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Mental Health Providers During COVID-19: Essential to the US Public Health Workforce and in Need of Support

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In 2015, the combined disease burden of mental health and substance use disorders in the United States was higher than that of any other health condition.[1] Given the mental health effects of isolation, stress, and economic strain, researchers forecast a devastating increase in poor mental health as a result of the coronavirus disease 2019 (COVID-19) pandemic[2,3]—estimating an additional 75 000 deaths as a result of substance abuse and suicide in the United States.[4] People with chronic and severe mental health conditions and people with substance use disorders will not only struggle to gain access to the services they need, but pandemic-related stressors are likely exacerbating these preexisting vulnerabilities.[5] The increase in mental health need will burden an already strapped mental health care system[6] and challenge the capacity of our mental health workforce to serve clients' needs in a mutually safe manner and with limited resources and supports. Furthermore, mental health providers (eg, therapists, counselors, psychologists) will also bear the primary responsibility of adapting and learning new modalities of service delivery while managing their own pandemic-related stressors.

Effect of the COVID-19 Pandemic on Mental Health Providers

Although much attention has been given to the health of frontline medical workers, the pandemic will soon also compromise the services and health of mental health providers. Mental health providers—although not typically considered frontline workers—will face the immediate challenge of addressing the mounting mental health crisis in the United States. Given widespread physical distancing measures, mental health providers swiftly responded by adopting teletherapy as the primary platform for delivering mental health services. For most of the mental health workforce, the shift to teletherapy was immediate, and it fundamentally challenged the way mental health providers are accustomed to delivering services.

Compassion and empathy form the foundation of a strong therapeutic relationship between mental health providers and their clients, and they are essential elements for providing good clinical care. However, the ability to cultivate and convey these feelings requires that mental health providers engage in and maintain their own self-care. The ubiquity of the pandemic, however, not only increases the stressors and needs of clients but also limits the emotional and material resources of the mental health providers committed to helping them. Mental health providers are also not impervious to personal challenges, loss, and stressors related to the pandemic, which are compounded by their responsibility to hold space for their clients on these very same issues. In other words, mental health providers are having to process both their own and their clients' stressors related to the pandemic, which is uniquely challenging.

We conducted a brief online survey focused on the impact of COVID-19 on mental health providers' work and mental health (n = 137) in June–July 2020. The survey was targeted to US-based mental health providers (eg, licensed social workers, marriage and family therapists, counseling psychologists) and included 5 open-ended response questions asking participants to reflect on their experiences offering mental health care during the early months of the pandemic in the United States:

1. How has the COVID-19 pandemic impacted your client's ability to access services?
2. How has the COVID-19 pandemic impacted your ability to serve clients?

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3. How are your experiences as a mental health provider during the COVID-19 pandemic affecting your mental health?
4. How has the stress that you are experiencing in your life [outside of clinical practice but related to COVID-19] affected your clinical practice?
5. What resources do you need right now to feel supported in your ability to provide therapy and for your own mental health?

A total of 112 of the 137 (82%) mental health providers surveyed, across a range of disciplines, shared that the pandemic had negatively affected their ability to serve clients. In addition, they highlighted that their clinical practice during the pandemic and the stressors that they were experiencing in their personal lives were having a substantial negative influence on their own mental health. One respondent stated, "I feel burned out and overwhelmed." Another respondent said, "I feel connected with my clients because of this shared experience, but I also feel that it compounds what I feel sometimes because I am helping them process through their emotions about the situation."

Survey respondents also discussed emotional and physical health implications of these stressors. They described feeling distressed, depressed, anxious, isolated, and fearful. Several respondents shared that they were not sleeping well, feeling physically exhausted, and having more migraines than usual. Several respondents shared their struggles with their own mental health; one respondent noted, "As [the pandemic] has gone on, I have become more distracted and fatigued conducting telehealth, especially without having a transition to home from work and having the two spaces blend together." Another respondent said, "Stress is up, anxiety is up."

Numerous respondents indicated teletherapy fatigue, and many disclosed feeling dissatisfied with work or questioning the meaningfulness of their work. One respondent mentioned how "providing teletherapy via video is more tiring than providing in-person therapy, which has added to my fatigue." Another provider reflected on how "telehealth can be a bit more exhausting and the technology can sometimes be frustrating." Yet another respondent noted how these modalities can challenge their competence: "I have an increased sense of imposter syndrome and a decreased sense of efficacy as a clinician." In my professional networks (M.M.) and in the online survey, clinicians have disclosed that they are experiencing elevated levels of empathic distress—an emotional state that affects people's capacity to bear witness and tolerate another person's pain and suffering—and at times feeling distracted and less engaged with their clients. Several respondents suggested that the "[pandemic has] made it harder to access empathy at times."

