Supporting patient and clinician mental health during COVID-19 via trauma-informed interdisciplinary systems

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The meteoric spread of COVID-19 across the globe has challenged health service providers in unprecedented ways. For general practitioners and allied specialists, disruptions have included providing in-person care with limited access to personal protective equipment (PPE), sudden influx in COVID-19 related patient concerns or displacement of non-COVID-19 care, desperate calls to redeploy clinicians to emergency rooms or other disaster response settings, a rapid shift to telehealth and virtual care (often without previous training or available technology), and increasing patient complexity 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] Additionally, as is the case in the current pandemic, a sizable body of research has demonstrated that traumatic events in patients, clinic, and society recapitulate across levels of the healthcare system, ultimately leading to "vicarious trauma" and "compassion fatigue" for providers, administrators, and the very systems most responsible for providing care.[2]

Simultaneously, our patients need us more than ever during times of crisis. As infection and illness spreads in the community, more individuals are being separated from their loved ones either at home due to social distancing (we prefer the term physical distancing), or in institutional care settings as a result of visitor restriction. All the while, social determinants of health (exacerbated by a catastrophic economic situation) are leading to the psychosocial and relational stressors that compromise health for families (e.g., marital conflict, disrupted parent-child relationships, potential for violence).[3] While the pandemic does not discriminate, providers for patients traditionally viewed as vulnerable may particularly notice these risk factors flaring up as the crisis worsens. Collectively, this can lead to new trauma or re-traumatization across the lifespan, while increasing incidence of adverse childhood experiences for younger patients.[4]

In a seemingly impossible 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 healthcare systems.[4] The importance of partnership with specialty providers of mental health services (e.g., clinical psychologists, 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-centered services, while simultaneously taking care of themselves and their families as we "flatten the curve."

Challenge 1: Balancing Patient Mental Health with COVID-19 Best Practices

In the face of a fatal pandemic, it would be easy to think that patient mental health and psychosocial concerns "take a back seat" for the time-being. This may arise from acute concerns in patients and clinicians regarding COVID-19 contagion and morbidity, or 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 may be simplified into either psychosocial or medical domains.[5,6] This is certainly true in the case of trauma, where psychiatric symptoms can interact with and exacerbate medical illness.[7] Furthermore, emotional distress may 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 healthcare, clinicians will consider the role of adversity (especially life-threatening events) in the emergence of human suffering, and respond compassionately with universal and targeted practices in order to optimize care and outcomes.[8,9] The theme of a patient's subjective feelings of safety are paramount, in order to avoid interventions that may exacerbate psychological symptoms

and reduce service seeking behaviors. 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 primary presenting concerns.

Challenge 2: Allocating (a Realistic Amount of) Time to Discuss Psychosocial Concerns

An obvious paradox emerges when practitioners first begin trauma-informed practice: it seems we are asking them to do more when they have less (in way of 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 preferred questions regarding emotional well-being (now, specifically in relation to the pandemic), and providing brief psychoeducation and/or motivational interviewing around the role of stress in health. Follow-up questions can include querying around mood, anxiety, unhealthy coping strategies (e.g., substances) and family conflict, while considering the potential of routine physical examinations acquiring additional emotional valence (i.e., being "triggering"). In the case of pediatric patients, the utilization of developmentally appropriate language around "germs" will be familiar, while providing an opportunity to punctuate parent-child attachment by emphasizing what caregivers are doing to promote safety (i.e., "mommy and daddy are making sure everyone stays at home so that children are safe and don't get sick because they are loved so 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 significantly derailing the usual flow of care and still addressing presenting concerns. In extreme situations (e.g., the case of mental health problems meriting ongoing treatment, grief counselling), providers can remind patients around the importance of their concern, which is why a high-quality referral is being presently made (see next section), in addition to providing their own follow-ups at the next encounter. Engaging patients in shared decision making as much as possible in this process further enhances the therapeutic alliance and outcomes of clinical encounters.

Challenge 3: Access to High Quality Referrals in a Disrupted Healthcare System

Clinicians may have found their referral networks have ground to a halt. In some instances, these referrals may simply be delayed without great consequence. In other instances, crucial medical care (e.g., cancer treatment, surgery) may be deferred due to the crisis, or there may be acute mental health concerns that warrant non-emergency treatment. In both instances, psychological services may 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 to providers who have telehealth operations in the jurisdiction in which the patient is eligible. This may 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 (see resources in Figure 1).

