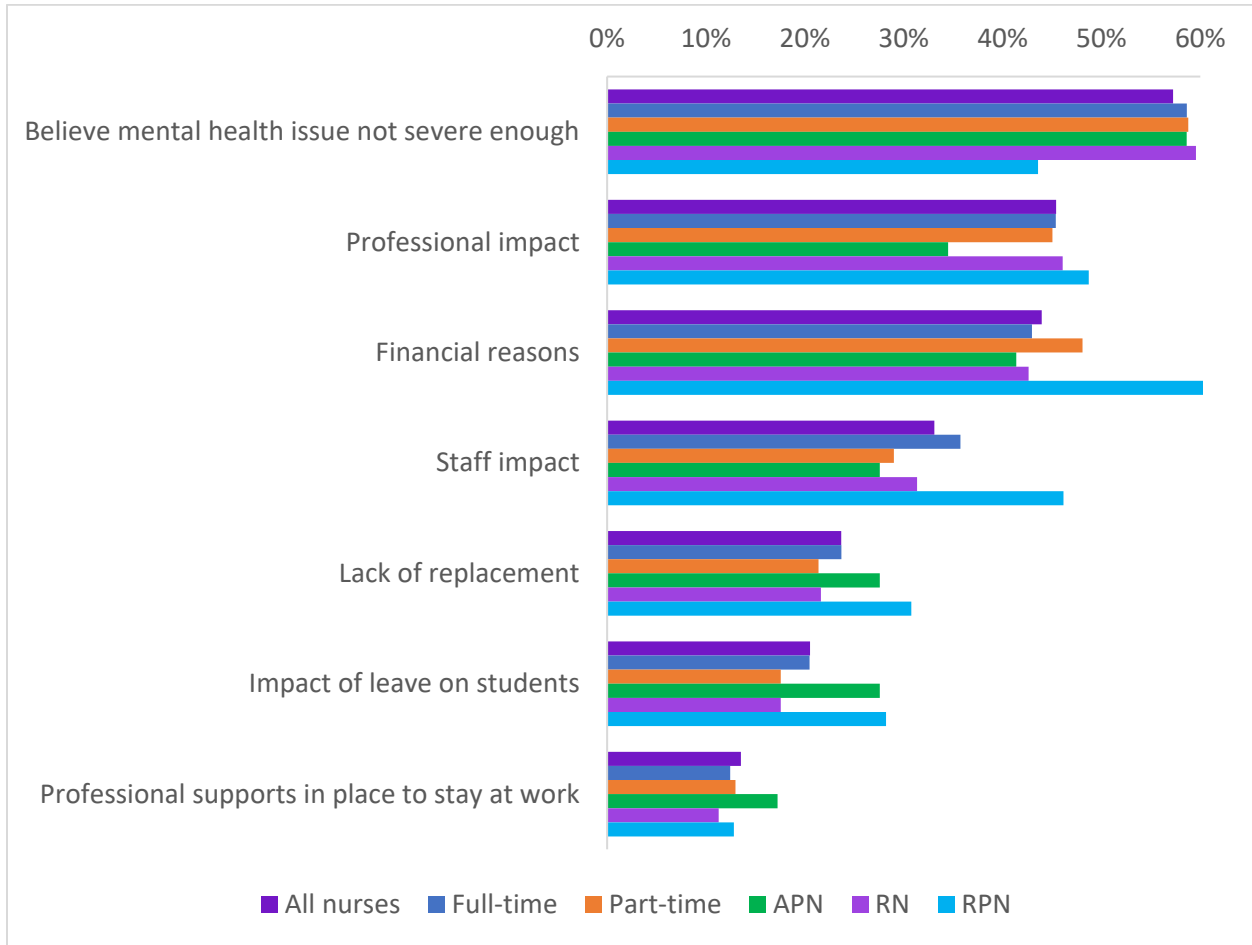
Most nurses (59%) who reported having a mental health issue over the course of their career also reported that they had considered taking a formal leave of absence, but only 38% reported taking a leave of absence. This did not differ significantly by contract type (full-time vs. part-time) or position type (RNs, RPNs, APNs).

#### Reasons for Not Taking Leave of Absence

As shown in Figure 12, the 62% of nurses who did not take a leave of absence were reluctant to do so primarily because they believed their mental health issue was not severe enough to take a leave (57%), because of the professional impact (i.e., stigma associated with disclosure, confidentiality, reputation impact on career opportunities, advancement or licensure) (45%), or because of financial reasons (44%). Full-time and part-time nurses did not differ significantly on any of the reasons reported for not taking a leave of absence. Compared to RNs and APNs, RPNs were significantly more likely to report that financial reasons were a reason for not taking leave,  $\chi^2(2) = 6.62, p = .04$ .



Figure 12. Reasons for Not Taking a Leave of Absence



*Facilitators and Barriers Taking a Leave of Absence*

Nurses who reported taking a formal leave of absence were also asked about facilitators and barriers to taking a leave. Figure 13 shows that the top facilitator was having financial support while on leave (36%) followed by having supportive colleagues (27%) and a supportive supervisor (24%). Figure 13 also shows that by far the most frequently reported barrier to taking a leave was having an unsupportive supervisor (27%). Responses to these questions were not broken down by contract type (full-time, part-time) or position type (RN, RPN, APN) because numbers were too small for meaningful interpretation and comparison.

*Returning to Work After a Leave of Absence*

Of the 258 nurses in our sample who took a formal leave of absence, 190 (74%) returned to the same work they were doing prior to taking their leave of absence. Full-time nurses were significantly more likely to report returning to the same work compared to part-time nurses,  $\chi^2(1) = 3.84, p = .05$ . There was no difference reported between RNs, RPNs, and APNs,  $\chi^2(2) = 0.46, p = .80$ .

*Facilitators and Barriers Returning to Work*

As shown in Figure 14, the top facilitator of returning to work was having supportive colleagues (42%). Having a supportive supervisor was also important – 29% indicated that having a *supportive* supervisor was a facilitator and 33% indicated having an *unsupportive* supervisor was a barrier to returning to work.

