Title: “A valid mixture of anxiety, despair, rage, grief”: Canadian clinician perspectives on climate-related extreme weather impacts and mental health

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Abstract

Climate change has been increasingly recognized as a determinant of mental health, yet limited research has examined how mental health care systems and clinicians are perceiving and responding to the impacts. This study explores the experiences of clinicians supporting people with mental health conditions in relation to climate change and extreme weather events (EWEs).

We conducted a cross-sectional qualitative descriptive study using four virtual focus groups with 25 clinicians in Ontario, Canada, representing diverse professional backgrounds. Semi-structured discussions explored clinicians' observations of climate-related impacts on patients, implications for clinical practice, and perspectives on individual- and system-level responses. Transcripts were analyzed using a codebook-based thematic analysis.

Clinicians reported a range of climate-related mental health impacts on patients, including climate anxiety, existential distress, suicidality, sleep disruption, and agitation during EWEs. Youth and women were perceived as particularly affected, with climate concerns shaping future outlooks and reproductive decision-making. Participants also described physical health vulnerabilities linked to medications, substance use, and social inequities. Clinicians experienced frustration and moral distress, and limited preparedness to address climate-related challenges.

Clinicians in Canada are already responding to the consequences of climate change within resource-constrained health care systems. Strengthening climate-informed training, addressing social determinants of vulnerability, and supporting clinician wellbeing and readiness are critical steps towards building climate-resilient mental health care.

1. Introduction

The link between changing weather patterns and mental health has received increasing public policy and scientific attention in recent years. In 2022, mental health has been acknowledged for the first time in Canada's National Adaptation Strategy in developing climate-resilient communities [1]. In the same year, the World Health Organization (WHO) published the first policy brief calling for action to address the mental health impacts of the climate crisis [2]. Primary studies have consistently identified increased incidence of depression, anxiety, and post-traumatic stress disorders (PTSD) in climate disaster settings, including wildfires [3] and flooding [4]. Epidemiological studies further suggest increased psychiatric presentations to hospitals during extreme temperatures related to self-harm and suicidal behaviours [5], psychosis exacerbation [6,7], and substance use [7].

Clinicians caring for people with mental health conditions are more than ever facing the burden that climate change directly and indirectly places on their patients and the associated rise in service utilization [8]. In response, a growing body of literature has provided practice-oriented considerations and clinical recommendations for climate-sensitive mental health care, including for nurses [9], pediatricians [10], and emergency medicine clinicians [11]. Professional organizations, including major psychiatric associations, have also issued position statements that recognize climate change as a mental health determinant and urge psychiatrists to engage in mitigation, adaptation, education, and advocacy efforts [12, 13, 14, 15]. In this context, however, additional empirical understanding of how clinicians directly perceive and experience climate-related impacts in their daily practice would provide insights into how mental health-related services can realistically prepare and adapt.

A small number of research studies have begun to explore clinicians' perceptions of climate change [16, 17]. Existing studies suggest that clinicians generally acknowledge the health

implications of climate change, but most commonly identify concerns with physical health conditions such as vector-borne, respiratory, and cardiovascular diseases, and allergic symptoms [18]. Two studies, conducted in the United Kingdom and Turkey, specifically explored perspectives on climate change among clinicians of mental health services [16,19]. Clinicians in both settings reported observing increased exposure to and complexity of climate change-related mental health presentations, ranging from emotional distress to aggressive behaviours, while the Turkish study additionally identified hopelessness, pessimism, and burnout among the clinician workforce [19]. Neither study examined the ways in which clinicians may be better supported in meeting the changing clinical demand.

Although climate change is a global challenge, its form and health impacts can vary widely depending on region [20]. An improved understanding of region-specific perspectives from frontline clinicians would be a critical step toward building a climate-resilient mental health system. Accordingly, the aim of this study is to explore how Canadian clinicians perceive the impacts of climate change and related extreme weather events (EWEs) on people with mental health conditions. To bridge the knowledge gap, we further explore how the clinicians view their own and their institution's roles in addressing these challenges, and what specific recommendations they have in order to inform education practices, resource allocation, and appropriate integration of climate considerations into mental health care.

