Adaptive Mentoring Networks: Mentees' Perceived Barriers to Managing Chronic Pain, Substance Use and Mental Health

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Introduction

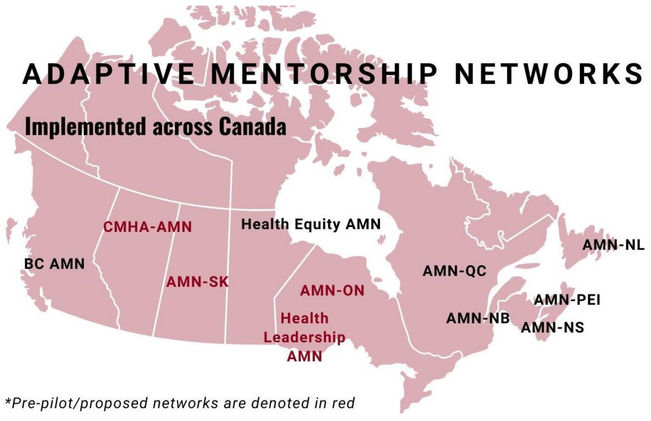
Background:

- Chronic pain (CP), mental health (MH), and substance use (SU) are complex and often intertwined medical issues causing significant morbidity and healthcare spending across Canada.[1]
- Barriers to effective treatment include poor accessibility based on patient socioeconomic factors[2-4] and low self-efficacy among care providers for managing these complex concerns.[5-7]
- Adaptive Mentorship Networks (AMNs) are a Canadian innovation to improve primary care capacity and provide compassionate, quality care for those with CP, MH, and SU concerns.
- Members of the AMNs differ in profession, clinical resources, and location. Understanding perceived care barriers and their link to clinical experience can guide targeted improvements, including professional development and regional policies.

Aim: The aim of this study is to examine associations between perceived barriers to care, and proportion of time spent in practice on CP, MH and SU among mentees in AMNs across Canada.

Methods

- This is an observational study based on survey data from mentees in AMNs in British Columbia (BC), New Brunswick (NB), Newfoundland & Labrador (NL), and Prince Edward Island (PEI).



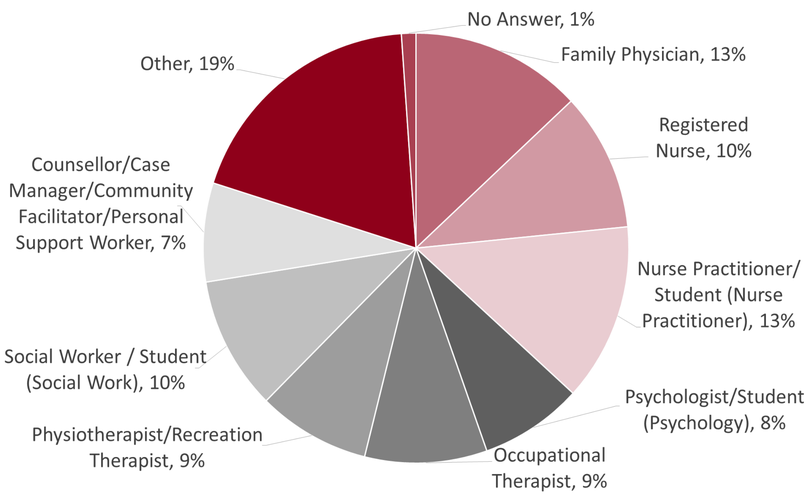
*Pre-pilot/proposed networks are denoted in red

- Survey data on time spent in practice and perceived barriers to care were collected from mentees from AMNs prior to entering the program in 2023 and 2024
- Descriptive statistics were calculated for each of the identified barriers and time spent in practice.
- **Analysis plan:** Hierarchical regressions were conducted with proportion of time spent managing CP, SU, and MH concerns as criterion variables. Rurality was entered into as a covariate and, perceived barriers were entered using a statistical criterion for entry which was set at $p<.05$.

Results

Participants Practice Characteristics

- **169 providers from NB, NL, and PEI (n=124) and BC (n=45) participated.**
- The mentees were from a variety of health professions:



Note: Other - Specialist Physician, Licensed Practical Nurse, Pharmacist/ Physiologist, Acupuncturist, Chiropractor, Kinesiologist, Dietitian, Osteopath, Registered Massage Therapist, Researcher/ Student/Policy Coordinator

- 55% of mentees spent **more than half** of their clinical time managing MH concerns.
- 23% spent **more than half** of their clinical time managing SU.
- 26% spent **more than half** of their clinical time managing CP.

Most Commonly Endorsed Barriers

Systemic Barrier	Respondents (n)	n(%) of Mentee's who endorsed it
Lack of timely access to specialty clinics	136	122 **(89.7)**
Lack of public funding for non-pharmacological therapies (chiropractic, massage, etc.)	127	104 **(81.9)**
Lack of access to psychological therapies including motivational interviewing and cognitive behavioural therapy	137	104 **(75.9)**
Lack of coordination when multiple providers are involved in the clients/patient's care	138	95 (68.8)
Lack of public funding for alternative pharmacotherapies such as topical therapies	111	70 (63.1)
Lack of access to referrals for clients/patients	126	52 (41.3)
None of my local colleagues do this kind of work and I don't have coverage while off or away	101	38 (37.6)
Lack of remuneration/specific billing codes	88	32 (36.4)
I have no way to do drug testing in my practice	88	23 (26.1)

Associations with Time Spent in Practice

- Mentees who spent **more time managing CP** were more likely to endorse **accessing specialty care** as a barrier, 37%vs.21%, $F(1,166)=9.651, p=.002, R^2=.056$.
- Mentees who spent **more time managing SU** were more likely to endorse **accessing specialty care** as a barrier, 50%vs.27%, $F(1,166)=15.065, p<.000, R^2=.084$.
- Mentees who spent **less time managing SU** were more likely to endorse **insufficient referrals** as a barrier 38%vs.47%, $F(1,165)=8.996, p=.003, R^2=.047$.
- Mentees who spent **more time managing MH** were more likely to endorse as barriers:
  - **insufficient coverage of non-pharmacological therapies**, 51%vs.27%, $F(1,166)=14.910, p<.000, R^2=.086$,
  - **funding for alternative pharmacotherapies**, 40%vs.21%, $F(1,165)=11.047, p=.001, R^2=.057$,
  - **lack of care coordination**, 41%vs.21%, $F(1,164)=4.815, p=.030, R^2=.024$
- **Practicing in urban or rural settings** was not a significant predictor of time spent managing CP, MH, or SU care.

Discussion

- **Barriers to providing effective care were commonly endorsed by mentees.**
- **CP, SU and MH Management – Mentees reporting:**
  - Mentees who spent more time managing CP were more likely to report limited access to specialty clinics, highlighting gaps in referral pathways.
    - Tailored educational content and mentoring around referral pathways and non-pharmacological options may help mitigate this barrier.
  - Mentees reporting limited specialty clinic access and insufficient referrals spent significantly more time managing SU concerns, suggesting a particular gap of addiction specialists and support systems in SU care.
  - Mentees reporting barriers in coverage for time away, funding for non-pharmacological therapies, and care coordination spent more time managing MH, indicating the need for integrated and well-supported multimodal mental health services.
- Endorsement of systemic barriers were similar in rural and urban practice settings.

Future Directions

- Continuing professional education is needed that effectively provides knowledge about regional referral options for managing CP, SU and MH concerns, and eligibility requirements, with particular emphasis placed on non-pharmacological options.
- Policy makers and governing bodies can look at supports for specialized clinics, supports for care coordination, and better funding of non-pharmacological options.

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