Figure 13. Facilitators & Barriers Identified by All Nurses for Taking a Formal Leave

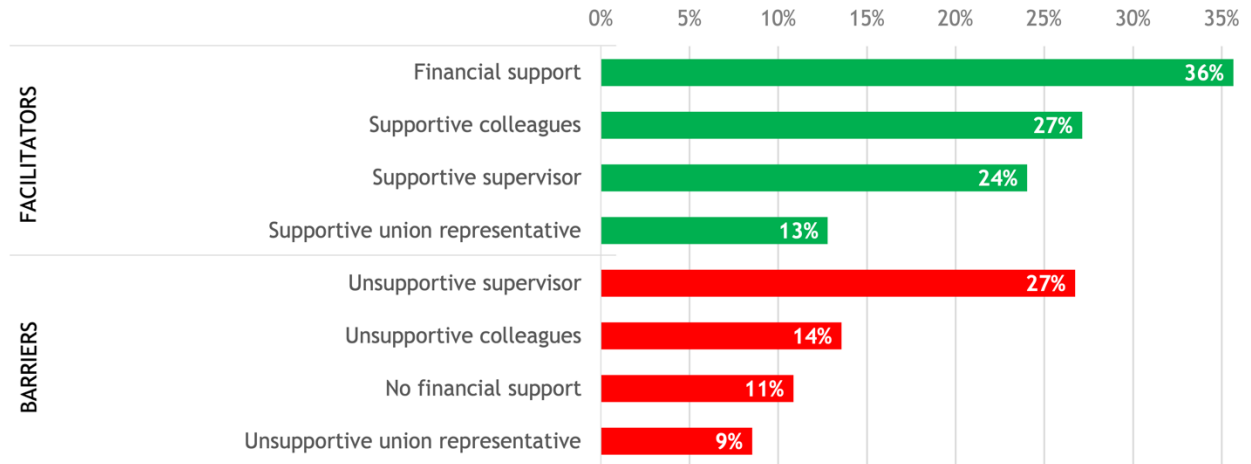
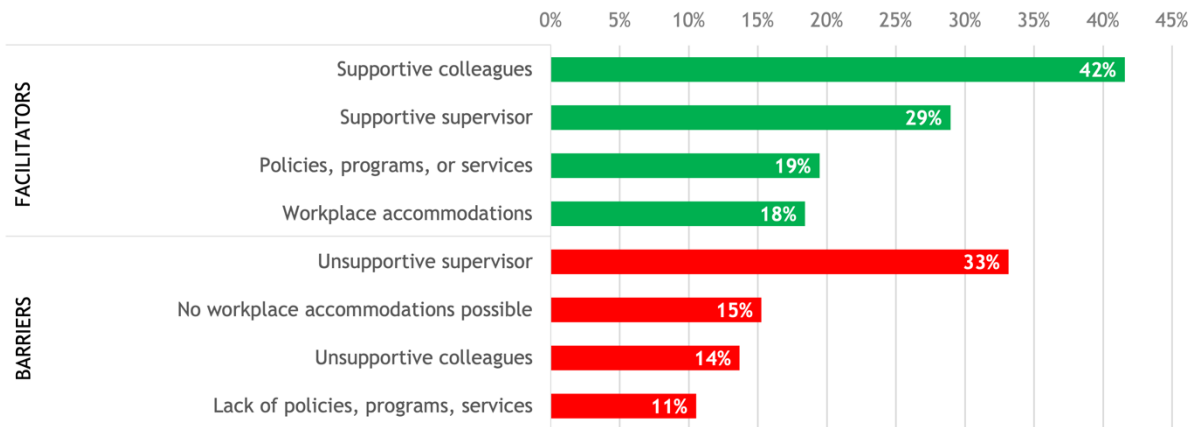


Figure 14. Facilitators & Barriers Identified by All Nurses for Returning to Work After a Leave



Impact of the Pandemic on the Mental Health of Nurses

Although the impact of the pandemic was not part of our original set of research questions, as it unfolded at the time of our data collection, it was clear that it was having an important impact on the mental health experiences of professionals at work and at home. The series of charts below show the impact of the pandemic on all nurses in our sample and breaks this down further for full-time and part-time nurses and for nurses categorized as APNs, RNs, RPNs, and. Each of these sub-groups reported a significant impact of the pandemic on measures of mental health, distress, presenteeism, and burnout. Effect sizes for paired-samples *t*-tests comparing changes in reported

levels of mental health, distress, presenteeism, and burnout for prior to and during the pandemic are reported as Cohen's *d*.

