MENTAL HEALTH POLICY RESPONSE DURING COVID-19: SUPPORT FOR CARE WORKERS

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| Authors  Kaylee Knowles ([Care Policy and Evaluation Centre, Department of Health Policy, London School of Economics and Political Science](http://www.lse.ac.uk/cpec))  ltccovid.org  This document is available through the website ltccovid.org, which was set up in March 2020 as a rapidly shared collection of resources for community and institution-based long-term care responses to Covid-19. The website is hosted by CPEC at the London School of Economics and Political Science and draws on the resources of the International Long Term Care Policy Network.  Corrections and comments are welcome at [info@ltccovid.org](mailto:info@ltccovid.org). This document was last updated on 7 June 2020 and may be subject to revision.  **Copyright:** © 2020 The Author(s). This is an open-access document distributed under the terms of the Creative Commons Attribution NonCommercial-NoDerivs 3.0 Unported International License (CC BY-NC-ND 3.0), which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited. See http://creativecommons.org/licenses/by-nc-nd/3.0/.  Suggested citation  Knowles, K. M. (2020). *Global mental health policy response during COVID-19: Support for care workers*. Report in LTCcovid.org, International Long-Term Care Policy Network, CPEC-LSE, 7 June 2020.  Follow us on Twitter  @LTCcovid, @\_KayleeKnowles  Acknowledgements  The author would like to thank Martin Knapp ([Care Policy and Evaluation Centre, Department of Health Policy, London School of Economics and Political Science](http://www.lse.ac.uk/cpec)) and Adelina Comas-Herrera ([Care Policy and Evaluation Centre, Department of Health Policy, London School of Economics and Political Science](http://www.lse.ac.uk/cpec)) for their support identifying the need for this research. |

# Key points

* The need to support care worker mental health is identified using evidence following prior large-scale traumatic events.
* Care workers with mental health problems during COVID-19 should be identified and connected to support services as early as possible.
* Summary of mental health policy response to support care workers in Australia and China.
* Policy recommendations to support the mental health of care workers include the use of digital technologies, creating a supportive working environment, debriefing adverse events, mental health first aid training, and counselling.
* The recovery approach may be used for care workers to continue employment or return to work with proper support.
* Implementation challenges in mental health policy are due to the integrated nature of mental health, and traditionally-segmented nature of funding resulting in the complications related to ‘delayed pay-off’, ‘transmitted pay-off’, and ‘silo mismatch’.
* Mental health policies must be locally tailored to the needs of care workers, which will vary according to the design of health and social care systems.

# Introduction

A health system is defined by the World Health Organization (WHO) as “all the activities whose primary purpose is to promote, restore or maintain health” (World Health Organization, 2000). By this definition mental health, ambulatory care, public health, home care, hospitals, nursing homes, etc. are all part of the health system. Research, however, is conducted in hospitals more than in other settings (Goddard & Jacobs, 2009). There is a marked lack of research regarding staff wellbeing in health and social care settings, and even less research about the mental health of these groups during a pandemic. This paper presents an overview of policies supporting the mental health of care workers during the coronavirus disease 2019 (COVID-19) pandemic. Policy responses from China and Australia are discussed. Suggestions are presented for further policy development according to learnings from prior events of mass trauma.

For the purposes of this paper a ‘care worker’ is defined as a person who is paid to provide care for individuals unable to manage without support and encompasses both health care workers and social care workers (Local Government Association & NHS Clinical Commissioners, 2018). ‘Health care worker’ refers to those employed within medical settings, such as doctors or nurses working in hospitals, primary care, mental health providers in medical settings, etc. ‘Social care worker’ refers to employees of adult social care settings, such as nursing home staff, social workers, paid in-home carers, etc. (School for Social Care Research, National Institute for Health Research, n.d.). Informal carers (unpaid caregivers) are excluded from this discussion.

# The need to support mental health for care workers

On 11 March 2020, the WHO declared COVID-19, the disease caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), to be a pandemic (World Health Organization, 2020). In early stages of the pandemic, the response to COVID-19 across most of the world was focused on wellbeing (Knapp, 2020c). Wellbeing encompasses physical health, mental health, independence, work/education, dignity, relationships, economics, and more (Local Government Association & NHS Clinical Commissioners, 2018). While the impact of COVID-19 on societal mental health has been discussed in the literature (Duan & Zhu, 2020; Xiang et al., 2020), how the situation is impacting care workers has been under-represented in the research.