Additional stressors in providers' personal lives and in their clients' lives as a result of the pandemic, coupled with a novel and challenging work environment, make mental health providers susceptible to compassion fatigue, burnout, and secondary traumatic stress. These negative consequences are also exacerbated by mental health providers' limited access to social and emotional support during the pandemic. Importantly, the experiences of compassion fatigue, burnout, and secondary traumatic stress have been shown to contribute to adverse outcomes, including job dissatisfaction, reduced professional efficacy and personal accomplishments, chronic fatigue, sleep disturbances, negative emotional states (eg, anxiety and depression), and gastrointestinal issues.[7]

Mental Health Is Public Health: Supporting Mental Health Providers

Traditionally, mental health has not been a central mission of the public health workforce.[5,8] Yet, given the growing awareness of the intersection of emotional well-being, morbidity, and all-cause mortality, mental health providers are essential employees of the public health workforce and critical for promoting the health of our nation. The COVID-19 pandemic highlights an urgent need for an integrated and innovative partnership between the public health workforce and the mental health workforce. In the coming months, opportunities for collaboration will be available in which both sectors can work together to bolster the well-being of populations across the country through public health messaging, education, and primary, secondary, and tertiary prevention.[5] These efforts must also attune to how social conditions contribute to poor physical and mental health and the inequities therein that unduly burden populations with high rates of poor mental health and unique barriers to accessing mental health services (eg, lesbian, gay, bisexual, transgender, and queer [LGBTQ] people, people of color, undocumented people, people experiencing economic precarity).[9,10]

We applaud mental health providers and their professional organizations and licensing boards for the swift adjustments to typical mental health delivery methods and access in the weeks after physical distancing orders were implemented. State licensing boards lifted several restrictions on jurisdictional coverage of services so that licensed clinicians can either practice teletherapy across state lines or apply for permission to practice in other states. Similarly, the Centers for Medicare & Medicaid Services temporarily waived telehealth requirements, making it easier to deliver and bill for telehealth services than before the pandemic.[11] These temporary changes were necessary to support the rapid transition to teletherapy, to promote the mental health of our society, and to protect our mental health providers. These changes will likely help to narrow gaps in mental health care seeking for populations that often struggle to find adequate mental health services or therapists with specific identities and specialties (eg, LGBTQ populations, rural populations, racial/ethnic minority groups). This shift in

policy also inadvertently presented new pathways to accessing mental health services for many populations that might not otherwise have been able to seek or afford care before these changes. Because these changes are temporary, it is imperative that researchers, in partnership with mental health providers, examine how these changes in access and billing affect access to care and the subsequent effect of revoking these temporary mandates when policy makers may no longer deem them necessary.

Although mental health providers and their professional organizations are adapting to the demands of the pandemic on their profession and clinical practice, the pandemic also challenges us to rethink aspects of clinical training and mental health workforce development in the months and years to follow. Most clinical training programs currently train students to deliver in-person treatment. The COVID-19 pandemic and other recent epidemics and disasters have accentuated the need for revisioning aspects of our mental health training across disciplines to include other modalities of treatment delivery (eg, by telephone, online, or mixed in-person and technology-based services). Given the shortage of mental health providers and an increased need for mental health services, it has never been more important to develop models for digital mental health care delivery and adaptations for various populations (eg, couples, children) and therapy modalities (eg, play therapy, eye-movement desensitization and reprocessing). Despite some innovation in this area, the development, evaluation, and integration of these models in clinical training and mental health care delivery is absent. Adaptations require analogous and (potentially) collaborative and complementary training for the public mental health workforce to identify and implement large-scale mental health interventions, particularly in ways that leverage digital technology but also circumvent disparities in access to the internet and electronic devices.[5]

Mental health providers also need to be trained in self-care strategies and in identifying signs of compassion fatigue, burnout, and secondary traumatic stress. Most mental health disciplines do not cover these topics systematically in their training of mental health providers. Numerous respondents to our online survey highlighted the need for addressing social isolation and emphasized the importance of support groups. They recommended that these groups should be geared toward providing consultation and support. One respondent mentioned that "an independent practice association in the state . . . provided so much information about the billing for services and telehealth stuff as well as how other therapists are navigating things . . . videos and activity ideas for sessions with clients. It's really been awesome!" Another respondent said, "I would love to be a part of a virtual consultation/support group with other clinicians. A webinar related to clinician stress and [the] pandemic would be helpful." Several survey respondents also mentioned the importance of having their own therapist at this time. It would be prudent for national organizations and state behavioral health networks to develop programs that provide integrated mental health support to clinicians and confidential screening for depression, anxiety, and suicidal ideation. Furthermore, national, state, and local professional organizations should facilitate the development of interest and support groups for mental health providers. To better care for clinicians, the organizations that employ them and independent practice associations should develop, implement, and promote policies and practices that emphasize workplace wellness as a strategy to promulgate well-being and self-care (eg, adjusted caseloads, walking clubs, meditation, and exercise classes).

It is not a matter of if but when the mental health consequences of the threat of disease, grief and loss, economic strain, and social changes resulting from the COVID-19 pandemic will overburden the mental health care system. Similar to the calls to protect our frontline workers, mental health providers need protection and support as they tackle the mental health wave of this pandemic and prepare for future events.

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