2. Methods

2.1. Study context

This cross-sectional, qualitative study was conducted in Southern Ontario, Canada. According to the 2023 Ontario Provincial Climate Change Impact Assessment Technical Report, the province has experienced increased mean annual temperature and precipitation over the last decades. Climate models further project continued temperature rises and greater variability in

weather patterns, including floods, forest fires, heatwaves, and temperature extremes [21]. These conditions have already affected communities across Ontario and are expected to place increasing strain on populational mental health. Southern Ontario, as the most densely populated region of the province and a major hub for healthcare delivery, represents a critical setting to examine how climate-related pressures are experienced by the mental health care system and the clinicians within. Ethical approval of this study was obtained from the Research Ethics Board of the Centre for Addiction and Mental Health (CAMH) (#2024/143), located in Toronto, the largest metropolitan centre in Southern Ontario and Canada.

Throughout this paper, we define climate change as a long-term phenomenon and EWEs as the proximate conditions through which climate change is experienced in daily life. While extreme heat and cold have always characterized the Southern Ontario climate, climate change is understood to amplify the frequency, intensity, and duration of such events. Clinicians' accounts in this study primarily reflect their experiences of caring for patients during EWEs, which are interpreted within the broader context of a changing climate.

2.2. Qualitative approach and research paradigm

Given the limited empirical research examining clinicians' perspectives on climate-related mental health impacts in Canada, we chose a qualitative design using focus groups to capture reflections, emergent concerns, and practice-based insights not easily elicited through quantitative methods. Focus groups were selected specifically to facilitate interprofessional dialogue and collective sense-making around climate-related clinical challenges and responses within mental health care.

We adopted an approach grounded in a constructivist–interpretivist research paradigm, which assumes that clinicians' understandings of climate change are socially situated and shaped

through professional experience, organizational context, and interaction with their patients. It was designed as a companion to a parallel qualitative exploration of how people living with mental health conditions in Ontario experience climate change and EWEs, currently under peer review. The paired studies enable an examination of complementary perspectives on shared system pressures and points of convergence and divergence between service users and providers.

2.3 Researcher characteristics and reflexivity

Focus groups were co-facilitated by two researchers (SX and LML) with experience in climate change and mental health research and training in qualitative methods. SX is a practicing psychiatrist, which facilitated familiarity with professional language and care delivery structures, and enabled the use of contextually relevant prompts. The clinical insider position may have shaped assumptions regarding practice norms. LML, a researcher with an advocacy background, brought an external and service-user-oriented perspective to the discussions, including through clarifying questions on implicit clinical assumptions.

Both facilitators identify as racialized women. While racial and gender identities may influence rapport, perceived authority, and interactional dynamics in qualitative research, their influence was considered alongside professional roles and institutional positioning. Neither facilitator held supervisory or evaluative roles over participants. However, some participants were professional colleagues within shared clinical settings, which may have influenced group dynamics or constrained expression of dissenting views.

Reflexivity during data collection and interpretation was supported through discussions with team members with expertise in lived experience of mental health and addiction (CM) and qualitative patient-oriented mental health research (LDH). Other team members with interdisciplinary expertise in psychiatry, psychology, and public mental health critically reviewed

the analyses and manuscript to support nuanced interpretation of clinicians' accounts.

2.4. Participant sampling and recruitment

Individuals who delivered direct clinical care to people with mental health conditions in Southern Ontario, Canada were eligible to participate. A broad definition of clinical care was employed, as we recognize that mental health services are delivered across hospital, community, emergency, long-term care, and other practice settings and by a range of regulated and non-regulated health professionals. Eligibility was therefore based on participants' self-identification as clinicians who served, though not necessarily exclusively, people with mental health conditions. Participants were recruited using convenience and snowball sampling strategies between March to July 2025. The research team identified potential participants through existing professional networks and contacted them by email. Recruitment materials described the study purpose and invited clinicians from diverse practice settings to participate, with particular emphasis on those working with groups disproportionately exposed to climate-related risks (e.g., youth, older adults, Indigenous communities, and people experiencing unstable housing). Clinicians were also encouraged to share the invitation with eligible colleagues. All participants provided written informed consent prior to participation.

2.5. Data collection

The semi-structured focus group guide used in this study mirrored the patient-facing guide in the companion study and was developed with guidance from the CAMH Lived Experience Research Committee (LERC), composed of mental health service users. Interview questions were refined and piloted with committee members to ensure relevance, clarity, and sensitivity. The guide explored three domains: (1) clinicians' observations of patients' direct and indirect experiences with climate change and EWEs; (2) perceived impacts on patients' mental health, daily

functioning, and access to care; and (3) views on clinical- and system-level responses, including adaptations to existing services and the need for new interventions.