As COVID-19 cases rose and restrictions became stricter, care workers continued through it all. Care workers regularly exposed to SARS-CoV-2 are at risk of anxiety, insomnia, stress, feelings of helplessness, isolation, and guilt related to their potential to spread the virus (Banerjee, 2020; Shultz et al., 2015; Xu et al., 2020). These mental health conditions may negatively impact their ability to function properly at work and at home. Without supportive measures, care workers are at increased risk of absenteeism and/or providing poor care to patients/clients (Banerjee, 2020). During COVID-19, health care workers are exposed to frequent trauma (Bao et al., 2020), and, compared to the general public, are at a greater risk of post-traumatic stress following a pandemic (Cheng et al., 2004; Wu et al., 2009). Workers in care homes are also exposed to trauma regularly, with 16% reporting to have witnessed abuse of residents living with dementia (Livingston et al., 2017).

New evidence about COVID-19 continues to emerge, and the risk of common mental health disorders associated with uncertainty intolerance is a concern (BeyondBlue, 2020b; Dar et al., 2017). The fear of contracting COVID-19 may precipitate mental health decline (Kavoor et al., 2020; Xiang et al., 2020). Work stress during ‘normal’ times may exacerbate an existing mental health condition or trigger the emergence of a new condition (Knapp, 2020a; Reid et al., 1999; The Sainsbury Centre for Mental Health, 2007). All of this is magnified during a pandemic. Social isolation can be harmful, as experienced by care workers and the general population during COVID-19. While care workers are interacting with people at their place of employment regularly, they may not able to meet with friends and family socially. A rapid review of quarantine during previous epidemics concluded that negative psychological effects include anger, confusion, and post-traumatic stress (Brooks et al., 2020).

Consequences of untreated mental illness include lack of help-seeking behaviour, social exclusion (Evans-Lacko et al., 2012; Rusch et al., 2005), stigma, decreased self-efficacy (Evans-Lacko et al., 2012; Link et al., n.d.), increased morbidity, premature mortality, delay in receiving treatment (Thornicroft et al., 2016), loss of productivity, unemployment, lower income (Evans-Lacko et al., 2012; Sharac et al., 2010), and poor physical health (Galea, 2020), among many others. The Nurses' Health Study II conducted in the United States found that having post-traumatic stress disorder increases the risk of type 2 diabetes mellitus and high body mass index for women (Roberts et al., 2015). Policies must adequately support care workers, not only to prevent them from the harmful effects of poor mental health, but to protect public health at large.

# Learnings from prior large-scale trauma

A traumatic event is defined as, “an experience that causes physical, emotional, psychological distress, or harm … is perceived and experienced as a threat to one’s safety or to the stability of one’s world” (Galea, 2020, p. 6). By this definition, COVID-19 is a traumatic event. The world has never experienced a coronavirus pandemic like this before (Adhanom Ghebreyesus, 2020). Therefore, we look to large-scale national and multi-national traumatic events, such as epidemics and war, for evidence of long-term effects on population mental health.

During the 2014 Ebola epidemic, health care workers were stigmatised in West Africa. Due to a lack of health literacy regarding the pathogen, health care workers were blamed for the disease spread. As a result, sick patients elected not to enter health care facilities and some died at home. Patients left facilities against medical advice, thereby spreading the disease even more. Health care workers were victims of violence due to this misunderstanding (Shultz et al., 2015). While violence specifically targeted at health care workers has not yet been witnessed during the COVID-19 pandemic, there may be potential for stigma as restrictions begin to lift and the public start to interact with each other. Banerjee argues that health care workers may be victims of mass hysteria, xenophobia, or stigma (Banerjee, 2020).

Twenty-five years after civil war in Liberia, post-traumatic stress disorder remains markedly increased in areas that experienced violence. Dr. Sandro Galea argues that similar long-term effects may be witnessed following the COVID-19 pandemic stating, “It's not just the initial trauma, but the initial trauma compounded by the stressors and compounded by the social and economic upheaval, which is exactly what we are seeing now with COVID” (Galea, 2020, p. 9).