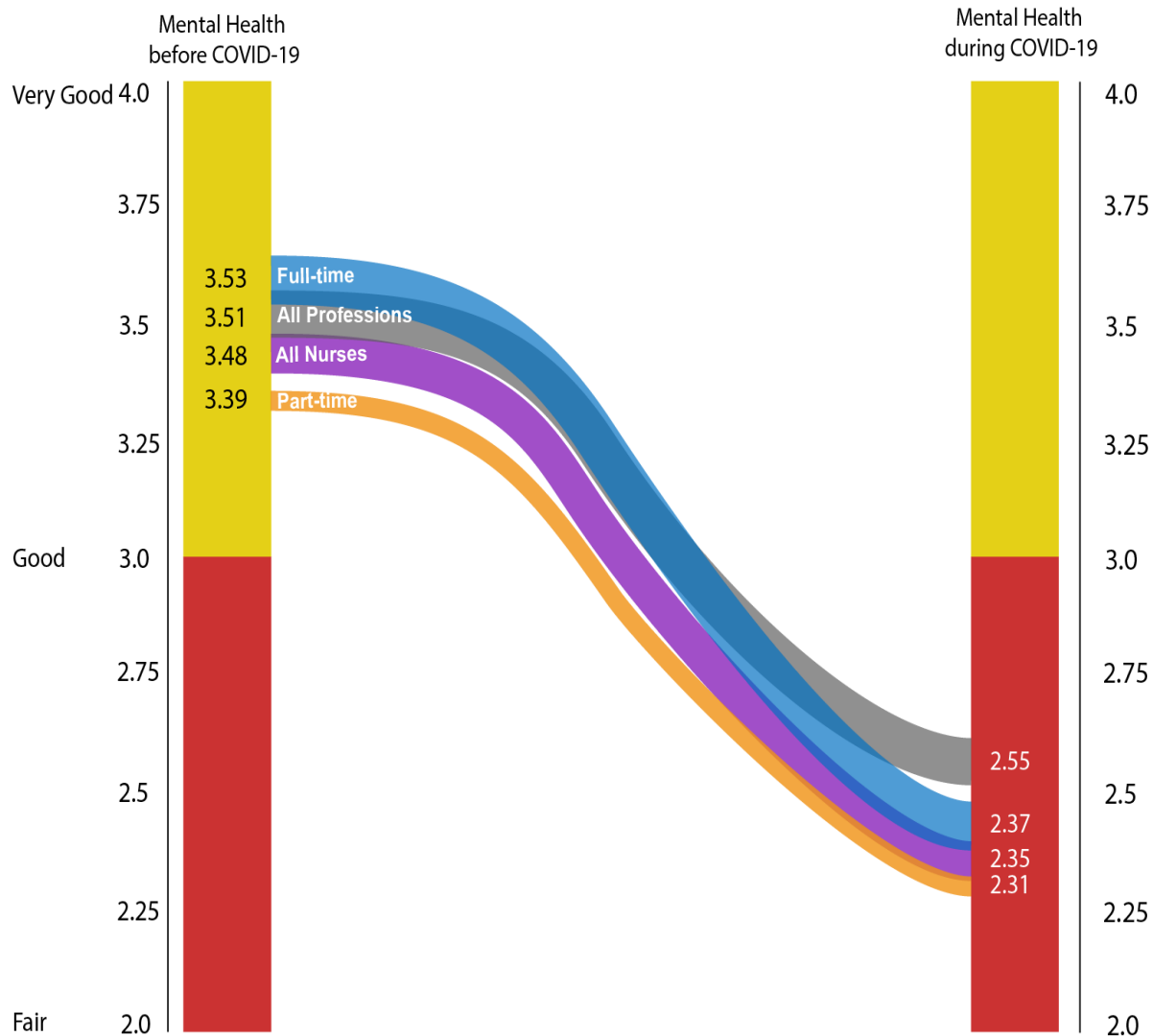
## Mental Health

### Figure 15 and

Figure 16 shows responses to the single-item measure asking participants to rate their mental health since the start of the pandemic and in the 4 weeks prior to the start of the pandemic. Response options were on a 5-point scale from 1 (poor) to 5 (excellent). Paired-samples *t*-tests indicated that nurses reported experiencing a significant decline in their mental health,  $t(984) = -33.37$ ,  $d = -1.07$ ,  $p < .001$ . By role type, effect sizes were largest for RPNs,  $t(111) = 11.84$ ,  $d = -1.20$ ,  $p < .001$ , followed by RNs,  $t(711) = -28.35$ ,  $d = -1.06$ ,  $p < .001$ , and APNs,  $t(99) = -9.81$ ,  $d = -0.98$ . Effect sizes were similar for full-time,  $t(610) = -26.90$ ,  $d = -1.09$ ,  $p < .001$ , and part-time nurses,  $t(309) = -17.70$ ,  $d = -1.01$ ,  $p < .001$ .

### Figure 15. Mental Health Before and During the Pandemic, By Gender and Contract Type

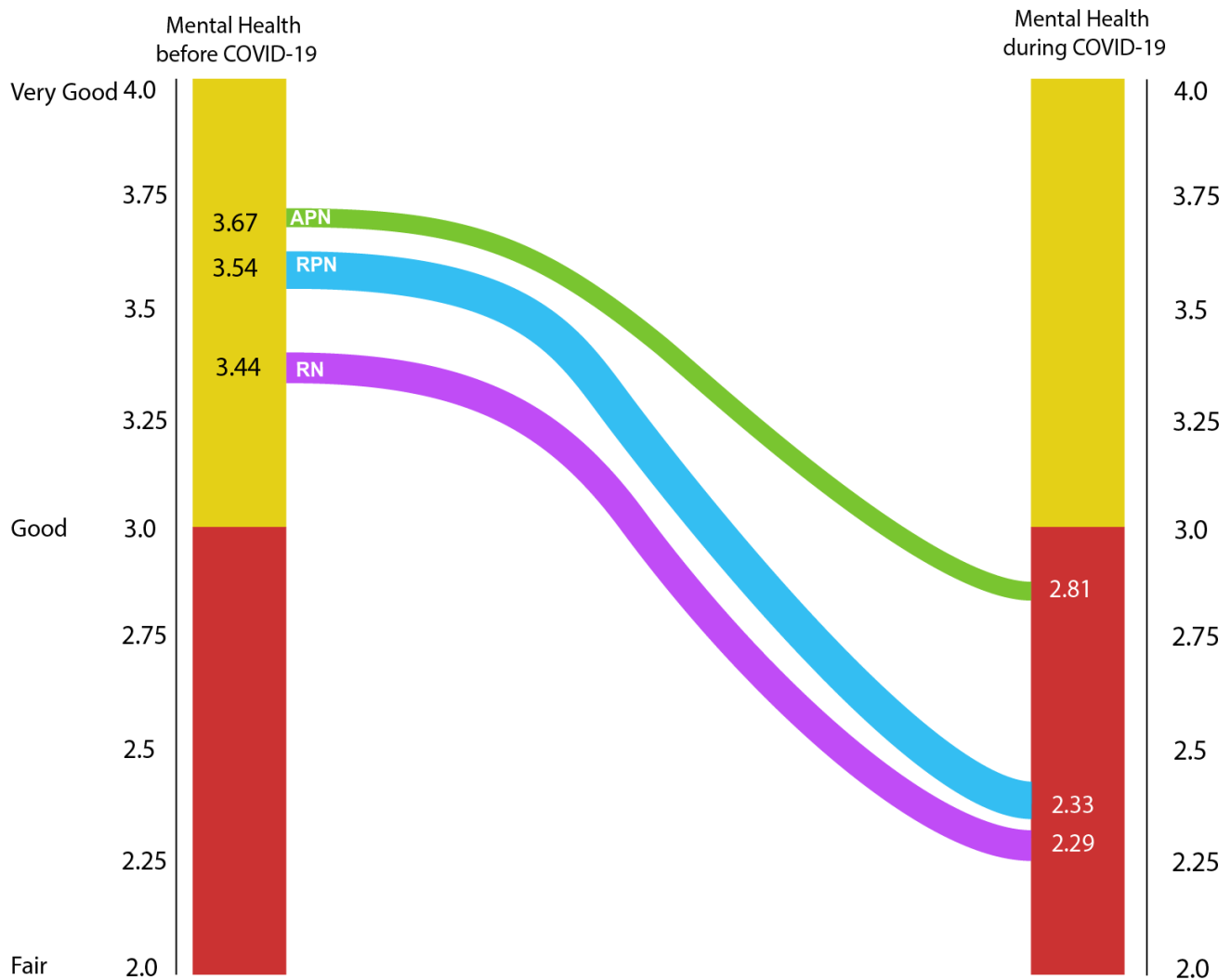
Examining mental health of nurses *prior to COVID*, independent-samples *t*-tests revealed



significant differences in reported mental health between full-time and part-time nurses,  $t(919) = 2.12, p = .03$ . A one-way ANOVA revealed that there were also significant differences reported in mental health between RNs, RPNs, and APNs,  $F(2, 921) = 2.92, p = .05$ . Follow-up *t*-tests indicated significant differences only between RNs and APNs,  $t(810) = -2.27, p = .02$ .