Focus groups were conducted virtually using a secure WebEx platform to facilitate participation across different institutions. Consent for audio-recording was re-confirmed at the start of each focus group, which were transcribed verbatim using WebEx automated transcription and subsequently reviewed and verified for accuracy by LML. All transcripts were de-identified prior to analysis. Focus groups were conducted until sufficient depth and redundancy of perspectives were achieved across sessions.

2.6. Data analysis

Transcripts were managed using NVivo 12 and analyzed using a codebook-based thematic analysis approach [22]. Primary coding was conducted by SX and LML, guided by an initial coding framework developed based on the study objectives, focus group guide, and preliminary readings of the transcripts. The framework incorporated both deductive codes aligned with the interview domains and inductive codes grounded in participants' accounts.

Coding and interpretation were refined through a series of analytic meetings with CM and LDH. These meetings provided a forum to discuss code definitions and areas of ambiguity or disagreement. Differences in interpretation were explored through dialogue. CM's lived experience expertise played a key role in identifying meanings that warranted greater analytic attention and situating clinicians' accounts in relation to service user experiences. Through iterative revisions of the coding framework, codes were organized into broader themes that reflected recurrent and salient patterns across focus groups.

3. Results

A total of twenty-five (25) participants engaged in four (4) focus group discussions, each lasting approximately 45 to 50 minutes. The participants represented a diverse array of professional backgrounds. The largest professional background represented was physicians (n=12), among whom 8 were psychiatrists, followed by social workers (n=4), nurses (n=3), pharmacists (n=2), program assistants (n=2), an occupational therapist (n=1), and a recreation therapist (n=1). The majority of participants (n=22) were based in academic hospitals in Toronto.

We identified four overarching themes. First, participants observed climate-related impacts on patients' mental health, ranging from emotional distress to suicidal ideation. Second, clinicians described physical health consequences of EWEs among patients with mental health conditions, particularly where psychiatric treatment, comorbid substance use, and social inequities heightened vulnerability. Third, clinicians shared their own emotional responses arising from providing mental health care in facing increasing climate-related pressures. Fourth, participants reflected on ways they have provided recommendations for change to address climate-related risks within mental health care systems.

3.1. Observed mental health consequences of climate-related stressors

Participants described their experiences with a range of strong emotions expressed by their patients. Some observed that their younger patients more readily discuss climate change-related stressors during outpatient mental health encounters, and are grappling with *"deep existential questions around stability… with a valid mixture of anxiety, despair, rage, grief" [ID#1].* Another participant gave an example of a young patient expressing that climate change significantly impacted her mental health, leading her to contemplate suicide as an extreme means to compensate for overpopulation and overconsumption, a theme echoed in the online communities she frequented. Participants discussed that climate change may be

disproportionately impacting youth mental health, considering young people's greater access to climate-related information and heightened perceptions of threat to their future wellbeing:

> *"I think the unique aspect is that they're young so that climate change has a specific meaning for them – their future. And how we address the climate now reflects on how much we value the younger generation." [ID#2]*

In addition to young people, participants observed the emotional impact of climate change on their women patients. Multiple participants described their women patients' reluctance to have children due to the prevailing sentiment that *"the world is…[approaching] doomsday" [ID#3]*:

> *"I find just in general, some of the women I've worked with and even my own experience… People are hopeless about what's going to happen in this world… The next generations to come. Is it worth it even having kids to potentially put them through such extreme events of climate change?" [ID#4]*

Among the general adult population, participants noted observing sleep difficulties related to extreme heat, which can have downstream negative effects on cognitive and emotional regulation abilities and contribute to apathy and fatigue. Participants working with older adults observed extreme heat-related agitation and confusion among patients with dementia.