# Country examples for mental health policy response to COVID-19

## China

The first known COVID-19 cases in the world were reported in China on 31 December 2019 (World Health Organization, 2020). On 7 May 2020, there were 83,968 confirmed cases and 4,637 deaths (Center for Systems Science and Engineering, Johns Hopkins University of Medicine, 2020a). As of 6 June 2020, those figures increased to 84,177 and 4,638, respectively (Center for Systems Science and Engineering, Johns Hopkins University of Medicine, 2020b). China was relatively well prepared to support the mental health of its care workers, having previously created national guidelines for large-scale mental health emergency response. These guidelines were created in 2004 following the severe acute respiratory syndrome (SARS) epidemic (Duan & Zhu, 2020). The strategy outlined the need to strengthen mental health literacy among medical providers, and specified necessity to deliver mental health support to health care workers (The State Council of the People’s Republic of China, 2004).

Having pre-existing guidelines enabled China to move quickly. In January 2020 the Chinese National Health Commission published guidance for mental health response to COVID-19. This includes a 24-hour crisis support hotline and therapeutic services for all people affected by COVID-19 (Duan & Zhu, 2020; National Health Commission of the People’s Republic of China, 2020). There is a stipulation for mental health workers to support frontline medical staff, but no mention is made regarding social care workers[[1]](#footnote-1) (National Health Commission of the People’s Republic of China, 2020).

Duan and Zhu report that implementation has been inadequate with a lack of coordination between medical and mental health services. COVID-19 patients are kept in isolation and appropriately-trained psychological staff are unable to reach them. This results in undue burden on health care workers because they must provide psychological support to patients without sufficient preparation (Duan & Zhu, 2020). Xiang et al. find that most health care workers in China do not receive mental health training.

No studies nor policies were found specifying the mental health needs of social care workers in China. This is likely due to the fact that China does not have a formal social care structure, as most caregiving is provided by family members within the home (Wang et al., 2014).

## Australia

The first case of COVID-19 in Australia was detected on 12 March 2020. As of 7 May 2020, there were 6,894 confirmed cases, with 97 deaths (Center for Systems Science and Engineering, Johns Hopkins University of Medicine, 2020a). By 6 June 2020, those figures had increased to 7,255 confirmed cases, with 102 deaths (Center for Systems Science and Engineering, Johns Hopkins University of Medicine, 2020b). Australia was also relatively well-prepared for the mental health impacts, as they already had a successful nation-wide mental health awareness programme (Highet et al., 2006). BeyondBlue is an exemplary government-sponsored campaign to reduce stigma related to mental illness (BeyondBlue, 2019). In 2018, BeyondBlue published guidelines to support mental health in health care settings (BeyondBlue, 2018).

In response to COVID-19, BeyondBlue launched a website devoted to mental health for care workers. The site normalises stress that will be felt by care workers and provides advice for self-care and colleague support. Tips include taking breaks, acknowledging distress, exercising, eating well, maintaining personal contacts via phone or video, using support networks, and connecting with mental health supports in the workplace. They helpfully advise, “for those already managing mental health issues, continue with your treatment plan and monitor for any new symptoms” (BeyondBlue, 2020c). BeyondBlue specifies the importance of managers creating a healthy working environment. They also link to pre-existing support services, including a mental health support line for doctors, and a separate service line for nurses and midwives. In addition, BeyondBlue links doctors to an independent, free, and confidential doctor-to-doctor advice line (BeyondBlue, 2020c). Though the Australian Code of Professional Conduct for Nurses emphasises supporting the health of colleagues, Joyce et al. found that most nurses lack sufficient mental health literacy to effectively support a colleague with a mental health condition (Joyce et al., 2012).

For the general public, BeyondBlue has created the Coronavirus Mental Wellbeing Support Service, which has a 24-hour telephone and chat line, an online community forum, and population-specific guidance such as ‘managing difficult conversations with employees’, and ‘supporting older people during the coronavirus pandemic’ (BeyondBlue, 2020a).