Examining mental health of nurses *during COVID*, independent-samples *t*-tests revealed no significant differences in mental health between full-time and part-time nurses,  $t(919) = 0.94, p = .35$ . A one-way ANOVA revealed significant differences in mental health between RNs, RPNs, and APNs,  $F(2, 921) = 13.02, p < .001$ . Follow-up *t*-tests indicated significant differences between RNs and APNs,  $t(810) = -5.13, p < .001$ , and between RPNs and APNs,  $t(210) = -3.50, p < .001$ .

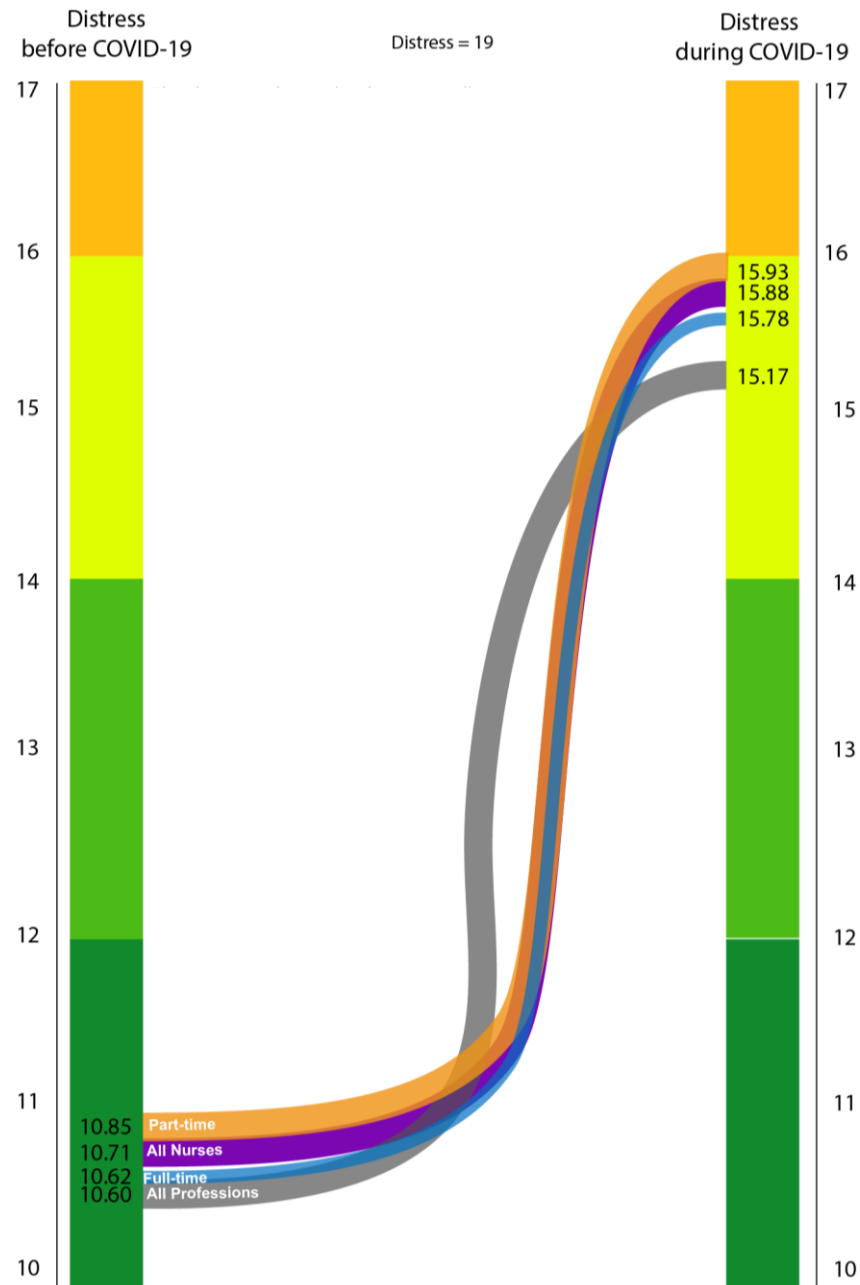
Figure 16. Mental Health Before and During the Pandemic, By Position Type



### Psychological Distress

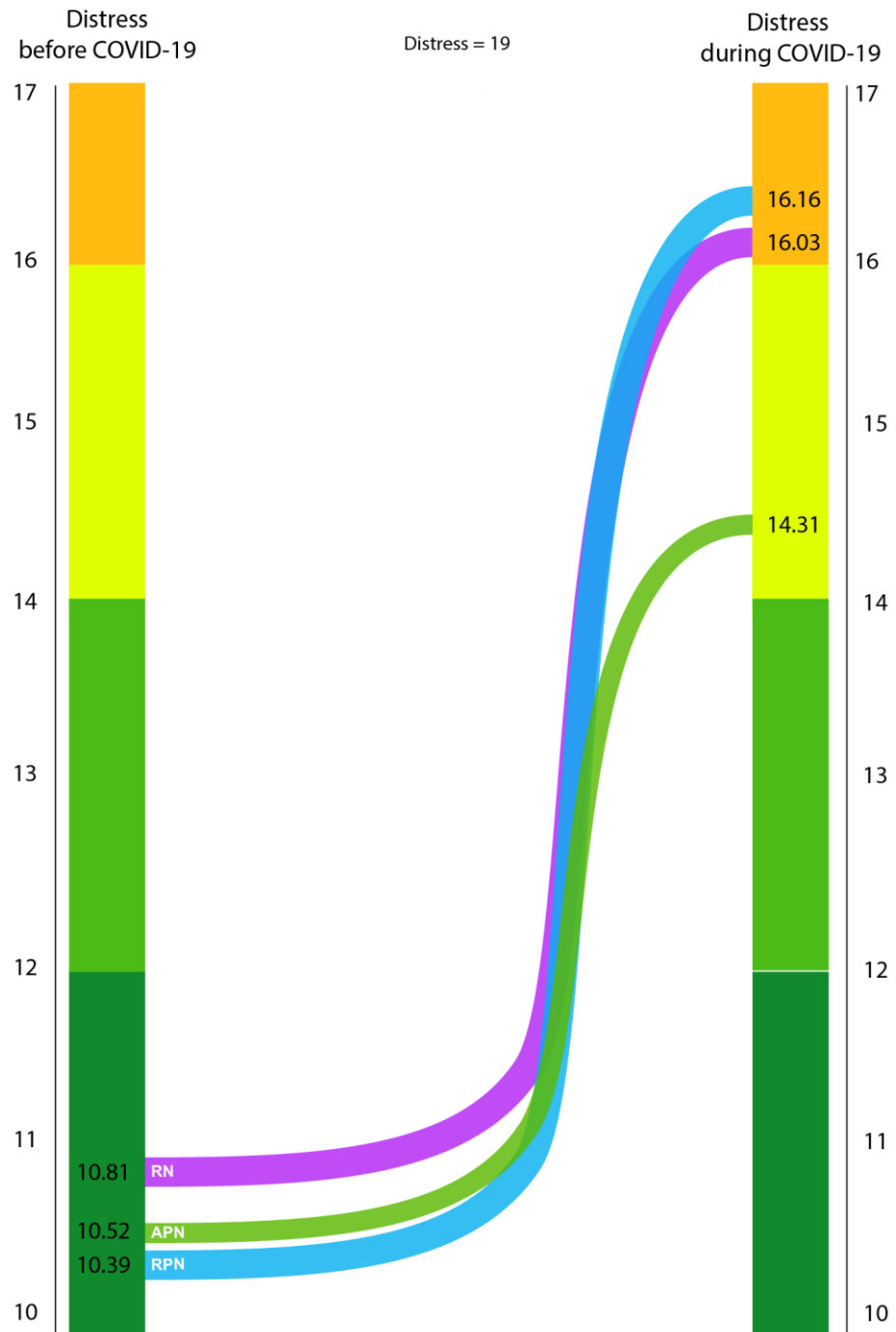
Figure 17 and Figure 18 shows responses to the Kessler Psychological Distress Scale (K6). Results indicated that nurses reported experiencing significant increases in psychological distress during the pandemic,  $t(977) = 34.81$ ,  $d = 1.11$ ,  $p < .001$ . This increase was significant for all groups of nurses. Effect sizes indicated only slight differences for full-time,  $t(606) = 26.37$ ,  $d = 1.07$ ,  $p < .001$ , as compared to part-time nurses,  $t(306) = 19.77$ ,  $d = 1.13$ ,  $p < .001$ , but the effect size for APNs,  $t(99) = 8.36$ ,  $d = 0.84$ ,  $p < .001$ , was notably lower as compared to RNs,  $t(705) = 29.96$ ,  $d = 1.13$ ,  $p < .001$ , and RPNs,  $t(110) = 11.92$ ,  $d = 1.13$ ,  $p < .001$ .