3.2. Observed physical health consequences among patients with mental health conditions

Participants emphasized that while EWEs affect many populations, physical health risks were particularly salient among patients with mental health conditions due to the effects of psychiatric medications, comorbid substance use, and social circumstances that complicate risk recognition, prevention, and follow-up. They discussed heat-related risks of antipsychotic

medications that their patients are often prescribed. One participant recalled a specific incident of heat stroke likely compounded by medication side effects:

> *"[During] a heatwave period, a patient who was on lithium and clozapine…they went out on a terrace and they actually ended up passing out… As a result of that, they no longer wanted to take their medication" [ID#5].*

During extreme cold, participants recounted seeing frostbite-related presentations to emergency departments, and in extreme cases required amputation. One participant shared a confluence of challenges with extreme cold, chronic pain, medication adherence, and overdose risks faced by their patients with addictions:

> "*Patients with chronic pain, who will talk about how their joints are more painful when it's cold or they're worried about falling and so they end up missing doses of methadone, and as a result, you'd need to have their dose dropped or sometimes even restarted… There is a correlation with people having more severe overdose presentations in the context of severe cold weather. I've had patients who had overdosed, but because they had been out in the very cold weather, they had even worse health outcomes and then they could go to ICU." [ID#6].*

Participants acknowledged that the physical health and mortality risks linked to climate change disproportionately impact their patient populations facing social and structural inequities, including those who are economically disadvantaged, Indigenous peoples, and patients with severe mental illnesses. They are concerned that these patients often have "no control over their physical environment" [ID#7], with many who live without air conditioners, lack access to clean water supplies, or face housing insecurity and homelessness.

3.3. Clinician distress from climate-related constraints

Participants described frustration, anger, and powerlessness emerging from their routine mental health practice, as they encountered patients whose climate-related vulnerabilities and extreme weather exposures exceeded what could be addressed within their existing clinical roles and resources. Several participants explained the tension between their professional responsibility and the limits of available resources, noting the difficulty of supporting patients who experience compounded vulnerabilities. As one participant said:

> "When I think about climate change, which in my view is something that is preventable; knowing that my patients, who are already dealing with so much, [receive] the highest burden of these structural vulnerabilities...It's very frustrating" [ID#6].

Participants had ongoing concern for their patients' immediate safety and well-being, particularly during periods of extreme cold. One social worker recalled encountering individuals who "[beg] for a place to stay overnight that's safe and warm", emphasizing the responsibility hospitals bear in supporting these patients. Another participant added, "I have clients that live through the winter outside… When I know that it's -30 [degrees Celsius] … I do worry even if they're not under my care" [ID#8].

3.4. Recommendations for change

Participants' recommendations for change spanned four domains: communication with patients about climate-related risks, adaptations within routine clinical practice to mitigate EWE exposure, clinician preparedness to engage with these issues, and patient-centred advocacy and system-level responses.

3.4.1. Patient-facing counselling and psychoeducation

Participants highlighted patient-facing communication and provision of climate-related health information as foundational strategies for supporting patients during EWEs. They recommended standardized, actionable guidance to help them cope with climate-related health risks, including psychoeducation resources on adaptive behaviours and psychotropic medication side effects. Examples participants provided include “action plans” during EWEs, such as protective behaviours on how to stay cool, or where to find safe cooling or warming centres.

As noted above, participants described concerns that certain medications, particularly antipsychotics, can disrupt thermoregulation, leaving patients less able to perceive heat or recognize the need to hydrate or cool down. Temperature extremes may also affect the stability and effectiveness of medications, underscoring the importance for physicians and pharmacists to provide explicit counselling during prescription and medication dispensing. Participants observed that assumptions embedded in routine care, such as instructions to store medications at “room temperature”, may be increasingly insufficient in the context of more frequent and intense EWEs:

> *“Pharmacists or healthcare providers… may not talk about climate impacts on medication. They might say things like keep at room temperature… [but] if there is an extreme condition and your medication is exposed to that temperature, what can you do? Do you have to throw it out?” [ID#9]*

3.4.2. Clinical practice adaptation

Clinicians described adaptations within routine mental health practice aimed at reducing patients’ exposure to EWE risks and supporting their mental health and daily functioning. These strategies spanned individual clinical decisions, team-based interventions, and community-level supports.

At the individual clinical level, participants highlighted proactive adjustments in care. For example, a few physicians considered being "more liberal in prescribing puffers" [ID#10] to enable patients to engage in outdoor activities even during poor air quality and to identify other healthy coping strategies. Participants also discussed modifying discharge timing, allowing patients to remain in the facility during EWEs, particularly for those lacking safe housing. These decisions were often balanced against institutional constraints such as bed availability and safety concerns.

Participants also emphasized team-based or outreach strategies to reach vulnerable patients. One team maintains a list of patients who may be “isolated” or have difficulty accessing temperature-controlled spaces, and contacts them during EWEs. Case management teams may assist patients in “[putting] away their winter clothes in the summer time” [ID#11], supporting people who may struggle to recognize temperature-related risks.

