

“Don’t Just Study our Distress, Do Something”: Implementing and Evaluating a Modified Stepped-Care Model for Health Care Worker Mental Health During the COVID-19 Pandemic

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“Ne faites pas qu’étudier notre détresse, faites quelque chose”:
mettre en œuvre et évaluer un modèle modifié de soins échelonnés
pour la santé mentale des travailleurs de la santé durant la
pandémie de la COVID-19

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Abstract

Objective: Throughout the COVID-19 pandemic, there have been concerns about the mental health of health care workers (HCW). Although numerous studies have investigated the level of distress among HCW, few studies have explored programs to improve their mental well-being. In this paper, we describe the implementation and evaluation of a program to support the mental health of HCW at University Health Network (UHN), Canada’s largest healthcare network.

Methods: Using a quality improvement approach, we conducted a needs assessment and then created and evaluated a modified stepped-care model to address HCW mental health during the pandemic. This included: online resources focused on psychoeducation and self-management, access to online support and psychotherapeutic groups, and self-referral for individual care from a psychologist or psychiatrist. We used ongoing mixed-methods evaluation, combining quantitative and qualitative analysis, to improve program quality.

Results: The program is ongoing, running continuously throughout the pandemic. We present data up to November 30, 2021. There were over 12,000 hits to the UHN’s COVID mental health intranet web page, which included self-management resources and information on group support. One hundred and sixty-six people self-referred for individual psychological or psychiatric care. The mean wait time from referral to initial appointment was 5.4 days, with an average of seven appointments

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for each service user. The majority had moderate to severe symptoms of depression and anxiety at referral, with over 20% expressing thoughts of self-harm or suicide. Post-care user feedback, collected through self-report surveys and semistructured interviews, indicated that the program is effective and valued.

Conclusions: Development of a high-quality internal mental health support for HCW program is feasible, effective, and highly valued. By using early and frequent feedback from multiple perspectives and stakeholders to address demand and implement changes responsively, the program was adjusted to meet HCW mental health needs as the pandemic evolved.

Abrégé

Objectif: Durant la pandémie de la COVID-19, des préoccupations ont été soulevées au sujet de la santé mentale des travailleurs de la santé (TLS). Bien que de nombreuses études aient investigué le niveau de détresse chez les TLS, peu d'entre elles ont exploré les programmes en vue d'améliorer leur bien-être mental. Dans le présent article, nous décrivons la mise en œuvre et l'évaluation d'un programme de soutien de la santé mentale des TLS au Réseau universitaire de santé (RUS), le plus vaste réseau de santé du Canada.

Méthode: À l'aide d'une approche d'amélioration de la qualité, nous avons mené une évaluation des besoins puis créé et évalué un modèle modifié de soins échelonnés pour aborder la santé mentale des TLS durant la pandémie. Cela comportait des ressources en ligne portant sur la psychoéducation et l'autogestion, l'accès au soutien en ligne et aux groupes thérapeutiques, et l'auto-orientation à des soins individuels d'un psychologue ou d'un psychiatre. Nous avons utilisé l'évaluation constante par méthodes mixtes, combinant l'analyse quantitative et qualitative, afin d'améliorer la qualité du programme.

Résultats: Le programme est en cours, et se poursuit continuellement durant la pandémie. Nous présentons des données jusqu'au 30 novembre 2021. Il y a eu plus de 12,000 visites à la page Web de l'intranet de santé mentale de la COVID du RUS, qui comportait des ressources d'autogestion et de l'information sur le soutien des groupes. Cent soixante-six personnes se sont auto-orientées à des soins psychologiques ou psychiatriques individuels. Le temps d'attente moyen de la référence au premier rendez-vous était de 5,4 jours, avec en moyenne 7 rendez-vous pour chaque utilisateur du service. La majorité avait des symptômes de modérés à graves de dépression et d'anxiété à la référence, et plus de 20 % exprimaient des idées d'autodestruction ou de suicide. La rétroaction des utilisateurs post-soins, recueillie par des sondages auto-déclarés et des entrevues semi-structurées, a indiqué que le programme est efficace et valorisé.

