



A health care workers mental health crisis line in the age of COVID-19

Robert E. Feinstein¹  | Sussann Kotara¹ | Barbara Jones^{2,3} | Donna Shanor⁴ | Charles B. Nemeroff¹ 

¹Department of Psychiatry and Behavioral Sciences, Dell Medical School, University of Texas, Austin, Texas

²Department of Health Social Work, Dell Medical School, Austin, Texas

³Steve Hicks School of Social Work, UT Austin, Austin, Texas

⁴UT Health Austin, Dell Medical School, Austin, Texas

Correspondence

Robert E. Feinstein, MD, Department of Psychiatry and Behavioral Sciences, Dell Medical School University of Texas, Austin, TX 78734.

Email: Robert.Feinstein@austin.utexas.edu

Abstract

Introduction: The COVID-19 pandemic has brought a health care crisis of unparalleled devastation. A mental health crisis as a second wave has begun to emerge in our front-line health care workers.

Objective: To address these needs, *The Healthcare Worker Mental Health COVID-19 Hotline*, based on crisis intervention principles, was developed and launched in 2 weeks.

Methods: Upon reflection of why this worked, we decided it might be useful to describe what we now recognize as 13-steps which led to our success. The process included the following: (1) anticipate mental health needs; (2) use leadership capable of mobilizing the systems and resources; (3) convene a multidisciplinary team; (4) delegate tasks and set timelines; (5) choose a clinical service model; (6) motivate staff as a workforce of volunteers; (7) develop training and educational materials; (8) develop personal, local, and national resources; (9) develop marketing plans; (10) deliver the training; (11) launch a 24 hr/7days per week *Healthcare Worker Mental Health COVID-19 Hotline*, and launch follow-up sessions for staff; (12) structure data collection to determine effectiveness and outcomes; and (13) obtain funding (not required).

Discussion: We believe the process we used is specifically useful for others who may want to develop a COVID-19 hotline services for health care workers and generally useful for the development of other mental health services.

Conclusion: We hope that this process may serve as a guide for other health care systems.

KEYWORDS

coping, COVID-19 mental health response, crisis intervention hotline, health care service, mental health hotline, problem-solving

1 | INTRODUCTION AND BACKGROUND

As COVID-19 moved into Austin, TX, critical needs and problems hit our city and country like a hurricane: little personal protective equipment, no COVID-19 testing, few ventilators, and the need to adapt to social distancing and stay-at-home orders. The onslaught of COVID-19 shredded the functioning of our community, as new needs

to adapt, work, live, relate to one another, and offer medical care was overwhelming.

2 | THE NEED

The dedication and resilience of our Health Care Workers (HCWs) is remarkable. Their urgent mental health needs were quickly

recognized by the Steve Hicks School of Social Work, University of Texas, the local chapter of NAMI, and community therapists.

Some of our COVID-19 HCWs are psychologically crashing; all are frightened, yet many do not ask for help. They are exhausted, not sleeping, some crying, all traumatized by dying and death, and vicariously traumatized by suffering families unable to visit with their terminal loved ones. Some work in a dissociated state, many drink, or use drugs, while others may contemplate or commit suicide.

The *Healthcare Worker Mental Health COVID-19 Hotline* was developed to provide crisis counseling by utilizing the expertise of psychiatrists, clinical social workers, psychiatric residents, and volunteer mental health professionals. We envisioned that the Hotline could alleviate some HCWs stress, and enable our frontline staff to continue working. This paper was written in the hope that our experiences setting up this Hotline may be useful to others wanting to offer similar services.

3 | HEALTHCARE WORKER MENTAL HEALTH COVID-19 HOTLINE

We focused on the perceived needs of HCWs within Dell Medical School Community and *Ascension/Seton Hospitals and Affiliates*. The near future goal was to serve the entire community. For us, this service developed organically with capable leadership, a cadre of interested and talented innovators and administrators. We spoke and e-mailed frequently, worked both independently and jointly in unstructured cycles. We set urgent timelines, developed what we needed, used existing resources, contracted with one external vendor for hotline technology, and launched. Upon reflection of our process and lessons learned, we decided it might be useful to describe what we now recognize as 13 elements of our success. We thought describing the process of setting up this service might be specifically useful for others who may, wanted to develop COVID-19 hotline services and perhaps generally useful for the development of other mental health services.