Some participants described broader community-level programs as models for building resilience. One cited a European initiative connecting older adults with volunteer agencies, healthcare providers, and government organizations to build social networks and safeguard those most susceptible to extreme heat and other environmental conditions.

3.4.3. Clinician preparedness: knowledge, confidence, and emotional readiness

In addition to patient-facing resources, there was a notable desire among participants to attend training and acquire additional knowledge to improve their capacity to support their patients more effectively. As one participant explained:

> *"I'd like to know what available resources are there… I would like to have a better knowledge about how I can help support clients or get them connected. I know how climate affects me so I can only imagine how it affects people who might be in a crisis" [ID#12].*

Beyond knowledge, participants underscored the importance of self-awareness, including recognizing and reflecting on their own emotional responses to climate change. This preparation may enable them to be "less afraid" [ID#13] to facilitate opportunities for patients to articulate their perspectives, especially on potentially sensitive or politically charged topics. Participants acknowledged that patient perspectives may go unexpressed and recommended clinicians to open up conversations with patients about how climate change might be affecting them:

> *"If we were to ask more of these questions [about climate change] ... or give space, would we find out that…there's more of [our clients] who are quite concerned about this and then we're just not aware of it because they have not shared that with us spontaneously for us to even think about?" [ID#12]*

3.4.4. Patient-centred advocacy and system-level responses

Participants described advocacy as initiatives that address the social and environmental conditions that shape vulnerability among people with mental health conditions. They discussed the need to increase the availability and accessibility of safe cooling or warming spaces, and to provide financial support or equipment such as fans and air conditioners for individuals facing structural disadvantage, in recognition that these efforts may be necessary extensions of mental health care in the context of EWEs.

Several participants referred to existing social support programs, including the Ontario Works and Ontario Disability Support Program (ODSP), which provide eligible individuals with coverage for an air conditioner when prescribed by a health care provider. Participants noted that these programs may be under-utilized and suggested that greater clinician awareness could meaningfully reduce individual climate-related health risks for patients.

Several participants situated advocacy efforts within a broader recognition that climate-related risks cannot be addressed solely at the level of individual patient care. As one participant shared:

> *I view [health risks associated with climate change] as a societal issue other than an individual patient issue, whereas psychiatry and mental health has been very focused on the individual patient issues. And the idea that we can heal people when everything around us is unhealthy, actually is a broken paradigm to me, right? We actually need the healing, part of the healing has to be about changing the larger structures [ID#14].*

4. Discussion

This study is the first qualitative study in Canada to examine clinicians' perspectives on how climate change and associated EWEs are experienced in mental health care. Across 25 clinicians from diverse professional backgrounds, the participants discussed the impact of climate change on their patients and practice, observing clinical presentations that encompass negative psychological and physical sequelae among different patient subpopulations, as well as their own emotional burden of managing these climate-related presentations. Participants identified gaps within the current mental health system and proposed several solutions. These findings suggest that climate change is already operating as a place-based and system-level

402 determinant of mental health care, and shapes both the types of presentations seen in clinical
403 settings and the constraints under which care is delivered.
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405 Clinicians in this study perceived that youth and women in their practice were more likely to
406 report climate-related anxiety and psychological stressors, which has been supported by
407 previous epidemiological studies. For example, a national survey of 1000 Canadian youth aged
408 16 to 25 showed that 78% of them have experienced negative effects of climate change on their
409 mental health [23]. Our participants highlighted that their young patients are worried about the
410 disproportionate impact of climate change on their future, as more climate-related adverse
411 events are expected to occur during their lifetime. For young women in particular, climate
412 anxiety also plays a role in family planning, and associated concerns about bringing children
413 into an unstable climate. Previous studies have suggested that young women are also more
414 prone to developing PTSD after adverse climate events, such as in the case of Hurricane Maria,
415 compared to young men [24]. These patterns highlight how climate-related distress is not
416 uniformly distributed and reflects differences in perceived future risk and social positioning, with
417 implications for how mental health services identify and respond to vulnerabilities. Screening
418 protocols and gender-focused tools may become increasingly relevant components of youth
419 mental health care. Some standardized tools are in process of being validated for youth climate
420 anxiety in a Canadian setting, such as the Climate Change Anxiety Scale-Short Form [25].
421
422 Clinicians also reported a range of climate-related medical presentations, including sleep
423 disruptions during heat events, worsening of agitation in patients with dementia, and heat-
424 related decompensation in patients taking antipsychotic medications. Existing epidemiologic
425 evidence supports these observations, including aggressive incidents on psychiatric wards on
426 heat days (>30 °C) [26], as well as decreased time of sleep and increased difficulties with falling
427 asleep [27]. In addition, a study of patients with schizophrenia found that patients on