Conclusions: L'élaboration d'un programme interne de grande qualité de soutien de la santé mentale du RUS est faisable, efficace, et hautement valorisé. En utilisant la rétroaction précoce et fréquente de multiples perspectives et intervenants afin de répondre à la demande et de mettre en œuvre des changements de façon responsable, le programme a été ajusté pour répondre aux besoins de santé mentale du RUS à mesure que progressait la pandémie.

Keywords

healthcare workers, COVID-19, mixed-methods, mental health

Introduction

The impact of pandemics on healthcare workers (HCW) is well established and there is a growing literature on the effect of the COVID-19 pandemic on their mental health.¹⁻⁶ These studies demonstrate that HCW experience high levels of anxiety, depression, insomnia, post-traumatic stress, and burnout.^{4,7-9} However, drawing conclusions from these data about the actual mental health needs of HCW is difficult, as most use either scales validated for clinical populations or self-report questionnaires that have not been validated.^{4,7,8} Moreover, quantitative methods may not fully capture the different elements or contextual aspects of distress affecting HCW during a highly dynamic

pandemic and do not include nuanced information on what might be needed to mitigate this distress.^{10,11}

Although it is likely that HCW would benefit from mental health support, there is limited evidence to guide the development and provision of mental health support to workers during the pandemic.^{12,13} A recent review by Branjerdporn et al. outlined institutional wellness initiatives and mental health programs described in the literature, including workplace initiatives (e.g., respite rooms, free meals), staff support and resilience groups, telephone hotlines, and individual mental health supports (e.g., psychological first aid, psychotherapeutic, or psychiatric intervention). They noted a lack of program evaluation as a major limitation, as most articles were nonempirical commentaries.¹⁴ Few institutions described the process used to establish their programs with limited information on the demographics of

those accessing services, reasons for engagement, and acceptability and feasibility of the program.^{15–20} This information is critical as health care institutions are increasingly called upon to support their HCW.^{21,22}

Early in the pandemic, the Centre for Mental Health at the University Health Network (UHN) was approached to develop a plan to support our institution's HCW. With limited data on how best to provide care to this population, we rapidly designed UHN CARES (Coping and Resilience for Employees and Staff), a modified stepped-care model. Stepped-care models attempt to maximize clinical effectiveness, while minimizing resource and service intensity.²³ The program design included plans for ongoing needs assessments, evaluation and improvement. We anticipated that this quality improvement approach, as compared to a research study, would enable us to adjust the program in response to the evolving nature of the pandemic and needs of our HCW.

In this paper, we outline the development of UHN CARES and the results of the mixed-methods program evaluation, using quantitative and qualitative data, which have been used to modify the program over the course of the pandemic.

Methods

Setting

UHN is a multisite academic healthcare institution in Toronto, Ontario, Canada, comprised of Toronto General and Western Hospitals (general hospitals), Princess Margaret Cancer Care (specialized cancer center), Michener Institute of Education (health education training), and Toronto Rehabilitation Institute (multiple sites across the city). UHN has approximately 21,000 employees and affiliated staff members. For the purpose of this paper, we refer to all as HCW. It is the largest health research organization in North America and is fully affiliated with the University of Toronto. UHN cared for over 2200 patients with COVID-19 from March 2020 to November 2021, with numerous individuals requiring intensive care unit admission, and ventilator and extracorporeal membrane oxygenation (ECMO) support. In 2003, UHN cared for patients during the severe acute respiratory syndrome (SARS) pandemic, leaving many HCW with significant memories of this challenging time, during which 73 staff were infected and four died in Ontario.^{5,24,25}

In March 2020, in response to a request from senior hospital administrators, members of the UHN Centre for Mental Health developed the UHN CARES program. This was a modified stepped-care model to support HCW mental health through the COVID-19 pandemic. In primary care stepped-care approaches, individuals are screened for mental health conditions and provided with varying levels of care based on symptom severity. Care can be “stepped up” and “stepped down” in response to symptom intensity and response. As it was neither feasible nor appropriate to

conduct mental health screening of all UHN workers, we decided to provide several steps of care, with people initially self-triaging based on their perceived needs. Resources could be accessed on the UHN corporate intranet, which had a web page dedicated to COVID-19 Mental Health Support, or by phoning our program coordinator who helped with care navigation during business hours. UHN CARES was envisioned to provide specific mental health services to complement corporate wellness supports, which included drop-in respite centers, an anonymous peer-to-peer support phone line, the external Employee Assistance Plan (EAP), and proactive outreach to care units and teams.^{26,27} In April 2020, we received funding through the UHN-Mount Sinai Hospital Academic Medical Organization Innovation Fund. It has been ongoing to the present time.