As soon as the pandemic was declared on 11 March, the Australian government announced additional training and funding for social care workers. Disease specialists were sent to do on-site consultations in long-term care facilities. Funding was allocated for quarterly COVID-19 retention bonus to be paid to social care workers. COVID-19 infection control training has been provided online for social care workers (Low, 2020). Guidance[[2]](#footnote-2) released to residential care facilities regarding prevention of COVID-19 outbreaks outlined that staff may be reduced by up to 1/3 of the norm due to quarantine restrictions. In anticipation of being short-staffed, work restrictions for international students were temporarily lifted to allow them to fill social care vacancies. There was no mention of employee mental health (Low, 2020).

# Mental health policy recommendations during and beyond COVID-19

Mental health policies cannot stand alone. In fact, it has been argued that there is no such thing as a ‘mental health policy’, but rather mental health must be considered for all policymaking. This applies to policy as it relates to health, housing, employment, law, education, immigration, environment, etc. (Knapp, 2020a). The WHO defines mental health policy to be “an organized set of values, principles and objectives for improving mental health and reducing the burden of mental disorders in a population” (World Health Organization, 2004, p. 12) Incorporating mental health considerations into policies is a statement that the government prioritises mental health (World Health Organization, 2004).

It is imperative that policy-makers and supervisors facilitate a supportive working environment for frontline care workers, which includes adequate services for mental health prevention and promotion. Employers should ensure that staff are offered opportunities to practice self-care, including sufficient breaks and rest (Xu et al., 2020). Casual interactions with colleagues should be encouraged, as this is a known protective factors against job-related stress among health care workers (Reid et al., 1999). Adverse events should be debriefed and safety protocol made clear (Shultz et al., 2015).

Mental health counselling should be offered to all care workers (Banerjee, 2020; Shultz et al., 2015; Xu et al., 2020). Early identification and intervention for care worker distress will be the best way to prevent harm (Banerjee, 2020; Xu et al., 2020), as connecting people to mental health services as soon as possible lowers their risk of serious long-term consequences (Fletcher-Brown, 2015). Mental health first aid training should be provided to all care workers. Campaigns may need to be conducted to improve the mental health literacy of health care workers and administrators so that they may recognise signs of mental health issues. Educating peers to identify symptoms will increase the likelihood of early recognition of mental health problems, and empower peers to conduct mental health first aid, as necessary (Joyce et al., 2012).

Quarantine was deemed necessary by most countries during COVID-19 (Hale et al., 2020). In order to limit harmful effects of quarantine, Brooks et al. advise the public should have access to adequate supplies, accurate public health information, and be informed about the importance of and protocol for quarantine. The authors suggest limiting quarantine to the minimum duration necessary for public safety (Brooks et al., 2020). While not necessarily a direct effect of isolation, it may also be harmful if loneliness occurs. For example, older people who feel lonely have an increased risk of depression, stroke, heart disease, and premature death (Courtin & Knapp, 2017). Efforts should be made to encourage care workers to maintain social connections during quarantine. Smartphone technologies may be used to decrease social isolation (Xiang et al., 2020).

Policy-makers must accommodate for mental illness in all areas including social services, health care, housing, etc. (Knapp & Iemmi, 2016). Many mental health advocates support a recovery approach to mental illness, acknowledging that “recovery is a process, a way of life, an attitude, and a way of approaching the day’s challenges” (Deegan, 1988; Knapp, 2020a). According to the recovery approach, mental wellness includes having a sense of purpose and identity, hope, connection with others, empowerment, and the ability to advocate for oneself (Faulkner, 2020; Shepherd et al., 2008). Factors that support mental health recovery include (but are not limited to) a healthy living environment, positive relationships, work satisfaction, and the ability to pause responsibilities during a time of personal crisis (Knapp, 2020b; Mental Health Foundation, 2018). Using this perspective, care workers may be able to ‘recover’ from mental health challenges encountered during and after COVID-19, and continue to have fulfilling lives and successful careers. While it may not be possible for care workers to resign work responsibilities at the moment, it is possible for others to step in to relieve them of their other burdens and stressors. For example, New York city is offering child care to health care workers during the pandemic (Castellucci, 2020).