Figure 17. Psychological Distress Before and During the Pandemic, by Contract Type



Even though there were no significant differences between RNs, RPNs, and APNs prior to the pandemic,  $F(2, 916) = 0.55, p = .58$ , APNs reported experiencing less psychological distress during the pandemic,  $F(2, 917) = 5.98, p = .003$ , compared to RNs,  $t(806) = 3.40, p = .001$ , and compared to RPNs,  $t(210) = 2.88, p = .005$ . This also resulted in a smaller effect size for the increase in psychological distress for APNs.

Figure 18. Psychological Distress Before and During the Pandemic, by Position Type



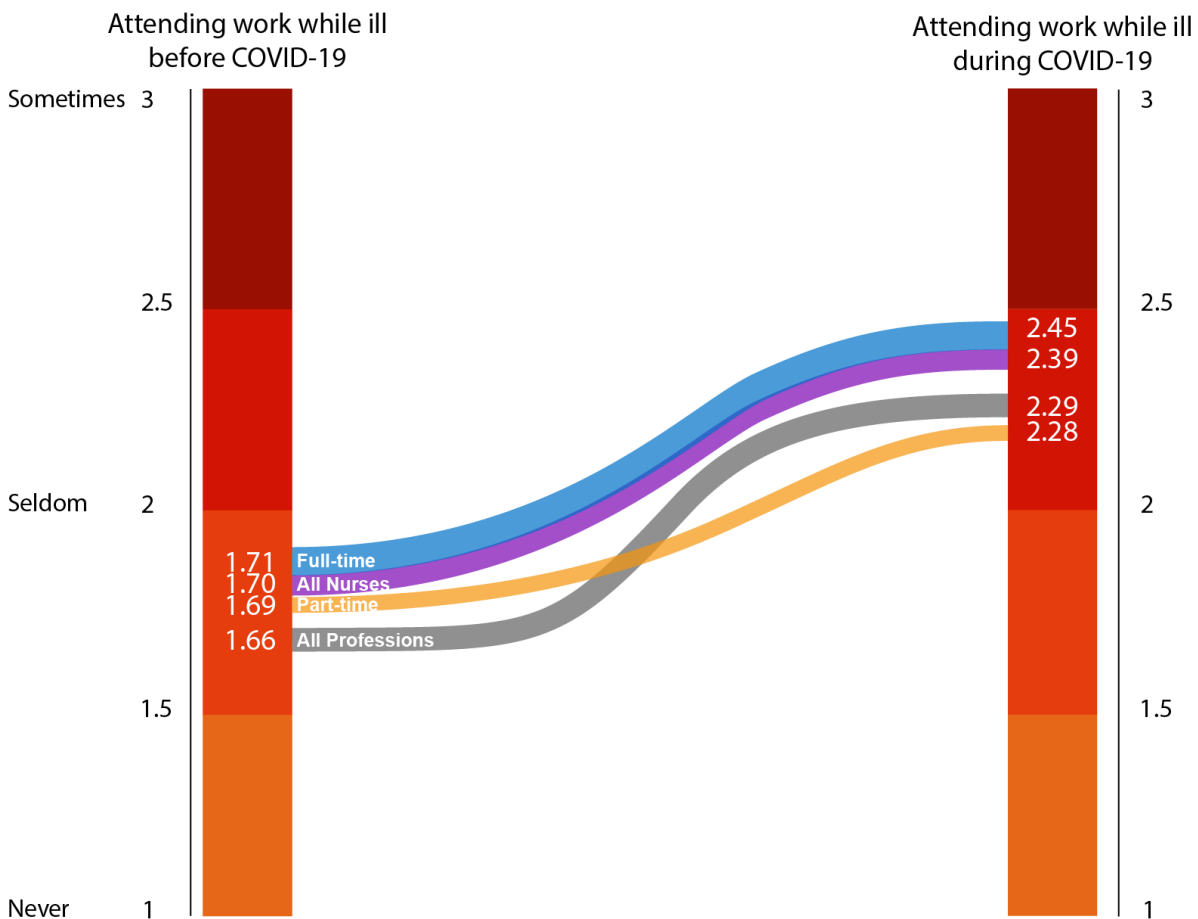
Presenteeism

Presenteeism was measured using a single item asking participant how often they had worked when they really should not have because of the state of their mental health. Responses were on a 4-point scale (1 = never, 2 = seldom, 3 = sometimes, 4 = often). Results (see Figure 19) indicated that nurses reported increased presenteeism during the pandemic,  $t(977) = 21.54, d = 0.69, p <$

.001. This increase was significant for all groups of nurses. Effect sizes were larger for full-time nurses,  $t(605) = 18.11$ ,  $d = 0.74$ ,  $p < .001$ , as compared to part-time,  $t(308) = 10.20$ ,  $d = 0.58$ ,  $p < .001$ , and largest for RPNs,  $t(110) = 8.79$ ,  $d = 0.83$ ,  $p < .001$ , followed by RNs,  $t(706) = 17.88$ ,  $d = 0.67$ ,  $p < .001$ , and then APNs,  $t(99) = 5.67$ ,  $d = 0.51$ ,  $p < .001$ .