This evaluation of the UHN CARES Program received a formal waiver from the UHN Research Ethics Board and was approved by the Quality Improvement Review Committee (QI ID #: 20-0069).

Needs Assessment

To date, four phases of needs assessments have been conducted. Firstly, between April 2020 and August 2020, we conducted individual and group narrative interviews ($n = 21$ participants over 16 interviews) with purposive sampling across a range of health care roles and workplace environments within UHN. A preliminary thematic analysis was carried out by SB and KS to guide program planning. Secondly, we undertook a critical discourse analysis (CDA) of online open forums for UHN staff between March and December 2020, where they could voice concerns or questions relating to the pandemic. This enabled our group to triangulate interview and survey findings against a much larger body of HCW in the institution.²⁸ Thirdly, in June 2020, a survey of HCW was conducted to assess symptoms of distress and their use of support.¹⁰ Finally, we tracked issues raised to our outreach team, which supported highly impacted clinical units. The outreach team documented concerns presented to them from April 2020 to November 2021, which we utilized within the needs assessment framework to further enhance the stepped-care program.

The findings of the needs assessment were similar, regardless of data source. Early needs assessment data highlighted the intersection of home stressors (caregiving for family, concern of contamination) and work-related stressors (increased duties, scarcity and impact of PPE), as well as challenges relating to symptoms of anxiety and depression. Staff described being concerned that little would be done to help them, with resources focused on measuring distress rather than on support. Following the first wave, the needs assessment increasingly identified fatigue, demoralization, and burnout as issues. In terms of support, participants highlighted the importance of confidentiality, having a choice between different interventions, and providing services

Table 1. Description of Modified Stepped Care Model.

Step	Description of Resources	Notes
1	<i>Curated self-directed mental health resources</i> UHN psychologists and psychiatrists developed tailored infographics, videos, and other resources which were available to all HCW through the UHN corporate intranet mental health web page. Links to other community supports (e.g. crisis lines, programs providing low- or no-cost COVID-19-related mental health care) were also provided.	Topics, derived from the needs assessment, included coping with uncertainty, dealing with loneliness, and strategies for anxiety (see Table 2).
2	<i>Virtual group-based interventions</i> HCW were able to access mental health support groups through links on the intranet page or by phoning our project coordinator.	These were run by community and academic groups, including acceptance and commitment therapy-based intervention run by UHN colleagues and a drop-in virtual mindfulness meditation group run by psychiatrists from UHN and other local hospitals. ^{29,30}
3 / 4	<i>Individual mental health care from psychologist/psychiatrist</i> Staff could self-refer for individual care from either a psychologist or psychiatrist. Individuals provided basic demographic and contact information, highlighted their main issues, and stated a preference for which type of provider they would like to see. The Patient Health Questionnaire (PHQ-9) and Generalized Anxiety Disorder (GAD-7) were administered to all who self-referred. Individual support was clinically driven, with no set number of appointments or length of care provision. Evening and weekend sessions were available, as providers were doing this work in conjunction with regular duties and HCW often required “off hours” appointments. Individual psychological and psychiatric was provided virtually.	Program information described care as short-term for issues related to the COVID-19 pandemic. If someone disclosed issues related to self-harm or suicidality, the program coordinator contacted one of the physician leads who called the HCW, completed a safety assessment, and developed a safety plan. As the needs assessment revealed that confidentiality and medical record stewardship were key concerns for HCW, the CARES team and UHN leaders in privacy, medical records, and legal departments developed a solution that enabled these records to be maintained outside of the institution’s electronic patient record.

which fit into their schedule. These findings informed the development of the UHN CARES program.

UHN CARES Program

All care steps, described in Table 1, were available to all HCW at UHN, who could self-triage to the level they felt was most appropriate. Information on each step could be accessed through the UHN corporate intranet COVID-19 mental health support web page, which provided direct access to self-guided resources and group support, as well as an option to email or phone for individual psychological or psychiatric care. A program coordinator was available to assist with care navigation for all steps by email or phone.