Challenge 4: Balancing Self-Care with Increasing Service Demands

Heightened levels of clinician distress, fatigue, burnout, and mental health challenges are an understandable and expected consequence of this pandemic.[14] Research has shown that clinician burnout can spill-over into

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 into roles of "being the patient" themselves. If there was ever a time for front-line practitioners to consider their own utilization of supportive mental health care, it is now. Counselling for physicians aimed at the symptoms of burnout significantly reduces distress and need for extended sick leave.[16] This suggested uptake should be free of guilt for overcrowding a struggling system. Quite the contrary. As declared by the World Health Organization, an effective pandemic response necessitates medical and affiliated healthcare providers who are emotionally, physically, cognitively, and spiritually well.[17]

Thus, our final recommendation is to ***consider specialized telehealth psychotherapy or counselling for front-line providers during the disaster response***, especially if facing 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 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 (see resources, Figure 1).

Trauma-Informed Suggestions for Balancing Clinician and Patient Mental Health during COVID-19

Challenge	Suggestion	Script and/or Resources
Challenge 1: 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 & 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."*
Challenge 2: Allocating Realistic Amount Time to Discuss Psychosocial Concerns	**Universal and Targeted:** inserting a brief conversation around emotional well-being early in patient encounters. If warranted, 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? Any significant changes in your emotions, relationships, or activities that you think I should know about? What about your relationships at home with partner and/or 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?"*
Challenge 3: Providing High Quality Referrals in a Disrupted Healthcare 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 and/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 will I 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."*
Challenge 4: Balancing Self-Care with Increasing Service Demands	**Clinician-Directed:** consider specialized telehealth psychotherapy or counselling for front-line providers, offered free of charge by psychology associations.	Free online psychological services (where applicable): • Canada: https://cpa.ca/corona-virus/psychservices/ • USA (see State specific board or State Website): https://www.asppb.net/page/BdContactNewPG

Figure 1. Summary of recommendations

Conclusion: "It Takes a Village"

Arguably every large-scale disaster in human history has benefited from a heroic response from the medical and health services community, notwithstanding pandemics. COVID-19 is no exception. Perhaps an important difference in today's situation is the remarkable development and expansion of trauma-informed healthcare paradigms and interdisciplinary practice across all sectors of health and social services, especially primary care.[18] Technological advancements in virtual and telehealth have also been leveraged tremendously during this pandemic, and new creative solutions can be designed with collaborative work. It is important to mobilize these partnerships and advancements in order to ease the burden on general practitioners and providers treating the direct biomedical fall-out of COVID-19. To quote an often-used African proverb, the response to COVID-19 is certainly "taking a village" … one that is global, more digitally connected than ever, and populated with non-physician providers of trauma-informed mental health care who are ready to respond (such as registered clinical psychologists doing telehealth). This sharing of the load, in concert with manageable and effective trauma-informed approaches taken by general practitioners and other front-line providers during encounters, will undoubtedly be on the best path forward.

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Dr. Phillips is a clinical psychologist and the Director of the Centre for Mental Health Research and Treatment, Department of Psychology, University of Waterloo. Throughout her career, she has worked with numerous institutions as both a clinician and administrator, developing, implementing and evaluating training programs and clinical services for children and families. At present, she has been consulting with various stakeholders in the province surrounding the move to telehealth during the COVID-19 crisis.

Dr. Roy is a clinical neuropsychologist and works at the Centre of Addiction and Mental Health, Toronto, Ontario. He is also an adjunct faculty in the Department of Psychology, York University, and the Director of Strategic Initiatives at Strata Health. He has been heavily involved in the development and roll-out of disaster response telehealth services in response to COVID-19 for psychologists. Dr. Roy was also the past president of the Ontario Psychological Association.

Dr. Shamon is a family physician and palliative care specialist in private practice in Cambridge, Ontario. She is also an Adjunct Professor in the Michael G. DeGroote School of Medicine at McMaster University. Dr. Shamon serves on numerous boards and organizations in the province to promote the development and implementation of Trauma-Informed Care for families across the lifespan.

Dr. Stephenson is a family physician and founding director of the Sanctuary Refugee Health Centre in Kitchener, Ontario. The clinic, which started with 6 patients on the first day of operations in 2013, has grown into a central

hub of primary care and resettlement services for newcomer families in the Waterloo Region, with over 5000 patients currently receiving services.

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