haloperidol, zuclopenthixol, and clozapine specifically were at higher risk of mortality compared with patients on other medication regimens during heat related events, due to a combination of disease severity, anticholinergic properties intrinsic to the antipsychotic medications, and the common practice of co-prescribing anticholinergic and antipsychotic medications [28]. These findings indicate that climate-related health risks are mediated through existing mental health treatment pathways and care environments. There is a need for further research aimed at mitigating heat-related risks in patients prescribed antipsychotics. Accessible patient education about such risks may be a practical starting point, though further research on the effectiveness of such interventions in reducing heat-related mortality remains limited and requires further study.

Clinicians reflected that climate change amplifies existing social and structural inequities, including lack of access to stable housing, air conditioning, and clean water. They expressed helplessness, frustration, and concern for their patients. Similar findings of a significant emotional toll on clinicians in the context of climate change have been reported internationally. For example, in a study of nurses in Turkey, they reported moral distress in providing care in climate crisis with limited resources, as well as burn-out in times of climate-related extreme weather events, which were associated with higher patient volumes [19]. These experiences suggest that climate change represent an emerging source of health system strain with implications for workforce sustainability and clinician wellbeing. A psychoeducation healthcare community intervention after hurricane Maria for healthcare professionals showed improvements in post-traumatic and secondary traumatic stress [29]; however, limited research has been done on supporting health care providers with regards to climate change and climate-related adverse events.

Participants stressed the importance of developing practical tools to guide discussions about climate change within mental health care. Clinicians have observed that patients may hesitate to raise environmental concerns during mental health encounters, highlighting the importance of creating clinical environments that invite and legitimize these discussions. Previous studies among physicians have suggested that they worry about discussing these topics, as they can create a sense of fear or powerlessness for the clinicians, and that they tend to prefer action-oriented conversations instead [30]. This discomfort may also be compounded by inadequate knowledge in the topic. Surveys conducted from 2817 medical schools globally suggested that only 15% have incorporated climate change content into medical curricula [31]. As recommended by participants, further education and training around climate change and mental health is also needed, with more focus on useable resources tailored to their field. This can increase clinicians' comfort levels with these topics and allow them to revisit their own fears and biases, and hence become better equipped to navigate climate-related discussions.

Clinician advocacy efforts, such as prescribing air conditioners, were identified as an additional way to assist patients in the context of social inequities. While access to air conditioning can alleviate acute concerns on an individual basis, mass use of air-conditioning contributes to greenhouse gas emission and can accelerate climate change [32]. Moreover, people who are homeless or do not have stable housing would not be able to install individual devices. Some experts have suggested taking cool showers before bed [33] or even heat acclimatization routines through physical exercise to help individuals prepare for heat events [34]. Similarly, our clinician participants discussed promoting the use of puffers or inhalers, whereas there is a growing body of research suggesting the carbon impact of these types of medications [35]. The tension points to the need for context-sensitive clinical decision-making that balances immediate patient safety with longer-term environmental impact.

Several limitations should be considered when interpreting our findings. Participants were mostly recruited from tertiary academic centres located in Toronto, which may miss the experience of community mental health providers and health settings in other regions across the province. As such, the findings may reflect an urban and resource-rich care context, which may differ from experiences in rural or under-resourced settings. We did not collect or analyze demographic characteristics of participants, and were therefore unable to examine whether factors such as gendered professional roles or career stage shaped perceptions of climate-related challenges. In addition, due to the snowball sampling, clinicians in the study were more likely to be aware of and attuned to climate change than the average mental health workforce. Lastly, because this study examines clinicians' perspectives, patients themselves may hold different views on the types of mental health care needed in the context of climate change.

5. Conclusions

Climate change is increasingly shaping the context in which mental health care is delivered in Canada. This study highlights how clinicians are encountering climate-related distress, symptom exacerbations, and worsening inequities among patients with mental health conditions. The findings contribute empirical insight into how mental health care systems may better recognize and respond to climate-related challenges.

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