4 | THIRTEEN STEPS TO DEVELOP A COVID-19 HOTLINE FOR HCWS

4.1 | Anticipate mental health needs

Watching the COVID-19 assault on our HCWs, while also feeling our limited ability to help medically, we wanted and needed to take action. Based on our collective awareness of mental health needs post September 11 (Rosoff, 2008), mental health needs post other epidemics (Kisely, Warren, McMahon, Dalais, & Henry, 2020), local information (Meadows Mental Health Institute White Paper, 2020), and the United Nations Policy Brief: COVID-19 and the Need for Action on Mental Health (2020), we anticipated there would be a similar local need. It was also immediately clear, by

contact with our colleagues, that the needs were both acute and long-term because the pandemic was going to be a marathon event.

4.2 | Use leadership capable of mobilizing the systems and needed resources quickly

The first indication and request for the services actually came from our local community of mental health providers. Our leadership team included: Psychiatry Department Associate Chair of Clinical Operation, Chair of Psychiatry, Chair of the Department of Health Social Work, and Director of Clinical Social Work. In addition, this mandate was immediately agreed upon by the Dean/Vice President for Health Affairs and all Associate Deans of the medical school. All agreed that the development of this service was a top priority and gave the message of urgency to get this done.

4.3 | Convene a multidisciplinary team

Leadership mobilized (a) an administrator for the service, (b) outreached medical school leadership for discussion, (c) involved the Associate Chair of Education, Directors of Psychiatry Residency Training, psychiatry chief residents, clinical social workers, faculty, staff, other educators, and a large cadre of volunteers.

4.4 | Delegate tasks and set timelines

Informal discussion led to our agenda, tasks, and assignments. Leadership obtained medical school approvals to launch the service. An administrator was given the monetary resources and tasked to find and contract with an outside vendor to supply the hotline technology. Clinician educators volunteered to research a clinical model and develop, offer, and disseminate the training. Psychiatric Residency Training and social work mobilized the voluntary workforce and arranged the 24/7 on call-schedule. Social work organized the resource guide, lists of national hotlines, and web-based community resources. Educators reviewed clinical models for the service and developed a list of evidence-based phone applications that might be useful to callers.

4.5 | Choose a clinical service model

Lessons learned from the New York 9/11 experience (Rosoff, 2008) taught us that a second wave of mental health crises would occur after an initial onslaught. The 2003 severe acute respiratory syndrome outbreak produced anxiety, social dysfunction, acute trauma, and posttraumatic stress disorder in HCWs (Klitzman & Freudenberg, 2003; Williams & Gonzalez-Medina, 2011). A recent meta-analysis (Kisely et al., 2020) examined the psychological stress of HCWs exposed to

viral outbreaks and epidemics. HCWs suffered greater levels of both acute and posttraumatic stress (odds ratio [OR], 1.71; 95% confidence interval [CI] = 1.28–2.29) and psychological distress (OR, 1.74; 95% CI = 1.50–2.03) when compared with the general population. Younger HCWs were at greatest risk as were junior clinicians, parents with young children, HCWs who lacked support or who had an infected family member, needed quarantine, or suffered from virus-related stigma. HCWs with access to personal protective equipment, rest, regular information, and those who had psychological support had reduced morbidity.

We reviewed trauma-focus, problem-oriented, brief counseling interventions geared toward building the HCWs support systems and the use of community resources. Inasmuch as there was no established evidence-based treatment model that covers all of these domains, we relied on clinical wisdom and experience using the crisis intervention and counseling approach (Caplan, 1961, 1964; Feinstein & Collins, 2015; Lindemann, 1944; Salmon, 1917).

4.6 | Motivate staff as a workforce of volunteers

The public media about the pandemic motivated our workforce for us. Providing our mental health professionals with a new clinical service, access to participate in a service that was practical, accessible, and meaningful was all the additional motivation needed. It was apparent that we could easily mobilize our psychiatric residents, fellows, faculty, and volunteer/mental health professionals. We developed our workforce by word-of-mouth and by e-mailing our Grand Round lists to gather interested professionals.

4.7 | Develop training and educational materials

Our training focused on the basics of crisis intervention. We did not include suicide and violence prevention or addiction screening/assessment, as our mental health professionals were already experienced with these interventions. The crisis didactic training covered these subjects: (a) the normal equilibrium state; (b) the precipitants and/or trauma initiating the crisis; (c) the individual's interpretation or meaning of the events; (d) understanding the crisis state itself as both "Danger" (dysfunction) or "Opportunity" (for successful coping); (e) system of social supports and resources available to help; (f) selective past history which can fuel the crisis; (g) the effects of pre-existing personality or psychiatric conditions which might affect the crisis; and (h) sequelae of a crisis or trauma. The prognosis after trauma depends on three factors: pretraumatic, traumatic, and posttraumatic functioning (McFarlane & Williams, 2012). (i) Postintervention referrals and use of community resources. The basics of contemporary crisis intervention are well described elsewhere (Feinstein & Collins, 2015; Feinstein & Snively, 2011). See Figure S1, for a review of crisis intervention theory and outcomes.