Program Evaluation

As we used a quality improvement approach, we developed a logic model to guide program evaluation (Table 2). Data for program evaluation were analyzed using both quantitative and qualitative methods. Quantitative metrics included volume of contacts, method of contact with program (email or phone), basic demographics for those seeking individual care, safety issues (self-harm or suicidal thoughts) at intake, severity of depressive (PHQ-9) and anxiety (GAD-7) symptoms at intake, time from referral to initial

appointment, number of appointments, self-reported improvement, and program satisfaction. Other metrics included contact with the project coordinator for resources that could be accessed independently online and work site of individuals receiving support as a proxy of awareness across the institution. We also tracked the number of psychologists and psychiatrists providing care over time.

Qualitative interviews were conducted with both service users and service providers, using purposive sampling to include individuals with varying experiences in the program. Interviews were narrative and open-ended, using prompts that solicited feedback on experiences in the program, aspects of quality and timeliness, and suggestions for improvement. Service users were asked prior to receiving care to indicate if they would be willing to be contacted for a post-care evaluation interview. To date, 10 service user interviews have been completed (out of 10 invited), reflecting CARES users who self-referred during the first and second waves of the pandemic (April–November 2020). Evaluation interviews have also been conducted with 10 CARES service providers. Seven service providers completed an initial evaluation interview during the first wave of the pandemic and were reinterviewed during the second and third (November 2020 to April 2021) waves to capture their experiences as the pandemic and the CARES program evolved. Three additional service providers were interviewed

Table 2. Logic Model for Evaluation of UHN CARES Program.

Purpose	Inputs	Activities	Outputs	Short-Term Outcomes
To provide TeamUHN healthcare workers with high-quality mental health supports during the COVID-19 pandemic	<ul style="list-style-type: none"> • Funding • Senior UHN leadership support • Engagement with Wellness and other staff supports • Partnership with hospital legal • Administrative support • Program leadership • Group therapy programs • Clinician (psychologists and psychiatrist) time • Needs assessment and evaluation administrative support 	<ul style="list-style-type: none"> • Needs assessment interviews and survey • Recruitment of care providers • Advertising (posters, emails, open forum mentions) • Intranet page for information and resources • Generation of self-directed resources • Compilation of community-based resources and group therapy programs • Individual psychological care • Individual psychiatric care 	<ul style="list-style-type: none"> • Number of evaluation interviews and survey respondents • Number of providers involved • Level of program engagement across sites and route of program awareness • Intranet page views of self-directed resources, community, group therapy programs • Volume of referrals • Volume of appointments • Time from referral to first appointment • Number of sessions • Number of referrals with safety concerns and time to assessment • Self-reported improvement and satisfaction with program 	<ul style="list-style-type: none"> • Provision of safe, effective, timely, efficient, equitable, and patient-centered to members of TeamUHN across all sites and areas of work • Improved mental health for those who receive care from program

once (following the third wave) to further triangulate initial interview themes and ensure no further thematic content developed as the pandemic evolved.

All interviews were audio-recorded and transcribed verbatim. Qualitative interviews were analyzed with the support of NVivo qualitative data analysis software, within an interpretivist–constructivist. Themes were delineated by an initial coder (SB or MD), who discussed emerging themes with KS, SA, CSQ, and LR. Themes emerging from the service provider interviews were member-checked during CARES provider check-in meetings. Themes from service user interviews were triangulated against other sources of data and initial themes were used as prompts in subsequent interviews, in an iterative fashion.

Results

Program Organization

The program was supported by a project coordinator, an administrative assistant initially redeployed full-time to UHN CARES for eight months and subsequently spending approximately five hours per week answering calls and emails, processing referrals for individual care, and appointment organization. Three psychiatrists led program

development and manage urgent safety assessments. A team of four institution-employed psychologists, in conjunction with two psychiatrists, initially developed the online resources and continued to be involved with the program. Since February 2021, individual psychological care has been provided primarily by one psychologist who has been redeployed from another clinical service to UHN CARES. Individual psychiatric care has been provided by 22 psychiatrists who voluntarily offered to support HCW, with remuneration for clinical care from the Ontario Health Insurance Program. The number of HCW seen by each mental health care provider (psychologist or psychiatrist) ranges from 1 to 83.

