Supporting patient and clinician mental health during COVID-19

Via trauma-informed interdisciplinary systems

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The swift spread of coronavirus disease 2019 (COVID-19) across the globe has challenged health service providers in unprecedented ways. Among the disruptions for general practitioners and allied specialists have been the need to provide in-person care with only limited access to personal protective equipment; a sudden influx of patient concerns related to COVID-19 and a displacement of non–COVID-19 care; desperate calls to redeploy clinicians to emergency departments or other disaster response settings; a rapid shift to telehealth and virtual care (often without previous training or the technologic resources); and increasing complexity in their patients' needs in the context of trauma responses that exacerbate mental health and other comorbidities. Ethical dilemmas abound in a system that cannot meet patient demands.[1] Further, a sizable body of research has demonstrated that the trauma experienced by patients, clinicians, and society during events such as the current pandemic reaches and reflects across all levels of the health care system, ultimately leading to "vicarious trauma" and "compassion fatigue" for providers, administrators, and the very structures most responsible for providing care.[2]

At the same time, our patients need us more than ever. As infection and illness spread in the community, more individuals are being separated from their loved ones, either because they are staying at home because of physical distancing guidelines, or they are living in institutional care settings where visits are restricted. All the while, the social determinants of health (exacerbated by a catastrophic economic situation) are leading to the psychosocial and relational stressors that compromise health for families (eg, marital conflict, disrupted parent-child relationships, potential for violence).[3] While the virus does not discriminate, providers for patients traditionally viewed as vulnerable might particularly notice these risk factors flaring up as the crisis worsens. The illness and hardship these patients experience during the pandemic could, collectively, lead to new trauma or retraumatization across adult patients' lifespans, while increasing the incidence of adverse childhood experiences for younger patients.[4]

As we wrestle with this situation, the purpose of this article is to humbly offer a few realistic and actionable suggestions that could immediately be of use to providers and policy makers, drawing upon the central tenets of trauma-informed health care systems.[4] The importance of partnership with specialty providers of mental health services (eg, clinical psychologists and social workers) is emphasized, including the role of telehealth. We want to convey hope that clinicians can (and will) weather the storm, providing optimal patient-centred services while they also take care of themselves and their families as we "flatten the curve."

Challenges

Challenge 1: balancing patient mental health with COVID-19 best practices. In the face of a deadly pandemic, it would be easy to think that patient mental health and psychosocial concerns "take a back seat" for the time being. This idea might arise from acute concerns in patients and clinicians regarding COVID-19 contagion and morbidity, or from feelings that mental health concerns are less important in the face of catastrophic illness. We caution against this approach and, instead, encourage clinicians to continue assessment for the documented positive feedback loop linking presentations that might otherwise be simplified into either psychosocial or medical domains.[5,6] This feedback loop is certainly evident in the case of trauma, where psychiatric symptoms can interact with and exacerbate medical illness.[7] Furthermore, emotional distress might limit an individual's capacity to learn new information and follow instructions, which could be extended to pandemic public health measures, including hand-washing, not touching one's face, and physical distancing.

In following the central tenets of trauma-informed health care, clinicians will consider the role of adversity (in particular, life-threatening events) in the development of human suffering, and respond compassionately with universal and targeted practices to optimize care and outcomes.[8,9] The theme of a patient's subjective feelings of safety is paramount to avoid interventions that might exacerbate psychological symptoms and reduce service-seeking behaviour. Thus, given the ubiquity of COVID-19, our recommendation is the trauma-informed universal practice of approaching each encounter open to the possibility that mental health problems and feelings of safety have become an increasing concern for patients. This stance will create a compassionate ethos for patient-provider alliance, thereby facilitating the raising of concerns such as health-related anxiety, loss, and compounding hardship, which likely interact with the primary presenting concerns.

Challenge 2: allocating a realistic amount of time to discuss psychosocial concerns. When health care providers first begin trauma-informed practice, a paradox

emerges: we are asking them to do more, it seems, when they have less (time, resources, and energy). However, trauma-informed care does not necessarily mean longer appointments. Brief strategies can be effective in the facilitation of trauma-informed communication surrounding mental health in primary care.[10] Indeed, clinicians might begin encounters in an open-ended way, following up with questions regarding emotional well-being (now, specifically in relation to the pandemic) and providing brief psychoeducation or motivational interviewing around the role of stress in health. Follow-up questions can include querying around mood, anxiety, unhealthy coping strategies (eg, substances), and family conflict, while considering the potential of routine physical examinations acquiring additional emotional valence (ie, being "triggering"). In encounters with pediatric patients, clinicians can apply the familiar strategy of using developmentally appropriate language around "germs" and take the opportunity to punctuate parent-child attachment by emphasizing what caregivers are doing to promote safety (eg, "Your mommy and daddy are making sure everyone stays at home so that children are safe and don't get sick, because they are loved very much").[11]

Thus, by inserting a brief and targeted conversation around emotional well-being early during patient encounters, providers can help cultivate a warm, secure, and (where applicable, developmentally appropriate) patient-provider alliance, without derailing the usual flow of care and while still addressing presenting concerns. In extreme situations (where mental health problems merit ongoing treatment, eg, grief counseling), providers can remind patients about the importance of their concern, which is why they are making a high-quality referral (see challenge 3), as well as providing their own follow-up at the next encounter. Engaging patients in shared decision making as much as possible in this process further enhances the therapeutic alliance and the outcomes of clinical encounters.

