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Implementing an Emotional Support and Mental Health Response Plan for Healthcare Workers During the COVID-19 Pandemic

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Institutions across the world are working to develop initiatives aimed at supporting the well-being of healthcare workers (HCWs) facing the psychological impacts of the novel coronavirus (COVID-19) pandemic. This Commentary identifies risks that HCWs are experiencing, reviews sources of fear and stress, and describes the implementation of a three-tiered model for the provision of emotional support and mental health services for clinical and nonclinical HCWs. The model recognizes the fluid, ever-evolving nature of the COVID-19 pandemic and includes proactive, visible, and easy-to-access supportive psychological services that expand the safety net and help address immediate and future mental health challenges of HCWs.

Keywords: COVID-19, emotional support, mental health, healthcare worker, response plan

As healthcare workers (HCWs) focus on caring for patients during the novel coronavirus (COVID-19) pandemic, organized, system-wide emotional support and mental health response plans guided by mental health clinicians and experts in disaster behavioral health planning and response are critical to supporting HCW well-being. Using a public health framework, COVID-19 emotional support and mental health response plans for HCWs must be flexible enough to promptly address the changing circumstances of the pandemic and the associated mental health consequences.

In this pandemic, HCWs are in high-risk occupations, and many are facing fears they never imagined or expected to experience. HCWs' fears are both work (patient and personnel) and family related. Regarding patients, HCWs have concerns about providing optimal patient care, accommodating a surge in patients with viral infections, caring for colleagues with COVID-19, and treating patients without the support of patients' loved ones due to restricted visitor policies. Other daily work-related concerns include accessing suitable personal protective equipment and adjusting to wearing this additional equipment, adequately performing job duties when redeployed, accessing accurate and timely COVID-19 testing, and becoming ill or dying themselves. Family-related fears for HCWs include potentially transmitting COVID-19 to family members, ensuring that they and their family members are taken care of if they become sick, accessing childcare, experiencing contagion-related stigma from community members, and meeting basic familial needs (e.g., food, clothing, and lodging) while balancing increased workloads (Chen et al., 2020; Kang et al., 2020; Shanafelt, Ripp, & Trockel, 2020). Especially salient ongoing concerns among medical trainees and younger workers are aspirational and developmental disruptions in achieving personal, career, and family goals.

In order to provide support to HCWs who are experiencing ongoing risks and adversities, institutional responses are being rapdily launched. This Commentary describes our institution's

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effort to implement and provide emotional support and mental health services to HCWs and summarizes the model adopted by our wellness and mental health workgroup to quickly introduce a range of supportive services across our health system.

As the number of COVID-19 cases increased locally, under the direction of health system, medical school, and institutional command center leadership, the authors assembled a wellness and mental health workgroup. This workgroup was charged with coordinating the emotional support and mental health response plan, acknowledging and normalizing the emotional impact of COVID-19, and providing visible, easy-to-access supportive psychological services for clinical and nonclinical HCWs across our large urban academic medical center and health system. Members of the COVID-19 wellness and mental health workgroup represent a wide variety of clinical and nonclinical institutional disciplines and possess unique skillsets. The workgroup adopted the 3-tiered public mental health model for disaster intervention recommended by the National Academy of Medicine, which is represented graphically as a pyramid consisting of three tiers. Each tier is overseen by a dedicated team, allowing for workgroup members to employ their specific expertise (Committee on Post-Disaster Recovery of a Community's Public Health, Medical, and Social Services, 2015; Pynoos, Goenjian, & Steinberg, 1998).

Tier 1 occupies the lowest level of the pyramid, and the Tier 1 team concentrates on providing broad-based practical, informational, and educational support for all members of our health system. The Tier 1 team has coordinated educational trainings, created a centralized repository of resources, and worked with diverse stakeholders to disseminate information through command center messaging and on a central wellness website. The Tier 1 team has also advocated for the practical needs of our HCWs (e.g., childcare, access to showers, and lodging for those that did not want to return home) as these needs were identified.