Self-Directed Mental Health Support

As of November 30, 2021, the UHN COVID-19 Mental Health Supports intranet page had 12,136 page views (Table 3). The web page included information on the UHN CARES Program (955 downloads) and the UHN CARES self-referral form (502 downloads), as well as self-management resources developed by UHN psychologists (2634 hits/downloads) and external resources including virtual support groups and mental health programs. The number of web page hits fluctuated with peaks in May

Table 3. Details of Information Provided on Intranet Page.

Topic	Type of Resource	Number of Hits/Downloads
COVID-19 Mental Health Supports Webpage	Web page on UHN intranet	12 136
UHN CARES Program Information	Downloadable word document	955
UHN CARES Self-Referral Form	Downloadable word document	502
Information on confidentiality	Downloadable word document	17
<i>Total</i>		<i>1 474</i>
Changing our relationship to fear	Video	424
Coping with uncertainty	Downloadable infographic	403
Preventing burnout during COVID-19	Downloadable infographic	185
Other therapy and crisis support resources for HCW at UHN	Downloadable list	178
Tips for managing stress	Downloadable infographic	174
Changing unhelpful thoughts	Video	172
Dealing with anger during COVID-19	Downloadable infographic	141
Improving sleep during COVID-19: Day shifts	Downloadable infographic	109
Coping with COVID-19 laughter	Downloadable infographic	98
Recognizing and managing symptoms of anxiety and panic	Downloadable infographic	91
Managing feelings of depression	Downloadable infographic	72
Dealing with isolation and loneliness during COVID-19	Downloadable infographic	63
General mental health and stress during COVID-19	Downloadable infographic	60
Unhelpful thinking styles	Downloadable infographic	60
Soles of the feet	Mindfulness exercise	58
Improving sleep during COVID-19: Night shifts	Downloadable infographic	55
How mindfulness can help during COVID-19	Downloadable infographic	51
Balancing work and caregiving	Downloadable infographic	44
Managing holidays during COVID-19	Downloadable infographic	41
Resources for managing finances during COVID-19	Downloadable list	33
Rain	Mindfulness exercise	31
Coping with grief	Downloadable infographic	30
Understanding and coping with trauma	Downloadable infographic	24
Consuming media during COVID-19	Downloadable infographic	18
Belly breathing	Mindfulness exercise	14
How to talk to your kids about COVID-19	Downloadable infographic	5
<i>TOTAL</i>		<i>2 634</i>
DeSouza Institute	Virtual support group	Unable to determine
PACER – Acceptance and Commitment Therapy Program	Virtual support program	Unable to determine
Pause 4 Providers – Mindfulness	Virtual support group	Unable to determine
Canadian Medical Association Wellness	Virtual support program	Unable to determine
External resources	Links to programs outside UHN	Unable to determine

2020, January 2021, and April 2021 (Figure 1). Only seven individuals contacted our project coordinator for self-guided resources ($n=4$) or group programming ($n=3$). Although we were not able to track the number of individuals who accessed mental health support groups or other external resources through our web page, the low number of individuals contacting the project coordinator in comparison to the number of web page hits suggested that few people likely required assistance to find these resources.

Individual Mental Health Care

One hundred and seventy-three people contacted our program coordinator by either phone ($n=50$, 28.9%) or email ($n=123$, 71.1%), with 166 initially self-referring for individual psychological ($n=116$, 69.9%) or psychiatric

care ($n=50$, 30.1%). As shown in Figure 1, self-referral for psychiatric care was higher at the beginning of the pandemic, with requests for psychological care outpacing psychiatric care requests since the summer of 2020. Similar to the use of self-directed resources, there were waves of referrals which corresponded to waves of COVID-19 community cases with the greatest numbers of referrals in May 2020, January 2021, and May 2021. Most individuals who self-referred for individual care provided demographic data ($n=165/166$, 99.4%) and completed the PHQ-9 and GAD-7 ($n=163/166$, 98.2%).