Challenge 3: access to high-quality referrals in a disrupted health care system. Clinicians might have found their referral networks have ground to a halt. In some instances, these referrals might simply be delayed without great consequence. In other instances, crucial medical care (eg, cancer treatment and surgery) might be deferred due to the crisis, or acute mental health concerns might warrant nonemergency treatment. In all instances, psychological services might be beneficial to address pre-existing or newly arising mental health concerns.[12] However, most outpatient mental health services have closed their doors to prevent the spread of the virus. As such, we recommend that providers become aware of local mental health professionals providing disaster response services using telehealth.[13] It is important that physicians refer patients to telehealth providers with operations in the jurisdiction in which patients are eligible. Finding them might require a Google search of the provincial or state professional psychology association for a list of providers. Many jurisdictions are rapidly onboarding licensed providers to expand coverage, and introducing new billing codes for the provision of telehealth, as in the case of the Ontario Health Insurance Program (the authors' jurisdiction) or Medicaid and Medicare in the United States (**Table 1**).

Challenge 4: balancing self-care with increasing service demands. Heightened levels of clinician distress, fatigue, burnout, and mental health challenges are understandable and expected consequences of this pandemic.[14] Research has shown that burnout can spill over into the clinician's own family life, creating interpersonal difficulties with family members and exacerbating an already difficult situation.[15]

Clinical wisdom tells us that those who enter helping professions often struggle to shift to "being the patient" themselves. If there was ever a time for front-line practitioners to consider their own use of supportive mental health care, it is now. Counseling for physicians with symptoms of burnout statistically significantly reduces distress and need for extended sick leave.[16] Physicians who take up this suggestion should do so free of guilt about "overcrowding" a struggling system. Instead, they can take to heart the World Health Organization's declaration that an effective pandemic response demands medical and affiliated health care providers who are emotionally, physically, cognitively, and spiritually well.[17]

Thus, our final recommendation is to consider specialized telehealth psychotherapy or counseling for front-line providers during the disaster response, especially for those responding to elevated levels of acute illness, emergency care, resource scarcity, and death. If this is not something being discussed in your clinic, agency, service, ward, unit, or care setting, we encourage you, junior clinicians and senior administrators alike, to facilitate these conversations. Many professional psychological associations are now providing these resources to front-line clinicians at no cost (**Table 1**).

Conclusion

Every large-scale disaster has depended on the medical and health services community's heroic response. The COVID-19 pandemic is no exception. Perhaps an important difference in today's situation is the remarkable development and expansion of trauma-informed health care paradigms and interdisciplinary practice across all sectors of health and social services, especially primary care.[18] Technologic advancements in virtual care and telehealth have also been used tremendously during this pandemic, and new creative solutions can be designed with collaborative work. It is important to mobilize these partnerships and advancements to ease the burden on general practitioners and other providers treating the direct biomedical fallout of COVID-19. To borrow an often-used proverb, the response to COVID-19 is certainly "taking a village"—one that is global and more digitally connected than ever. Among those ready to respond are nonphysician providers of trauma-informed mental health care (such as registered clinical psychologists doing telehealth).

Table 1. Summary of recommendations and additional resources: *Trauma-informed suggestions for balancing clinician and patient mental health during COVID-19.*

CHALLENGE	SUGGESTION	SCRIPT OR RESOURCES
Balancing patient mental health with COVID-19 best practices	Universal: approaching each encounter open to the possibility that feelings of safety and mental health have become an increasing concern for patients	Psychoeducation and normalizing: "It's common for people to experience higher levels of anxiety and lower mood during times of crisis like COVID-19. Sometimes this can show up in family relationships that have become more tense and hostile, or distant and cold. Other times people can rely on unhealthy coping strategies, or let their self-care practices slip"
Allocating a realistic amount of time to discuss psychosocial concerns	Universal and targeted: insert a brief conversation around emotional well-being early in patient encounters. If warranted, use targeted follow-up questions via motivational interviewing followed by additional domain-specific psychoeducation and interventions	Supportive interviewing: "I wanted to check in and see how you are doing emotionally in response to the pandemic. Are there any substantial changes in your emotions, relationships, or activities that you think I should know about? What about your relationships at home with your partner, your children, etc?" Miracle question: "If you could change one thing about how things are going at home during the pandemic, what would you change? Why?"
Providing high-quality referrals in a disrupted health care system	Targeted: prioritizing psychosocial, emotional, and medical concerns meriting immediate treatment. Become aware of local mental health professionals providing disaster response services using telehealth	Follow-up or referral: "Those are important concerns. I understand things have been hard for you. We will have time to address all of those issues today and I will be sure to follow up at our next appointment" OR "I want to make sure that we provide adequate attention to that area. That's why I want to refer you to a specialist who focuses on these sorts of concerns during the pandemic. Even though I am referring you, we can always talk about this issue and I will be following up at our next appointment"
Balancing self-care with increasing service demands	Clinician directed: consider specialized telehealth psychotherapy or counseling for front-line providers, offered free of charge by psychology associations	Free online psychological services (where applicable): • Canada: **https://cpa.ca/corona-virus/psychservices/** • United States (see state-specific board or website): **https://www.asppb.net/page/BdContactNewPG**

COVID-19—coronavirus disease 2019.

This sharing of the load, in concert with manageable and effective trauma-informed approaches taken by general practitioners and other front-line providers during their encounters with patients, will undoubtedly be the best path forward.

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Competing interests
None declared

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