Examining presenteeism of nurses *prior to COVID*, independent-samples  $t$ -tests revealed no significant differences in presenteeism between full-time and part-time nurses,  $t(914) = 0.32$ ,  $p = .75$ . A one-way ANOVA revealed no significant differences in presenteeism between RNs, RPNs, and APNs,  $F(2, 916) = 0.16$ ,  $p = .86$ .

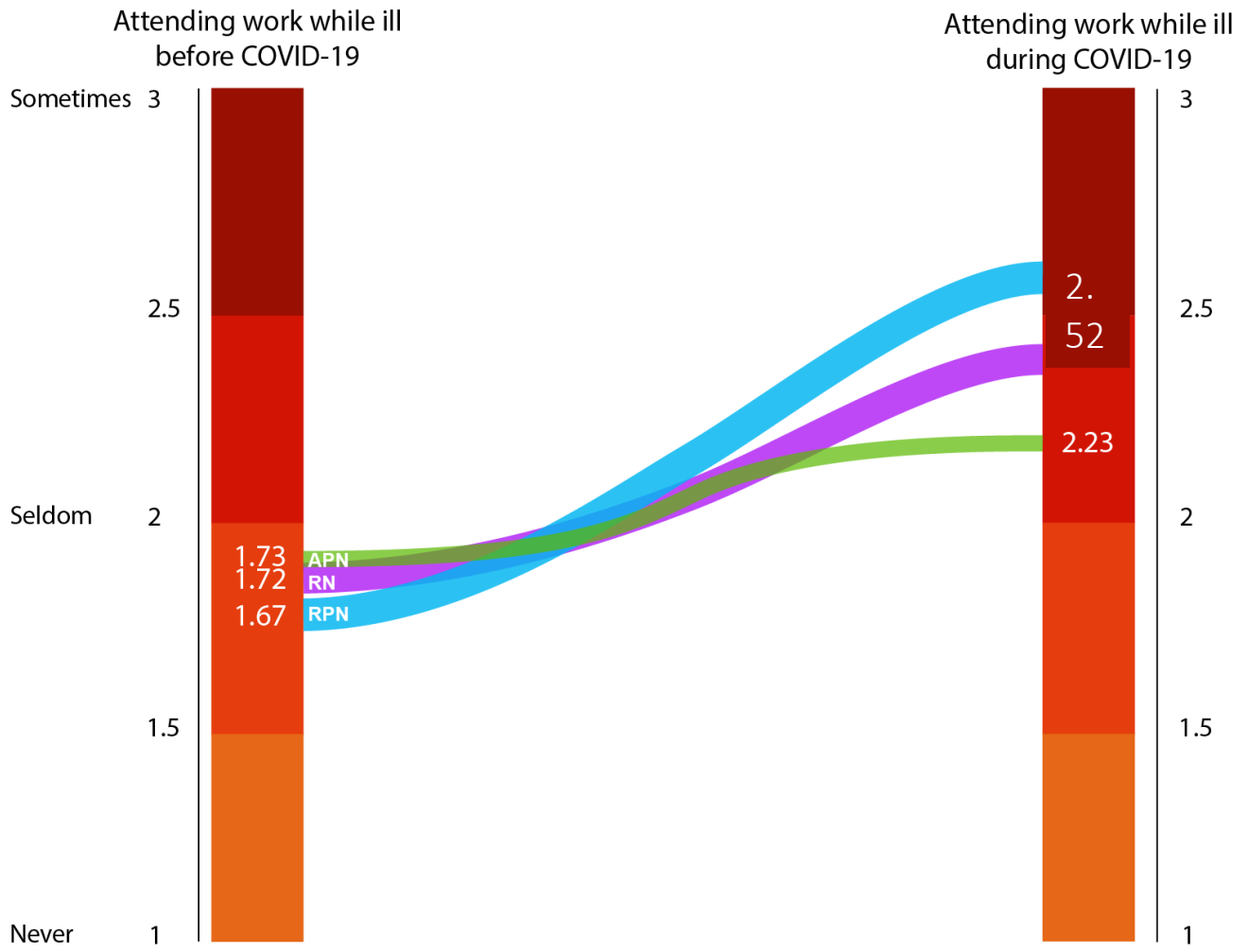
Figure 19. Presenteeism Before and During the Pandemic, by Contract Type



Examining presenteeism of nurses *during COVID*, independent-samples  $t$ -tests revealed significant differences in presenteeism between full-time ( $M = 2.45$ ,  $SD = 1.04$ ) and part-time nurses ( $M = 2.28$ ,  $SD = 1.05$ ),  $t(914) = 2.18$ ,  $p = .03$ . A one-way ANOVA revealed no significant differences in presenteeism between RNs ( $M = 2.40$ ,  $SD = 1.03$ ), RPNs ( $M = 2.52$ ,  $SD = 1.08$ ), and APNs ( $M = 2.23$ ,  $SD = 1.04$ ),  $F(2, 918) = 2.04$ ,  $p = .13$ .