Digital technologies have been used successfully for mental health interventions (Kavoor et al., 2020; Patel et al., 2018; Thornicroft et al., 2016), and should be used to provide support to care workers. Patel et al. propose that mental health specialists use digital technology to train and mentor health care workers as they respond to the mental health needs of patients. This would lessen the emotional burden on frontline medical staff and prevent burnout (Patel et al., 2018). Teletherapy should be explored to provide counselling to care workers. McKinsey & Company found that 74% of people who attend a telehealth appointment report high satisfaction with their appointment (McKinsey & Company, 2020). Orbit Health launched a free telepsychiatry service for health care workers in the United States, citing social distancing recommendations as the reason for providing this service (‘Orbit Health Launches Telepsychiatry Initiative to Reduce Impact of COVID-19 (Coronavirus)’, 2020). A mental health clinic in Australia switched to telemedicine with success, limiting in-person care to only those that are unable to access the telemedicine feature (Kavoor et al., 2020). Overall, the adoption of digital technologies in mental health has historically been happening much less frequently than in other professions.

The WHO Mental Health Action Plan calls for governments and leaders to provide comprehensive mental health care via prevention, promotion, social care services, research, and policies (Knapp, 2020b; World Health Organization, 2013). As soon as possible, each country should endeavour to create such a plan, including a mental health crisis response plan. Protective policies should be introduced to retain health care workers.

# Implementation challenges

Due to the integrated nature of mental health, there is no single department that is fully responsible for mental health policy response. This lack of accountability, and designated budget, often results in an unproductive standstill. Even when mental health initiatives are proven to be cost-effective, finding the resources to implement can be a challenge (Knapp, 2020c). In addition, there is the phenomenon that Knapp and Wong refer to as ‘silo mismatch’. This occurs when the cost of the mental health intervention occurs within one budget, while the benefit is felt in a different department/area (Knapp, 2020c; Knapp & Wong, 2020). Using the New York example, the decision to pay for the childcare of health care workers may come from the city’s budget, while the financial beneficiaries are employers and employees.

‘Delayed pay-off’ and ‘transmitted pay-off’ make it difficult to measure the impact of a mental health policy. ‘Delayed pay-off’ occurs when an investment today will not bring benefit for many years (Knapp & Wong, 2020). In this case, we know that investing in the mental health of care workers will result in the immediate pay off of having more resilient staff, while the long-term benefits will be a healthier person that uses fewer resources later in life. ‘Transmitted pay-off’ is when the policy directly impacts Person A, but the benefits are mostly seen in Person B (Knapp & Wong, 2020). For example, investing in the mental health of care workers today will help to prevent illness not only for the care worker, but also for the care worker’s children. This is because adverse childhood events are associated with mental illness as an adult (Patel et al., 2018). Together ‘delayed pay-off’, ‘transmitted pay-off’, and ‘silo mismatch’ require creative diagnol accounting because the cost happens today in one sector, but the benefits may be felt several years later in another sector (Knapp & Wong, 2020).

Mental health policy cannot be easily transferred from one country to another without adaptation (Knapp, 2020c). This is because local context plays an important role in the acceptance and success of a policy. Therefore, mental health advocacy groups should be consulted when adapting and creating mental health policies to ensure that the needs of the population are being addressed. For example, in Australia, the advocacy group blueVoices helped to identify discriminatory employment policies that needed to be improved (Hickie, 2004). Mental health initiatives must be tailored to fit the specific needs of each country’s care workers, and the care workers themselves should provide the expertise for what they need. Prior to designing a mental health policy, care workers should be asked about common threats to policy success, such as self-stigma, public opinion, etc. (World Health Organization, 2004). Due to variance in populations and settings, policies should be flexible enough to allow for tailored interventions within small geographic region, such as by county/state/province.

# Conclusion

In conclusion, there is evidence from previous large-scale traumatic events to build upon to support the mental health of care workers. China and Australia provide examples for how care worker mental health may be supported on a national scale. Care workers that suffer from mental health problems during this crisis must be connected to services as soon as possible. Digital technologies should be used to provide mental health support to care workers. When possible, care workers should be enabled to continue employment, or return to work using the recovery approach. The world is slowly opening its eyes to the necessity of mental health policy. Hopefully the global community will learn from this painful time and build stronger health systems as a result.

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1. This cite was translated from Chinese (Simplified) to English using Google Translate, and therefore possible that the accuracy of this statement may be challenged due to nuance lost in the translation. [↑](#footnote-ref-1)
2. Residential care employees are referred to as ‘health care workers’ in these guidelines (Communicable Diseases Network Australia, 2020) [↑](#footnote-ref-2)