Primary issues of concern at intake were stress, anxiety/fear/worry, and sadness/depression. Safety issues (thoughts of self-harm or suicide) were noted at the time of referral for over 20% of HCW ($n=35/166$, 21.1%). Most of those seeking individual support identified as women ($n=132/$

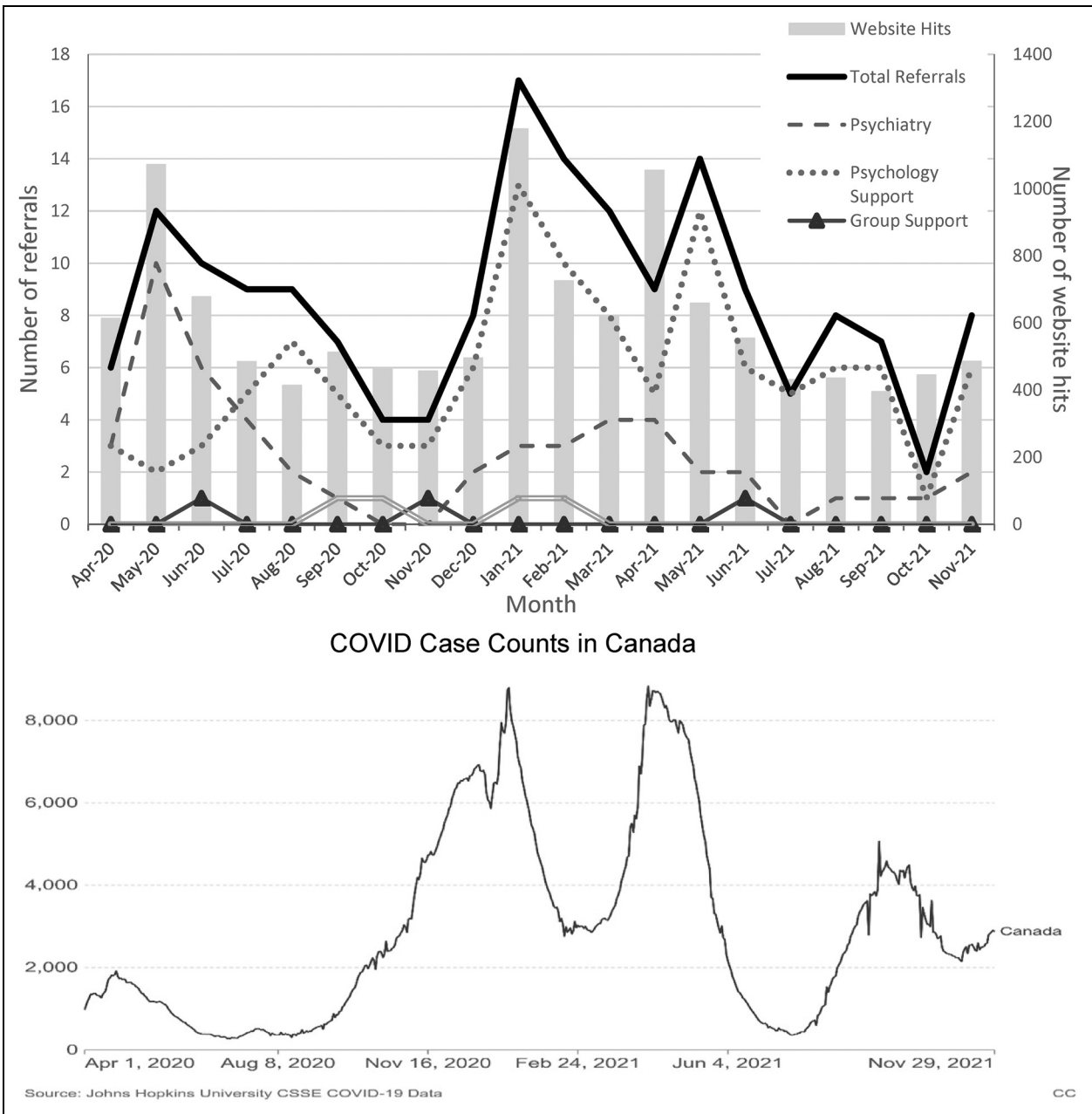


Figure I. Number of referrals and website hits for UHN CARES program compared to COVID-19 cases in Canada from April 2020 to November 2021.