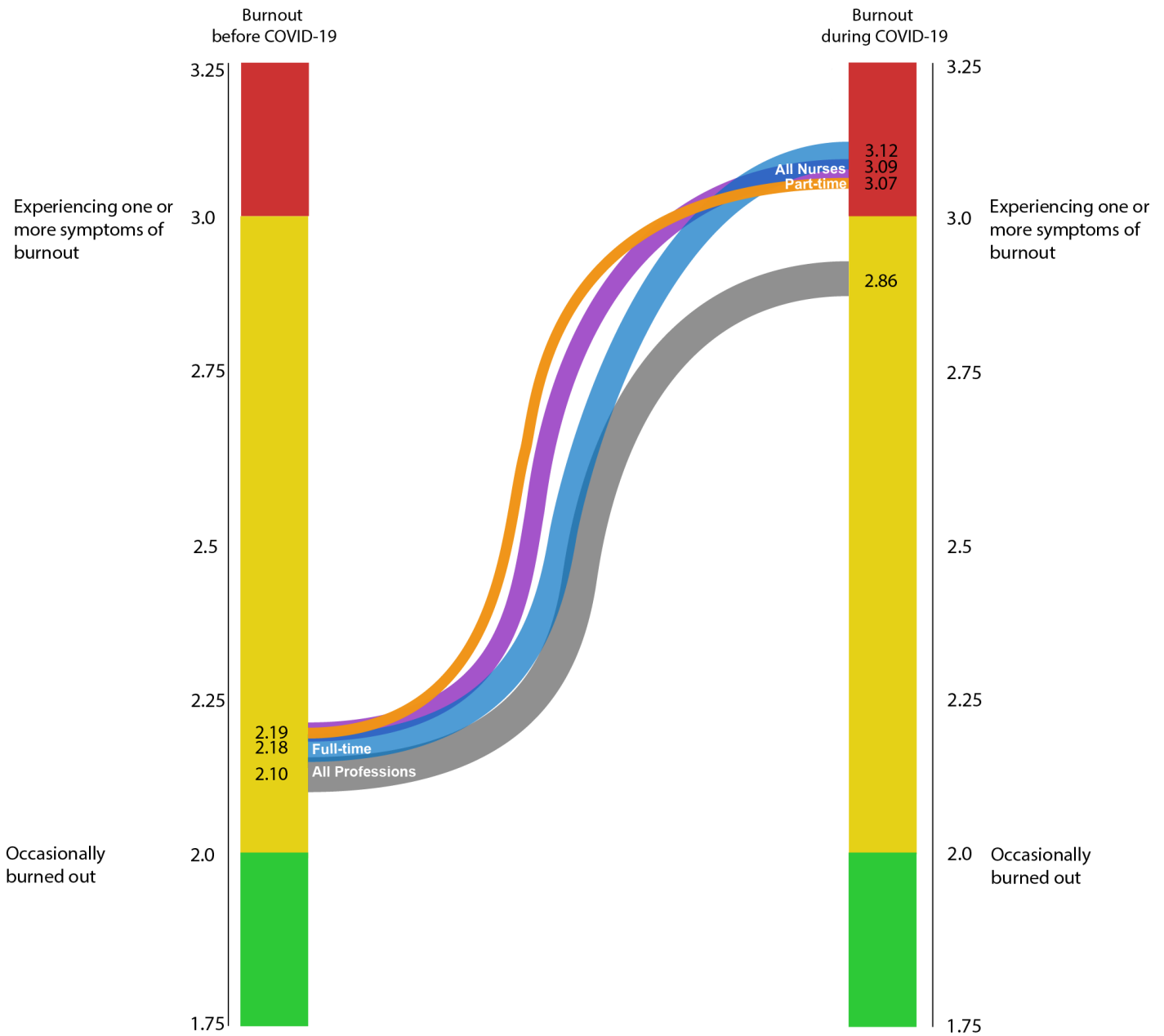
Figure 20. Presenteeism Before and During the Pandemic, by Position Type



Burnout

Based on responses to the single item taken from the Physician Worklife Survey, nurses reported increased rates of burnout,  $t(977) = 25.53, d = 0.82, p < .001$ , during the pandemic (see Figure 21). This increase was significant for all groups of nurses with effect sizes being somewhat larger for full-time,  $t(605) = 21.49, d = 0.87, p < .001$ , as compared to part-time nurses,  $t(308) = 13.15, d = 0.75, p < .001$ , and somewhat smaller for APNs,  $t(99) = 7.79, d = 0.78, p < .001$ , as compared to RNs,  $t(707) = 21.74, d = 0.82, p < .001$ , and RPNs,  $t(110) = 9.40, d = 0.89, p < .001$ .

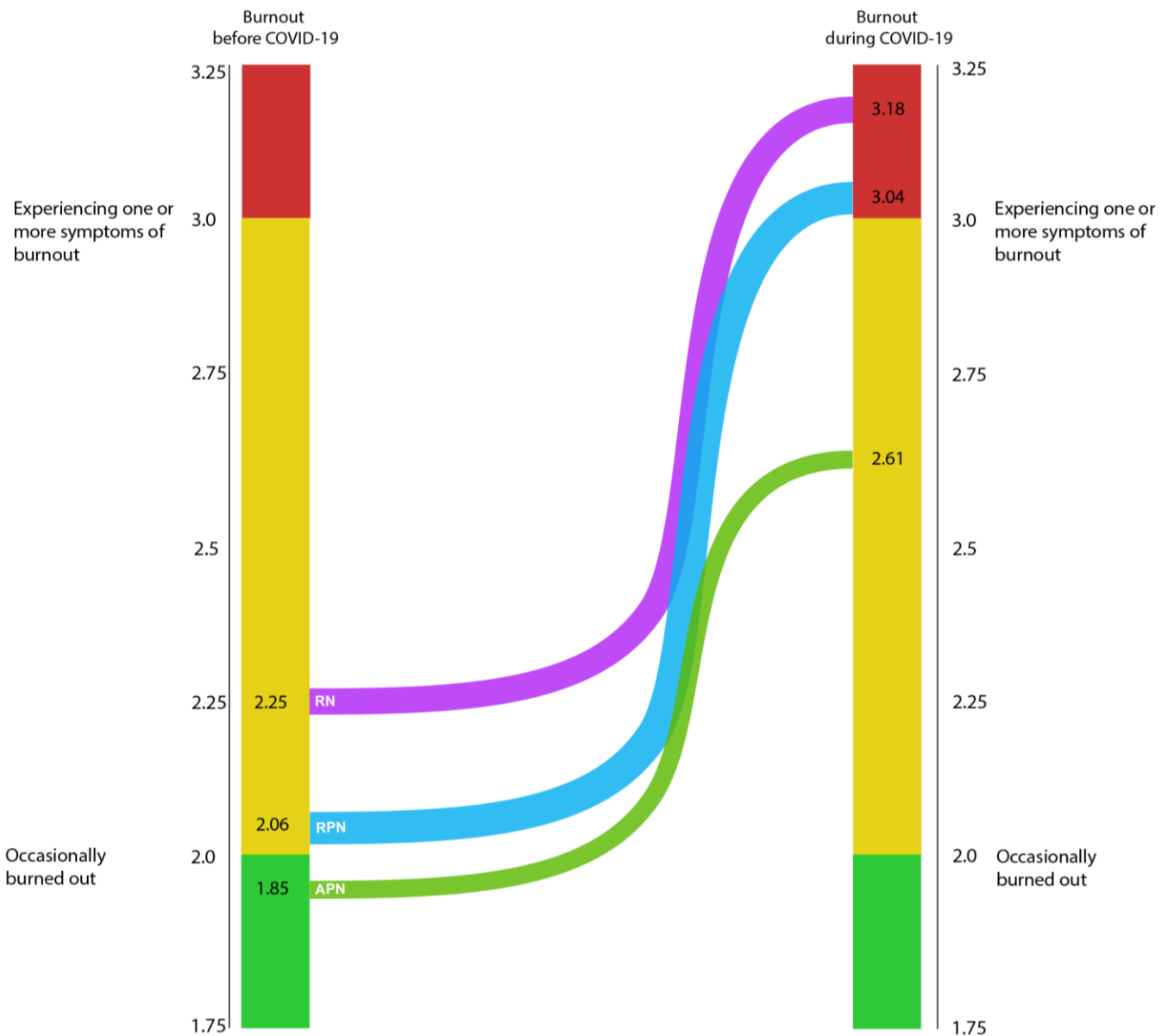
Figure 21. Burnout Before and During the Pandemic, by Contract Type