In coordination with the Tier 1 team, the American Foundation for Suicide Prevention developed a brief online, anonymous, and interactive screening program for all HCWs that is specifically designed to examine COVID-19-related stress and anxiety. This program is hosted on the Foundation's platform, and trained counselors at our institution monitor the screening program, respond to requests for dialogue, and help support and connect users with available resources, depending on users' needs. Within 12 hr of the first letter of invitation being circulated, we had received 30 responses, indicating that many HCWs are most comfortable using confidential services. Realizing that a menu of support options would best serve a large group, the Tier 1 team also developed an emotional support request line for the health system, which can be accessed by phone or text. The line is primarily staffed by psychology and psychiatry residents and fellows trained in psychological first aid, with faculty supervision available. These clinicians also conduct check-ins with HCWs who have tested positive for COVID-19 or indicated they would like to receive a callback from an emotional support clinician after contacting the institution's call center for COVID-19-related concerns and symptom monitoring.

Finally, the leadership team of Tier 1 has participated in institution-wide townhalls, monitored the institution's capacity to provide mental health services, and collected outcome data on interventions in Tiers 2 and 3 and aggregated mental health–related concerns, ensuring that information pertaining to HCW well-being is communicated to health system leadership.

Tier 2 strategies, which are represented in the middle section of the pyramid, focus on screening and providing emotional support to HCWs in high-risk units or departments. Trained faculty and staff mental health clinicians, some of whom are already embedded within units or teams, are proactively offering individual and group check-ins, as well as educational or clinical resources, with the goal of fostering peer support. In addition, these mental health clinicians are working to triage individuals to higher levels of care, if needed. Approximately 25 hospital units, departments, or workgroups have a designated mental health point person or team thus far, with more being assigned as they are requested.

Situated at the peak of the pyramid, Tier 3 focuses on providing direct mental health services to individual HCWs in need of services, as well as their immediate family members. Ideally, broad-based support and the tiered approach of the utilized model can help identify individuals in need of safety net mental health services. An expedited referral network has also been established to triage and efficiently direct requests for mental health services to clinicians with availability.

Appreciating the experiences of institutions around the world and reports on mental health initiatives for HCWs facing major surges in China and Italy (Chen et al., 2020; Fondazione Policlinico Universitario Agostino Gemelli IRCCS, 2020; Kang et al., 2020), we designed and implemented an extensive 3-tiered system of emotional support to best address the needs of our HCWs who faced a significant surge, albeit one of a lower magnitude than in other hotspots. Our system incorporated elements of both the aforementioned public mental health model (Committee on Post-Disaster Recovery of a Community's Public Health, Medical, and Social Services, 2015; Pynoos et al., 1998) and previously reported supportive services for HCWs (Chen et al., 2020; Fondazione Policlinico Universitario Agostino Gemelli IRCCS, 2020; Kang et al., 2020), while also offering additional services to HCWs for sustained, proactive support. These adjustments were aimed at acknowledging HCW concerns and providing a highly visible array of options for psychological support that HCWs could choose to engage with, depending on their specific situation or comfort level.

More specifically, Tier 1 messaging validated both the repercussions of HCWs' experiences to date and concerns related to meeting the challenges of ongoing accommodations in the healthcare system and their personal lives. Also, the Tier 1 emotional support request line and online, anonymous, and interactive COVID-19 stress and anxiety screening program provide HCWs with two distinct services for use: one that is completely confidential and another that is informal. Additionally, since HCWs may not need or seek formal psychiatric care due to a variety of barriers, we focused on ensuring that Tier 2 embedded designated mental health point people address the current concerns and needs of HCWs in high-risk units or units with COVID-19-related deaths and provide services that are proactive, highly visible, easily accessible, and nonstigmatizing. Tier 2 support was also directed at assisting leadership teams for units or workgroups as they address reverberations from the first phase of response and work to resolve ongoing issues among their staff in service adjustments and overall concerns. Finally, since many of the acutely distressed HCWs have preexisting psychiatric conditions and may experience an exac-

erbation, we strengthened the Tier 3 referral network to increase capacity in the event of a surge.

The demand for emotional support and mental health services by HCWs is expected to rise following the immediacy of performing critical work and providing care to ill and hospitalized patients; we hope that other institutions can learn from our experience and utilize existing facets within their health systems to provide HCWs with tailored emotional support and mental health interventions. Although challenging, disaster situations, much like the COVID-19 pandemic, provide us an opportunity to build and evaluate sustainable emotional support and mental health systems. The psychological footprint of the pandemic will remain visible for some time; let us make the most of this opportunity to care for the caregivers of today and beyond.

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