The clinical approach taught to our mental health professionals was complemented with a brief "Tip Sheet for Crisis Counseling" and a book chapter (Feinstein & Collins, 2015).

This approach included: (a) listening to the caller's feelings, emphasizing the caller's strengths (Hootz, Mykota, & Fauchoux, 2016) and focusing on the "Why now?" of the call. The social readjustment rating scale (Holmes & Rahe, 1967) is a useful list of 43 common precipitants of a crisis; (b) understanding the meanings of the stressors, in the context of the caller's life. (c) Uncovering the 6-week timeline of events that led up to the call, see Figure S2, a 6-week timeline. (d) Developing an ecological map (Greene, 2017). This is a representation (Feinstein & Snively, 2015) which includes the caller's complete family genogram, network of other helpers (e.g., physicians, faith-based support, neighbors, friends), and community and national resources, see Figure S3. The ecological map is used to help view and determine what people or resources are available, interested and competent to help a caller. (e) It is essential to focus on one major problem, progress to a list of contributing problems, prioritized these in order of urgency, and link each problem to a specific solution. A wheel and spoke diagram depicts this process (Feinstein & Collins, 2015; see Figure S4). (f) In addition, using problem-solving therapy (Haley, 1987) integrated with crisis intervention is important to discover maladaptive coping styles and encourage adaptive problem-solving (Feinstein & Collins, 2015; see Table S1). (g) We also utilized a 12-step crisis resolution strategy as a guide for crisis counselors which can also be used as a self-help strategy by callers' after the initial hotline contact (see Table S2).

4.8 | Develop personal, local, and national resources

The crisis counselor and the caller jointly determine which personal resources may help and other assistance that may be provided by local community or national resources. This begins by choosing resources from the caller's ecological map. We used existing resource guides, developed by social work and population health. Our educators local and national websites served as additional resources for our callers. We also developed a list of evidence-based phone applications (Bakker, Kazantzis, Rickwood, & Rickard, 2016; Marshall, Dunstan, & Bartik, 2019) that might be useful to callers (see Table S3).

4.9 | Develop marketing plans

We used local medical school publications, our own website, and social media to get the word out. Media outlets will be used in the future.

4.10 | Deliver the training

The training was delivered online to 43 participants via Zoom. The didactic/theoretical material was presented in 30 min; 30 min

was left for questions and answers. As noted above, a brief tips sheet and one book chapter (Feinstein & Collins, 2015) was also distributed via e-mail to all volunteers. The Zoom presentation was recorded and also distributed for asynchronous viewing for volunteers who could not attend the initial training.

4.11 | Launch the service and launch follow-up activities

The service was launched in 2 weeks. We circulated different frequently asked questions (FAQs) about the service available to our HCWs and crisis callers. We continue to develop and update these growing lists of FAQs. We also scheduled regular weekly online Zoom drop in sessions for mental health crisis counselors who needed additional support or had other questions.

4.12 | Structure data collection to determine effectiveness and outcome

Shortly after the launch, we developed a data collection process to be used to determine our ultimate effectiveness and outcomes. This data will be presented in a follow-up publication.

4.13 | Consider funding opportunities

Our leadership was also able to obtain some funding from a local foundation with which we were already working with and was able to obtain some private donations as well. These are welcomed but were not required to launch the hotline.

5 | CONCLUSION

We used a coherent, useful, and successful approach to developing a COVID-19 Mental Health Hotline in our efforts to prevent an emerging mental health crisis in our front-line HCWs. We describe the 13-step process which we believe led to our success. We described the process of setting up this service with the hope that it might be specifically useful to others who may want to develop COVID-19 hotline services, and perhaps as a generally useful process for the development of other mental health services.

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CONFLICT OF INTERESTS

The authors declare that there are no conflict of interests.

ORCID

Robert E. Feinstein  <http://orcid.org/0000-0003-2927-0795>

Charles B. Nemeroff  <http://orcid.org/0000-0001-7867-1160>

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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