165, 80.0%) and were under the age of 40 ($n = 103/165$, 62.4%). Of those who completed the PHQ-9 and GAD-7, over half ($n = 93/163$, 57.7%) had moderate to severe depressive symptom scores (PHQ-9 cutoff = ≥ 10) and nearly one-third ($n = 102/163$, 62.6%) had moderate to severe anxiety symptom scores (GAD-7 cutoff = ≥ 10). Time from referral to initial appointment averaged 5.4 days (range: 0–21). A total of 1125 appointments were provided across the program, with an average of seven appointments per individual (range: 1–55). Twenty-three individuals (23/166, 13.8%) received stepped-care. Care was stepped from psychology to

psychiatry ($n = 15/23$) for either assessment for medication or diagnostic clarification. Stepped-care from psychiatry to psychology was typically for a course of psychotherapy ($n = 8/23$). At the time of discharge from individual care from either service, care was typically stepped to self-management and/or transitioned to a primary care provider. Following self-referral, only seven people did not respond to follow up communication or not presented for their initial appointment.

The program was designed to be short-term and focused on pandemic-related distress and 128 individuals have

completed their course of care. These individuals were invited to complete an anonymous feedback survey (completion rate: $n = 41/128$, 32.0%) and/or participate in a qualitative interview (completion rate: $n = 10/10$, 100%). This provided an opportunity to better understand who has received care in the program and their feedback. As shown in Appendix 1, many sought support elsewhere before reaching out to the program (33/41, 80.5%) and the vast majority ($n = 38/41$, 92.7%) said the program helped them to feel better during the pandemic. Over 95% ($n = 39/41$) said they would recommend it to a colleague. The proportion of people seeking support from hospital-based services increased substantially during the pandemic. Themes emerging from service users' qualitative data demonstrated appreciation of providers' knowledge of the context in which service users worked, the program being free and easily accessible, confidentiality, and recognition of high-quality nature of the care (Appendix 1). Themes focused on program improvement related to a desire to see the program continue beyond the pandemic, the importance of it being more widely advertised, and increasing its utilization across the institution.

Themes emerging from care providers' data included appreciation of a way to contribute to healthcare as a psychologist or psychiatrist during the pandemic and suggestions for program improvement (Table 4). The main area for improvement focused on having better information to assist with transitions of care from UHN CARES to the HCW's primary care provider. Program improvements based on service user and provider feedback were rapidly implemented, including changes in our advertising strategy, highlighting the

Table 4. Themes from Mental Health Care Provider Qualitative Evaluation.

Theme	Subtheme
Successful Program Characteristic	Flexibility of scheduling and clinical care High level of administrative support Confidentiality and separateness from workplace health records Program adaptation following provider feedback
Positive Aspects of Provider Experience	Finding meaning, purpose, and motivation in clinical work during the pandemic Familiar clinical care issues within their scope of expertise Clinically varied population requiring a range of strategies and interventions
Challenges within Provider Experience	Vicarious moral injury Virtual care/technological challenges Navigating and maintaining boundaries in shared work setting Managing requests, referrals, follow-up care outside of the workplace program

confidential nature of care, and creating templates and pathways to aid with transitions out of the CARES program.

Discussion

In this paper, we demonstrate that an institution-based modified stepped-care program, providing high-quality mental health information and individual psychological and psychiatric care, is feasible and highly valued during the COVID-19 pandemic. Similar to other institution-wide mental health support programs described in the literature, we developed a program with a variety of services to meet the needs of our HCW workforce.^{18,19,31–33} This suggests that stepped or tiered care is a model that can be applied beyond primary care to the workplace setting.³⁴ However, there has been little published data about who has accessed these HCW programs, their impact on mental health, and whether they reached those with the highest mental health needs. We believe our program provides unique insight into these issues and has been successful because of several factors.

Firstly, we actively engaged with HCW throughout the institution to promote the program and fully understand both needs and barriers to access for people working in different areas and roles. Assessing need from a variety of perspectives was critical to truly appreciate HCW distress, the interventions needed to support them, and the acceptability of these interventions to individuals working in various areas of the institution.^{15,33}

Increasing awareness and advertising to this large organization required planning and institutional leadership engagement. UHN CARES was promoted by executive leadership in institution-wide emails and online forums, unit managers in meetings, posters in locker rooms and elevators banks, COVID-19-focused intranet pages, proactive outreach to teams by our consultation-liaison psychiatry team, weekly UHN Wellness newsletters, and word-of-mouth. Despite this, our web page had approximately 12,000 hits, suggesting a maximal program reach to just over 50% of UHN HCW. We modified our advertising approach to increase awareness and tailored this to specific groups and locations. However, this had little impact on uptake, as measured by tracking web page hits or referrals following changes in advertising strategy.