Examining burnout of nurses *prior to COVID*, independent-samples *t*-tests revealed no significant differences in burnout between full-time and part-time nurses,  $t(917) = -0.25, p = .81$ . A one-way ANOVA revealed significant differences in burnout between RNs, RPNs, and APNs,  $F(2, 920) = 7.87, p < .001$ . Follow-up *t*-tests indicated a significant difference between RNs and APNs,  $t(810) = 3.67, p < .001$ .

Examining burnout of nurses *during COVID*, independent-samples *t*-tests revealed no significant differences in burnout between full-time and part-time nurses,  $t(914) = 0.61, p = .54$ . A one-way ANOVA revealed significant differences in burnout between RNs, RPNs, and APNs,  $F(2, 916) = 11.35, p < .001$ . Follow-up *t*-tests indicated a significant difference between RNs and APNs,  $t(806) = 4.69, p < .001$ , and between RPNs and APNs,  $t(209) = 2.94, p = .004$ .

Figure 22. Burnout Before and During the Pandemic, by Position Type



## Summary & Next Steps

### **Pathway from Mental Health to Leaves of Absence and Return to Work:**

Most nurses (67%) reported experiencing a mental health issue over the course of their career or training:

- ✓ More RNs reported having experienced a mental health issue (70% of RNs, 59% of RPNs, 59% of APNs).
- ✓ There were no significant differences between part-time and full-time nurses or between RNs, RPNs, and APNs in terms of making changes to work, considering taking a leave of absence, or taking a leave of absence.
- ✓ Full-time nurses were significantly more likely to return to the work they were doing prior to their leave of absence compared to part-time nurses (78% of full-time, 66% of part-time).

For the 674 nurses who did report having a mental health issue:

- ✓ 65% made changes to their work.
- ✓ 59% considered taking a formal leave of absence from work.
- ✓ 38% took a formal leave of absence from work.
- ✓ 74% who took a formal leave of absence returned to the same work as prior to their leave.

What types of changes did nurses report making?

- ✓ The most frequently reported changes were retreating from work by taking sick days or vacation (41%), seeking help from a medical doctor (40%), and seeking help from an allied health professional (36%).
- ✓ Only a small percentage (11%) of nurses sought support from their union or formal accommodations from their employer (9%).
- ✓ More part-time nurses (27%) than full-time nurses (14%) reported reducing their workload.
- ✓ Compared to RNs and APNs, a significantly lower percentage of RPNs reported seeking help from an allied health professional or changing units.

What were the top reasons for NOT taking a leave of absence?

- ✓ 57% – Believed their mental health issue was severe enough
- ✓ 45% – Professional impact
- ✓ 44% – Financial Reasons
- ✓ Compared to RNs and APNs, RPNs were significantly more likely to report that financial reasons were a reason for not taking leave.

What were the top facilitators of and barriers to taking a leave of absence?

- ✓ Top facilitators were having financial support while on leave (36%), having supportive colleagues (27%), and having a supportive supervisor (24%).
- ✓ The top barriers to taking a leave was having an unsupportive supervisor (27%).

What were the top facilitators of and barriers to returning to work?

- ✓ The top facilitator of returning to work was having supportive colleagues (42%).
- ✓ Having a supportive supervisor was important – 29% indicated having a *supportive* supervisor was a facilitator and 33% indicated having an *unsupportive* supervisor was a barrier to returning to work.

### **Impact of the COVID-19 Pandemic:**

Mental health declined and psychological distress, presenteeism, and burnout significantly increased during the pandemic for all sub-groups of nurses. Effect sizes for declines in mental health were large for all sub-groups of nurses.

- ✓ Full-time nurses reported better mental health prior to the pandemic as compared to part-time nurses, but there were no differences during the pandemic.
- ✓ APNs reported significantly better mental health both prior to and during the pandemic compared to RNs.
- ✓ RPNs reported the largest decline in mental health followed by RNs and APNs.

All sub-groups of nurses reported significantly more psychological distress during the pandemic, and effect sizes were large.

- ✓ Prior to the pandemic, there were no differences in distress between RNs, RPNs, and APNs, but this changed during the pandemic with RNs and RPNs reporting more distress compared to APNs.
- ✓ Effect sizes for the increase in distress were notably higher for RNs and RPNs as compared to APNs.

The pandemic increased how often nurses worked while ill (i.e., increased presenteeism).

- ✓ Effect sizes for increases in presenteeism were larger for full-time nurses compared to part-time nurses.
- ✓ Increases were largest for RPNs followed by RNs and APNs.
- ✓ Differences between full-time and part-time nurses were not significant prior to the pandemic, but greater increases in presenteeism resulted in full-time nurses reporting significant more presenteeism during the pandemic.

Average scores of burnout increased from close to 2 (*occasionally I am under stress and I don't always have as much energy as I once did, but I don't feel burned out*) up to 3 (*I am definitely burning out and have one or more symptoms of burnout, such as physical and emotional exhaustion*) on a 5-point scale from 1 to 5.

- ✓ Prior to the pandemic, there were significant differences between RNs, RPNs, and APNs, with RNs reporting the highest average level of burnout followed by RPNs and APNs.

- ✓ During the pandemic, larger increases in reported burnout for RNs and RPNs meant that APNs reported lower average burnout than both RNs and RPNs, but there were no longer differences between RNs and RPNs.

The survey findings we have presented offer an informative view of issues facing nurses with mental health challenges, for which we will next tap into the rich dataset provided by the in-depth interviews with stakeholders and nurses. By combining this survey analyses with the qualitative analyses of our in-depth interviews we can develop interventions specific to the nursing work context.

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## Endnotes

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i Organisation for Economic Co-operation and Development [OECD]. (2012). *Sick on the job?: myths and realities about mental health and work*. OECD Publishing.

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