Secondly, we focused on the provision of high-quality mental health support, through our self-directed resources and individual care. A significant proportion, over 20%, of those self-referring for individual care reported experiencing suicidal or self-harm ideation in the previous two weeks, and the vast majority had moderate to severe depressive or anxiety symptoms. Given this level of symptomatology, it was critical for HCW to have access to a breadth of support from self-management to structured psychotherapy and medication. It also required a process to triage and manage urgent care. Although UHN CARES explicitly

stated it was a program for short-term support for pandemic-related distress, several individuals accessing our service had significant preexisting mental health concerns requiring longer-term care. We developed mechanisms to identify these individuals early in the referral process and assist with care navigation. Ensuring that the program was consistently of high-quality required ongoing data collection and analysis of evaluation metrics for accessibility, timeliness, and satisfaction. Through the program evaluation process, we identified that transitions of care were an issue and developed referral pathways to assist our providers.

Finally, we acknowledged the benefits and limitations of providing support “in-house.” In the program evaluation survey and interviews, we were surprised how much having a care provider who understood the context in which you worked was valued. Programs that refer to external services may not have this benefit. Institutionally-based programs providing individual support may have limited uptake when these are not seen as sufficiently confidential or distanced from human resource processes.¹⁴ As our needs assessment also highlighted that confidentiality was a concern, we worked closely with the hospital legal department to establish a streamlined process for record-keeping outside of the institutional electronic medical record. We included information on the limits of confidentiality on our intranet page and provided this information at intake. Our evaluation data indicate that this was well-received and important to participating health care workers.

Challenges and Limitations

Although funding was for an initial six-month project, the pandemic has continued for much longer than expected. Providing ongoing resources and care has required continued engagement from our project coordinator, psychologists, and psychiatrists, as well as updating of self-directed resources and external group support information. We have been judicious with our funding and have received a no-cost extension for our grant. This has enabled us to continue support into the pandemic’s second year. Similar to other programs, provider burnout has been a concern.³² Through regular provider check-in meetings, a community of practice helped providers learn from each other and find meaning in their work.

Prior to the start of the program, we wondered whether we may be overwhelmed by requests for care. However, we received requests for individual care from less than 1% of staff members. This is in keeping with data from other institutions which found low uptake of mental health services for HCW, despite high levels of reported distress.³⁵ There are several hypotheses about what underlies this low uptake, including stigma, concerns about reporting to clinician licensing bodies, issues of confidentiality, and potential mismatch between a program for individual support while HCW may want changes to workplace conditions and environment.

Further research to help us better understand this gap will be critical if such programs are to be impactful.³⁶

Although we included a fulsome plan for program evaluation, we were only able to provide data on HCW seeking individual support and have no demographic or clinical information on those seeking self-directed resources. We do not have outcome data beyond self-reported improvement and satisfaction, and these data were only from those who completed the post-care survey. To date, less than 10% of service users have participated in a qualitative interview following their course of care which may limit the generalizability of these findings. Finally, we made an explicit decision at the beginning of this endeavour to take a quality improvement approach, rather than conducting a research study. Although there are strengths to this approach, it limits our ability to establish causal relationships between the program and outcomes. We do not have data on more objective clinical outcomes (e.g., PHQ-9 or GAD-7 scores) from a comparison group to explore the mental health of those not involved with the UHN CARES program or to determine the specific impact of having stepped-care versus a single option for individual mental health care.

Conclusions

HCW have numerous mental health needs during the COVID-19 pandemic and distress can be high. In this paper, we provided evidence that an institution-based mental health support program for HCW is feasible and valued. Moreover, we included elements of a high-quality mental health program, incorporating needs assessment with service user input, ongoing quantitative and qualitative evaluation, flexible care options to meet user needs, low-barrier self-referral options and online tools, and triaging to ensure rapid response to those identify safety concerns with minimal delay from referral to assessment. Although promoting mental and physical wellness during the pandemic is important, the provision of targeted interventions to help those with more impairing symptoms in a safe and confidential way is critical to supporting HCWs.

Authors’ Note

Susan E. Abbey and Suze G. Berkhout are co-senior authors, contributing equally to this work.

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Supplemental Material

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